RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

Selected Measures (Local) Report
Performance Measure List and Definitions

Version 14.1
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Office of Information Technology
Division of Information Resource Management
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1.0 CRS Selected Measures (Local) Report

The performance measure topics and their definitions that are included in the Clinical Reporting System (CRS) 2014 version 14.1 Selected Measures (Local) Reports are shown in Section 1.2.5. Performance measures that are also included in the National Government Performance and Results Act of 1993 (GPRA)/GPRA Modernization Act (GPRAMA) Report are shown in Section 1.1.

Many performance measure topics include both the Active Clinical and User Population denominators. For brevity, the User Population denominator is not listed separately. To see which topics include the User Population denominator, refer to the *CRS Clinical Performance Measure Logic Manual for FY 2014 Clinical Measures.*

1.1 Performance Measures Included in the CRS 2014 National GPRA/GPRAMA Report

The following performance measures are reported in the CRS 2014 National GPRA/GPRAMA Report.

Notations used in this document are described in Table 1-1.

Table 1-1: Document Notations

Notation	Location	Meaning
GPRA:	Preceding a measure	An official GPRA measure reported in the National GPRA Report submitted to the 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.
Plus Sign (+)	Preceding a measure	The measure is *not* an official GPRA measure but *is included* in the National GPRA Report provided to OMB and Congress to provide context to a GPRA measure.
Section Symbol (§)	Preceding a measure	The measure is *not* an official GPRA measure and *is not included* in the National GPRA Report provided to OMB and Congress. Included in this document to provide context to a GPRA measure.

Notation	Location	Meaning
Asterisk (*)	Anywhere in a code	A *wildcard* character indicating that the code given has one or more additional characters at this location.

DIABETES GROUP

- DIABETES PREVALENCE
  - +Diabetes Diagnosis Ever
  - §Diabetes Diagnosis during GPRA Year
- GLYCEMIC CONTROL
  - +Documented Alc
  - Poor Glycemic Control
  - §A1c equal to or greater than (=>)7 and less than (<) 8
  - GPRAMA: Good Glycemic Control
  - A1c less than (<) 7
- BLOOD PRESSURE CONTROL
  - §Blood Pressure (BP) Assessed
  - GPRA: Controlled BP (less than (<) 140/90)
- LOW DENSITY LIPOPROTEIN (LDL) ASSESSMENT
  - GPRA: LDL Assessed
  - §LDL less than (<) 100
- NEPHROPATHY ASSESSMENT
  - GPRA: Estimated Glomerular Filtration Rate (GFR) & Urine Albumin-to-Creatinine Ratio (UACR) or History of End Stage Renal Disease (ESRD)
- RETINOPATHY ASSESSMENT
  - GPRA: Retinopathy Evaluation (No Refusals)

DENTAL GROUP

- ACCESS TO DENTAL
  - GPRA: Annual Dental Visit (No Refusals)
- DENTAL SEALANTS
  - GPRA: Dental Sealants (rate)
  - §Dental Sealants (No Refusals; count; not rate)

- TOPICAL FLUORIDE
  - GPRA: Topical Fluoride (rate)
  - §Topical Fluoride Application (No Refusals; count; not rate)

IMMUNIZATIONS

- INFLUENZA
  - GPRA: Influenza Immunization
- ADULT IMMUNIZATIONS
  - GPRA: Up to Date Pneumovax
- CHILDHOOD IMMUNIZATIONS (19 THROUGH 35 MONTHS)
  - §Active Clinical Patients with 4:3:1:3*:3:1:4 (No Refusals)
  - GPRAMA: Active IMM Patients with 4:3:1:3*:3:1:4 (No Refusals)
  - §4 DTaP
  - §3 Polio
  - §1 MMR
  - §3 or 4 HiB
  - §3 Hepatitis B
  - §0 Varicella
  - §4 Pneumococcal

CANCER SCREENING

- PAP SMEAR RATES
  - GPRA: Pap smear in past 3 years or for age 30+, Pap & HPV in past 5 years (No Refusals)
- MAMMOGRAM RATES
  - GPRA: Mammogram (No Refusals)
- COLORECTAL CANCER SCREENING
  - GPRA: Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) during report period, Flexible Sigmoidoscopy in past 5 years, or Colonoscopy in past 10 years (No Refusals)
  - §FOBT or FIT
- TOBACCO USE AND EXPOSURE ASSESSMENT
  - §Tobacco Assessment
  - §Tobacco Users
    - §Smokers

  - §Smokeless Users
- §Exposed to Environmental Tobacco Smoke (ETS)

- TOBACCO CESSATION
  - §Tobacco Cessation Counseling or Smoking Cessation Aid (No Refusals)
  - §Quit Tobacco Use
  - GPRA: Tobacco Cessation Counseling, Smoking Cessation Aid, or Quit Tobacco Use

BEHAVIORAL HEALTH

- ALCOHOL SCREENING (FETAL ALCOHOL SYNDROME [FAS] PREVENTION)
  - GPRA: Alcohol Screening (No Refusals)
- INTIMATE PARTNER VIOLENCE/DOMESTIC VIOLENCE (IPV/DV) SCREENING
  - GPRA: IPV/DV Screening (No Refusals)
- DEPRESSION SCREENING
  - GPRAMA: Depression Screening or Mood Disorder Diagnosis (No Refusals)
  - §Depression Screening
  - §Mood Disorder Diagnosis

CARDIOVASCULAR DISEASE-RELATED

- CHILDHOOD WEIGHT CONTROL
  - GPRA: BMI 95% and Up
- CONTROLLING HIGH BLOOD PRESSURE – MILLION HEARTS
  - GPRA: BP less than (<) 140/90
- COMPREHENSIVE CVD-RELATED ASSESSMENT
  - GPRAMA: BP, LDL, and Tobacco Assessed, BMI, and Lifestyle Counseling
    (No Refusals)
  - §Depression Screen

STD GROUP

- HIV SCREENING
  - GPRA: Prenatal HIV Screening (No Refusals)

OTHER CLINICAL

- BREASTFEEDING RATES
  - Patients 30 through 394 days of age screened for infant feeding choice (IFC) at least once
  - Patients 30 through 394 days of age screened for IFC at the age of 2 months
  - Patients 30 through 394 days of age screened for IFC at the age of 6 months
  - Patients 30 through 394 days of age screened for IFC at the age of 9 months
  - Patients 30 through 394 days of age screened for IFC at the age of 1 year
  - GPRA: Patients 30 through 394 days of age who were exclusively or mostly breastfed at 2 months of age
  - Patients 30 through 394 days of age who were exclusively or mostly breastfed at 6 months of age
  - Patients 30 through 394 days of age who were exclusively or mostly breastfed at 9 months of age
  - Patients 30 through 394 days of age who were exclusively or mostly breastfed at the age of 1 year

Note: Definitions for all performance measure topics included in CRS begin on Section 2.0. Definitions for numerators and denominators that are preceded by "GPRA" represent measures that are reported to OMB and Congress.

1.2 CRS Denominator Definitions

1.2.1 For All Denominators

- All patients with name "DEMO, PATIENT" or who are included in the RPMS Demo/Test Patient Search Template (DPST option located in the Patient Care Component (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.

1.2.2 Active Clinical Population

1.2.2.1 National GPRA/GPRAMA Reporting

- Must have two visits to medical clinics in the past 3 years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least 1 visit must be to a core medical clinic. Refer to the *Clinical Reporting System (CRS) for FY2014 Clinical Measures User Manual* for a 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.

1.2.2.2 Local Reports

- Must have two visits to medical clinics in the past 3 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 *CRS for FY2014 Clinical Measures User Manual* for a 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.

1.2.3 User Population

1.2.3.1 National GPRA/GPRAMA Reporting

- 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.
- Must be 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 CHS catchment area.

1.2.3.2 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.

1.2.4 Active Clinical Plus BH Population

1.2.4.1 National GPRA/GPRAMA Reporting

- Must have two visits to medical clinics in the past 3 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 a listing of these clinics.
- 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 GPRA community taxonomy, defined as all communities of residence in the defined CHS catchment area.

1.2.4.2 Local Reports

- Must have two visits to medical clinics in the past 3 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 a 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.

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 Selected Measures (Local) 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 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; *not* reported to OMB and Congress)

2.1.1.3 Denominators

1. User Population patients.

2.1.1.4 Numerators

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

2.1.1.5 Definitions

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.*.

2.1.1.6 Patient List

Diabetic patients with most recent diagnosis

2.1.2 Diabetes: Comprehensive Care

Changes from CRS v14.0 are noted

2.1.2.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.2.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.1.2.3 Denominators

1. Active Diabetic patients, 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.

2. Active Diabetic patients, 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, without a documented history of bilateral blindness.

3. Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the Report Period, *and* at least two visits during the Report Period, *and* twoDM-related visits ever, without a documented history of bilateral foot amputation or two separate unilateral foot amputations.

2.1.2.4 Numerators

1. Patients with hemoglobin A1c documented during the report period, regardless of result.

2. Patients with blood pressure documented during the report period

3. Patients with controlled blood pressure during the report period, defined as less than 140/90. This measure is not included in the comprehensive measure (Numerator 8)

4. Patients with LDL completed during the report period, regardless of result.

5. 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.

6. Patients receiving a qualified retinal evaluation during the report period.

Note: This numerator does *not* include refusals.

7. Patients with diabetic foot exam during the report period.

> **Note:** This numerator does *not* include refusals.

8. Patients with A1c *and* BP assessed *and* LDL *and* Nephropathy Assessment *and* Retinal exam *and* Diabetic Foot Exam.

> **Note:** This numerator does *not* include controlled BP, only BP assessment.

2.1.2.5 Definitions

Diabetes

First POV 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 none 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

BP Documented

BP documented is defined as having a minimum of two BPs documented during 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)

CRS uses the mean of the last 3 BPs documented during the report period. If 3 BPs are not available, it uses the mean of 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 two) 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 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 previously. 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, CPT 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 less than 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.

LDL

Finds the last test done during the report period; defined as one 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

Nephropathy Assessment

Defined as any of the following:

- Estimated GFR with result during the report period, defined as any of the following:
  - Site-populated taxonomy BGP GPRA ESTIMATED GFR TAX
  - LOINC taxonomy

- Urine Albumin-to-Creatinine Ratio during the report period, defined as any of the following:
  - CPT 82043 WITH 82570
  - LOINC taxonomy
  - Site-populated taxonomy BGP QUANT UACR TESTS

Note: Be sure to check with your laboratory supervisor that the names added to your taxonomy reflect quantitative test values.

- End Stage Renal Disease 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.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
  - International Classification of Diseases (ICD) Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Qualified Retinal Evaluation

Either of the following:

- Diabetic retinal exam
- 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 7 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 validated[1] ETDRS photographic equivalent.

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

- CPT 2022F Dilated retinal eye exam, 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, 2026F Eye imaging formally validated[2] to match the diagnosis from 7 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

Any of the following during the report period:

- Non-DNKA (did not keep appointment) visits to ophthalmology, optometry or formally validated[3] teleophthalmology retinal evaluation clinics
- Non-DNKA visits to an optometrist or ophthalmologist. Searches for the following codes in the following order:
  - Clinic codes A2 (Diabetic Retinopathy)[4], 17, 18
  - 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

Diabetic Foot Exam

Any of the following:

- Exam code 28 Diabetic Foot Exam, Complete
- Non-DNKA visit with a podiatrist (Provider codes 33, 84, 25)
- Non-DNKA visit to Podiatry Clinic (Clinic code 65)
- CPT 2028F

Bilateral foot amputation

- CPT 27290.50 through 27295.50, 27590.50 through 27592.50, 27598.50, 27880.50 through 27882.50 (50 modifier indicates bilateral)

Unilateral foot amputation

- Must have two separate occurrences for either CPT or Procedure codes on 2 different dates of service:

[2] Ibid.
[3] Ibid.
[4] Validated photographic (teleophthalmology) retinal surveillance.

- CPT 27290 through 27295, 27590 through 27592, 27598, 27880 through 27882
- Procedure ICD-9: 84.10, 84.13 through 84.19; ICD-10: 0Y6*0ZZ, 0Y6C0Z*, 0Y6D0Z*, 0Y6H0Z*, 0Y6J0Z*, 0Y6M0Z0, 0Y6N0Z0

2.1.2.6 Patient List

Diabetic patients with documented tests, if any.

2.1.3 Diabetes: Glycemic Control

No changes from Version 14.0

2.1.3.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.3.3 Denominators

1. All User Population patients diagnosed with diabetes prior to the report period.
2. GPRAMA: Active Diabetic patients; defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at two visits in the past year, *and* two DM-related visits ever. Key denominator for this and all diabetes-related topics that follow.
3. Active Adult Diabetic patients, defined by meeting the following criteria:
   - Who are 19 or older at the beginning of the report period
   - Whose first ever DM diagnosis occurred prior to the report period
   - Who had at least two DM related visits ever
   - With at least one encounter with DM POV in a primary clinic with a primary provider during the report period
   - Never have had a creatinine value greater than (>) 5

2.1.3.4 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 greater than or equal to (>=) 12.
4. Poor control: A1c greater than (>) 9.5 and less than (<) 12.
5. Fair control A1c is greater than or equal to (>=) 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.

2.1.3.5 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.

Serum Creatinine

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

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 any of the following:
  - CPT 83036, 83037, 3044F through 3046F, 3047F (old code)
  - 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.

2.1.3.6 GPRA 2014 Description

Good Glycemic Control: During FY 2014, achieve the target rate of 48.3%for the proportion of patients with diagnosed diabetes who have good glycemic control (defined as A1c less than (<) 7).

2.1.3.7 Patient List

Diabetic patients with most recent A1c value, if any.

2.1.4 Diabetes: Blood Pressure Control

No changes from Version 14.0

2.1.4.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.4.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.4.3 Denominators

1. All User Population patients diagnosed with diabetes prior to the report period
2. GPRA**:** Active Diabetic patients, 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.
3. Active Adult Diabetic patients, defined by meeting the following criteria:
    - Who are 19 or older at the beginning of the report period
    - Whose first ever DM diagnosis occurred prior to the report period
    - Who had at least two DM related visits ever
    - With at least one encounter with DM POV in a primary clinic with a primary provider during the report period
    - Never have had a creatinine value greater than (>) 5

2.1.4.4 Numerators

1. Patients with BP documented during the report period.
2. GPRA**:** Patients with controlled BP, defined as less than 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.

2.1.4.5 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.

Serum Creatinine

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

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 three (or two). 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 previously where BP is less than (<) 140/90. If *both* the mean systolic and diastolic values do not 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 on non-ER visits 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 less than (<) 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.

2.1.4.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 64.6% for the proportion of patients with diagnosed diabetes who have achieved BP control (defined as less than (<) 140/90).

2.1.4.7 Patient List

List of diabetic patients with BP value, if any.

2.1.5 Diabetes: LDL Assessment

Changes from CRS v14.0 are noted

2.1.5.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.5.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.5.3 Denominators

1. All User Population patients diagnosed with diabetes prior to the report period.
2. GPRA**:** Active Diabetic patients; 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. Key denominator for this and all diabetes-related topics that follow.
3. Active Adult Diabetic patients, defined by meeting the following criteria:
   - Who are 19 or older at the beginning of the report period
   - Whose first ever DM diagnosis occurred prior to the report period
   - Who had at least two DM related visits ever
   - With at least one encounter with DM POV in a primary clinic with a primary provider during the report period
   - Never have had a creatinine value greater than (>) 5

2.1.5.4 Numerators

1. GPRA**:** Patients with 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 between 100 and 129.

2.1.5.5 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.

Serum Creatinine

Either of the following:

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

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 less than 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.

2.1.5.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 73.9% for the proportion of patients with diagnosed diabetes who are assessed for dyslipidemia (LDL cholesterol).

2.1.5.7 Patient List

List of diabetic patients with documented LDL cholesterol test, if any.

2.1.6 Diabetes: Nephropathy Assessment

Changes from CRS v14.0 are noted

2.1.6.1 Owner and Contact

Diabetes Program: Dr. Ann Bullock

2.1.6.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.6.3 Denominators

1. All User Population patients diagnosed with diabetes prior to the report period.

2. GPRA**:** Active Diabetic patients; 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. Key denominator for this and all diabetes-related topics that follow.

3. Active Adult Diabetic patients, defined by meeting the following criteria:

   - Who are 19 or older at the beginning of the report period
   - Whose first ever DM diagnosis occurred prior to the report period
   - Who had at least two DM related visits ever
   - With at least one encounter with DM POV in a primary clinic with a primary provider during the report period
   - Never have had a creatinine value greater than (>) 5

2.1.6.4 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.

2.1.6.5 Definitions

Diabetes

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

Serum Creatinine

- Site-populated taxonomy DM AUDIT CREATININE TAX, or
- LOINC taxonomy

> **Note**: CPT codes are not included since they do not store the result, which is used in this topic.

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

- End Stage Renal Disease 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.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
  - Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

2.1.6.6 GPRA 2014 Description

During FY 2014, establish a baseline for the proportion of patients with diagnosed diabetes who are assessed for nephropathy.

2.1.6.7 Patient List

List of diabetic patients with nephropathy assessment, if any.

