



RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

Elder Care Report Performance Measure List and Definitions

Version 14.1
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1.0 Introduction

The Elder Care Report contains clinical quality measures for older patients. Most of the measures are available for all ages in other reports. For this report, the denominator is changed to primarily focus on patients 55 years and older, though the age range may differ for some measures. The intent of this report is to provide a tool with which to focus on the quality of care provided to older patients.

Notations used in this document are described in the following table.

Table 1-1: Document Notations

Notation	Location	Meaning
GPRA:	Preceding a measure	An official GPRA measure reported in the National GPRA Report submitted to Office of Management and Budget (OMB) and Congress in the annual IHS budget process.
GPRAMA:	Preceding a measure	An official GPRAMA measure reported in the National GPRA Report submitted to the Office of Management and Budget (OMB) and Congress, and included in the annual HHS Online Performance Appendix.
Asterisk (*)	Anywhere in a code (CPT, POV, Edu.,etc.)	A 'wildcard' character indicating that the code given has one or more additional characters at this location.

1.1 CRS Denominator Definitions

1.1.1 For All Denominators

- All patients with name “DEMO, PATIENT” or who are included in the Resource and Patient Management System (RPMS) Demo/Test Patient Search Template (DPST option located in the PCC Management Reports, Other section) will be excluded automatically for all denominators.
- For all measures except as noted, patient age is calculated as of the beginning of the Report Period.

1.1.2 Active Clinical Population

1.1.2.1 National GPRA/GPRAMA Reporting

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2014 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the Report Period.
- Must be American Indian/Alaska Native (AI/AN); defined as Beneficiary 01.
- Must reside in a community specified in the site's GPRA community taxonomy, defined as all communities of residence in the defined Contract Health Service (CHS) catchment area.

1.1.2.2 Local Reports

- Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2014 Clinical Measures User Manual* for listing of these clinics.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

1.1.3 User Population

1.1.3.1 National GPRA/GPRAMA Reporting

- Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- Must be AI/AN; defined as Beneficiary 01.

- Must reside in a community specified in the site's GPRC community taxonomy, defined as all communities of residence in the defined CHS catchment area.

1.1.3.2 Local Reports

- Must have been seen at least once in the 3 years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
- Must be alive on the last day of the Report Period.
- User defines population type: AI/AN patients only, non AI/AN, or both.
- User defines general population: single community, group of multiple communities (community taxonomy), user-defined list of patients (patient panel), or all patients regardless of community of residence.

2.0 Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the CRS 2014 version 14.0 Elder Care Report.

2.1 Diabetes Group

2.1.1 Diabetes Prevalence

No changes from Version 14.0

2.1.1.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.1.2 Denominators

1. All User Population users ages 55 and older, broken down by gender and age groups.

2.1.1.3 Numerators

1. Anyone diagnosed with diabetes ever.
2. Anyone diagnosed with diabetes during the report period.

2.1.1.4 Definition

Diabetes Diagnosis

Diabetes diagnosis is defined as at least one Purpose of Visit [POV] diagnosis ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.*.

2.1.1.5 Patient List

List of diabetic patients 55 and older with most recent diagnosis.

2.1.2 Diabetes: Glycemic Control

No changes from Version 14.0

2.1.2.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.2.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, and at least two visits in the past year, and two Diabetes Mellitus (DM)-related visits ever. Broken down by age groups.

2.1.2.3 Numerators

1. Hemoglobin A1c documented during the report period, *regardless of result*.
2. Poor control: A1c greater than (>) 9.5.
3. Very poor control: A1c equals or greater than (=>) 12.
4. Poor control: A1c greater than (>) 9.5 and less than (<) 12.
5. Fair control: A1c equals or greater than (=>) 8 and less than or equal to (<=) 9.5.
6. A1c is greater than or equal to (>=) 7 and less than (<) 8
7. GPRAMA: Good control: A1c less than (<) 8.
8. A1c less than (<) 7.
9. Without result. Patients with A1c documented but no value.

2.1.2.4 Definitions

Diabetes

First Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

A1c

Searches for most recent A1c test with a result during the report period. If more than one A1c test is found on the same day or the same visit and one test has a result and the other does not, the test with the result will be used. If both tests have a result, the last test done on the visit will be used.

If an A1c test with a result is not found, CRS searches for the most recent A1c test without a result.

- A1c defined as:
 - Current Procedural Terminology (CPT) 83036, 83037, 3044F through 3046F, 3047F (old code)
 - Logical Observations Identifiers, Names, Codes (LOINC) taxonomy

- Site-populated taxonomy DM AUDIT HGB A1C TAX
- Without result is defined as A1c documented but with no value.
- CPT 3044F represents A1c less than (<) 7 and will be included in the A1c less than (<) 7 and A1c less than (<) 8 numerators.

2.1.2.5 Patient List

List of diabetic patients 55 and older with most recent A1c value, if any.

2.1.3 Diabetes: Blood Pressure Control

No changes from Version 14.0

2.1.3.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.3.2 Denominators

1. Active Diabetic patients ages 55 and older defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits during the report period, *and* two DM-related visits ever. Broken down by age groups.

2.1.3.3 Numerators

1. Patients with Blood Pressure documented during the report period.
2. GPRA: Patients with controlled blood pressure (BP), defined as below 140/90, i.e., the mean systolic value is less than 140 *and* the mean diastolic value is less than 90.
3. Patients with BP that is not controlled.

2.1.3.4 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Exclusions

When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)

- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

BP Documented

CRS uses mean of last 3 BPs documented during the report period. If 3 BPs are not available, uses mean of last 2 BPs. If a visit contains more than 1 BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) BPs and dividing by 3 (or 2).

If CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F or POV ICD-9: V81.1 documented during the report period.

Controlled BP

CRS uses a mean, as described above where BP is below 140/90. If the mean systolic and diastolic values do not *both* meet the criteria for controlled, then the value is considered not controlled.

BP Documented and Controlled BP

If CRS is not able to calculate a mean BP from blood pressure measurements, it will search for the most recent of any of the following codes documented during the report period:

- **BP Documented:** CPT 0001F or 2000F or POV ICD-9: V81.1; OR
- **Systolic:** CPT 3074F, 3075F, or 3077F **WITH Diastolic:** CPT 3078F, 3079F, or 3080F. The systolic and diastolic values do not have to be recorded on the same day. If there are multiple values on the same day, the CPT indicating the lowest value will be used.
- The following combinations represent BP below 140/90 and will be included in the Controlled BP numerator: CPT 3074F or 3075F *and* 3078F or 3079F. All other combinations will *not* be included in the Controlled BP numerator.

2.1.3.5 Patient List

List of diabetic patients 55 and older with BP value, if any.

2.1.4 Diabetes: LDL Assessment

Changes from CRS v14.0 are noted

2.1.4.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.4.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, and at least two visits in the past year, and two DM-related visits ever. Broken down by age groups.

2.1.4.3 Numerators

1. GPRA: Patients with Low-Density Lipoprotein (LDL) completed during the report period, regardless of result.
2. Patients with LDL results less than 130.
 - A. Patients with LDL results less than 100.
 - B. Patients with LDL results 100 to 129.