2.1.7 Diabetic Retinopathy

No changes from Version 14.0

2.1.7.1 Owner and Contact

Diabetes Program: Dr. Mark Horton

2.1.7.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.1.7.3 Denominators

1. All User Population patients diagnosed with diabetes prior to the report period, without a documented history of bilateral blindness.

2. GPRA: Active Diabetic patients; 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. Key denominator for this and all diabetes-related topics that follow.

3. Active Adult Diabetic patients, without a documented history of bilateral blindness, defined by meeting the following criteria:

   - Who are 19 or older at the beginning of the report period
   - Whose first ever DM diagnosis occurred prior to the report period
   - Who had at least two DM related visits ever
   - With at least one encounter with DM POV in a primary clinic with a primary provider during the report period
   - Never have had a creatinine value greater than (>) 5

2.1.7.4 Numerators

1. GPRA: Patients receiving a qualified retinal evaluation[5] during the report period.

   Note: This numerator does *not* include refusals.

   A. Patients receiving diabetic retinal exam during the report period.

   B. Patients receiving other eye exams during the report period.

   C. Patients with a JVN visit during the Report Period.

   D. Patients with an Ophthalmology visit during the Report Period.

   E. Patients with an Optometry visit during the Report Period.

2.1.7.5 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.

[5] Validation study properly powered and controlled against the ETDRS gold standard.

Serum Creatinine

Either of the following:

- Site-populated taxonomy DM AUDIT CREATININE TAX
- LOINC taxonomy

Note: CPT codes are not included since they do not store the result, which is used in this topic.

Qualified Retinal Evaluation

- Diabetic retinal exam
- Other eye exam.

The following methods are qualifying for this measure:

- Dilated retinal evaluation by an optometrist or ophthalmologist.
- Seven standard fields stereoscopic photos (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 validated[6] 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 validated[7] to match the diagnosis from 7 standard field stereoscopic photos, S0620 Routine ophthalmological examination including refraction; new patient, S0621 Routine ophthalmological examination including refraction; established patient, or S3000 Diabetic indicator; retinal eye exam, dilated, bilateral.

Other Eye Exam

- Non-DNKA visits to ophthalmology, optometry or formally validated[8] teleophthalmology retinal evaluation clinics
- Non-DNKA visits to an optometrist or ophthalmologist. Searches for the following codes in the following order:

[6] Validation study properly powered and controlled against the ETDRS gold standard.
[7] Ibid.
[8] Ibid.

- Clinic codes A2 (Diabetic Retinopathy)[9], 17, 18
- Provider code 24, 79, 08
- CPT 67028, 67038 (old code), 67039, 67040, 92002, 92004, 92012, 92014

JVN Visit

- Clinic code A2

Ophthalmology Visit

- Clinic code 17
- Provider code 79

Optometry Visit

- Clinic code 18
- Provider codes 08, 24

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

2.1.7.6 GPRA 2014 Description:

During FY 2014, achieve the target rate of 58.6% for the proportion of patients with diagnosed diabetes who receive an annual retinal examination.

2.1.7.7 Patient List

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

2.1.8 RAS Antagonist Use in Diabetic Patients

Changes from CRS v14.0 are noted

2.1.8.1 Owner and Contact

Chris Lamer, PharmD

2.1.8.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

[9] Validated photographic (teleophthalmology) retinal surveillance.

2.1.8.3 Denominators

1. Active Diabetic patients with HTN, defined as all Active Clinical patients diagnosed with diabetes and hypertension prior to the Report Period, *and* at least two visits during the Report Period, *and* two DM-related visits ever, and no documented history of ESRD.

2.1.8.4 Numerators

1. Patients receiving a RAS Antagonist medication during the Report Period.

2. Patients with contraindication or previous adverse reaction to RAS Antagonist therapy.

2.1.8.5 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.

Hypertension

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 401.* or ICD-10: I10 prior to the Report period, and at least one hypertension POV during the Report period.

ESRD

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, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), S2065, S9339
- POV ICD-9: 585.6, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

RAS Antagonist Numerator Logic

Renin Angiotensin System (RAS) Antagonist medication codes defined with medication taxonomy BGP PQA RASA MEDS.

ACEI medications are:

- Angiotensin Converting Enzyme Inhibitors (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).
- Antihypertensive Combinations (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Enalapril-Felodipine, Fosinopril-hydrochlorothiazide, Lisinopril-hydrochlorothiazide, Moexipril-hydrochlorothiazide, Quinapril-hydrochlorothiazide, Trandolapril-verapamil).

ARB (Angiotensin Receptor Blocker) medications are:

- Angiotensin II Inhibitors (Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan).
- Antihypertensive Combinations (Amlodipine-valsartan, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-olmesartan, Azilsartan-Chlorthalidone, Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Irbesartan-hydrochlorothiazide, Losartan-hydrochlorothiazide, Olmesartan-amlodipine-hydrochlorothiazide, Olmesartan-hydrochlorothiazide, Telmisartan-amlodipine, Telmisartan-hydrochlorothiazide, Valsartan-hydrochlorothiazide).

Direct Renin Inhibitor medications are:

- Direct Renin Inhibitors (Aliskiren).
- Direct Renin Inhibitor Combination Products (Aliskiren-amlodipine, Aliskiren-amlodipine-hydrochlorothiazide, Aliskiren-hydrochlorothiazide, Aliskiren-valsartan).

Contraindications to RAS Antagonist

- Pregnancy, defined as at least two visits during the Report Period with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36, where the primary provider is not a Community Health Representative (CHR: Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit.

- Miscarriage definition
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
- Abortion definition

  - POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
  - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267
  - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z
- Breastfeeding, defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period
- Diagnosis ever for moderate or severe aortic stenosis (POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, or 747.22) or
- NMI (not medically indicated) refusal for any RAS Antagonist at least once during the Report Period

Adverse drug reaction or documented RAS Antagonist allergy

- POV ICD-9: 995.0 through 995.3 *and* E942.6; ICD-10: T46.4X5*
- "ace inhibitor", "ACEI", "Angiotensin Receptor Blocker" or "ARB" entry in ART (Patient Allergies File); or
- "ace i*", "ACEI", "Angiotensin Receptor Blocker" or "ARB" contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

2.1.8.6 Patient List

List of diabetic patients with hypertension, with RAS Antagonist medication, contraindication, or adverse drug reactions (ADR), if any.

2.1.9 Diabetic Access to Dental Services

Changes from CRS v14.0 are noted

2.1.9.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.1.9.2 National Reporting

Not reported nationally

2.1.9.3 Denominators

1. Active Diabetic patients; 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.

2.1.9.4 Numerators

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

Note: This numerator does *not* include refusals.

2.1.9.5 Definitions

Diabetes

First DM POV 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.

2.1.9.6 Patient List

List of diabetic patients 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 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.2.1.3 Denominators

1. GPRA**:** User Population patients, broken down by age groups: 0 through 5 years, 6 through 21 years, 22 through 34 years, 35 through 44 years, 45 through 54 years, 55 through 74 years, 75 years and older.

2.2.1.4 Numerators

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

Note: This numerator does *not* include refusals.

2.2.1.5 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.

2.2.1.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 29.2% for the proportion of patients who receive dental services.

2.2.1.7 Patient List

List of patients with documented dental visit and date.

2.2.2 Dental Sealants

No changes from Version 14.0

2.2.2.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.2.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.2.2.3 Denominators

1. GPRA: User Population patients ages 2 through 15. Broken down by age groups 3 through 5, 6 through 9, 10 through 12, and 13 through 15.
2. No denominator. This measure is a total count only, not a percentage. Broken down by age groups 2 through 15 and greater than 15.

2.2.2.4 Numerators

1. GPRA: Patients with at least 1 or more intact dental sealants.
2. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of dental sealants during the report period.

Note: This numerator does *not* include refusals.

2.2.2.5 Definitions

Intact Dental Sealant

- Any of the following documented during the Report Period:
  - Dental ADA codes 1351, 1352
  - CPT codes D1351, D1352
- OR any of the following documented during the past 3 years from the end of the Report Period, as long as it is not documented on the same visit as any of the above codes:
  - Dental ADA code 0007

If both ADA and CPT codes are found on the same visit, only the ADA will be counted.

For the count measure, only 2 sealants per tooth will be counted during the report period. Each tooth is identified by the data element Operative Site in RPMS.

2.2.2.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 13.9% for the proportion of patients with at least one or more intact dental sealants.

2.2.2.7 Patient List

List of patients with intact dental sealants.

2.2.3 Topical Fluoride

No changes from Version 14.0

2.2.3.1 Owner and Contact

Dental Program: Dr. Patrick Blahut

2.2.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.2.3.3 Denominators

1. GPRA: User Population patients ages 1 through15.
2. No denominator. This measure is a total count only, not a percentage.

2.2.3.4 Numerators

1. GPRA: Patients who received one or more topical fluoride applications during the report period.
2. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of patients with at least one topical fluoride treatment during the report period.

Note: This numerator does *not* include refusals.

   A. Topical fluoride treatment in patients 1 through 15 yrs.

3. Count only (no percentage comparison to denominator). For patients meeting the User Population definition, the total number of appropriate topical fluoride applications based on a maximum of four per patient per year.

2.2.3.5 Definitions

Topical Fluoride Application

Defined as any of the following:

- Dental ADA codes 1201 (old code), 1203 (old code), 1204 (old code), 1205 (old code), 1206, 1208, 5986
- CPT codes D1203 (old code), D1204 (old code), D1206, D1208, D5986
- POV ICD-9: V07.31

For the count measure, a maximum of one application per patient per visit is allowed. A maximum of four topical fluoride applications are allowed per patient per year for the applications measure.

2.2.3.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 26.7% for the proportion of patients who received one or more topical fluoride applications.

2.2.3.7 Patient List

List of patients who received at least one topical fluoride application during report period.

2.3 Immunization Group

2.3.1 Influenza

Changes from CRS v14.0 are noted

2.3.1.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.3.1.3 Denominators

1. Active Clinical patients broken down by age groups (younger than18 years, 18 through 49 years, 50 through 64 years, 65 years and older).

   A. GPRA: Active Clinical patients ages 65 years and older.

2. Active Clinical patients ages 18 through 49 years and considered high risk for influenza.

3. Active Diabetic patients, 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.

4. User Population patients broken down by age groups (younger than 18 years, 18 through 49 years, 50 through 64 years, 65 years and older).

5. User Population patients ages 18 through 49 years and considered high risk for influenza

2.3.1.4 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.

2.3.1.5 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.

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, 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

Persons Considered High Risk for Influenza

Those who have two or more visits in the past 3 years with a POV or Problem diagnosis of any of the following:

- HIV Infection: ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08; ICD-10: B20, B52.0, B97.35, Z21
- Diabetes: ICD-9: 250.00 through 250.93; ICD-10: E08.2*, E09.2*, E10.* through E13.*
- Rheumatic Heart Disease: ICD-9: 393. through 398.99; ICD-10: I05.* through I09.*
- Hypertensive Heart Disease: ICD-9: 402.00 through 402.91; ICD-10: I11.*
- Hypertensive Heart or Renal Disease: ICD-9: 404.00 through 404.93; ICD-10: I13.*
- Ischemic Heart Disease: ICD-9: 410.00 through 414.9; ICD:10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- Pulmonary Heart Disease: ICD-9: 415.0 through 416.9; ICD-10: I26.* through I27.*
- Other Endocardial Heart Disease: ICD-9: 424.0 through 424.9; ICD-10: I34.* through I39
- Cardiomyopathy: ICD-9: 425.0 through 425.9; ICD-10: I42.*, I43
- Congestive Heart Failure: ICD-9: 428.0 through 428.9, 429.2; ICD-10: I50.1, I50.20, I50.22 through I50.30, I50.32 through I50.40, I50.42 through I50.9
- Chronic Bronchitis: ICD-9: 491.0 through 491.9; ICD-10: J41.*, J42
- Emphysema: ICD-9: 492.0 through 492.8; ICD-10: J43.*
- Asthma: ICD-9: 493.00 through 493.91; ICD-10: J45.21 through J45.902
- Bronchiectasis, CLD, COPD: ICD-9: 494.0 through 496.; ICD-10: J44.*, J47.*
- Pneumoconioses: ICD-9: 500 through 505; ICD-10: J60 through J64, J66.8 through J67.6, J67.8 through J67.9
- Chronic Liver Disease: ICD-9: 571.0 through 571.9; ICD-10: K70.11 through K70.41, K73.0 through K74.5, K74.69, K75.81
- Nephrotic Syndrome: ICD-9: 581.0 through 581.9; ICD-10: N02.*, N04.*, N08
- Renal Failure: ICD-9: 585.6, 585.9; ICD-10: N18.6 through N19

- Transplant: ICD-9: 996.80 through 996.89; ICD-10: T86.00 through T86.819, T86.83*, T86.850 through T86.899, Z48.21 through Z48.280, Z48.290, Z94.0 through Z94.4, Z94.6, Z94.81 through Z94.84, Z95.3, Z95.4
- Kidney Transplant: ICD-9: V42.0 through V42.89
- Chemotherapy: ICD-9: V58.1; ICD-10: Z51.11, Z51.12
- Chemotherapy follow-up: ICD-9: V67.2; ICD-10: Z08

2.3.1.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 69.1% for the proportion of non-institutionalized adults aged 65 years and older who receive an influenza immunization.

2.3.1.7 Patient List

List of patients with Influenza code, if any.

2.3.2 Adult Immunizations

Changes from CRS v14.0 are noted

2.3.2.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.3.2.3 Denominators

1. Active Clinical patients ages 19-59.
2. Active Clinical patients ages 60-64.
3. GPRA**:** Active Clinical patients ages 65 or older.
4. Active Clinical patients ages 18 through 64 years and considered high risk for pneumococcal.
5. Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the report period, *and* at two visits during the report period, *and* two DM-related visits ever.

6. User Population patients ages 19-59.
7. User Population patients ages 60-64.
8. User Population patients ages 65 years and older.
9. User Population patients ages 18 through 64 years and considered high risk for pneumococcal.
10. Active Clinical patients ages 18 and older, broken down by age groups.
11. User Population patients ages 18 and older, broken down by age groups.

2.3.2.4 Numerators

1. Patients who have received 1 dose of Tdap or Td in the past 10 years, including contraindications and evidence of disease.

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

   A. Patients with a contraindication or a documented NMI refusal

2. Patients who have received 1 dose of Tdap ever, including contraindications and evidence of disease.

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

   A. Patients with a contraindication or a documented NMI refusal

3. 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 NMI refusals.

   A. Patients with a contraindication or a documented NMI refusal

4. Patients who have received 1 dose of Zoster ever, including contraindications and evidence of disease.

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

   A. Patients with a contraindication or a documented NMI refusal

5. 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

6. Patients who have received the 1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period), including contraindications and evidence of disease.

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

   A. Patients with a contraindication or a documented NMI refusal

7. Patients who have received the 1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, 1 Zoster ever), including contraindications and evidence of disease.

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

   A. Patients with a contraindication or a documented NMI refusal

8. Patients who have received the 1:1:1:1:1 combination (i.e., 1 Tdap/Td in the past 10 years, 1 Tdap ever, 1 influenza during the Report Period, 1 Zoster ever, 1 up-to-date Pneumovax), including contraindications and evidence of disease.

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

   A. Patients with a contraindication or a documented NMI refusal

9. Patients with Pneumococcal vaccine or contraindication documented at any time before the end of the report period.

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

2.3.2.5 Definitions

Diabetes

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

Pneumococcal Vaccine

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

Persons Considered High Risk for Pneumococcal

Those who have 2 or more visits in the past 3 years with a POV or Problem diagnosis of any of the following:

- HIV Infection: ICD-9: 042, 042.0 through 043.9 (old codes), 044.9 (old code), 079.53, V08; ICD-10: B20, B52, B97.35, Z21
- Diabetes: ICD-9: 250.00 through 250.93; ICD-10: E08.2*, E09.2*, E10.* through E13.*
- Chronic alcoholism: ICD-9: 303.90, 303.91; ICD-10: F10.20, F10.220 through F10.29
- Congestive Heart Failure: ICD-9: 428.0 through 428.9, 429.2; ICD-10: I50.1, I50.20, I50.22 through I50.30, I50.32 through I50.40, I50.42 through I50.9
- Emphysema: ICD-9: 492.0 through 492.8; ICD-10: J43.*
- Asthma: ICD-9: 493.00 through 493.91; ICD-10: J45.21 through J45.902
- Bronchiectasis, CLD, COPD: ICD-9: 494. through 496.; ICD-10: J44.*, J47.*
- Pneumoconioses: ICD-9: 501. through 505.; ICD-10: J60 through J64, J66.8 through J67.6, J67.8 through J67.9
- Chronic Liver Disease: ICD-9: 571.0 through 571.9; ICD-10: K70.11 through K70.41, K73.0 through K74.5, K74.69, K75.81
- Nephrotic Syndrome: ICD-9: 581.0 through 581.9; ICD-10: N02.*, N04.*, N08

- Renal Failure: ICD-9: 585.6, 585.9; ICD-10: N18.6 through N19
- Injury to spleen: ICD-9: 865.00 through 865.19
- Transplant: ICD-9: 996.80 through 996.89; ICD-10: T86.00 through T86.819, T86.83*, T86.850 through T86.899, Z48.21 through Z48.280, Z48.290, Z94.0 through Z94.4, Z94.6, Z94.81 through Z94.84, Z95.3, Z95.4
- Kidney Transplant: ICD-9: V42.0 through V42.89
- Chemotherapy: ICD-9: V58.1; ICD-10: Z51.11, Z51.12
- Chemotherapy follow-up: ICD-9: V67.2; ICD-10: Z08

Tdap Immunization:

Any of the following documented during the applicable time frame:

- Immunization (CVX) code: 115
- CPT 90715

Tdap Contraindication

Any of the following documented any time before the end of the Report Period:

- Immunization Package contraindication of "Anaphylaxis"
- PCC NMI Refusal

Td Immunization

Any of the following documented in the past 10 years:

- Immunization (CVX) code 9, 113, 138, 139
- POV ICD-9: V06.5
- CPT 90714, 90718

Td Contraindication

Any of the following documented any time before the end of the Report Period:

- Immunization Package contraindication of "Anaphylaxis"
- PCC NMI Refusal

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, 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

Zoster Vaccine

Any of the following documented ever:

- Immunization (CVX) codes 121
- CPT 90736

Contraindication to Zoster Vaccine

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

- Contraindication in the Immunization Package of Immune Deficiency or Anaphylaxis
- PCC NMI Refusal

2.3.2.6 GPRA 2014 Description

During FY 2014, establish a baseline for the proportion of adult patients age 65 years and older who receive a pneumococcal immunization.

2.3.2.7 Patient List

List of patients equal to or greater than (=>) 18 yrs or DM DIAGNOSIS with IZ, evidence of disease, or contraindication, if any.

2.3.3 Childhood Immunizations

Changes from CRS v14.0 are noted

2.3.3.1 Owner and Contact

Epidemiology Program: Amy Groom, MPH

2.3.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.3.3.3 Denominators

1. Active Clinical patients ages 19 through 35 months at end of report period.
2. GPRAMA: User Population patients active in the Immunization Package who are 19 through 35 months of age at end of report period.

> **Note:** Sites must be running the RPMS Immunization package for this denominator. Sites not running the package will have a value of zero for this denominator.

2.3.3.4 Numerators

1. GPRAMA: Patients who have received the 4:3:1:3*:3:1:4 combination (i.e., 4 DTaP, three Polio, one MMR, 3 or 4 HiB, 3 Hepatitis B, 1 Varicella, and 4 Pneumococcal), including contraindications, and evidence of disease.

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

   A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

2. Patients who have received 4 doses of DTaP ever, including contraindications.

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

   A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

3. Patients who have received 3 doses of Polio ever, including contraindications, and evidence of disease.

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

   A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

4. Patients who have received 1 dose of MMR ever, including contraindications, and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

5. Patients who have received 3 or 4 doses of HiB ever, including contraindications.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

6. Patients who have received 3 doses of Hepatitis B vaccine ever, including contraindications, and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

7. Patients who have received one dose of Varicella ever, including contraindications, and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

8. Patients who have received 4 doses of Pneumococcal conjugate vaccine ever, including contraindications, and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

9. Patients who have received 1 dose of Hepatitis A vaccine ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI (not medically indicated) refusal.

10. Patients who have received 2 or 3 doses of Rotavirus vaccine ever, including contraindications and evidence of disease.

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

   A. Patients with (1) a contraindication or (2) a documented NMI (not medically indicated) refusal.

11. Patients who have received 2 doses of Influenza ever, including contraindications.

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

   A. Patients with (1) a contraindication or (2) a documented NMI (not medically indicated) refusal.

2.3.3.5 Definitions

Patient Age

Since the age of the patient is calculated at the beginning of the report period, the age range will be adjusted to 7 through 23 months at the beginning of the report period, which makes the patient between the ages of 19 through 35 months at the end of the report period.

Timing of Doses

Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Active Immunization Package Patients Denominator

Same as User Population definition *except* includes only patients flagged as active in the Immunization Package.

> **Note:** Only values for the current period will be reported for this denominator since currently there is not a way to determine if a patient was active in the Immunization Package during the previous year or baseline periods.

Dosage and Types of Immunizations

- **4 Doses of DTaP**
  - 4 DTaP or DTP or Tdap
  - 1 DTaP or DTP or Tdap and 3 DT or Td
  - 1 DTaP or DTP or Tdap and 3 each of Diphtheria and Tetanus

  - 4 DT and 4 Acellular Pertussis
  - 4 Td and 4 Acellular Pertussis
  - 4 each of Diphtheria, Tetanus, and Acellular Pertussis
- **3 Doses of Polio**
  - 3 OPV
  - 3 IPV
  - Combination of OPV and IPV totaling three doses
- **1 Dose of MMR**
  - MMR
  - 1 M/R and 1 Mumps
  - 1 R/M and one1 Measles
  - 1 each of Measles, Mumps, and Rubella
- **3 doses of Hepatitis B**
- **3 or 4 doses of HIB**
- **0 dose of Varicella**
- **4 doses of Pneumococcal**
- **1 dose of Hepatitis A**
- **2 or 3 doses of Rotavirus, depending on the vaccine administered**
- **2 doses of Influenza**

Not Medically Indicated (NMI) Refusal, Contraindication, and Evidence of Disease Information

Except for the Immunization Program Numerators, the following will also count toward meeting the definition, as defined in the following subsections:

- NMI refusals
- Evidence of disease
- Contraindications for individual immunizations

Note: NMI refusals are not counted as refusals; rather, they are counted as contraindications.

- For immunizations that allow a different number of doses (e.g., 2 or 3 Rotavirus): To count toward the numerator with the smaller number of doses, all of the patient's vaccinations must be part of the smaller dose series. For example, for a patient to count toward the Rotavirus numerator with only 2 doses, all 2 doses must be included in the 2-dose series codes listed in the Rotavirus definition. A patient with a mix of 2-dose and 3-dose series codes will need 3 doses to count toward the numerator. An exception to this is for the HIB vaccine: if the first 2 doses are CVX code 49, then the patient only needs 3 doses (even if the third dose is included in the 4-dose series).
- Each immunization must be refused and documented separately. For example, if a patient has an NMI refusal for Rubella only, then there must be an immunization, contraindication, or separate NMI refusal for the Measles and Mumps immunizations.
- For immunizations where required number of doses is greater than one, only one NMI refusal is necessary to be counted in the numerator. For example, if there is a single NMI refusal for Hepatitis B, the patient will be included in the numerator.
- For immunizations where required number of doses is greater than one, only one contraindication is necessary to be counted in the numerator. For example, if there is a single contraindication for HiB, the patient will be included in the numerator.
- Evidence of disease will be checked for at any time in the child's life (prior to the end of the report period).
- To be counted in Subnumerator A, a patient must meet the numerator definition AND have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be included in Subnumerator A.
- For the separate numerator for REF refusal (Patient Refusal for Service) in PCC or a Parent or Patient refusal in the IZ program, the conditions must be met:
  - Each immunization must be refused and documented separately. For example, if a patient has an REF refusal for Rubella, then there also must be an immunization, contraindication, or separate REF refusal for Measles and Mumps.
  - Where the required number of doses is greater than one, only one REF refusal in PCC or one Parent or Patient refusal in the IZ program is necessary to be counted in the numerator. For example, for the 4 DTaP numerators, only one refusal is necessary to be counted in the refusal numerator.

NMI Refusal Definitions

PCC Refusal type NMI for any of the following codes:

- **DTaP**
  - Immunization (CVX) codes 20, 50, 106, 107, 110, 120, 130, 132, 146
  - CPT 90696, 90698, 90700, 90721, 90723
- **DTP**
  - Immunization (CVX) codes 1, 22, 102
  - CPT 90701, 90711 (old code), 90720
- **Tdap**
  - Immunization (CVX) code 115
  - CPT 90715
- **DT**
  - Immunization (CVX) code 28
  - CPT 90702
- **Td**
  - Immunization (CVX) codes 9, 113, 138, 139
  - CPT 90714, 90718
- **Diptheria**
  - CPT 90719
- **Tetanus**
  - Immunization (CVX) codes 35, 112
  - CPT 90703
- **Acellular Pertussis**
  - Immunization (CVX) code 11
- **OPV**
  - Immunization (CVX) codes 2, 89
  - CPT 90712
- **IPV**
  - Immunization (CVX) codes 10, 89, 110, 120, 130, 132, 146
  - CPT 90696, 90698, 90711 (old code), 90713, 90723
- **MMR**
  - Immunization (CVX) codes 3, 94
  - CPT 90707, 90710

- **M/R**
  - Immunization (CVX) code 4
  - CPT 90708
- **R/M**
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- **Measles**
  - Immunization (CVX) code 5
  - CPT 90705
- **Mumps**
  - Immunization (CVX) code 7
  - CPT 90704
- **Rubella**
  - Immunization (CVX) code 6
  - CPT 90706
- **HiB**
  - Immunization (CVX) codes 17, 22, 46 through 49, 50, 51, 102, 120, 132, 146
  - CPT 90645 through 90648, 90698, 90720 through 90721, 90737 (old code), 90748
- **Hepatitis B**
  - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
  - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- **Varicella**
  - Immunization (CVX) codes 21, 94
  - CPT 90710, 90716
- **Pneumococcal**
  - Immunization (CVX) codes 33, 100, 109, 133, 152
  - CPT 90669, 90670, 90732, G0009, G8115 (old code)
- **Hepatitis A**
  - Immunization (CVX) codes 31, 52, 83, 84, 85, 104
  - CPT 90632 through 90634, 90636, 90730 (old code)
- **Rotavirus**

  - Immunization (CVX) codes 74, 116, 119, 122
  - CPT 90680
- **Influenza**
  - Immunization (CVX) codes 15, 16, 88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158
  - CPT 90654 through 90658, 90659 (old code), 90660 through 90662, 90672, 90673, 90685, 09686, 90688, 90724 (old code), G0008, G8108 (old code)

Immunization Definitions

- **DTaP IZ Definitions**
  - Immunization (CVX) codes 20, 50, 106, 107, 110, 120, 130, 132, 146
  - POV ICD-9: V06.1
  - CPT 90696, 90698, 90700, 90721, 90723
- **DTaP Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **DTP IZ Definitions**
  - Immunization (CVX) codes 1, 22, 102
  - POV ICD-9: V06.1, V06.2, V06.3
  - CPT 90701, 90711 (old code), 90720
- **DTP Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Tdap IZ Definitions**
  - Immunization (CVX) code 115
  - CPT 90715
- **Tdap contraindication definition**
  - Immunization Package contraindication of Anaphylaxis
- **DT IZ Definitions**
  - Immunization (CVX) code 28
  - POV ICD-9: V06.5
  - CPT 90702
- **DT Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Td IZ Definitions**
  - Immunization (CVX) codes 9, 113, 138, 139

  - POV ICD-9: V06.5
  - CPT 90714, 90718
- **Td Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Diphtheria IZ Definitions**
  - POV ICD-9: V03.5
  - CPT 90719
- **Diphtheria Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Tetanus Definitions**
  - Immunization (CVX) codes 35, 112
  - POV ICD-9: V03.7
  - CPT 90703
- **Tetanus Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Acellular Pertussis Definitions**
  - Immunization (CVX) code 11
  - POV ICD-9: V03.6
- **Acellular Pertussis Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **OPV Definitions**
  - Immunization (CVX) codes 2, 89
  - CPT 90712
- **OPV Contraindication Definition**
  - Immunization Package contraindication of Immune Deficiency
- **IPV Definitions**
  - Immunization (CVX) codes 10, 89, 110, 120, 130, 132, 146
  - POV ICD-9: V04.0, V06.3
  - CPT 90696, 90698, 90711 (old code), 90713, 90723
- **IPV Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: 730.70 through 730.79; ICD-10: M89.6*
- **IPV contraindication definition:**

  - Immunization Package contraindication of Anaphylaxis or Neomycin Allergy
- **MMR Definitions**
  - Immunization (CVX) codes 3, 94
  - POV ICD-9: V06.4
  - CPT 90707, 90710
- **MMR Contraindication Definitions**
  - Immunization Package contraindication of Anaphylaxis, Immune Deficiency, or Neomycin Allergy
- **M/R Definitions**
  - Immunization (CVX) code 4
  - CPT 90708
- **M/R Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **R/M Definitions**
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- **R/M Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Measles Definitions**
  - Immunization (CVX) code 5
  - POV ICD-9: V04.2
  - CPT 90705
- **Measles Evidence of Disease Definition**
  - POV or PCC Problem List (active or inactive) ICD-9: 055*; ICD-10: B05.*
- M**easles Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Mumps Definitions**
  - Immunization (CVX) code 7
  - POV ICD-9: V04.6
  - CPT 90704
- **Mumps Evidence of Disease Definition**

  - POV or PCC Problem List (active or inactive) ICD-9: 072*; ICD-10: B26.*

- **Mumps Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Rubella Definitions**
  - Immunization (CVX) code 6
  - POV ICD-9: V04.3
  - CPT 90706
- **Rubella Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: 056*, 771.0; ICD-10: B06.*
- **Rubella Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **HiB Definitions**
  - Three-dose series:
    - Immunization (CVX) codes 49, 51
    - CPT 90647, 90748
  - Four-dose series:
    - Immunization (CVX) codes 17, 22, 46 through 48, 50, 102, 120, 132, 146
    - POV ICD-9: V03.81
    - CPT 90645 through 90646, 90648, 90698, 90720 through 90721, 90737 (old code)
- **HiB Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Hepatitis B Definitions**
  - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
  - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- **Hepatitis B Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: V02.61, 070.2*, 070.3*; ICD-10: B16.*, B19.1*, Z22.51
- **Hepatitis B contraindication definition**
  - Immunization Package contraindication of Anaphylaxis

- **Varicella Definitions**
  - Immunization (CVX) codes 21, 94
  - POV ICD-9: V05.4
  - CPT 90710, 90716
- **Varicella Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: 052*, 053*; ICD-10: B01.* through B02.*
  - Immunization Package contraindication of “Hx of Chicken Pox” or “Immune”
- **Varicella Contraindication Definitions**
  - Immunization Package contraindication of Anaphylaxis, Immune Deficiency, or Neomycin Allergy
- **Pneumococcal Definitions**
  - 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 Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Hepatitis A Definitions**
  - Immunization (CVX) codes 31, 52, 83, 84, 85, 104
  - CPT 90632 through 90634, 90636, 90730 (old code)
- **Hepatitis A Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: 070.0, 070.1; ICD-10: B15.*
- **Hepatitis A Contraindication Definition**
  - Immunization Package contraindication of "Anaphylaxis"
- **Rotavirus Definitions**
  - 2-dose series
    - Immunization (CVX) codes 119
    - CPT 90681
  - 3-dose series
    - Immunization (CVX) codes 74, 116, 122
    - POV ICD-9: V05.8

- CPT 90680

- **Rotavirus Contraindication Definition**
  - Immunization Package contraindication of "Anaphylaxis" or "Immune Deficiency"
- **Influenza Definitions**
  - Immunizations (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, V06.6
  - CPT 90654 through 90658, 90659 (old code), 90660 through 90662, 90672, 90673, 90685, 90686, 90688, 90724 (old code), G0008, G8108 (old code)
- **Influenza Contraindication Definition**
  - Immunization Package contraindication of "Egg Allergy" or "Anaphylaxis"

2.3.3.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 74.8%for the proportion of AI/AN children ages 19 through 35 months who have received the recommended immunizations.

> **Notes:** In FY 2013, the GPRA measure changed to the 4:3:1:3*:3:1:4 combination, which includes 3 or 4 HiB.
>
> In FY 2011, the GPRA measure changed to the 4:3:1:3:3:1:4 combination, which includes pneumococcal.

2.3.3.7 Patient List

List of patients 19 through 35 months of age with IZ, if any. If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had two DTaP, no IZ will be listed for DTaP.

> **Note:** Because age is calculated at the beginning of the report period, the patient's age on the list will be between 7 and 23 months

2.3.4 Adolescent Immunizations

Changes from CRS v14.0 are noted

2.3.4.1 Owner and Contact

Epidemiology Program: Dr. Scott Hamstra, Amy Groom, MPH

2.3.4.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.3.4.3 Denominators

1. Active Clinical patients age 13 years.
2. Male Active Clinical patients age 13 years.
3. Female Active Clinical patients age 13 years.
4. Active Clinical patients ages 13 through 17 years.
5. Male Active Clinical patients ages 13 through 17 years.
6. Female Active Clinical patients ages 13 through 17 years.

2.3.4.4 Numerators

1. Patient who have received the 1:3:2:1 combination (i.e., 1 Td or Tdap, 3 Hepatitis B, 2 MMR, 1 Varicella), including contraindications and evidence of disease.

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

   A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

2. Patients who have received the 1:1:3 combination (i.e., 1 Tdap or Td, 1 Meningococcal, 3 HPV), including contraindications and evidence of disease.