2.1.4.4 Definitions**Diabetes**

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

LDL

Searches for most recent LDL test with a result during the report period. If more than one LDL test is found on the same day or the same visit and one test has a result and the other does not, the test with the result will be used. If an LDL test with a result is not found, CRS searches for the most recent LDL test without a result.

- LDL test defined as any of the following:
 - CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F
 - LOINC taxonomy
 - Site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX
- For numerator LDL below 130, CPT 3048F and 3049F will count as meeting the measure.
- For numerator LDL less than 100, CPT 3048F will count as meeting the measure.

2.1.4.5 Patient List

List of diabetic patients 55 and older with LDL cholesterol test, if any.

2.1.5 Diabetes: Nephropathy Assessment

Changes from CRS v14.0 are noted

2.1.5.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.5.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, and at least two visits in the past year, and two DM-related visits ever. Broken down by age groups.

2.1.5.3 Numerators

1. GPRA: Patients with nephropathy assessment, defined as an estimated Glomerular Filtration Rate (GFR) with result *and* a Urine Albumin-to-Creatinine Ratio (UACR) during the report period *or* with evidence of diagnosis or treatment of end-stage renal disease (ESRD) at any time before the end of the report period.

2.1.5.4 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Estimated GFR

- Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX or
- LOINC taxonomy

Urine Albumin-to-Creatinine Ratio

- CPT 82043 WITH 82570
- LOINC taxonomy, or
- Site-populated taxonomy BGP QUANT UACR TESTS

Note: Check with your laboratory supervisor to confirm that the names you add to your taxonomy reflect quantitative test values.

ESRD

- ESRD diagnosis or treatment defined as any of the following ever:
 - CPT 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90951 through 90970 or old codes 90918 through 90925, 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, 3066F, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), S2065, S9339
 - POV ICD-9: 585.6, V42.0, V45.1 (old code), V45.11, V45.12, V56.*
 - Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2

2.1.5.5 Patient List

List of patients 55 and older with nephropathy assessment, if any.

2.1.6 Diabetic Retinopathy

No changes from Version 14.0

2.1.6.1 Owner and Contact

Diabetes Program: Dr. Mark Horton

2.1.6.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits in the past year, *and* two DM-related visits ever, without a documented history of bilateral blindness. Broken down by age groups.

2.1.6.3 Numerators

1. GPRA: Patients receiving a qualified retinal evaluation¹ during the report period.

Note: This numerator does <i>not</i> include refusals.

- A. Patients receiving diabetic retinal exam during the report period.
- B. Patients receiving other eye exams during the report period.

¹ Validation study properly powered and controlled against the ETDRS gold standard.

2.1.6.4 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Qualified Retinal Evaluation

- Diabetic retinal exam or
- Other eye exam.

The following methods are qualifying for this measure:

- Dilated retinal evaluation by an optometrist or ophthalmologist.
- Seven standard fields stereoscopic photos (Early Treatment Diabetic Retinopathy Study [ETDRS]) evaluated by an optometrist or ophthalmologist.
- Any photographic method formally validated to seven standard fields (ETDRS).

Diabetic Retinal Exam

Any of the following during the report period:

- Exam code 03 Diabetic Eye Exam (dilated retinal examination or formally validated² ETDRS photographic equivalent)
- CPT 2022F Dilated retinal eye exam, 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, 2026F Eye imaging formally validated³ to match the diagnosis from seven standard field stereoscopic photos, S0620 Routine ophthalmological examination including refraction; new patient, S0621 Routine ophthalmological examination including refraction; established patient, S3000 Diabetic indicator; retinal eye exam, dilated, bilateral.

Other Eye Exam

- Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or formally validated⁴ tele-ophthalmology retinal evaluation clinics or
- Non-DNKA visits to an optometrist or ophthalmologist. Searches for the following codes in the following order:
 - Clinic codes A2 (Diabetic Retinopathy)⁵, 17, 18

² Validation study properly powered and controlled against the ETDRS gold standard.

³ Ibid.

⁴ Ibid.

⁵ Validated photographic (tele-ophthalmology) retinal surveillance.

- Provider code 24, 79, 08
- CPT 67028, 67038 (old code), 67039, 67040, 92002, 92004, 92012, 92014

Bilateral Blindness

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 369.01, 369.03, 369.04; ICD-10: H54.0 through H54.12

2.1.6.5 Patient List

List of diabetic patients 55 and older with qualified retinal evaluation, if any.

2.1.7 Diabetic Access to Dental Services

Changes from CRS v14.0 are noted

2.1.7.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.1.7.2 Denominators

1. Active Diabetic patients ages 55 and older; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at least two visits during the report period, *and* two DM-related visits ever. Broken down by age groups.

2.1.7.3 Numerators

1. Patients with a documented dental visit during the report period.

Note: This numerator does not include refusals.

2.1.7.4 Definitions

Diabetes

First DM Purpose of Visit ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.* recorded in the V POV file prior to the report period.

Documented Dental Visit

For non-CHS visits, searches for any of the following:

- Dental ADA code 0000, 0190, 0191
- CPT code D0190, D0191
- Exam code 30
- POV ICD-9: V72.2; ICD-10: Z01.20, Z01.21

For CHS dental visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file.

2.1.7.5 Patient List

List of diabetic patients 55 and older and documented dental visit, if any.

2.2 Dental Group

2.2.1 Access to Dental Services

Changes from CRS v14.0 are noted

2.2.1.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.2.1.2 Denominators

1. User Population patients ages 55 and older, broken down by age groups.

2.2.1.3 Numerators

1. GPRA: Patients with documented dental visit during the report period.

Note: This numerator does not include refusals.

2.2.1.4 Definitions

Documented Dental Visit

For non-CHS dental visits, searches for any of the following:

- Dental ADA codes 0000, 0190, 0191
- CPT code D0190, D0191
- Exam 30
- POV ICD-9: V72.2; ICD-10: Z01.20, Z01.21

For CHS dental visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file.

2.2.1.5 Patient List

List of patients 55 and older with documented dental visit and date.

2.3 Immunization Group

2.3.1 Adult Immunizations: Influenza

Changes from CRS v14.0 are noted

2.3.1.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.1.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by age groups.

2.3.1.3 Numerators

1. GPRA: Patients with influenza vaccine documented during the report period or with a contraindication documented at any time before the end of the report period.

Note: The only refusals included in this numerator are not medically indicated (NMI) refusals.

- A. Patients with a contraindication or a documented NMI refusal.

2.3.1.4 Definitions

Influenza Vaccine

Any of the following during the report period:

- Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158
- POV ICD-9: V04.8 (old code), V04.81 NOT documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142, or V06.6 NOT documented with 90663, 90664, 90666 through 90668, 90470, G9141 or G9142
- CPT 90654 through 90662 (old code), 90672, 90673, 90685, 90686, 90688, 90724 (old code), G0008, G8108 (old code)

Contraindication to Influenza Vaccine

Any of the following documented at any time before the end of the report period:

- Contraindication in the Immunization Package of “Egg Allergy” or “Anaphylaxis”
- PCC NMI Refusal

2.3.1.5 Patient List

List of patients 55 and older with influenza immunization or contraindication and date, if any.