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

   A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

3. Patients who have received the 1:1 combination (i.e., 1 Tdap or Td, 1 Meningococcal), including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

4. Patients who have received 1 dose of Tdap or Td ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

B. Patients who have received 1 dose of Tdap ever, including contraindications and evidence of disease.

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

5. Patients who have received 2 doses of MMR ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

6. Patients who have received 3 doses of Hepatitis B ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

7. Patients who have received 1 dose of Varicella ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

8. Patients who have received 1 dose of meningococcal ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

9. Patients who have received 3 doses of HPV ever, including contraindications and evidence of disease.

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

A. Patients with (1) evidence of the disease, (2) a contraindication, or (3) a documented NMI refusal.

2.3.4.5 Definitions

Timing of Doses

Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Dosage and Types of Immunizations

- 1 dose of Td or Tdap
- 2 doses of MMR
  - 2 MMRs
  - 2 M/R and 2 Mumps
  - 2 R/M and 2 Measles
  - 2 each of Measles, Mumps, and Rubella
- 3 doses of Hepatitis B *or* 2 doses *if* documented with CPT 90743
- 1 dose of Varicella
- 1 dose of Meningococcal
- 3 doses of HPV

Not Medically Indicated (NMI) Refusal, Contraindication, and Evidence of Disease Information

Not Medically Indicated refusals, evidence of disease, and contraindications for individual immunizations will also count toward meeting the definition, as defined in the following subsections.

> **Note**: NMI refusals are not counted as refusals; rather, they are counted as contraindications.

- Each immunization must be refused and documented separately. For example, if a patient has an NMI refusal for Rubella only, then there must be an immunization, contraindication, or separate NMI refusal for the Measles and Mumps immunizations.
- For immunizations where required number of doses is greater than one, only one NMI refusal is necessary to be counted in the numerator. For example, if there is a single NMI refusal for Hepatitis B, the patient will be included in the numerator.
- For immunizations where required number of doses is greater than one, only one contraindication is necessary to be counted in the numerator. For example, if there is a single contraindication for HiB, the patient will be included in the numerator.
- Evidence of disease will be checked for at any time in the child's life (prior to the end of the report period.)
- To be counted in sub-numerator A, a patient must have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be included in sub-numerator A.

NMI Refusal Definitions

PCC Refusal type NMI for any of the following codes:

- **MMR**
  - Immunization (CVX) codes 3, 94
  - CPT 90707, 90710
- **M/R**
  - Immunization (CVX) code 4
  - CPT 90708
- **R/M**
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- **Measles**
  - Immunization (CVX) code 5
  - CPT 90705
- **Mumps**
  - Immunization (CVX) code 7
  - CPT 90704

- **Rubella**
  - Immunization (CVX) code 6
  - CPT 90706
- **Hepatitis B**
  - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
  - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021 (old code), Q3023 (old code)
- **Varicella**
  - Immunization (CVX) codes 21, 94
  - CPT 90710, 90716
- **Tdap**
  - Immunization (CVX) codes 115
  - CPT 90715
- **Td**
  - Immunization (CVX) codes 9, 113
  - CPT 90714, 90718
- **Meningococcal**
  - Immunization (CVX) codes 32, 108, 114, 136, 147
  - CPT 90733, 90734
- **HPV**
  - CPT 90649, 90650

Immunization Definitions

- **MMR**
  - Immunization (CVX) codes 3, 94
  - POV ICD-9: V06.4
  - CPT 90707, 90710
- **MMR Contraindication Definitions**
  - Immunization Package contraindication of Anaphylaxis, Immune Deficiency, or Neomycin Allergy
- **M/R**
  - Immunization (CVX) code 4
  - CPT 90708
- **M/R Contraindication Definition**

  - Immunization Package contraindication of Anaphylaxis
- **R/M**
  - Immunization (CVX) code 38
  - CPT 90709 (old code)
- **R/M Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Measles**
  - Immunization (CVX) code 5
  - POV ICD-9: V04.2
  - CPT 90705
- **Measles Evidence of Disease Definition**
  - POV or PCC Problem List (active or inactive) ICD-9: 055*; ICD-10: B05.*
- **Measles Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Mumps**
  - Immunization (CVX) code 7
  - POV ICD-9: V04.6
  - CPT 90704
- **Mumps Evidence of Disease Definition**
  - POV or PCC Problem List (active or inactive) ICD-9: 072*; ICD-10: B26.*
- **Mumps Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Rubella**
  - Immunization (CVX) code 6
  - POV ICD-9: V04.3
  - CPT 90706
- **Rubella Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: 056*, 771.0; ICD-10: B06.*
- **Rubella Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Hepatitis B**

  - Immunization (CVX) codes 8, 42 through 45, 51, 102, 104, 110, 132, 146
  - CPT 90636, 90723, 90731 (old code), 90740, 90743 through 90748, G0010, Q3021, Q3023
- **Hepatitis B Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: V02.61, 070.2*, 070.3*; ICD-10: B16.*, B19.1*, Z22.51
- **Hepatitis B Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Varicella**
  - Immunization (CVX) codes 21, 94
  - POV ICD-9: V05.4
  - CPT 90710, 90716
- **Varicella Evidence of Disease Definitions**
  - POV or PCC Problem List (active or inactive) ICD-9: 052*, 053*; ICD-10: B01.* through B02.*
  - Immunization Package contraindication of “Hx of Chicken Pox” or “Immune”
- **Varicella Contraindication Definitions**
  - Immunization Package contraindication of Anaphylaxis, Immune Deficiency, or Neomycin Allergy
- **Tdap**
  - Immunization (CVX) code 115
  - CPT 90715
- **Tdap Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Td**
  - Immunization (CVX) code 9, 113, 138, 139
  - POV ICD-9: V06.5
  - CPT 90714, 90718
- **Td Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **Meningococcal**
  - Immunization (CVX) codes: 32, 108, 114, 136, 147
  - CPT 90733, 90734

- **Meningococcal Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis
- **HPV**
  - Immunization (CVX) codes: 62, 118, 137
  - CPT 90649, 90650
- **HPV Contraindication Definition**
  - Immunization Package contraindication of Anaphylaxis

2.3.4.6 Patient List

List of patients 13 through 17 years of age with IZ, if any. If a patient did not have all doses in a multiple dose vaccine, the IZ will not be listed. For example, if a patient only had two Hepatitis B, no IZ will be listed for Hepatitis B.

2.4 Childhood Diseases Group

2.4.1 Appropriate Treatment for Children with Upper Respiratory Infection

Changes from CRS v14.0 are noted

2.4.1.1 Owner and Contact

Dr. Scott Hamstra

2.4.1.2 National Reporting

Not reported nationally

2.4.1.3 Denominators

1. Active Clinical patients who were ages 3 months through 18 years who were diagnosed with an upper respiratory infection during the period 6 months (182 days) prior to the report period through the first 6 months of the report period.

2.4.1.4 Numerators

1. Patients who were *not* prescribed an antibiotic on or within 3 days after diagnosis. In this measure, appropriate treatment is not to receive an antibiotic.

2.4.1.5 Definitions

Age

Age is calculated as follows: Children 3 months as of 6 months (182 days) of the year prior to the report period to 18 years as of the first 6 months of the report period.

Upper Respiratory Infection

- POV ICD-9: 460, 465.*; ICD-10: J00

Outpatient Visit

- Service Category A, S, O

Antibiotic Medications:

- Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS.
  - Medications are: Amoxicillin, Amoxicillin and Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftibuten, Cefpodoxime, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephradine, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Erythromycin ethylsuccinate, Erythromycin lactobionate, Erythromycin stearate, Erythromycin-sulfisoxazole, Levofloxacin, Minocycline, Moxifloxacin, Ofloxacin, Penicillin VK, Penicillin G, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-Sulfamethoxazol. Medications must not have a comment of RETURNED TO STOCK.
  - Procedure ICD-9: 99.21; ICD-10: 3E00X29, 3E01329, 3E02329, 3E03029, 3E03329, 3E04029, 3E04329, 3E05029, 3E05329, 3E06029, 3E06329, 3E0E329, 3E0E729, 3E0E829, 3E0F329, 3E0F729, 3E0F829, 3E0G329, 3E0G729, 3E0G829, 3E0H329, 3E0H729, 3E0H829, 3E0J329, 3E0J729, 3E0J829, 3E0K329, 3E0K729, 3E0K829, 3E0L329, 3E0M329, 3E0N329, 3E0N729, 3E0N829, 3E0P329, 3E0P729, 3E0P829, 3E0Q329, 3E0R329, 3E0S329, 3E0U029, 3E0U329, 3E0V329, 3E0W329, 3E0Y329
- To be included in the denominator *all* of the following conditions must be met:
  - Patient's diagnosis of an upper respiratory infection (URI) must have occurred at an outpatient visit.
  - If outpatient visit was to Clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as Service Category H, either on the same day or the next day with URI diagnosis.
  - Patient's visit must *only* have a diagnosis of URI. If any other diagnosis exists, the visit will be excluded.

- The patient did not have a new or refill prescription (Rx) for antibiotics within 30 days prior to the URI visit date.
- The patient did not have an active prescription for antibiotics as of the URI visit date. "Active" prescription defined as:
- Rx Days' Supply must be greater than or equal to the URI Visit Date minus the Rx Date

If there are multiple visits that meet the criteria, the first visit will be used.

2.4.1.6 Patient List

List of patients 3 months to 18 years with upper respiratory infection, with antibiotic prescription, if any.

2.4.2 Appropriate Testing for Children with Pharyngitis

Changes from CRS v14.0 are noted

2.4.2.1 Owner and Contact

Dr. Scott Hamstra

2.4.2.2 National Reporting

Not reported nationally

2.4.2.3 Denominators

1. Active Clinical patients who were ages 2 through 18 years who were diagnosed with pharyngitis and prescribed an antibiotic during the period 6 months (182 days) prior to the report period through the first 6 months of the report period.

2.4.2.4 Numerators

1. Patients who received a Group A strep test.

2.4.2.5 Definitions

Age

Age is calculated as follows: Children 2 years as of 6 months (182 days) of the year prior to the report period to 18 years as of the first 6 months of the report period.

Pharyngitis

- POV ICD-9: 462, 463, 034.0; ICD-10: J02.0, J03.*

Outpatient Visit

- Service Category A, S, O

Antibiotic Medications

- Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS
  - Medications are: Amoxicillin, Amoxicillin and Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil, Cefazolin, Cefdinir, Cefixime, Cefditoren, Ceftibuten, Cefpodoxime, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, Cephradine, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Erythromycin ethylsuccinate, Erythromycin lactobionate, Erythromycin stearate, Erythromycin-sulfisoxazole, Levofloxacin, Minocycline, Moxifloxacin, Ofloxacin, Penicillin VK, Penicillin G, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-Sulfamethoxazol. Medications must not have a comment of RETURNED TO STOCK.
- Procedure ICD-9: 99.21; ICD-10: 3E00X29, 3E01329, 3E02329, 3E03029, 3E03329, 3E04029, 3E04329, 3E05029, 3E05329, 3E06029, 3E06329, 3E0E329, 3E0E729, 3E0E829, 3E0F329, 3E0F729, 3E0F829, 3E0G329, 3E0G729, 3E0G829, 3E0H329, 3E0H729, 3E0H829, 3E0J329, 3E0J729, 3E0J829, 3E0K329, 3E0K729, 3E0K829, 3E0L329, 3E0M329, 3E0N329, 3E0N729, 3E0N829, 3E0P329, 3E0P729, 3E0P829, 3E0Q329, 3E0R329, 3E0S329, 3E0U029, 3E0U329, 3E0V329, 3E0W329, 3E0Y329

Group A Streptococcus Test

- CPT 87430 (by enzyme immunoassay), 87650 through 87652 (by nucleic acid), 87880 (by direct optical observation), 87081 (by throat culture), 3210F (Group A Strep Test)
- Site-populated taxonomy BGP GROUP A STREP
- LOINC taxonomy

To be included in the denominator *all* of the following conditions must be met:

- Patient's diagnosis of pharyngitis must have occurred at an outpatient visit.
- If outpatient visit was to Clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as service category H, either on the same day or the next day with pharyngitis diagnosis.
- Patient's visit must *only* have a diagnosis of pharyngitis. If any other diagnosis exists, the visit will be excluded.

- The patient did not have a new or refill prescription for antibiotics within 30 days prior to the pharyngitis visit date.
- The patient did not have an active prescription for antibiotics as of the pharyngitis visit date. "Active" prescription defined as:
- Rx Days' Supply must be greater than or equal to the URI Visit Date minus the Rx Date
- The patient filled a prescription for antibiotics on or within three days after the pharyngitis visit.

If there are multiple visits that meet the criteria, the first visit will be used.

- **To be included in the numerator**
  - A patient must have received a Group A Streptococcus test within the 7-day period beginning 3 days prior through 3 days after the Pharyngitis visit date.

2.4.2.6 Patient List

List of patients 2 through 18 years of age with pharyngitis and a Group A Strep test, if any.

2.5 Cancer Screen Group

2.5.1 Cancer Screening: Pap Smear Rates

Changes from CRS v14.0 are noted

2.5.1.1 Owner and Contact

Carolyn Aoyama, CNM, MPH

2.5.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.5.1.3 Denominators

1. GPRA**:** Female Active Clinical patients ages 24 through 64 years without a documented history of hysterectomy. Patients must be at least 24 years of age at the beginning of the report period and less than 65 years of age as of the end of the report period.

2. Female Active Clinical patients ages 24 through 29 without documented history of Hysterectomy.
3. Female Active Clinical patients ages 30 through 64 without documented history of Hysterectomy.
4. Female User Population patients ages 24 through 64 years without a documented history of Hysterectomy.
5. Female User Population patients ages 24 through 29 without documented history of Hysterectomy.
6. Female User Population patients ages 30 through 64 without documented history of Hysterectomy.

2.5.1.4 Numerators

1. GPRA**:** Patients with documented Pap smear in past 3 years, or if patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years.

Note: This numerator does *not* include refusals.

2. Patients with a Pap Smear documented in the past 3 years.

Note: This numerator does *not* include refusals.

3. Patients with a Pap Smear documented 3-5 years ago and an HPV DNA documented in the past 5 years.

Note: This numerator does *not* include refusals.

2.5.1.5 Definitions

Age

Age of the patient is calculated at the beginning of the report period. Patients must be at least 24 years of age at the beginning of the report period and less than 65 years of age as of the end of the report period.

Hysterectomy

Defined as any of the following ever:

- Procedure ICD-9: 68.4 through 68.9; ICD-10: 0UT9*ZZ

- CPT 51925, 56308 (old code), 58150, 57540, 57545, 57550, 57555, 57556, 58152, 58200 through 58294, 58548, 58550 through 58554, 58570 through 58573, 58951, 58953 through 58954, 58956, 59135
- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 618.5, 752.43, V67.01, V76.47, V88.01, V88.03; ICD-10: N99.3, Z12.72, Z90.710 through Z90.712, Q51.5
- Women's Health procedure called Hysterectomy

Pap Smear

- Lab Pap Smear
- POV ICD-9: V76.2 Screen Mal Neop-Cervix, V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4
- CPT 88141 through 88154, 88160 through 88167, 88174 through 88175, G0123, G0124, G0141, G0143 through G0145, G0147, G0148, P3000, P3001, Q0091
- Women's Health procedure called Pap Smear and where the result does NOT have "ERROR/DISREGARD"
- LOINC taxonomy
- Site-populated taxonomy BGP PAP SMEAR TAX

HPV DNA

- Lab HPV
- POV ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51
- CPT 87620 through 87622
- LOINC taxonomy
- Site-populated taxonomy BGP HPV TAX

2.5.1.6 GPRA 2014 Description

During FY 2014, establish a baseline for the proportion of female patients ages 24 through 64 years without a documented history of hysterectomy who have had a Pap screen within the previous 3 years, or if the patient is over 30, had a Pap screen in the past 3 years or a Pap screen and HPV DNA within the previous 5 years.

2.5.1.7 Patient List

List of women 24 through 64 years of age with documented Pap smear, if any.

2.5.2 Cancer Screening: Mammogram Rates

Changes from CRS v14.0 are noted

2.5.2.1 Owner and Contact

Carolyn Aoyama, CNM, MPH

2.5.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.5.2.3 Denominators

1. GPRA**:** Female Active Clinical patients ages 52 through 64 years, without a documented bilateral mastectomy or two separate unilateral mastectomies.

2. Female Active Clinical patients ages 52 through 74 without a documented history of bilateral mastectomy or two separate unilateral mastectomies.

2.5.2.4 Numerators

1. GPRA**:** All patients with documented mammogram in past 2 years.

Note: This numerator does *not* include refusals.

2. Patients with documented mammogram refusal in past year.

2.5.2.5 Definitions

Age

Age of the patient is calculated at the beginning of the report period. For all denominators, patients must be at least the minimum age as of the beginning of the report period. For the 52 through 64 years of age denominator, the patients must be less than 65 years of age as of the end 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

- 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 Diagnosis Bilateral, Mammogram Diagnosis Unilateral, 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

2.5.2.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 54.7% for the proportion of female patients ages 52 through 64 years who have had mammography screening within the last two years.

2.5.2.7 Patient List

List of women 52 through 74 with mammogram or refusal, if any.

2.5.3 Colorectal Cancer Screening

No changes from Version 14.0

Notes: Based on the HEDIS definition which has lowered the upper age from 80 to 75 years.

Numerator does not include Double Contrast Barium Enema (DCBE).

2.5.3.1 Owner: Contact

Epidemiology Program: Don Haverkamp

2.5.3.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.3.3 Denominators

1. GPRA: Active Clinical patients ages 50 through 75 years without a documented history of colorectal cancer or total colectomy, broken out by gender.

Note: Since HEDIS calculates age at the end of the report period, the patient's at the beginning of the report period must be at least 50 years of age and 51 years of age at the end of the report period.

2.5.3.4 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 FIT during the Report Period
   B. Flexible sigmoidoscopy in the past 5 years
   C. Colonoscopy in the past 10 years
2. Patients with documented CRC screening refusal in the past year.
3. Patients with Fecal Occult Blood test (FOBT) or Fecal Immunochemical Test (FIT) during the Report period.
4. Patients with a flexible sigmoidoscopy in the past 5 years or a colonoscopy in the past 10 years.

2.5.3.5 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:

- 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 any of the following:

  - Lab Fecal Occult Blood test
  - CPT code 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code)

- Flexible Sigmoidoscopy

  Refusal of any of the following:

  - Procedure ICD-9: 45.24; ICD-10: 0DJD8ZZ
  - CPT 45330 through 45345, G0104

- Colonoscopy

Refusal of any of the following:

- 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

2.5.3.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 35.0% for the proportion of clinically appropriate patients ages 50-75 who have received colorectal screening.

2.5.3.7 Patient List

List of patients 50 through 75 with CRC screening or refusal, if any.

2.5.4 Comprehensive Cancer Screening

Changes from CRS v14.0 are noted

2.5.4.1 Owner and Contact

Epidemiology Program: Don Haverkamp, Carolyn Aoyama

2.5.4.2 National Reporting

NATIONAL (included in IHS Performance Report; *not* reported to OMB and Congress)

2.5.4.3 Denominators

1. GPRA Developmental: Active Clinical patients ages 24 through 75 years who are eligible for cervical cancer, breast cancer, or colorectal cancer screening.

   A. Active Clinical female patients ages 24 through 75 years.

   B. Active Clinical male patients ages 50 through 75 years.

2.5.4.4 Numerators

1. GPRA Developmental: Patients who have had all screenings for which they are eligible.

2. Female patients with cervical cancer, breast cancer, or colorectal cancer screening.

3. Male patients with colorectal cancer screening.

2.5.4.5 Definitions

Cervical Cancer Screening

To be eligible for this screening:

- Patients must be female Active Clinical ages 24 years 64 and not have a documented history of hysterectomy.
- Patients must be at least 24 years of age at the beginning of the Report Period and less than 65 years of age as of the end of the Report Period.
- To be counted as having the screening, the patient must have had a Pap Smear documented in the past 3 years, or if the patient is 30 to 64 years of age, either a Pap Smear documented in the past 3 years or a Pap Smear and an HPV DNA documented in the past 5 years.

Hysterectomy

Any of the following ever:

- Procedure ICD-9: 68.4 through 68.9; ICD-10: 0UT9*ZZ
- CPT 51925, 56308 (old code), 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200 through 58294, 58548, 58550 through 58554, 58570 through 58573, 58951, 58953 through 58954, 58956, 59135
- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 618.5, 752.43, V67.01, V76.47, V88.01, V88.03; ICD-10: N99.3, Z12.72, Z90.710 through Z90.712, Q51.5
- Women’s Health procedure called Hysterectomy

Pap Smear

- Lab Pap Smear
- POV ICD-9: V76.2 Screen Mal Neop-Cervix, V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, 795.0*; ICD-10: R87.61*, R87.810, R87.820, Z01.42, Z12.4
- CPT 88141 through 88154, 88160 through 88167, 88174 through 88175, G0123, G0124, G0141, G0143 through G0145, G0147, G0148, P3000, P3001, Q0091
- Women's Health procedure called Pap Smear and where the result does NOT have "ERROR/DISREGARD"
- LOINC taxonomy
- Site-populated taxonomy BGP PAP SMEAR TAX

HPV DNA

- Lab HPV
- POV ICD-9: V73.81, 079.4, 796.75, 795.05, 795.15, 796.79, 795.09, 795.19; ICD-10: B97.7, R85.618, R85.81, R85.82, R87.628, R87.810, R87.811, R87.820, R87.821, Z11.51
- CPT 87620 through 87622
- LOINC taxonomy
- Site-populated taxonomy BGP HPV TAX

Breast Cancer Screening

To be eligible for this screening

- Patients must be female Active Clinical ages 52 through 64 years and not have a documented history ever of bilateral mastectomy or two separate unilateral mastectomies
- Patients must be at least 52 years of age as of the beginning of the report period and must be less than 65 years of age as of the end of the report period
- To be counted as having the screening, the patient must have had a Mammogram documented in the past 2 years

Bilateral Mastectomy

Any of the following ever:

- 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

- Procedure ICD-9: 85.42, 85.44, 85.46, 85.48; ICD-10: 0HTV0ZZ

Unilateral Mastectomy

Must have 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
- Procedure ICD-9: 85.41, 85.43, 85.45, 85.47; ICD-10: 07T50ZZ, 07T60ZZ, 07T70ZZ, 07T80ZZ, 07T90ZZ, 0HTT0ZZ, 0HTU0ZZ, 0KTH0ZZ, 0KTJ0ZZ

Screening Mammogram

- Radiology or CPT 77052 through 77059, 76090 (old code), 76091 (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 Diagnosis Bilateral, Mammogram Diagnosis Unilateral and where the mammogram result does *not* have "ERROR/DISREGARD"

Colorectal Cancer Screening

To be eligible for this screening:

- Patients must be Active Clinical ages 50 through 75 years and not have a documented history ever of colorectal cancer or total colectomy
- To be counted as having the screening, patients must have had any of the following:
  - FOBT or FIT during the report period
  - Flexible Sigmoidoscopy in the past 5 years
  - Colonoscopy in the past 10 years

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

- Procedure ICD-9: 45.8*; ICD-10: 0DTE*ZZ

- CPT 44150 through 44151, 44152 (old code), 44153 (old code), 44155 through 44158, 44210 through 44212

FOBT or FIT

- CPT 82270, 82274, 89205 (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

2.5.4.6 Patient List

List of patients 24 through 75 years of age with comprehensive cancer screening, if any.

2.5.5 Tobacco Use and Exposure Assessment

No changes from Version 14.0

2.5.5.1 Owner and Contact

Chris Lamer, PharmD, Epidemiology Program: Dayle Knutson

2.5.5.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; *not* reported to OMB and Congress)

2.5.5.3 Denominators

1. Active Clinical patients ages 5 and older, broken down by gender and age groups: 5 through 13 years, 14 through 17 years, 18 through 24 years, 25 through 44 years, 45 through 64 years, 65 years and older (HP 2020).

2. Pregnant female User Population patients with no documented miscarriage or abortion.

2.5.5.4 Numerators

1. Patients screened for tobacco use during the report period (during the past 20 months for pregnant female patients denominator).

2. Patients identified during the report period (during the past 20 months for pregnant female patients denominator) as current tobacco users.

   A. Current smokers

   B. Current smokeless tobacco users

3. Patients exposed to ETS during the report period (during the past 20 months for pregnant female patients denominator).

2.5.5.5 Definitions

Pregnancy

At least two visits with POV ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*,

O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36 during the past 20 months, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (Clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the past 20 months, CRS will use the first two visits in the 20-month period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit. In addition, the patient must have at least one pregnancy-related visit occurring during the reporting period. An additional 8 months is included for patients who were pregnant during the report period but who had their tobacco assessment prior to that.

Miscarriage

- Occurring after the second pregnancy POV and during the past 20 months
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830

Abortion

- Occurring after the second pregnancy POV and during the past 20 months
  - POV ICD-9: 635*, 636*, 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
  - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267
  - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

Tobacco Screening

Time frame for pregnant female patients is the past 20 months

- Any Health Factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS-CHEWING/DIP), TOBACCO (EXPOSURE)
- Tobacco-related diagnoses (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 (tobacco-related diagnosis); 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

Time frame for pregnant female patients is the past 20 months

- 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

Time frame for pregnant female patients is the past 20 months

- 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

Time frame for pregnant female patients is the past 20 months

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

ETS

Time frame for pregnant female patients is the past 20 months

- Health Factors: Smoker in Home, Exposure to ETS

2.5.5.6 Patient List

List of patients five and older with documented tobacco screening, if any.

2.5.6 Tobacco Cessation

No changes from Version 14.0

2.5.6.1 Owner: Contact

Chris Lamer, PharmD, Epidemiology Program: Dayle Knutson

2.5.6.2 National Reporting

NATIONAL (included in IHS Performance Report; reported to OMB and Congress)

2.5.6.3 Denominators

1. GPRA: Active clinical patients identified as current tobacco users or tobacco users in cessation, broken down by gender and age groups: less than 12 years, 12 through 17 years, 18 years and older.

2.5.6.4 Numerators

1. Patients who have received tobacco cessation counseling or received a prescription for a smoking cessation aid anytime during the Report Period.
2. Patients identified as having quit their tobacco use anytime during the Report Period.

3. GPRA: Patients who received tobacco cessation counseling, received a prescription for a tobacco cessation aid, or quit their tobacco use anytime during the Report Period.

2.5.6.5 Definitions

Denominator

Current Tobacco Users or Tobacco Users in Cessation:

CRS will search first for all health factors documented in the Tobacco, TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories during the Report Period.

If health factor(s) are found and at least one of them is one of the health factors listed below, the patient is counted as a current tobacco user or tobacco user in cessation. The patient is not counted as receiving cessation counseling.

Tobacco User Health Factors (TUHFs):

- Cessation-Smoker
- Cessation-Smokeless
- Current Smoker
- Current Smokeless
- Current Smoker and Smokeless
- Current Smoker, status unknown
- Current Smoker, every day
- Current Smoker, some day
- Heavy Tobacco Smoker
- Light Tobacco Smoker

If a health factor is found and it is *not* a TUHF, CRS will then search for CPT 1034F or 1035F documented after the health factor. If one of these codes is found, the patient will be considered a tobacco user.

If no health factor was found, CRS will then search for any of the following codes documented during the Report Period:

- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) 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)

If any of these codes are found, the patient will be considered a tobacco user.

If no health factor or other tobacco user-defining code listed above was found during the specified timeframe, CRS will then search for the most recent health factor documented during an *expanded* timeframe of any time prior to the report period. For example, a patient with the most recent health factor being documented 5 years prior to the report period.

Note: If multiple health factors were documented on the same date and if any of them are TUHF(s), all of the health factors will be considered as TUHF(s).

If a health factor is found during the expanded timeframe, and is a TUHF, the patient will be considered a potential tobacco user.

If a health factor is found during the expanded timeframe and it is not one of the TUHFs, CRS will then search for CPT 1034F or 1035F documented after the health factor. If one of these codes is found, the patient will be considered a potential tobacco user.

If no health factor was found, CRS will then search for any of the following codes documented through the beginning of the Report Period:

- Tobacco-related diagnoses (POV or Problem List entry where the status is not Inactive or Deleted) 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)

If any of these codes are found, the patient will be considered a potential tobacco user. If one of these codes is not found, the patient is considered a non-tobacco user and will not be included in the denominator.

If the patient is considered a potential tobacco user, CRS will then search for diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.13 Tobacco use in remission (old code), V15.82; ICD-10: F17.2*1, Z87.891 with a date occurring after the health factor date and through the beginning of the report period. If one of these diagnoses is found, the patient will be considered as having quit their tobacco use and will not be included in the denominator. If a diagnosis is not found, the patient is included as a current tobacco user and will be included in the denominator.

Tobacco Cessation Counseling

Any of the following documented anytime during the Report Period:

- Patient education codes containing "TO-", "-TO", "-SHS", 305.1, 305.1* (old codes), 649.00 through 649.04, D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402, G8453
- Clinic code 94 (tobacco cessation clinic)
- Dental code 1320
- CPT D1320, 99406, 99407, G0375 (old code), G0376 (old code), 4000F, G8402, G8453

Prescription for Tobacco Cessation Aid

Any of the following documented anytime during the Report Period:

- Prescription for medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy that does not have a comment of RETURNED TO STOCK
- Prescription for any medication with name containing “NICOTINE PATCH”, “NICOTINE POLACRILEX”, “NICOTINE INHALER”, “NICOTINE NASAL SPRAY” that does not have a comment of RETURNED TO STOCK
- CPT 4001F

Quit Tobacco Use

Any of the following documented anytime during the Report Period *and* after the date of the code found indicating the patient was a current tobacco user:

- Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 305.13 Tobacco use in remission (old code), V15.82; ICD-10: F17.2*1, Z87.891
- Health Factor (looks at the last documented health factor): Previous Smoker, Previous Smokeless, Previous (former) smoker, Previous (former) smokeless

2.5.6.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 45.7% for the proportion of tobacco-using patients who receive tobacco cessation intervention or quit tobacco use.

2.5.6.7 Patient List

List of tobacco users with tobacco cessation intervention, if any, or who have quit tobacco use.

2.6 Behavioral Health Group

2.6.1 Alcohol Screening (FAS Prevention)

No changes from Version 14.0

2.6.1.1 Owner and Contact

Carolyn Aoyama; IHS Division of Behavioral Health (DBH)

2.6.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.6.1.3 Denominators

1. GPRA: Female Active Clinical patients ages 15 to 44 (child-bearing age).

2.6.1.4 Numerators

1. GPRA: Patients screened for alcohol use, had an alcohol-related diagnosis or procedure, received alcohol-related patient education, during the report period.

Note: This numerator does *not* include refusals.

   A. Patients with alcohol screening during the report period.

   B. Patients with alcohol-related diagnosis or procedure during the report period.

   C. Patients with alcohol-related patient education during the report period.

   D. Patients with documented refusal in past year.

2.6.1.5 Definitions

Alcohol Screening

Any of the following during the report period:

- Exam code 35
- Any CAGE Alcohol Health Factor
- POV ICD-9: V11.3, V79.1, or Behavioral Health System (BHS) Problem code 29.1
- CPT 99408, 99409, G0396, G0397, H0049, H0050, 3016F
- Measurement in PCC or Behavioral Health (BH) of AUDT, AUDC, or CRFT

Alcohol-Related Diagnosis or Procedure

Any of the following during the report period:

- Alcohol-related Diagnosis
  - POV, Current PCC or BHS Problem List ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220 through F10.29, F10.920 through F10.982, F10.99, G62.1
  - BHS POV 10, 27, 29
- Alcohol-related Procedure
  - Procedure ICD-9: 94.46, 94.53, 94.61 through 94.63, 94.67 through 94.69

Alcohol-Related Patient Education

Any of the following during the report period:

- All Patient Education codes containing "AOD-" or "-AOD", "CD-" or "-CD" (old codes), or V11.3, V79.1, 303.*, 305.0*, 291.*, 357.5*, 99408, 99409, G0396, G0397, H0049, H0050, 3016F

2.6.1.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 65.9% for the proportion of female patients ages 15 through 44 years who receive screening for alcohol use.

2.6.1.7 Patient List

List of female patients with documented alcohol screening if any.

2.6.2 Alcohol Screening and Brief Intervention (ASBI) in the ER

No changes from Version 14.0

2.6.2.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.6.2.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.6.2.3 Denominators

1. Number of visits for Active Clinical Plus BH patients age 15 through 34 years seen in the ER for injury during the report period. Broken down by gender and age groups of 15 through 24 years and 25 through 34 years.

2. Number of visits for Active Clinical Plus BH patients age 15 through 34 years seen in the ER for injury and screened positive for hazardous alcohol use during the report period. Broken down by gender and age groups of 15 through 24 years and 25 through 34 years.

3. Number of visits for User Population patients age 15 through 34 years seen in the ER for injury during the report period. Broken down by gender and age groups of 15 through 24 years and 25 through 34 years.

4. Number of visits for User Population patients age 15 through 34 years seen in the ER for injury and screened positive for hazardous alcohol use during the report period. Broken down by gender and age groups of 15 through 24 years and 25 through 34 years.

2.6.2.4 Numerators

1. Number of visits where patients were screened in the ER for hazardous alcohol use.

   A. Number of visits where patients were screened positive (also used as denominator #2)

2. Number of visits where patients were provided a brief negotiated interview (BNI) at or within seven days of the ER visit (used only with denominator #2).