2.3.2 Adult Immunizations: Pneumovax

Changes from CRS v14.0 are noted

2.3.2.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.2.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by age groups.

2.3.2.3 Numerators

1. GPRA: Patients with Pneumococcal vaccine or contraindication documented ever and, if patient is older than 65 years, either a dose of pneumovax after the age of 65 or a dose of pneumovax in the past 5 years.

Note: The only refusals included in this numerator are NMI refusals.

- A. Patients with a contraindication or a documented NMI refusal

2.3.2.4 Definitions

Pneumococcal Immunization

Any of the following documented any time before the end of the report period:

- Immunization (CVX) codes 33, 100, 109, 133, 152
- POV ICD-9: V06.6, V03.82
- CPT 90669, 90670, 90732, G0009, G8115 (old code)

Pneumococcal Contraindication

Any of the following documented any time before the end of the report period:

- Contraindication in the Immunization Package of “Anaphylaxis”
- PCC NMI Refusal

2.3.2.5 Patient List

List of patients 55 and older with pneumovax immunization or contraindication and date, if any.

2.4 Cancer Screen Group

2.4.1 Cancer Screening: Mammogram Rates

No changes from Version 14.0

2.4.1.1 Owner and Contact

Carolyn Aoyama

2.4.1.2 Denominators

1. Female Active Clinical patients ages 55 and older without a documented history of bilateral mastectomy or two separate unilateral mastectomies, broken down by age groups.

2.4.1.3 Numerators

1. GPRA: All patients with documented mammogram in past two years.

Note: This numerator does not include refusals.

2. Patients with documented mammogram refusal in past year.

2.4.1.4 Definitions

Age

Age of the patient is calculated at the beginning of the report period. For the denominator, patients must be at least the minimum age as of the beginning of the report period.

Bilateral Mastectomy

- CPT 19300.50 through 19307.50 *or* 19300 through 19307 with modifier 09950 (50 and 09950 modifiers indicate bilateral), or old codes 19180, 19200, 19220, or 19240, with modifier of 50 or 09950 or
- International Classification of Diseases (ICD) Procedure ICD-9: 85.42, 85.44, 85.46, 85.48; ICD-10: 0HTV0ZZ

Unilateral Mastectomy

Requires two separate occurrences for either CPT or procedure codes on either two different dates of service or on the same date of service if the codes include both a right side modifier (RT) and left side modifier (LT).

- CPT 19300 through 19307, or old codes 19180, 19200, 19220, 19240 or
- Procedure ICD-9: 85.41, 85.43, 85.45, 85.47; ICD-10: 07T50ZZ, 07T60ZZ, 07T70ZZ, 07T80ZZ, 07T90ZZ, 0HTT0ZZ, 0HTU0ZZ, 0KTH0ZZ, 0KTJ0ZZ

Mammogram

- Radiology or CPT 77052 through 77059, 76090 (old code), 76092 (old code), G0206, G0204, G0202
- POV ICD-9: V76.11 screening mammogram for high risk patient, V76.12 other screening mammogram, 793.80 Abnormal mammogram, unspecified, 793.81 Mammographic microcalcification, 793.89 Other abnormal findings on radiological exam of breast; ICD-10: R92.0, R92.1, R92.8, Z12.31
- Procedure ICD-9: 87.36 Xerography of breast, 87.37 Other Mammography; ICD-10: BH00ZZZ, BH01ZZZ, BH02ZZZ
- Women's Health procedure called Mammogram Screening, Mammogram Dx Bilat, Mammogram Dx Unilat, and where the mammogram result does *not* have "ERROR/DISREGARD"

Refusal Mammogram

Any of the following in the past year:

- Radiology MAMMOGRAM for CPT 77052 through 77059, 76090 (old code), 76091 (old code), 76092 (old code), G0206, G0204, G0202

2.4.1.5 Patient List

List of female patients 55 and older with mammogram or refusal, if any.

2.4.2 Colorectal Cancer Screening

No changes from Version 14.0

2.4.2.1 Owner and Contact

Epidemiology Program: Don Haverkamp

2.4.2.2 Denominators

1. Active Clinical patients ages 55 and older without a documented history of colorectal cancer or total colectomy, broken out by gender and age groups.

2.4.2.3 Numerators

1. GPRA: Patients who have had *any* Colorectal Cancer (CRC) screening, defined as any of the following:
 - A. Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during the report period
 - B. Flexible sigmoidoscopy in the past 5 years
 - C. Colonoscopy in the past 10 years

Note: This numerator does not include refusals.

2. Patients with documented CRC screening refusal in the past year.
3. Patients with FOBT or FIT during the report period.
4. Patients with a flexible sigmoidoscopy in the past 5 years or a colonoscopy in the past 10 years.

2.4.2.4 Definitions

Denominator Exclusions

Any diagnosis ever of one of the following:

- Colorectal Cancer
 - POV ICD-9: 153.*, 154.0, 154.1, 197.5, V10.05; ICD-10: C18.*, C19, C20, C78.5, Z85.030, Z85.038
 - CPT G0213 through G0215 (old codes), G0231 (old code)
- Total Colectomy
 - CPT 44150 through 44151, 44152 (old code), 44153 (old code), 44155 through 44158, 44210 through 44212
 - Procedure ICD-9: 45.8*; ICD-10: 0DTE*ZZ

Colorectal Cancer Screening

The most recent of any of the following during applicable timeframes (changed to look at most recent screening):

- FOBT or FIT
 - CPT 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)
 - LOINC taxonomy
 - Site-populated taxonomy BGP GPRA FOB TESTS
- Flexible Sigmoidoscopy

- Procedure ICD-9: 45.24; ICD-10: 0DJD8ZZ
- CPT 45330 through 45345, G0104
- Colonoscopy
 - Procedure ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; ICD-10: 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX, 0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ
 - CPT 44388 through 44394, 44397, 45355, 45378 through 45387, 45391, 45392, G0105, G0121

Screening Refusals in Past Year

- FOBT or FIT
 - Refusal of Lab Fecal Occult Blood test
 - CPT code 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)
- Flexible Sigmoidoscopy
 - Refusal of Procedure ICD-9: 45.24; ICD-10: 0DJD8ZZ
 - CPT 45330 through 45345, G0104
- Colonoscopy

- Refusal of Procedure ICD-9: 45.22, 45.23, 45.25, 45.42, 45.43; 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX, 0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ
- CPT 44388 through 44394, 44397, 45355, 45378 through 45387, 45391, 45392, G0105, G0121

2.4.2.5 Patient List

List of patients 55 and older with CRC screening or refusal, if any.

2.4.3 Tobacco Use and Exposure Assessment

No changes from Version 14.0

2.4.3.1 Owner and Contact

Chris Lamer, PharmD: Epidemiology Program, Dayle Knutson

2.4.3.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by gender and age groups.