   A. Number of visits where patients were provided a BNI at the ER visit.

   B. Number of visits where patients were provided a BNI not at the ER visit but within seven days of the ER visit.

2.6.2.5 Definitions

ER Visit

Clinic code 30

Injury through

Primary or secondary POV ICD-9: 800.0 through 999.9, E800.0 through E989; ICD-10: (All codes ending in A, B, or C only) S00.00XA, S00.01XA, S00.03XA through S00.05XA, S00.07XA through S00.219A, S00.241A through S00.259A, S00.271A through S00.31XA, S00.33XA through S00.35XA, S00.37XA through S00.419A, S00.431A through S00.459A, S00.471A through S00.512A, S00.531A through S00.552A, S00.571A through S00.81XA, S00.83XA through S00.85XA, S00.87XA through S00.91XA, S00.93XA through S00.95XA, S00.97XA, S01.* through S05.*, S06.**0A, S06.**1A, S06.**2A, S06.**9A, S07.* through S09.*, S10.0XXA through S10.11XA, S10.14XA, S10.15XA, S10.17XA through S10.81XA, S10.83XA through S10.85XA, S10.87XA through S10.91XA,

S10.93XA through S10.95XA, S10.97XA, S11.* through S19.*, S20.00XA through S20.119A, S20.141A through S20.159A, S20.171A through S20.319A, S20.341A through S20.359A, S20.371A through S20.419A, S20.441A through S20.459A, S20.471A through S20.91XA, S20.94XA, S20.95XA, S20.97XA, S21.* through S29.*, S30.0XXA through S30.817A, S30.840A through S30.857A, S30.870A through S30.98XA, S31.* through S39.*, S40.011A through S40.219A, S40.241A through S40.259A, S40.271A through S40.819A, S40.841A through S40.859A, S40.871A through S40.929A, S41.* through S49.*, S50.00XA through S50.319A, S50.341A through S50.359A, S50.371A through S50.819A, S50.841A through S50.859A, S50.871A through S50.919A, S51.* through S59.*, S60.00XA through S60.319A, S60.341A through S60.359A, S60.371A through S60.419A, S60.440A through S60.459A, S60.470A through S60.519A, S60.541A through S60.559A, S60.571A through S60.819A, S60.841A through S60.859A, S60.871A through S60.949A, S61.* through S69.*, S70.00XA through S70.219A, S70.241A through S70.259A, S70.271A through S70.319A, S70.341A through S70.359A, S70.371A through S70.929A, S71.* through S79.*, S80.00XA through S80.219A, S80.241A through S80.259A, S80.271A through S80.819A, S80.841A through S80.859A, S80.871A through S80.929A, S81.* through S89.*, S90.00XA through S90.416A, S90.441A through S90.456A, S90.471A through S90.519A, S90.541A through S90.559A, S90.571A through S90.819A, S90.841A through S90.859A, S90.871A through S90.936A, S91.* through S99.*, T07 through T34.*, T36.*X1A, T36.*X2A, T36.*X3A, T36.*X4A, T36.91XA through T36.94XA, T37.*X1A, T37.*X2A, T37.*X3A, T37.*X4A, T37.91XA through T37.94XA, T38.**1A, T38.**2A, T38.**3A, T38.**4A, T39.**1A, T39.**2A, T39.**3A, T39.**4A, T39.91XA through T39.94XA, T40.**1A, T40.**2A, T40.**3A, T40.**4A, T41.**1A, T41.**2A, T41.**3A, T41.**4A, T41.41XA through T41.44XA, T42.**1A, T42.**2A, T42.**3A, T42.**4A, T42.71XA through T42.74XA, T43.**1A, T43.**2A, T43.**3A, T43.**4A, T43.91XA through T43.94XA, T44.**1A, T44.**2A, T44.**3A, T44.**4A, T45.**1A, T45.**2A, T45.**3A, T45.**4A, T45.91XA through T45.94XA, T46.**1A, T46.**2A, T46.**3A, T46.**4A, T47.**1A, T47.**2A, T47.**3A, T47.**4A, T47.91XA through T47.94XA, T48.**1A, T48.**2A, T48.**3A, T48.**4A, T49.**1A, T49.**2A, T49.**3A, T49.**4A, T49.91XA through T49.94XA, T50.**1A, T50.**2A, T50.**3A, T50.**4A, T51.* through T76.*, T79.*, V00.* through Y35.*

Denominator and Numerator Logic

If a patient has multiple ER visits for injury during the report period, each visit will be counted in the denominator. For the screening numerator, each ER visit with injury at which the patient was screened for hazardous alcohol use will be counted. For the positive alcohol use screen numerator, each ER visit with injury at which the patient screened positive for hazardous alcohol use will be counted.

For the BNI numerators, each visit where the patient was either provided a BNI at the ER or within 7 days of the ER visit will be counted.

An example of this logic is shown in Table 2-1.

Table 2-1: Denominator and Numerator Logic

ER Visit with Injury	Denom Count	Scm Num	Post Scm Num Count	BNI Num Count
John Doe, July 17, 2014, Screened Positive at ER, BNI at ER	1	1	1	1
John Doe, September 1, 2014, Screened Positive at ER, No BNI	1	1	1	0
John Doe, November 15, 2014, No Screen	1	0	0	0
Counts:	3	2	2	1

ER Screening for Hazardous Alcohol Use

Any of the following conducted during the ER visit:

- Exam code 35
- Any Alcohol Health Factor (i.e., CAGE)
- POV ICD-9: V79.1 Screening for Alcoholism
- CPT G0396, G0397, H0049, 99408, 99409, 3016F
- Measurement in PCC of AUDT, AUDC, CRFT

Positive Screen for Hazardous Alcohol Use

Any of the following for the screening performed at the ER visit:

- Exam code 35 Alcohol Screening result of Positive
- Health factor of CAGE result of 1/4, 2/4, 3/4 or 4/4
- CPT G0396, G0397, 99408, 99409
- Any of the following:
  - AUDT result ≥ 8
  - AUDC result ≥ 4 (men)
  - AUDC result ≥ 3 (women)
  - CRFT result ≥ 2 and CRFT result ≤ 6

BNI

Any of the following documented at the ER visit or within 7 days of the ER visit at a face-to-face visit, which excludes chart reviews and telecommunication visits:

- CPT G0396, G0397, H0050, 99408, 99409
- Patient education code containing AOD-BNI, G0396, G0397, H0050, 99408, 99409

2.6.2.6 Patient List

List of patients seen in the ER for an injury, with screening for hazardous alcohol use, with results of screen and BNI, if any.

2.6.3 Intimate Partner (Domestic) Violence Screening

No changes from Version 14.0

2.6.3.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.6.3.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.6.3.3 Denominators

1. Female Active Clinical patients ages 13 years and older at beginning of report period.
2. GPRA**:** Female Active Clinical patients ages 15 through 40 years.

2.6.3.4 Numerators

1. GPRA**:** Patients screened for or diagnosed with IPV/DV during the report period.

Note: This numerator does *not* include refusals.

   A. Patients with documented IPV/DV exam.

   B. Patients with IPV/DV related diagnosis.

   C. Patients provided with IPV/DV patient education or counseling.

2.6.3.5 Definitions

IPV/DV Screening

Defined as at least one of the following:

- **IPV/DV Screening**
  - Exam code 34
  - 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

2.6.3.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 64.1% for the proportion of female patients ages 15 through 40 years who receive screening for domestic violence.

2.6.3.7 Patient List

List of female patients 13 years of age and older with documented IPV/DV screening, if any.

2.6.4 Depression Screening

Changes from CRS v14.0 are noted

2.6.4.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.6.4.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.6.4.3 Denominators

1. GPRAMA: Active Clinical patients ages 18 and older, broken down by gender.

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

2. Active Diabetes patients, 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 gender.

3. Active coronary heart disease (CHD) patients, defined as all Active Clinical patients diagnosed with CHD prior to the report period, *and* at least two visits during the report period, *and* two CHD-related visits ever. Broken down by gender.

2.6.4.4 Numerators

1. GPRAMA: 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 GPRAMA numerator and is included as a separate numerator only.

2.6.4.5 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.

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
  - CABG Procedure
    - POV ICD-9: V45.81; ICD-10: Z95.1

- CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209
- Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*

– PCI Procedure

- POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
- CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290
- Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

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 BH of PHQ2 or PHQ9

Mood Disorders

At least two visits in 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* or 296.3*, "BH-" (behavioral and social health), 290 through 319, 995.5*, or 995.80 through 995.85, "SB-" (suicidal behavior) or 300.9, or "PDEP-" (postpartum depression) or 648.44

2.6.4.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 66.9% for the proportion of adults ages 18 and older who receive annual screening for depression.

2.6.4.7 Patient List

List of patients with documented depression screening or diagnosed with mood disorder, if any.

2.6.5 Antidepressant Medication Management

Changes from CRS v14.0 are noted

2.6.5.1 Owner and Contact

IHS Division of Behavioral Health (DBH)

2.6.5.2 National Reporting

Not reported nationally

2.6.5.3 Denominators

1. As of the 120th day of the report period, Active Clinical Plus BH patients 18 years and older who were diagnosed with a new episode of depression and treated with antidepressant medication in the past year.

2. As of the 120th day of the Report period, User Population patients 18 years and older who were diagnosed with a new episode of depression and treated with antidepressant medication in the past year.

2.6.5.4 Numerators

1. Effective Acute Phase Treatment: Patients who filled a sufficient number of separate prescriptions or refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks).

2. Effective Continuation Phase Treatment: Patients who filled a sufficient number of separate prescriptions or refills of antidepressant medication treatment to provide continuous treatment for at least 180 days (6 months).

2.6.5.5 Definitions

Major Depression

POV ICD-9: 296.20 through 296.25, 296.30 through 296.35, 298.0, 311; ICD-10: F32.0 through F32.4, F32.8 through F33.3, F33.41, F33.9

Index Prescription (Rx) Start Date

The date of the earliest prescription for antidepressant medication filled during this period.

Antidepressant Medications

Medication taxonomy BGP HEDIS ANTIDEPRESSANT MEDS.

- Medications are: Tricyclic antidepressants (TCA) and other cyclic antidepressants, Selective serotonin reuptake inhibitors (SSRI), Monoamine oxidase inhibitors (MAOI), Serotonin-norepinephrine reuptake inhibitors (SNRI), and other antidepressants. Medications must not have a comment of RETURNED TO STOCK.

Denominator Inclusions

To be included in the denominator, patient must meet the following condition:

- Filled a prescription for an antidepressant medication (see the list of medications above) within the 121st day of the year prior to the Report period to the 120th day of the Report period. For example, if report period is July 1, 2013 through June 30, 2014, patient must have filled a prescription during November 01, 2012 through October 29, 2013.In V Medication, Date Discontinued must not be equal to the prescription, (i.e., visit date).

Denominator Exclusions

Patients with any of the following will be excluded from the denominator:

- Patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 60 days prior to the IPSD (inclusive) through 60 days after the IPSD (inclusive).
- Patients who had a new or refill prescription for antidepressant medication (see the list of medications that follows) within 105 days prior to the Index Rx Start Date are excluded as they do not represent new treatment episodes.

Effective Acute Phase Treatment Numerator

For all antidepressant medication prescriptions filled (see the list of medications that follows) within 114 days of the Index Rx Date, from V Medication CRS counts the days prescribed (i.e., treatment days) from the Index Rx Date until a total of 84 treatment days has been established. If the patient had a total gap exceeding 30 days or if the patient does not have 84 treatment days within the 114 day timeframe, the patient is not included in the numerator.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

Example of Patient Included in Numerator:

- First prescription:
  - Index Rx Date: November 1, 2013
  - Number of Days Prescribed: 30

  $November\ 1, 2013\ + 30\ days = December\ 1, 2013$

  Prescription covers the patient through December 1, 2013

- Second prescription:
  - Rx Date: December 15, 2013
  - Number of Days Prescribed: 30:
  - Gap #1 equals 14 days:

  $December\ 15,\ 2013 - December\ 1,\ 2013 = 14\ days$

  Prescription covers the patient through January 14, 2014.

- Third prescription:
  - Rx Date: January 10, 2014
  - Number of Days Prescribed: 30
  - No gap days

  $November\ 1, 2013\ + 114\ days = February\ 23, 2014$

  Prescription covers the patient through February 13, 2014.

- Patient's 84th treatment day occurs on February 7, 2014:

  $$February\ 7, 2014 \leq February\ 23, 2014$$

  $$Number\ of\ gap\ days = 14, which\ is\ < 30$$

  Patient is included in the Numerator.

Example of Patient Not Included in Numerator:

- First prescription:
  - Index Rx Date: November 1, 2013
  - Number of Days Prescribed: 30

    $$November\ 1, 2013\ + 30\ days = December\ 1, 2013$$

    Prescription covers the patient through December 1, 2013.

- Second prescription:
  - Rx Date: December 15, 2013
  - Number of Days Prescribed: 30:
  - Gap #1 equals 14 days:

    $$December\ 15,\ 2013 - December\ 1,\ 2013 = 14\ days$$

    Prescription covers the patient through January 14, 2014.

- Third prescription:
  - Rx Date: February 1, 2014
  - Number of Days Prescribed: 30
  - Gap #2 equals 18 days:

    $$February\ 1, 2014 - January\ 14, 2014 = 18$$

  - Total number of gap days = 32:

    $$14 + 18 = 32$$

    Patient is not included in the numerator.

Effective Continuation Phase Treatment Numerator

For all antidepressant medication prescriptions (see the previous list of medications) filled within 231 days of the Index Rx Date, CRS counts the days prescribed (i.e., treatment days) (from V Medication) from the Index Rx Date until a total of 180 treatment days has been established. If the patient had a total gap exceeding 51 days or if the patient does not have 180 treatment days within the 231 day timeframe, the patient is not included in the numerator.

> **Note:** If a 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:
> $November\ 19, 2014 - November\ 15, 2014 = 4$

2.6.5.6 Patient List

List of patients with new depression diagnosis and acute phase treatment (APT) and continuation phase treatment (CONPT), if any.

2.7 Cardiovascular Disease Related Group

2.7.1 Obesity Assessment

No changes from Version 14.0

2.7.1.1 Owner and Contact

Nutrition Program, Alberta Becenti

2.7.1.2 Denominators

1. Active Clinical patients ages 2 through 74 years, broken down by gender and age groups: 2 through 5 years, 6 through 11 years, 12 through 19 years, 20 through 24 years, 25 through 34 years, 35 through 44 years, 45 through 54 years, 55 through 74 years.

2. User Population patients ages 2 through 74 years, broken down by gender and age groups: 2 through 5 years, 6 through 11 years, 12 through 19 years, 20 through 24 years, 25 through 34 years, 35 through 44 years, 45 through 54 years, 55 through 74 years.

2.7.1.3 Numerators

1. All patients for whom 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.

2.7.1.4 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 ages 19 through 50 years, height and weight must be recorded within last five years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day. Overweight but not obese is defined as BMI of 25 through 29 for adults ages 19 years and older. Obese is defined as BMI of 30 or more for adults 19 years of age and older. For ages 2 through 18 years, definitions are 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 years and under, both the height and weight must be refused on the same visit at any time during the past year. For ages 19 years and older, the height and weight must be refused during the past year and are not required to be on the same visit.

2.7.1.5 Patient List

List of patients with current BMI, if any.

2.7.2 Childhood Weight Control

No changes from Version 14.0

2.7.2.1 Owner and Contact

Nutrition Program, Lorraine Valdez, MPA, BSN, RN

2.7.2.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.7.2.3 Denominators

1. GPRA: Active Clinical Patients two to five years for whom a BMI could be calculated, broken down by age groups and gender.

2.7.2.4 Numerators

1. Patients with BMI in the 85th to 94th percentile
2. GPRA: Patients with a BMI at or above the 95th percentile.
3. Patients with a BMI at or above the 85th percentile.

2.7.2.5 Definitions

Age

All patients for whom a BMI could be calculated and who are between the ages of 2 and 5 at the beginning of the report period and who do not turn age 6 during the report period are included in this measure. Age in the age groups is calculated based on the date of the most current BMI found. For example, a patient may be two at the beginning of the time period but is 3 at the time of the most current BMI found. That patient will fall into the Age 3 group.

BMI

CRS looks for the most recent BMI in the report period. CRS calculates BMI at the time the report is run, using NHANES II. A height and weight must be taken on the same day any time during the report period. The BMI values for this measure reported differently than in Obesity Assessment since this age group is children ages 2 to 5, whose BMI values are age-dependent. The BMI values are categorized as Overweight for patients with a BMI in the 85th to 94th percentile and Obese for patients with a BMI at or above the 95th percentile.

A patient whose BMI either is greater or less than the Data Check Limit range shown in Table 2-2 will not be included in the report counts for Overweight or Obese.

Table 2-2: Data Check Limit

Low-High Ages	Sex	BMI (Overweight)	BMI (Obese)	Data Check Limits	
				BMI >	BMI <
2-2	Male	17.7	18.7	36.8	7.2
2-2	Female	17.5	18.6	37.0	7.1
3-3	Male	17.1	18.0	35.6	7.1
3-3	Female	17.0	18.1	35.4	6.8
4-4	Male	16.8	17.8	36.2	7.0
4-4	Female	16.7	18.1	36.0	6.9
5-5	Male	16.9	18.1	36.0	6.9
5-5	Female	16.9	18.5	39.2	6.8

2.7.2.6 Patient List

List of patients ages two through 5 years, with current BMI.

2.7.3 Weight Assessment and Counseling for Nutrition and Physical Activity

No changes from Version 14.0

2.7.3.1 Owner and Contact

Alberta Becenti and Samantha Interpreter, RD

2.7.3.2 Denominators

1. Active Clinical patients ages 3 and older, broken down by gender and age groups.

2.7.3.3 Numerators

1. Patients with comprehensive assessment, defined as having BMI documented, counseling for nutrition, and counseling for physical activity during the Report Period.
2. Patients with BMI documented during the Report Period.
3. Patients with counseling for nutrition during the Report Period.
4. Patients with counseling for physical activity during the Report Period.