2.4.3.3 Numerators

1. Patients screened for tobacco use during the report period.
2. Patients identified during the report period as current tobacco users.
 - A. Current smokers
 - B. Current smokeless tobacco users

3. Patients exposed to environmental tobacco smoke (ETS) during the report period.

2.4.3.4 Definitions

Tobacco Screening

- Any Health Factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS – CHEWING/DIP), TOBACCO (EXPOSURE)
- Tobacco-related diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82; ICD-10: F17.2*, O99.33*, Z87.891
- Dental code 1320
- Patient Education codes containing “TO-”, “-TO”, “-SHS,” 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code)
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), G8455 through G8457 (old codes), G8402 (old code), G8453 (old code), 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), 1036F (Current Tobacco Non-User), 1036F (Current Tobacco Non-User), 1000F (Tobacco Use Assessed)

Tobacco Users

- Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, Current smoker, some day, Heavy Tobacco Smoker, Light Tobacco Smoker
- POV ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, 1035F, G8455 (old code), G8456 (old code), G8402 (old code), G8453 (old code)

Current Smokers

- Health Factors: Current Smoker, Current Smoker and Smokeless, Cessation-Smoker, Current Smoker, status unknown, Current smoker, every day, Current smoker, some day, Heavy Tobacco Smoker, Light Tobacco Smoker
- POV ICD-9: 305.1, 305.10 through 305.12 (old codes), 649.00 through 649.04; ICD-10: F17.200, F17.203 through F17.210, F17.213 through F17.290, F17.293 through F17.299, O99.33*
- CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F, G8455 (old code), G8402 (old code), G8453 (old code)

Current Smokeless

- Health Factors: Current Smokeless, Current Smoker and Smokeless, Cessation-Smokeless
- POV ICD-10: F17.220, F17.223 through F17.229
- CPT 1035F, G8456 (old code)

Environmental Tobacco Smoke (ETS)

- Health Factors: Smoker in Home, Exposure to Environmental Tobacco Smoke

2.4.3.5 Patient List

List of patients 55 and older with no documented tobacco screening.

2.5 Behavioral Health Group**2.5.1 Intimate Partner (Domestic) Violence Screening**

No changes from Version 14.0

2.5.1.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.5.1.2 Denominators

1. Female Active Clinical patients ages 55 and older, broken down by age groups.

2.5.1.3 Numerators

1. GPRA: Patients screened for or diagnosed with intimate partner (domestic) violence during the report period.

Note: This numerator does not include refusals.

- A. Patients with documented Intimate Partner Violence/Domestic Violence (IPV/DV) exam.
- B. Patients with IPV/DV related diagnosis.
- C. Patients provided with IPV/DV patient education or counseling.

2.5.1.4 Definitions

IPV/DV Screening

Defined as at least one of the following:

- IPV/DV Screening
 - Exam code 34
 - Behavioral Health System (BHS) IPV/DV exam
- IPV/DV Related Diagnosis
 - POV, Current PCC or BHS Problem List ICD-9: 995.80 through 83, 995.85, V15.41, V15.42, V15.49; ICD-10: T74.11XA, T74.21XA, T74.31XA, T74.91XA, T76.11XA, T76.21XA, T76.31XA, T76.91XA, Z91.410
 - BHS POV 43.*, 44.*
- IPV/DV Patient Education
 - Patient Education codes containing “DV-” or “-DV”, 995.80 through 83, 995.85, V15.41, V15.42, V15.49
- IPV/DV Counseling
 - POV ICD-9: V61.11; ICD-10: Z69.11

2.5.1.5 Patient List

List of female patients equal to or greater than (\Rightarrow) 55 with documented IPV/DV screening, if any.

2.5.2 Depression Screening

No changes from Version 14.0

2.5.2.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.5.2.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by gender and age groups.

2.5.2.3 Numerators

1. GPRA: Patients screened for depression or diagnosed with mood disorder at any time during the report period.

Note: This numerator does not include refusals.

- A. Patients screened for depression during the report period.
 - B. Patients with a diagnosis of a mood disorder during the report period.
2. Patients with depression-related education in past year.

Note: Depression-related patient education does not count toward the GPRA numerator and is included as a separate numerator only.

2.5.2.4 Definitions

Depression Screening

Any of the following:

- Exam code 36
- POV ICD-9: V79.0
- CPT 1220F
- BHS problem code 14.1 (screening for depression)
- Measurement in PCC or Behavioral Health (BH) of PHQ2 or PHQ9

Mood Disorders

At least two visits in Patient Care Component (PCC) or BHS during the report period with POV for: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder NOS, Bipolar I or II Disorder, Cyclothymic Disorder, Bipolar Disorder NOS, Mood Disorder Due to a General Medical Condition, Substance-induced Mood Disorder, or Mood Disorder NOS. These POV codes are:

- ICD-9: 296.*, 291.89, 292.84, 293.83, 300.4, 301.13, 311; ICD-10: F06.31 through F06.34, F1*.*4, F10.159, F10.180, F10.181, F10.188, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F30.*, F31.0 through F31.71, F31.73, F31.75, F31.77, F31.81 through F31.9, F32.* through F39
- BHS POV 14, 15

Depression-Related Patient Education

Any of the following during the report period:

- Patient education codes containing “DEP-” (depression), 296.2*, 296.3*, “BH-” (behavioral and social health), 290-319, 995.5*, 995.80 through 995.85, “SB-” (suicidal behavior), 300.9, “PDEP-” (postpartum depression), 648.44

2.5.2.5 Patient List

List of patients 55 and older not screened for depression or diagnosed with mood disorder.

2.6 Cardiovascular Disease Related Group

2.6.1 Obesity Assessment

No changes from Version 14.0

2.6.1.1 Owner and Contact

Nutrition Program, Alberta Becenti

2.6.1.2 Denominators

1. Active Clinical patients ages 55 through 74, broken down by gender and age groups.

2.6.1.3 Numerators

1. All patients for whom Body Mass Index (BMI) can be calculated.

Note: This numerator does not include refusals.

- A. For those with a BMI calculated, patients considered overweight but not obese using BMI and standard tables.
 - B. For those with a BMI calculated, patients considered obese using BMI and standard tables.
 - C. Total of overweight and obese.
2. Patients with documented refusal in past year.

2.6.1.4 Definitions

BMI

CRS calculates BMI at the time the report is run, using NHANES II. For 18 and under, a height and weight must be taken on the same day any time during the report period. For 19 through 50, height and weight must be recorded within last five years, not required to be on the same day. For over 50, height and weight within last two years not required to be recorded on same day. Overweight but not obese is defined as BMI of 25 through 29 for adults 19 and older. Obese is defined as BMI of 30 or more for adults 19 and older. For ages 2 through 18, definitions based on standard tables.

Patients whose BMI either is greater or less than the Data Check Limit range shown in the BMI Standard Reference Data Table in PCC will not be included in the report counts for Overweight or Obese.

Refusals

Include REF (refused), NMI and UAS (unable to screen) and must be documented during the past year. For ages 18 and under, both the height and weight must be refused on the same visit at any time during the past year. For ages 19 and older, the height and weight must be refused during the past year and are not required to be on the same visit.

2.6.1.5 Patient List

List of patients 55 through 74 for whom BMI could *not* be calculated.

2.6.2 Cardiovascular Disease and Blood Pressure Control

Changes from CRS v14.0 are noted

2.6.2.1 Owner and Contact

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.6.2.2 Denominators

1. All Active Clinical patients ages 55 and over, broken down by gender and age groups.

2.6.2.3 Numerators

1. Patients with Blood Pressure value documented during the Report Period.

- A. Patients with normal BP, defined as under 120/80, i.e., the mean systolic value is less than 120 AND the mean diastolic value is less than 80.
- B. Patients with Pre Hypertension I BP, defined as 120/80 or higher and below 130/80, i.e., the mean systolic value is 120 or higher and below 130 AND the mean diastolic value is equal to 80.
- C. Patients with Pre Hypertension II BP, defined as 130/80 or higher and below 140/90, i.e., the mean systolic value is 130 or higher but below 140 AND the mean diastolic value is 80 or higher but below 90.
- D. Patients with Stage 1 Hypertension BP, defined as 140/90 or higher and below 160/100, i.e., the mean systolic value is 140 but below 160 AND the mean diastolic value is 90 or higher but below 100.
- E. Patients with Stage 2 Hypertension BP, defined as 160/100 or higher, i.e., the mean systolic value is 160 or higher AND the mean diastolic value is 100 or higher.

2.6.2.4 Definitions

BP Values (all numerators)

Exclusions: When calculating all BPs (using vital measurements or CPT codes), the following visits will be excluded:

- Service Category H (Hospitalization), I (In Hospital), S (Day Surgery), or O (Observation)
- Clinic code 23 (Surgical), 30 (ER), 44 (Day Surgery), C1 (Neurosurgery), or D4 (Anesthesiology)

CRS uses the mean of the last three BPs documented in the past 2 years. If 3 BPs are not available, uses mean of the last 2 BPs. If a visit contains more than one BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) blood pressures and dividing by 3 (or 2). If the systolic and diastolic values do not *both* meet the current category, then the value that is least controlled determines the category.

For the BP documented numerator only, if CRS is not able to calculate a mean BP, it will search for CPT 0001F, 2000F, 3074F through 3080F or POV ICD-9: V81.1 documented during the report period.

2.6.2.5 Patient List

List of patients 55 and older with mean BP, if any.

2.6.3 Cardiovascular Disease and Cholesterol Screening

Changes from CRS v14.0 are noted

2.6.3.1 Owner and Contact

Dr. Dena Wilson, Chris Lamer, PharmD, and Mark Veazie

2.6.3.2 Denominators

1. Active Clinical patients ages 55 and older; broken out by gender and age groups.

2.6.3.3 Numerators

1. Patients with documented blood total cholesterol screening any time in the past 5 years.
 - A. Patients with high total cholesterol levels, defined as 240 or higher.
2. Patients with LDL completed in the past 5 years, regardless of result.
 - A. Patients with LDL less than 100
 - B. Patients with LDL 100 through 130
 - C. Patients with LDL 131 through 160
 - D. Patients with LDL above 160

2.6.3.4 Definitions

Total Cholesterol Panel

Searches for most recent cholesterol test with a result during the report period. If more than one cholesterol test is found on the same day or the same visit and one test has a result and the other does not, the test with the result will be used. If a cholesterol test with a result is not found, CRS searches for the most recent cholesterol test without a result.

Total Cholesterol definition:

- CPT 82465
- LOINC taxonomy
- Site-populated taxonomy DM AUDIT CHOLESTEROL TAX

LDL

Searches for most recent LDL test with a result during the report period. If more than one LDL test is found on the same day or the same visit and one test has a result and the other does not, the test with the result will be used. If an LDL test with a result is not found, CRS searches for the most recent LDL test without a result.

LDL Definition:

- CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F
- LOINC taxonomy
- Site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX
- For numerator LDL less than 100, CPT 3048F will count as meeting the measure

2.6.3.5 Patient List

List of patients 55 and older with cholesterol or LDL value if any.

2.7 Other Clinical Measures Group**2.7.1 Osteoporosis Management**

No changes from Version 14.0

2.7.1.1 Owner and Contact

Dr. Lisa Sumner

2.7.1.2 Denominators

1. Female Active Clinical patients ages 55 and older who had a new fracture occurring 6 months (182 days) prior to the report period through the first 6 months of the report period with no osteoporosis screening or treatment in year prior to the fracture. Broken down by age groups.

2.7.1.3 Numerators

1. Patients treated or tested for osteoporosis after the fracture.

2.7.1.4 Definitions

Fracture

Does not include fractures of finger, toe, face, or skull. CRS will search for the first (i.e., earliest) fracture during the period 6 months (182) days prior to the beginning of the report period and the first 6 months of the report period. If multiple fractures are present, only the first fracture will be used.

The Index Episode Start Date is the date the fracture was diagnosed. If the fracture was diagnosed at an outpatient visit (Service Category A, S, or O), the Index Episode Start Date is equal to the Visit Date. If diagnosed at an inpatient visit (Service Category H), the Index Episode Start Date is equal to the Discharge Date.

Denominator Exclusions

- Patients receiving osteoporosis screening or treatment in the year (365 days) prior to the Index Episode Start Date. Osteoporosis screening or treatment is defined as a Bone Mineral Density (BMD) test (see below for codes) or receiving any osteoporosis therapy medication (see below for codes).
- Patients with a fracture diagnosed at an outpatient visit, which *also* had a fracture within 60 days prior to the Index Episode Start Date.
- Patients with a fracture diagnosed at an inpatient visit, which *also* had a fracture within 60 days prior to the ADMISSION DATE.

Osteoporosis Treatment and Testing

For fractures diagnosed at an outpatient visit:

- A non-discontinued prescription within 6 months (182 days) of the Index Episode Start Date (i.e., visit date) or
- A BMD test within 6 months of the Index Episode Start Date.

For fractures diagnosed at an inpatient visit, a BMD test performed during the inpatient stay.

- Fracture codes:
 - CPT 21800 through 21825, 22305 through 22314, 22316 through 22324, 22520, 22521, 22523, 22524, 23500 through 23515, 23570 through 23630, 23665 through 23680, 24500 through 24585, 24620, 24635, 24650 through 24685, 25500 through 25609, 25611 (old code), 25620 (old code), 25622 through 25652, 25680, 25685, 27193 through 27248, 27254, 27500 through 27514, 27520 through 27540, 27750 through 27828, S2360, S2362