2.7.3.4 Definitions

Age

Age is calculated at the end of the report period.

BMI

Any of the following during the Report Period:

- 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 ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day.
- POV ICD-9: V85*; ICD-10: Z68.20 through Z68.54

Counseling for nutrition

- CPT 97802 through 97804, G0270, G0271, G0447, S9449, S9452, S9470
- POV ICD-9: V65.3; ICD-10: Z71.3
- Patient Education codes ending “-N” or "-MNT" (or old code “-DT” (Diet)) or containing V65.3, 97802 through 97804, G0270, G0271, G0447, S9449, S9452, S9470

Counseling for physical activity

- CPT G0447, S9451
- POV ICD-9: V65.41
- Patient education codes ending “-EX” (Exercise) or containing V65.41, G0447, or S9451

2.7.3.5 Patient List

List of patients ages three plus (+) with assessments, if any.

2.7.4 Nutrition and Exercise Education for At Risk Patients

No changes from Version 14.0

2.7.4.1 Owner and Contact

Patient Education Program: Chris Lamer, PharmD
Nutrition Program: Alberta Becenti

2.7.4.2 National Reporting

Not reported nationally

2.7.4.3 Denominators

1. Active Clinical patients ages 6 and older considered overweight (including obese). Broken down by gender.

   A. Active Clinical patients ages 6 and older considered obese. Broken down by age and gender and age groups.

2. Active Diabetic patients, 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.

2.7.4.4 Numerators

1. Patients provided with medical nutrition therapy during the report period.
2. Patients provided with nutrition education during the report period.
3. Patients provided with exercise education during the report period.
4. Patients provided with other related exercise and nutrition (lifestyle) education.

2.7.4.5 Definitions

Diabetes

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

Overweight Categories

Defined as including both obese and overweight categories calculated by BMI.

- **Overweight**
  - Ages 19 years and older, BMI greater than or equal to 25.
- **Obese**
  - Ages 19 years and older, BMI greater than or equal to 30.
- For ages 18 years and under, definition based on standard tables. CRS calculates BMI at the time the report is run, using NHANES II. For ages 18 years and under, a height and weight must be taken on the same day any time during the report period. For ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over ages 50 years, height and weight within last 2 years, not required to be recorded on same day.

Medical Nutrition Therapy

- CPT 97802 through 97804, G0270, G0271

- Primary or secondary provider codes 07, 29
- Clinic codes 67, 36

Nutrition Education

- Patient Education codes ending “-N” or "-MNT" (or old code “-DT” (Diet)) or containing V65.3, 97802 through 97804, G0270, G0271
- POV ICD-9: V65.3; ICD-10: Z71.3

Exercise Education

POV ICD-9: V65.41 exercise counseling or patient education codes ending "-EX" (Exercise) or containing V65.41.

Related Exercise and Nutrition Education

- Patient education codes ending "-LA" (lifestyle adaptation) or containing "OBS-" (obesity) or 278.00, 278.01, S9449, S9451, S9452, S9470
- CPT S9449, S9451, S9452, S9470

2.7.4.6 Patient List

List of at risk patients, with education if any.

2.7.5 Physical Activity Assessment

No changes from Version 14.0

2.7.5.1 Owner and Contact

Patient Education Program: Chris Lamer, PharmD
Nutrition Program: Alberta Becenti

2.7.5.2 Denominators

1. Active Clinical patients ages 5 and older. Broken down by gender and age groups.
2. Numerator 1 (Active Clinical Patients assessed for physical activity during the Report Period). Broken down by gender and age groups.
3. User Population patients ages 5 and older. Broken down by gender.
4. Numerator 1 (User Population Patients assessed for physical activity during the Report Period). Broken down by gender.

2.7.5.3 Numerators

1. Patients assessed for physical activity during the Report Period.

    A. Patients from Numerator 1 who have received exercise education following their physical activity assessment.

2.7.5.4 Definitions

Physical Activity Assessment

Any health factor for category Activity Level documented during the Report Period.

Exercise Education

- POV ICD-9: V65.41 exercise counseling
- Patient education codes ending "-EX" (Exercise) or containing V65.41

2.7.5.5 Patient List

List of patients with physical activity assessment and any exercise education.

2.7.6 Comprehensive Health Screening

No changes from Version 14.0

2.7.6.1 Owner and Contact

Dr. Lyle Ignace, MD

2.7.6.2 Denominators

1. Active Clinical patients ages 2 years and older.
2. Active Clinical patients ages 2 years and older.
3. Active Clinical patients ages 12 to 75 years.
4. Active Clinical patients ages 18 years and older.
5. Female Active Clinical patients ages 15 through 40 years.
6. Active Clinical patients ages 5 years and older.
7. Active Clinical patients ages 2 years through 74.
8. All Active Clinical patients ages 20 years and over.

9. Active Clinical patients ages 5 years and older.

2.7.6.3 Numerators

1. All Comprehensive Health Screening: Patients with Comprehensive Health Screening for which they are eligible, defined as having alcohol, depression, and IPV/DV screening, BMI calculated, and tobacco use, BP, and physical activity assessed.

   Note: This does *not* include refusals.

2. Comprehensive Health Screening: Patients with Comprehensive Health Screening minus physical activity assessment for which they are eligible, defined as having alcohol, depression, and IPV/DV screening, BMI calculated, and tobacco use and BP assessed.

   Note: This does *not* include physical activity assessment and does *not* include refusals.

3. Alcohol Screening: Patients screened for alcohol use or had an alcohol-related diagnosis or procedure during the Report Period.

   Note: This numerator does *not* include refusals or alcohol-related patient education.

4. Depression Screening: Patients screened for depression or diagnosed with a mood disorder at any time during the Report Period.

   Note: This numerator does *not* include refusals.

5. IPV/DV Screening: Patients screened for IPV/DV at any time during the Report Period.

   Note: This numerator does *not* include refusals.

6. Tobacco Use Assessed: Patients who have been screened for tobacco use during the Report period.

7. BMI Available: Patients for whom a BMI could be calculated.

   Note: This numerator does *not* include refusals.

8. BP Assessed: Patients with BP value documented at least twice in prior 2 years.

9. Physical Activity Assessed: Patients assessed for physical activity during the Report Period.

2.7.6.4 Definitions

Alcohol Screening

Any of the following during the report period:

- Exam code 35
- Any CAGE Alcohol Health Factor
- POV ICD-9: V11.3, V79.1, or BHS Problem code 29.1
- CPT 99408, 99409, G0396, G0397, H0049, H0050, 3016F
- Measurement in PCC or BH of AUDT, AUDC, or CRFT

Alcohol-Related Diagnosis or Procedure

Any of the following during the report period:

- Alcohol-Related Diagnosis
  - POV, Current PCC or BHS Problem List ICD-9: 303.*, 305.0*, 291.*, 357.5*; ICD-10: F10.1*, F10.20, F10.220 through F10.29, F10.920 through F10.982, F10.99, G62.1
  - BHS POV 10, 27, 29
- Alcohol-Related Procedure
  - Procedure ICD-9: 94.46, 94.53, 94.61 through 94.63, 94.67 through 94.69

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 BH of PHQ2 or PHQ9

Mood Disorders

At least two visits in 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

IPV/DV Screening

Defined as at least one of the following:

- **IPV/DV Screening**
  - Exam code 34
  - 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

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)

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 ages 19 through 50 years, height and weight must be recorded within last 5 years, not required to be on the same day. For over 50 years of age, height and weight within last 2 years, not required to be recorded on same day.

BP Documented

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 mean of last 3 BPs documented in the past 2 years. If 3 BPs are not available, uses mean of 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.

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.

Physical Activity Assessment

- Any health factor for category Activity Level documented during the Report Period.

2.7.6.5 Patient List

List of patients with assessments received, if any.

2.7.7 Cardiovascular Disease and Cholesterol Screening

Changes from CRS v14.0 are noted

2.7.7.1 Owner and Contact

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

2.7.7.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.7.3 Denominators

1. Active Clinical patients age 23 and older; broken down by gender.
2. Active CHD patients, defined as all Active Clinical patients diagnosed with CHD prior to the report period, *and* at 2 two visits during the report period, *and* 2 CHD-related visits ever. Broken down by gender.
3. User Population patients age 23 and older; broken down by gender.

2.7.7.4 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 greater than or equal to 240.
2. Patients with LDL completed in the past 5 years, regardless of result.
   A. Patients with LDL less than (<) to 100
   B. Patients with LDL 100 through 130
   C. Patients with LDL 131 through 160
   D. Patients with LDL greater than (>) 160

2.7.7.5 Definitions

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
  - CABG Procedure
    - POV ICD-9: V45.81; ICD-10: Z95.1
    - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209
    - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
  - PCI Procedure
    - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
    - CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290
    - Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

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**
  - 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

2.7.7.6 Patient List

List of patients with cholesterol or LDL value if any.

2.7.8 Cardiovascular Disease and Blood Pressure Control

Changes from CRS v14.0 are noted

2.7.8.1 Owner and Contact

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

2.7.8.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.8.3 Denominators

1. All Active Clinical patients ages 18 and over, broken down by gender.
2. Active CHD patients, defined as all Active Clinical patients diagnosed with CHD prior to the report period, *and* at least two visits during the report period, and two CHD-related visits ever. Broken down by gender.
3. All User Population patients ages 18 and over, broken down by gender.

2.7.8.4 Numerators

1. Patients with BP value documented during the Report Period.
   A. Patients with normal BP, defined as below120/80, i.e., the mean systolic value is less than 120 *and* the mean diastolic value is less than 80.

B. Patients with Prehypertension I BP, defined as 120/80 or higher, but below 130/80, i.e., the mean systolic value is 120 or higher, but lower than 130 *and* the mean diastolic value is equal to 80.

C. Patients with Prehypertension II BP, defined as 130/80 or higher, but below 140/90, i.e., the mean systolic value is 130 or higher, but lower than 140 *and* the mean diastolic value is 80 or higher, but less than 90.

D. Patients with Stage 1 Hypertension BP, defined as 140/90 or higher, but below 160/100, i.e., the mean systolic value is 140 or higher, but less than 160 *and* the mean diastolic value is 90 or higher, but less than 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.

2.7.8.5 Definitions

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
  - CABG Procedure
    - POV ICD-9: V45.81; ICD-10: Z95.1
    - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209
    - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
  - PCI Procedure
    - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
    - CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290
    - Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

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 mean of last 3 BPs documented during the Report Period. If 3 BPs are not available, uses mean of the 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) 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 the report period.

2.7.8.6 Patient List

List of Patients 18 years of age or older, or who have CHD with BP value, if any.

2.7.9 Controlling High Blood Pressure

Changes from CRS v14.0 are noted

2.7.9.1 Owner and Contact

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

2.7.9.2 National Reporting

Not reported nationally

2.7.9.3 Denominators

1. Active Clinical patients ages 18 through 85 years diagnosed with hypertension and no documented history of ESRD, broken down by gender and age groups (18 through 85 years, 18 through 45 years, 46 through 85 years).

2.7.9.4 Numerators

1. Patients with BP values documented during the report period.

   A. Patients with normal BP, defined as below120/80, i.e., the mean systolic value is less than 120 *and* the mean diastolic value is less than 80.

   B. Patients with Prehypertension I BP, defined as 120/80 or higher, but below 130/80, i.e., the mean systolic value is 120 or higher, but lower than 130 *and* the mean diastolic value is equal to 80.

   C. Patients with Prehypertension II BP, defined as 130/80 or higher, but below 140/90, i.e., the mean systolic value is 130 or higher, but lower than 140 *and* the mean diastolic value is 80 or higher, but less than 90.

   D. Patients with Stage 1 Hypertension BP, defined as 140/90 or higher, but below 160/100, i.e., the mean systolic value is 140 or higher, but less than 160 *and* the mean diastolic value is 90 or higher, but less than 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.

2.7.9.5 Definitions

ESRD

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, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), S2065, S9339
- POV ICD-9: 585.6, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Hypertension

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 401.*; ICD-10: I10 prior to the report period, and at least 1 hypertension POV during the report period.

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)

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 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.

2.7.9.6 Patient List

List of patients with hypertension and BP value, if any.

2.7.10 Controlling High Blood Pressure – Million Hearts

Changes from CRS v14.0 are noted

2.7.10.1 Owner and Contact

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

2.7.10.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.7.10.3 Denominators

1. GPRA: Million Hearts (NQF 0018): User Population patients ages 18 through 85 years diagnosed with hypertension and no documented history of ESRD or current diagnosis of pregnancy.

2.7.10.4 Numerators

1. GPRA: Million Hearts (NQF 0018): Patients with BP less than (<) 140/90, i.e., the systolic value is less than (<) 140 AND the diastolic value is less than (<) 90.

2.7.10.5 Definitions

Age

Age of the patient is calculated at end of the Report period.

Hypertension

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 401.*; ICD-10: I10 ever through the first 6 months of the Report Period, and at least 1 hypertension POV during the report period.

ESRD

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, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 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, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Pregnancy Definition

At least two visits during the Report Period with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12,

O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit.

- Miscarriage definition:
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
- Abortion definition:
  - POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
  - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
  - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

BP Values

Exclusions: When calculating all BPs, 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 last Blood Pressure documented during the Report Period.

2.7.10.6 GPRA 2014 Description

During FY 2014, establish a baseline for the proportion of patients with BP less than (<)140/90.

2.7.10.7 Patient List

List of patients with hypertension and BP value, if any.

2.7.11 Comprehensive CVD-Related Assessment

Changes from CRS v14.0 are noted

2.7.11.1 Owner and Contact

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

2.7.11.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.7.11.3 Denominators

1. GPRAMA: Active CHD patients ages 22 and older, defined as all Active Clinical patients diagnosed with CHD prior to the report period, *and* at least two visits during the report period, *and* two CHD-related visits ever.

   A. Active CHD patients 22 and older who are not Active Diabetic.

   B. Active CHD patients 22 and older who are Active Diabetic.

2.7.11.4 Numerators

1. Patients with BP value documented at least twice in prior 2 years.
2. Patients with LDL completed during the Report Period, regardless of result.
3. Patients who have been screened for tobacco use during the report period.
4. BMI Available: Patients for whom a BMI could be calculated.
5. Patients who have received any lifestyle adaptation counseling, including medical nutrition therapy, or nutrition, exercise or other lifestyle education during the report period.
6. GPRAMA: Patients with comprehensive CVD assessment, defined as having BP, LDL, and tobacco use assessed, BMI calculated and lifestyle counseling.

Note: This does *not* include depression screening.

7. Patients screened for depression or diagnosed with a mood disorder or suicide ideation at any time during the report period.

2.7.11.5 Definitions

Diabetes

Diagnosed with diabetes (first POV in V POV with ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.*) prior to the current report period, *and* at least two visits during the current report period, *and* two DM-related visits ever. Patients not meeting these criteria are considered non-diabetics.

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
  - CABG Procedure
    - POV ICD-9: V45.81; ICD-10: Z95.1
    - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209
    - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
  - PCI Procedure
    - POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
    - CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290
    - Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

BP

Having a minimum of two BPs documented in past 2 years. If CRS does not find two BPs, it will search for CPT 0001F, 2000F, 3074F through 3080F or POV ICD-9: V81.1 documented during the past 2 years. The following visits will be excluded:

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

LDL

Finds the most recent test done during the Report Period, regardless of the results of the measurement.

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

Tobacco Screening

At least one of the following:

- Any health factor for category Tobacco, TOBACCO (SMOKING), TOBACCO (SMOKELESS-CHEWING/DIP), TOBACCO (EXPOSURE) documented during report period
- Tobacco-related diagnoses (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
- Any patient education code 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), 1034F, 1035F, 1036F, 1000F, G8455 through G8457 (old codes), G8402 (old code), G8453 (old code)

BMI

CRS calculates BMI at the time the report is run, using NHANES II. For ages 19 through 50 years, height and weight must be recorded within last 5 years, not

required to be on the same day. For over 50 years of age, height and weight within last 2 years not required to be recorded on same day.

Medical Nutrition Therapy

- Any of the following:
  - CPT 97802 through 97804, G0270, G0271
  - Primary or secondary provider codes 07, 29
  - Clinic codes 67 (dietary), 36 (WIC)

Nutrition education:

- POV ICD-9: V65.3 dietary surveillance and counseling; ICD-10: Z71.3
- Patient education codes ending “-N” (Nutrition) or “-MNT” or containing V65.3 (or old code “-DT” (Diet))
- Patient Goal with Goal Type of “Nutrition” and Goal Status of "Goal Set", "Goal Met", "Maintaining Goal", or "No Change" during the Report Period

Exercise education:

- POV ICD-9: V65.41 exercise counseling
- Patient education codes ending “-EX” (Exercise) or containing V65.41
- Patient Goal with Goal Type of “Physical Activity” and Goal Status of "Goal Set", "Goal Met", "Maintaining Goal", or "No Change" during the Report Period

Related exercise and nutrition education:

- Patient education codes ending “-LA” (lifestyle adaptation) or containing “OBS-” (obesity) or 278.00 or 278.01.