- POV ICD-9: 733.1*, 805* through 806*, 807.0* through 807.4, 808* through 815*, 818* through 825*, 827*, 828*; ICD-10: M48.5*XA, M80.**A, M84.40xA through M84.443A (ending in A only), M84.451A through M84.476A (ending in A only), M84.48xA, S22.0*0A, S22.0*0B, S32.0*0A, S32.0*0B, S52.001A through S52.236C (ending in A, B, or C only), S52.251A through S52.279C (ending in A, B, or C only), S52.291A through S52.336C (ending in A, B, or C only), S52.351A through S52.366C (ending in A, B, or C only), S52.391A through S52.92xC (ending in A, B, or C only), S62.001A through S62.186B (ending in A or B only), S72.001A through S72.019C (ending in A, B, or C only), S72.031A through S72.92xC (ending in A, B, or C only), S82.001A through S82.856C (ending in A, B, or C only), S82.891A through S82.92XC (ending in A, B, or C only)
- Procedure ICD-9: 79.01 through 79.03, 79.05 through 79.07, 79.11 through 79.13, 79.15 through 79.17, 79.21 through 79.23, 79.25 through 79.27, 79.31 through 79.33, 79.35 through 79.37, 79.61 through 79.63, 79.65 through 79.67, 81.65, 81.66; ICD-10: 0PSC***, 0PSD***, 0PSF***, 0PSG***, 0PSH***, 0PSJ***, 0PSK***, 0PSL***, 0PU337Z, 0PU33JZ, 0PU347Z, 0PU34JZ, 0PU437Z, 0PU43JZ, 0PU447Z, 0PU44JZ, 0QS6***, 0QS7***, 0QS8***, 0QS9***, 0QSB***, 0QSC***, 0QSG***, 0QSH***, 0QSJ***, 0QSK***, 0QU037Z, 0QU03JZ, 0QU047Z, 0QU04JZ, 0QU137Z, 0QU13JZ, 0QU147Z, 0QU14JZ
- BMD Test:
 - CPT 77078, 76070 (old code), 77079, 76071 (old code), 77080, 76075 (old code), 77081, 76076 (old code), 77083, 76078 (old code), 76977, 78350, 78351, G0130
 - Procedure ICD-9: 88.98
 - POV ICD-9: V82.81; ICD-10: Z13.820

Osteoporosis Treatment Medication

Medication taxonomy BGP HEDIS OSTEOPOROSIS MEDS.

- Medications are Alendronate, Alendronate-Cholecalciferol (Fosomax Plus D), Calcium carbonate-risedronate, Ibandronate (Boniva), Risedronate, Zoledronic acid, Calcitonin, Denosumab, Raloxifene, Estrogen, Injectable Estrogens, and Teriparatide. Medications must not have a comment of RETURNED TO STOCK.

2.7.1.5 Patient List

List of female patients 55 and older with new fracture who had osteoporosis treatment or testing, if any.

2.7.2 Osteoporosis Screening in Women

No changes from Version 14.0

2.7.2.1 Owner and Contact

Dr. Lisa Sumner

2.7.2.2 Denominators

1. Female Active Clinical patients ages 65 and older without a documented history of osteoporosis, broken down by age groups.

2.7.2.3 Numerators

1. Patients who had osteoporosis screening documented after the age of 65.

Note: This numerator does <i>not</i> include refusals.

2.7.2.4 Definitions

Patients without Osteoporosis

No osteoporosis diagnosis ever (POV ICD-9: 733.*; ICD-10: M80.***A, M81*, M84.4**A, M84.6**A)

Osteoporosis Screening

Any one of the following after age 65:

- **Central DEXA:** Radiology or CPT 77080, 76075 (old code)
- **Peripheral DEXA:** Radiology or CPT 77081, 76076 (old code)
- **SEXA:** Radiology or CPT G0130
- **Central CT:** Radiology or CPT 77078, 76070 (old code)
- **Peripheral CT:** Radiology or CPT 77079, 76071 (old code)
- **US Bone Density:** Radiology or CPT 76977
- **Quantitative CT:** Procedure ICD-9: 88.98
- **POV ICD-9:** V82.81 Special screening for other conditions, Osteoporosis; ICD-10: Z13.820

2.7.2.5 Patient List

List of female patients 65 and older with osteoporosis screening, if any.

2.7.3 Osteoarthritis Medication Monitoring

No changes from Version 14.0

2.7.3.1 Owner and Contact

Dr. Charles (Ty) Reidhead

2.7.3.2 Denominators

1. Active Clinical patients ages 55 and older diagnosed with osteoarthritis (OA) prior to the report period and with at least two OA-related visits any time during the report period and prescribed maintenance therapy medication chronically during the report period. Broken down by age groups.

2.7.3.3 Numerators

1. Patients who received appropriate monitoring of chronic medication during the report period.

2.7.3.4 Definitions

OA

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 715.*; ICD-10: M15.* through M19.* prior to the report period, and at least two OA POVs during the report period.

Maintenance Therapy Medications and Monitoring

For all maintenance therapy medications, each medication must be prescribed within the past 465 days of the end of the report period (i.e., the medication period) and the sum of the days' supply 348 or more. This means the patient must have been on the medication at least 75% of the medication period. The following two examples illustrate this logic. Medications must not have a comment of RETURNED TO STOCK.

- **Example of Patient Not on Chronic Medication (not included in Denominator):**

- Report Period: January 1, 2014 through December 31, 2014
- Medication Period: 465 days from end of report period (December 31, 2014): September 22, 2013 through December 31, 2014

Medication Prescribed:

- Diclofenac:
 - First Prescription: October 15, 2013

- Days' Supply: 90
- Second Prescription: January 1, 2014
- Days' Supply: 90
- Third prescription: March 15, 2014
- Days' Supply: 90

Total Days' Supply:

$$90 + 90 + 90 = 270 \text{ and } 270 \leq 348$$

Patient is not considered on chronic medication and is not included in the denominator.

- **Example of Patient on Chronic Medication (included in Denominator):**

- Report period: January 1 through December 31, 2014
- Medication Period: 465 days from end of report period (December 31, 2014): September 22, 2013 through December 31, 2014

Medication Prescribed:

- Etodolac:
 - First prescription: September 30, 2013
 - Days' Supply: 90
 - Second prescription: December 30, 2013
 - Days' Supply: 90
 - Third prescription: March 15, 2014
 - Days' Supply: 180.

Total Days' Supply:

$$90 + 90 + 180 = 360 \text{ and } 360 > 348$$

Patient is considered on chronic medication and is included in the denominator.

The days' supply requirement may be met with a single prescription or from a combination of prescriptions for the same medication that were filled during the medication period. However, for all medications, there must be at least one prescription filled during the report period.

Note: If the medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2014
- Discontinued Date: November 19, 2014

Recalculated number of Days Prescribed:
November 19, 2014 – November 15, 2014 = 4

- Appropriate monitoring of osteoarthritis medications is defined with laboratory tests and varies by medication, as shown in below.

Maintenance Therapy Medications

- NSAID Medications: All of the following NSAID medications must have Creatinine, Liver Function Tests, and Complete Blood Count (CBC) during the report period:
 - Diclofenac, Etodolac, Indomethacin, Ketorolac, Sulindac, Tolmetin, Meclofenamate, Mefenamic Acid, Nabumetone, Meloxicam, Piroxicam, Fenoprofen, Flurbiprofen, Ibuprofen, Ketoprofen, Naproxen, Oxaprozin, Aspirin, Choline Magnesium Trisalicylate, Diflunisil, Magnesium Salicylate, Celcoxib.
 - All of these medications *except* aspirin are defined with medication taxonomy BGP RA OA NSAID MEDS.
 - Aspirin defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.
- All NSAID medications must have Creatinine, Liver Function Tests and CBC during the report period.
- Example of Patient Not Included in Numerator:

Medication Prescribed and Required Monitoring:

 - Diclofenac, last Rx June 15, 2014. Requires Creatinine, LFT, and CBC during report period
 - Only the LFT was performed during report period
 - Patient is not in numerator
- Example of Patient Included in Numerator:

Medications Prescribed and Required Monitoring:

 - Diclofenac, last Rx September 1, 2014. Requires Creatinine, LFT, and CBC during report period
 - Creatinine, LFT, and CBC performed during report period
 - Patient is in the numerator

Monitoring Test Definitions

- Serum Creatinine:
 - CPT 82540, 82565 through 75
 - LOINC taxonomy
 - Site-populated taxonomy DM AUDIT CREATININE TAX
- CBC:
 - CPT 85025, 85027
 - Site-populated taxonomy BGP CBC TESTS
 - LOINC taxonomy
- Liver Function Tests: Any one of the following:
 - ALT
 - CPT 84460
 - Site-populated taxonomy DM AUDIT ALT
 - LOINC taxonomy
 - AST
 - CPT 84450
 - Site-populated taxonomy DM AUDIT AST
 - LOINC taxonomy
 - Liver Function
 - CPT 80076
 - Site-populated taxonomy BGP LIVER FUNCTION
 - LOINC taxonomy

2.7.3.5 Patient List

List of OA patients 55 and older prescribed maintenance therapy medication with monitoring laboratory tests, if any. The numerator values for patients who meet the measure are prefixed with “YES:” and patients who did not meet the measure are prefixed with “NO:” All lab tests the patient *did* have are displayed.

2.7.4 Functional Status Assessment in Elders

No changes from Version 14.0

2.7.4.1 Owner and Contact

Dr. Bruce Finke

2.7.4.2 Denominators

1. Active Clinical patients ages 55 and older, broken down by gender and age groups.

2.7.4.3 Numerators

1. Patients screened for functional status at any time during the report period.

2.7.4.4 Definitions

Functional Status

Any non-null values in V Elder Care for the following:

- At least one of the following ADL fields: toileting, bathing, dressing, transfers, feeding, or continence.
- At least one of the following IADL fields: finances, cooking, shopping, housework/chores, medications, or transportation during the report period.

2.7.4.5 Patient List

List of patients 55 and older with functional status codes, if any.

The following abbreviations are used in the Numerator column:

- TLT–Toileting
- BATH–Bathing
- DRES–Dressing
- XFER–Transfers
- FEED–Feeding
- CONT–Continence
- FIN–Finances
- COOK–Cooking
- SHOP–Shopping
- HSWK–Housework/Chores
- MEDS–Medications
- TRNS–Transportation

2.7.5 Asthma

No changes from Version 14.0

2.7.5.1 Owner and Contact

Chris Lamer, PharmD

2.7.5.2 Denominators

1. Active Clinical patients ages 55 and older, broken out by age groups.
2. Numerator 1 (Patients who have had two asthma-related visits during the report period or with persistent asthma) broken out by age groups: under 5, 5 through 64, 65 and older.

2.7.5.3 Numerators

1. Patients who have had two asthma-related visits during the report period or with persistent asthma.
 - A. Patients from Numerator 1 who have been hospitalized at any hospital for asthma during the report period.

2.7.5.4 Definitions

Asthma Visits

Asthma visits are defined as diagnosis (POV) ICD-9: 493.*; ICD-10: J45.20 through J45.52.

Persistent Asthma

Any of the following:

- Problem List entry where the status is not Inactive or Deleted for ICD-9: 493.*; ICD-10: J45.20 through J45.52 with Severity of 2, 3 or 4 at ANY time before the end of the report period or
- Most recent visit-related asthma entry (i.e., V Asthma) with Severity of 2, 3, or 4 documented *any* time before the end of the report period.

Hospitalizations

Hospitalizations are defined as service category H with primary POV ICD-9: 493.*; ICD-10: J45.20 through J45.52.

2.7.5.5 Patient List

List of patients 55 and older diagnosed with asthma and any asthma-related hospitalizations.

2.7.6 Public Health Nursing

No changes from Version 14.0

2.7.6.1 Owner and Contact

Tina Tah, RN, BSN, MBA

2.7.6.2 Denominators

1. Number of visits to User Population patients by Public Health Nurses (PHNs) in any setting, including Home, broken down by age groups.
 - A. Number of visits to patients ages 55 through 64 years
 - B. Number of visits to patients ages 65 through 74 years
 - C. Number of visits to patients ages 75 through 84 years
 - D. Number of visits to patients ages 85 and older
 - E. Number of PHN driver/interpreter (Provider code 91) visits.
2. Number of visits to User Population patients by PHNs in Home setting, broken down by age groups.
 - A. Number of Home visits to patients ages 55 through 64 years
 - B. Number of Home visits to patients ages 65 through 74 years
 - C. Number of Home visits to patients ages 75 through 84 years
 - D. Number of Home visits to patients ages 85 and older
 - E. Number of PHN driver/interpreter (Provider code 91) visits

2.7.6.3 Numerator

No numerator. This measure is a total count only, not a percentage.

2.7.6.4 Definitions**PHN Visit-Any Setting**

Any visit with primary or secondary Provider codes 13 or 91.

PHN Visit-Home

Any visit with one of the following:

- Clinic code 11 and a primary or secondary Provider code of 13 or 91
- Location Home (as defined in Site Parameters) and a primary or secondary Provider code 13 or 91

2.7.6.5 Patient List

List of patients 55 and older with PHN visits documented.

Numerator codes in patient list:

- **All PHN.** Number of PHN visits in any setting
- **Home.** Number of PHN visits in home setting
- **Driver.** All Number of PHN driver/interpreter visits in any setting
- **Driver.** Home Number of PHN driver/interpreter visits in home setting

2.7.7 Fall Risk Assessment in Elders

No changes from Version 14.0

2.7.7.1 Owner and Contact

Dr. Bruce Finke

2.7.7.2 Denominators

1. Active Clinical patients ages 65 and older, broken down by gender.

2.7.7.3 Numerators

1. Patients who have been screened for fall risk or with a fall-related diagnosis in the past year.

Note: This numerator does *not* include refusals.

- A. Patients who have been screened for fall risk in the past year.
- B. Patients with a documented history of falling in the past year.
- C. Patients with a fall-related injury diagnosis in the past year.
- D. Patients with abnormality of gait or balance or mobility diagnosis in the past year.

2. Patients with a documented refusal of fall risk screening exam in the past year.

2.7.7.4 Definitions

Fall Risk Screen

Any of the following:

- Fall Risk Exam defined as: Exam code 37
- CPT 1100F, 1101F, 3288F
- History of Falling defined as: POV ICD-9: V15.88 (Personal History of Fall); ICD-10: Z91.81
- Fall-related Injury Diagnosis defined as: POV ICD-9: (Cause codes #1 through 3) E880.*, E881.*, E883.*, E884.*, E885.*, E886.*, E888.*; ICD-10: (All codes ending in A or D only) W01.*, W06.* through W08.*, W10.*, W18.*, W19.*
- Abnormality of Gait or Balance or Mobility defined as: POV ICD-9: 781.2, 781.3, 719.7, 719.70 (old code), 719.75 through 719.77 (old codes), 438.84, 333.99, 443.9; ICD-10: G25.7*, G25.89, G25.9, G26, I69.*93, I73.9, R26.*, R27.*

Refusal

Refusal of Exam 37

2.7.7.5 Patient List

List of patients 65 years or older with fall risk assessment, if any.

2.7.8 Use of High Risk Medications in the Elderly

No changes from Version 14.0

2.7.8.1 Owner and Contact

Dr. Bruce Finke

2.7.8.2 Denominators

1. Active Clinical patients ages 65 and older, broken down by gender and age groups.

2.7.8.3 Numerators

1. Patients who received at least one high risk medication for the elderly during the report period.

- A. Patients who received at least one prescription for a Health Plan Employer Data and Information Set- (HEDIS-) defined high-risk medication from the anticholinergic medication class during the Report Period.
 - B. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the antithrombotic medication class during the Report Period.
 - C. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the anti-infective medication class during the Report Period.
 - D. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the cardiovascular medication class during the Report Period.
 - E. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the typical central nervous system medication class during the Report Period.
 - F. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the endocrine medication class during the Report Period.
 - G. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the gastrointestinal medication class during the Report Period.
 - H. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the pain medication class during the Report Period.
 - I. Patients who received at least one prescription for a HEDIS-defined high-risk medication from the skeletal muscle relaxant medication class during the Report Period.
2. Patients who received at least two different high risk medications for the elderly during the report period.

2.7.8.4 Definitions

Note: The logic below is a deviation from the logic written by PQA, as PQA requires at least two prescriptions fills for the same high-risk medication during the Report Period, while the logic below only requires one prescription fill.

- For nitrofurantoin, a patient must have received a cumulative days supply for any nitrofurantoin product greater than 90 days during the Report Period.
- For nonbenzodiazepine hypnotics (BGP HEDIS NONBENZODIAZ MEDS), a patient must have received a cumulative days supply for any nonbenzodiazepine hypnotic products greater than 90 days during the Report Period.

High Risk Medications for the Elderly

Defined with medication taxonomies:

- BGP HEDIS ANTICHOLINERGIC MEDS
 - First-generation antihistamines (Includes combination drugs) (Brompheniramine, Carbinoxamine, Chlorpheniramine, Clemastine, Cyproheptadine, Dexbrompheniramine, Dexchlorpheniramine, Diphenhydramine (oral), Doxylamine, Hydroxyzine, Promethazine, Triprolidine); Antiparkinson agents (Benztropine (oral), Trihexyphenidyl)
- BGP HEDIS ANTITHROMBOTIC MEDS
 - (Ticlopidine, Dipyridamole, oral short-acting)
- BGP HEDIS ANTI-INFECTIVE MEDS
 - (Nitrofurantoin)
- BGP HEDIS CARDIOVASCULAR MEDS
 - Alpha blockers, central (Guanabenz, Guanfacine, Methyldopa, Reserpine); Cardiovascular, other (Disopyramide, Digoxin, Nifedipine, immediate release)
- BGP HEDIS CENTRAL NERVOUS MEDS
 - Tertiary TCAs (Includes combination drugs) (Amitriptyline, Clomipramine, Doxepin, Imipramine, Trimipramine); Antipsychotics, first-generation (conventional) (Thioridazine, Mesoridazine); Barbiturates (Amobarbital, Butobarbital, Butalbital, Mephobarbital, Pentobarbital, Phenobarbital, Secobarbital); Central Nervous System, other (Chloral hydrate, Meprobamate); Nonbenzodiazepine hypnotics (Eszopiclone, Zolpidem, Zaleplon); Vasodilators (Ergoloid mesylates, Isoxsuprine)
- BGP HEDIS ENDOCRINE MEDS
 - Endocrine (Desiccated thyroid, Estrogens with or without progesterone (oral and topical patch products only), Megestrol); Sulfonylureas, long-duration (Chlorpropamide, Glyburide)
- BGP HEDIS GASTROINTESTINAL MED
 - (Trimethobenzamide)
- BGP HEDIS PAIN MEDS
 - Other (Meperidine, Pentazocine); Non-COX-selective NSAIDs (Indomethacin, Ketorolac)
- BGP HEDIS SKL MUSCLE RELAX MED
 - (Includes combination drugs) (Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Metaxalone, Methocarbamol, Orphenadrine)

Note: For each medication, the days' supply must be greater than zero. If the medication was started and then discontinued, CRS will recalculate the number of Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. For example:

- Rx Date: November 15, 2014
- Discontinued Date: November 19, 2014

Recalculated number of Days Prescribed:
November 19, 2014 – November 15, 2014 = 4

2.7.8.5 Patient List

List of patients 65 and older with at least one prescription for a potentially harmful drug.

2.7.9 Palliative Care

No changes from Version 14.0

2.7.9.1 Owner and Contact

Dr. Bruce Finke

2.7.9.2 Denominators

1. No denominator, count only.

2.7.9.3 Numerators

1. No denominator; count only. The total number of Active Clinical patients 55 and older with at least one palliative care visit during the Report Period. Broken down by gender and age groups.
2. No denominator; count only. The total number of palliative care visits for Active Clinical patients 55 and older during the Report Period. Broken down by gender and age groups.

2.7.9.4 Definitions

Age

Age is calculated at the beginning of the report period

Palliative Care Visit

POV ICD-9: V66.7; ICD-10: Z51.5

2.7.9.5 Patient List

List of patients 55 and older with at least one palliative care visit during the Report Period.

2.7.10 Annual Wellness Visit

No changes from Version 14.0

2.7.10.1 Owner and Contact

Dr. Bruce Finke

2.7.10.2 Denominators

1. Active Clinical patients ages 65 and older. Broken down by gender and age groups.

2.7.10.3 Numerators

1. Patients with at least one Annual Wellness Exam in the past 15 months.

2.7.10.4 Definitions**Age**

Age is calculated at the beginning of the report period

Annual Wellness Exam

CPT G0438, G0439, G0402

2.7.10.5 Patient List

List of patients 65 or older with at least one annual wellness exam in the past 15 months.

List of Acronyms

AI/AN	American Indian/Alaska Native
ASA	Aspirin (acetylsalicylic acid)
BH	Behavioral Health
BHS	Behavioral Health System
BMI	Body Mass Index
BP	Blood Pressure
CBC	Complete Blood Count
CHS	Contract Health Service
CPT	Current Procedural Terminology
CRC	Colorectal Cancer
CRS	Clinical Reporting System
CVX	Vaccine Code
DM	Diabetes Mellitus
DNKA	Did Not Keep Appointment
DPST	Demo/Test Patient Search Template
ER	Emergency Room
ESRD	End Stage Renal Disease
ETDRS	Early Treatment Diabetic Retinopathy Study
ETS	Environmental Tobacco Smoke

FAS	Fetal Alcohol Syndrome
FIT	Fecal Immunochemical Test
FOBT	Fecal Occult Blood Test
FY	Fiscal Year
GFR	Glomerular Filtration Rate
GPRA	Government Performance and Results Act of 1993
ICD	International Classification of Diseases
IHS	Indian Health Service
IPV/DV	Intimate Partner Violence/Domestic Violence
LDL	Low-Density Lipoprotein
LOINC	Logical Observations Identifiers, Names, Codes
OMB	Office of Management and Budget
PCC	Patient Care Component
POV	Purpose of Visit
RPMS	Resource and Patient Management System

Contact Information

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