Depression Screening and Mood Disorder Diagnosis or Suicide Ideation DX

Any of the following during the report period:

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

- Mood Disorder diagnosis
  - At least two visits in 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
- Suicide Ideation DX
  - POV ICD-9: V62.84; ICD-10: R45.851
  - BHS Problem code 39 during the Report Period

2.7.11.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 51.0% for the proportion of at-risk patients who have a comprehensive assessment.

2.7.11.7 Patient List

List of patients with assessments received, if any.

2.7.12 Appropriate Medication Therapy after a Heart Attack

Changes from CRS v14.0 are noted

2.7.12.1 Owner and Contact

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

2.7.12.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.12.3 Denominators

1. Active Clinical patients 35 and older discharged for an Acute Myocardial Infarction (AMI) during the first 51 weeks of the report period and were not readmitted for any diagnosis within seven days of discharge. Broken down by gender.

2.7.12.4 Numerators

1. Patients with active prescription for or who have a contraindication or previous adverse reaction to beta-blockers.

   Note: This numerator does *not* include refusals.

   A. Patients with active prescription for beta-blockers.

   B. Patients with contraindication or previous adverse reaction to beta-blocker therapy.

2. Patients with active prescription for or who have a contraindication or previous adverse reaction to ASA (aspirin) or other anti-platelet agent.

   Note: This numerator does *not* include refusals.

   A. Patients with active prescription for ASA (aspirin) or other anti-platelet agent.

   B. Patients with contraindication or previous adverse reaction to ASA (aspirin) or other anti-platelet agent.

3. Patients with active prescription for or who have a contraindication or previous adverse reaction to ACEIs/ARBs.

   Note: This numerator does *not* include refusals.

   A. Patients with active prescription for ACEIs/ARBs

   B. Patients with contraindication or previous adverse reaction to ACEIs/ARBs

4. Patients with active prescription for or who have a contraindication or previous adverse reaction to statins.

   Note: This numerator does *not* include refusals.

   A. Patients with active prescription for statins

   B. Patients with contraindication or previous adverse reaction to statins

5. Patients with active prescriptions for all post-AMI medications (i.e., beta-blocker, ASA or anti-platelet, ACEI/ARB, and statin) or who have a contraindication or previous adverse reaction.

Note: This numerator does *not* include refusals.

2.7.12.5 Definitions

AMI

POV ICD-9: 410.*1; ICD-10: I21.*, I22.* (i.e., first eligible episode of an AMI) with Service Category H. If patient has more than one episode of AMI during the first 51 weeks of the report period, CRS will include only the first discharge.

Denominator Exclusions

Patients meeting any of the following conditions will be excluded from the denominator.

- Patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."
- Patients readmitted for any diagnosis within 7 days of discharge.
- Patients with a Diagnosis Modifier of C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable), R (Resolved), S (Suspect, Suspicious), or T (Status Post).
- Patients with a Provider Narrative beginning with "Consider," "Doubtful," "Maybe," "Possible," "Perhaps," "Rule Out," "R/O,", "Probable," "Resolved," "Suspect," "Suspicious," or "Status Post."

To be included in the numerators,

A patient must meet one of the following two conditions:

- An active prescription (not discontinued as of (discharge date plus 7 days) and does not have a comment of RETURNED TO STOCK) that was prescribed prior to admission, during the inpatient stay, or within 7 days after discharge. "Active" prescription defined as:

  $$Days\ Prescribed > (Discharge\ Date + 7\ days - Order\ Date)$$

- Have a contraindication or previous adverse reaction to the indicated medication.

Contraindication or previous ADR or allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a contraindication, ADR, or allergy will be counted in sub-numerator B.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

Numerator Logic

In the logic that follows, "ever" is defined as anytime through the end of the report period.

Beta-Blocker Numerator Logic

- **Beta-blocker medication codes**
  - Defined with medication taxonomy BGP HEDIS BETA BLOCKER MEDS
  - Medications are:
    - Noncardioselective Beta Blockers: Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol
    - Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
    - Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, and Hydrochlorothiazide-propranolol.
- **Contraindications to beta-blockers**

  Defined as any of the following occurring ever unless otherwise noted:
  - **Asthma**. Two diagnoses (POV) of ICD-9: 493*; ICD-10: J45.20 through J45.52 on different visit dates
  - **Hypotension**. One diagnosis of ICD-9: 458*; ICD-10: I95.*
  - **Heart block greater than 1 degree**. One diagnosis of ICD-9: 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, 426.7; ICD-10: I44.1, I44.2, I45.2, I45.3, I45.6
  - **Sinus bradycardia**. One diagnosis of ICD-9: 427.81; ICD-10: I49.5, R00.1
  - **COPD**. Two diagnoses on different visit dates of ICD-9: 491.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8, or a combination of any of these codes, such as one visit with 491.20 and one with 496

  - NMI refusal for any beta-blocker at least once during hospital stay through seven days after discharge date
  - CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) (old code) at least once during hospital stay through 7 days after discharge date

- **Adverse drug reaction or documented beta blocker allergy**

  Defined as any of the following occurring ever:

  - POV ICD-9: 995.0 through 995.3 *and* E942.0
  - Beta block* entry in ART (Patient Allergies File)
  - Beta block*, bblock* or b block* contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ASA (aspirin) or Other Anti-Platelet Numerator Logic

- **ASA medication codes**
  - Defined with medication taxonomy DM AUDIT ASPIRIN DRUGS
- **Other antiplatelet medication codes**
  - Defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy
- **Contraindications to ASA or other antiplatelet**

  Defined as any of the following occurring ever unless otherwise noted:

  - Patients with active prescription for Warfarin (Coumadin) at time of arrival or prescribed at discharge, using site-populated BGP CMS WARFARIN MEDS taxonomy
  - Hemorrhage diagnosis (POV ICD-9: 459.0; ICD-10: R58)
  - NMI refusal for any aspirin at least once during hospital stay through 7 days after discharge date
  - CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) (old code) at least once during hospital stay through 7 days after discharge date
- **Adverse drug reaction, documented ASA, or other antiplatelet allergy**

  Defined as any of the following occurring ever:

  - POV ICD-9: 995.0 through 995.3 *and* E935.3; ICD-10: T39.015* or T39.095*
  - Aspirin entry in ART (Patient Allergies File)
  - ASA or aspirin contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ACEI/ARB Numerator Logic

- **Ace Inhibitor (ACEI) medication codes**

  Defined with medication taxonomy BGP HEDIS ACEI MEDS.

  – **ACEI medications are:** Angiotensin Converting Enzyme Inhibitors (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).

- **Antihypertensive Combinations:** (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Trandolapril-verapamil).

- **Contraindications to ACEI** defined as any of the following:

  – **Pregnancy:** See the definition that follows

  – **Breastfeeding:** defined as POV ICD-9: V24.1; ICD-10: Z39.1 or Breastfeeding Patient Education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period

  – **Diagnosis ever for moderate or severe aortic stenosis**

    - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22

  – **NMI refusal** for any ACEI at least once during hospital stay through 7 days after discharge date.

- **Adverse drug reaction or documented ACEI allergy**

  Defined as any of the following occurring ever:

  – POV ICD-9: 995.0 through 995.3 *and* E942.6; ICD-10: T46.4X5*

  – Ace inhibitor or ACEI entry in ART (Patient Allergies File)

  – Ace i* or ACEI contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

- **ARB medication codes**

  Defined with medication taxonomy BGP HEDIS ARB MEDS

  – **ARB medications are:** Angiotensin II Inhibitors (Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan.)

- **Antihypertensive Combinations**
  - Aliskiren-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-olmesartan, Amlodipine-Telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan
- **Contraindications to ARB** defined as any of the following:
  - **Pregnancy:** See the definition that follows
  - **Breastfeeding:** Defined as POV V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period
  - **Diagnosis ever for moderate or severe aortic stenosis**
    - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
  - **NMI refusal** for any ARB at least once during hospital stay through 7 days after discharge date.
- **Adverse drug reaction or documented ARB allergy**

  Defined as any of the following occurring ever:
  - POV ICD-9: 995.0 through 995.3 *and* E942.6
  - Angiotensin Receptor Blocker or ARB entry in ART (Patient Allergies File)
  - Angiotensin Receptor Blocker or ARB contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.

Statins Numerator Logic:

- **Statin medication codes**
  - Defined with medication taxonomy BGP PQA STATIN MEDS.
  - **Statin medications are:** Atorvastatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altocor, Altoprev, Mevacor), Pravastatin (Pravachol), Pitavastatin (Livalo), Simvastatin (Zocor), Rosuvastatin (Crestor).
- **Statin Combination Products**
  - Niacin-lovastatin, Niacin-simvastatin, Ezetimibe-simvastatin, Amlodipine-Atorvastatin, Sitagliptin-simvastatin, Ezetimibe-atorvastatin, Aspirin-pravastatin.
- **Contraindications to Statins:** defined as any of the following:
  - **Pregnancy:** See the definition that follows

- **Breastfeeding**: defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period
- **Acute Alcoholic Hepatitis**: defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period
- **NMI refusal** for any statin at least once during hospital stay through 7 days after discharge date.

- **Adverse drug reaction or documented statin allergy**

  Defined as any of the following:

  - ALT or AST greater than three times the Upper Limit of Normal (ULN) (i.e., Reference High) on two or more consecutive visits during the Report Period
  - Creatine Kinase (CK) levels greater than 10 times ULN or CK greater than 10,000 IU/L during the Report Period
  - Myopathy or Myalgia, defined as any of the following during the Report Period:
    - POV ICD-9: 359.0 through 359.9, 729.1, 710.5, 074.1; ICD-10: G71.14, G71.19, G72.0, G72.2, G72.89, G72.9, M35.8, M60.80 through M60.9, M79.1
  - Any of the following occurring ever:
    - POV ICD-9: 995.0 through 995.3 *and* E942.9
    - Statin or Statins entry in ART (Patient Allergies File)
    - Statin or Statins contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Pregnancy Definition

At least two visits during the Report Period with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68,

O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit.

- **Miscarriage definition:**
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
- **Abortion definition:**
  - POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
  - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
  - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

All Medications Numerator Logic

To be included in this numerator, a patient must have a prescription or a contraindication for *all* of the four medication classes (i.e., beta-blocker, ASA or other anti-platelet, ACEI/ARB, AND statin).

Test Definitions

- **ALT**
  - Site-populated taxonomy DM AUDIT ALT TAX

  - LOINC taxonomy
- **AST**
  - Site-populated taxonomy DM AUDIT AST TAX
  - LOINC taxonomy
- **Creatine Kinase**
  - Site-populated taxonomy BGP CREATINE KINASE TAX
  - LOINC taxonomy

2.7.12.6 Patient List

List of patients with AMI, with appropriate medication therapy, if any.

2.7.13 Persistence of Appropriate Medication Therapy after a Heart Attack

Changes from CRS v14.0 are noted

2.7.13.1 Owner and Contact

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

2.7.13.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.13.3 Denominators

1. Active Clinical patients 35 and older diagnosed with an AMI six months prior to the report period through the first 6 months of the report period. Broken down by gender.

2.7.13.4 Numerators

1. Patients with a 135-day course of treatment with beta-blockers or who have a contraindication or previous adverse reaction to beta-blocker therapy.

Note: This numerator does *not* include refusals.

   A. Patients with 135-day treatment with beta-blockers.

   B. Patients with a contraindication or previous adverse reaction to beta-blockers.

2. Patients with a 135-day course of treatment with ASA (aspirin) or other antiplatelet agent or who have a contraindication or previous adverse reaction to ASA or antiplatelet therapy.

   Note: This numerator does *not* include refusals.

   A. Patients with 135-day treatment with ASA (aspirin) or other anti-platelet agent.

   B. Patients with a contraindication or previous adverse reaction to ASA (aspirin) or other anti-platelet agent.

3. Patients with a 135-day course of treatment with ACEIs/ARBs or who have a contraindication or previous adverse reaction to ACEI/ARB therapy.

   Note: This numerator does *not* include refusals.

   A. Patients with 135-day treatment with ACEIs/ARBs.

   B. Patients with a contraindication or previous adverse reaction to ACEIs/ARBs.

4. Patients with a 135-day course of treatment with statins or who have a contraindication or previous adverse reaction to statin therapy.

   Note: This numerator does *not* include refusals.

   A. Patients with 135-day treatment with statins.

   B. Patients with a contraindication or previous adverse reaction to statins.

5. Patients with a 135-day course of treatment for all post-AMI medications, (i.e., beta-blocker, ASA or anti-platelet, ACEI/ARB, AND statin) following first discharge date or visit date, including previous active prescriptions, or who have a contraindication or previous adverse reaction.

   Note: This numerator does *not* include refusals.

2.7.13.5 Definitions

AMI

POV or Problem List ICD-9: 410.0* through 410.9*, 412; ICD-10: I21.*, I22.*. AMI diagnosis may be made at an inpatient or outpatient visit but must occur between 6 months prior to beginning of report period through first 6 months of the report period. Inpatient visit defined as Service Category of H (Hospitalization). If patient has more than 1 episode of AMI during the timeframe, CRS will include only the first hospital discharge or ambulatory visit.

Denominator Exclusions

Patients meeting any of the following conditions will be excluded from the denominator.

- If inpatient visit, patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."
- Patients with a Diagnosis Modifier of C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable), R (Resolved), S (Suspect, Suspicious), or T (Status Post).
- Patients with a Provider Narrative beginning with "Consider," "Doubtful," "Maybe," "Possible," "Perhaps," "Rule Out," "R/O," "Probable," "Resolved," "Suspect,", "Suspicious," or "Status Post."

To Be Included in the Numerators

A patient must meet one of the two conditions that follow:

- A total days' supply greater than or equal to 135 days in the 180 days following discharge date for inpatient visits or visit date for ambulatory visits. Medications must not have a comment of RETURNED TO STOCK. Prior active prescriptions can be included if the treatment days fall within the 180 days following discharge or visit date. Prior active prescription defined as most recent prescription (see the codes that follow) prior to admission or visit date with the number of days' supply equal to or greater than the discharge or visit date minus the prescription date
- Have a contraindication or previous adverse reaction to the indicated medication.

Contraindications, previous ADR, or allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a contraindication, ADR, or allergy will be counted in sub-numerator B.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

Example of patient included in the beta-blocker numerator who has prior active prescription:

- Admission Date: February 1, 2014

- Discharge Date: February 15, 2014
- Must have 135 days prescribed by August 13, 2014:

  $Discharge\ Date\ + 180\ days$
- Prior Beta-Blocker Rx Date: January 15, 2014
- Number of Days Prescribed: 60 (treats patient through March 15, 2014)
- Discharge Date minus Rx Date:

  $February\ 15, 2014\ - January\ 15, 2014 = 31\ days$

  $60 \geq 31$

  Prescription is considered Prior Active Rx
- March 15, 2014 is between February 15 and August 13, 2014, thus remainder of Prior Active Rx can be counted toward 180-day treatment period
- Number of Remaining Days Prescribed from Prior Active Rx:

  $60 - (Discharge\ Date - Prior\ Prescription\ Date) = Remaining\ Days$

  $60 - (February\ 15, 2014 - January\ 15, 2014) = Remaining\ Days$

  $60 - 31 = 29$
- Second Prescription: April 1, 2014
- Number of Days Prescribed: 90
- Third Prescription: July 10, 2014
- Number of Days Prescribed: 90
- Total Days' Supply Prescribed between February 15 and August 13, 2014:

  $29 + 90 + 90 = 209$

Numerator Logic

In the logic that follows, "ever" is defined as anytime through the end of the report period.

Beta-Blocker Numerator Logic

- **Beta-blocker medication codes:**
  - Defined with medication taxonomy BGP HEDIS BETA BLOCKER MEDS
  - Medications are:
    - Noncardioselective Beta Blockers: Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol

- Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
- Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, and Hydrochlorothiazide-propranolol.

- **Contraindications to beta-blockers**

  Defined as any of the following occurring ever unless otherwise noted:

  – **Asthma**. Two diagnoses (POV) of ICD-9: 493*; ICD-10: J45.20 through J45.52 on different visit dates
  – **Hypotension**. One diagnosis of ICD-9: 458*; ICD-10: I95.*
  – **Heart block greater than 1 degree**. One diagnosis of ICD-9: 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, 426.7; ICD-10: I44.1, I44.2, I45.2, I45.3, I45.6
  – **Sinus bradycardia**. One diagnosis of ICD-9: 427.81; ICD-10: I49.5, R00.1
  – **COPD**. Two diagnoses on different visit dates of ICD-9: 491.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8, or a combination of any of these codes, such as one visit with 491.20 and one with 496
  – NMI refusal for any beta-blocker at least once during the period admission or visit date through the 180 days after discharge or visit date
  – CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) (old code) at least once during the period admission or visit date through the 180 days after discharge or visit date

- **Adverse drug reaction or documented beta blocker allergy**

  Defined as any of the following occurring anytime up to the 180 days after discharge or visit date:

  – POV ICD-9: 995.0 through 995.3 *and* E942.0
  – Beta block* entry in ART (Patient Allergies File)
  – Beta block*, bblock* or b block* contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ASA (aspirin) Numerator Logic

- **ASA medication codes**

  – Defined with medication taxonomy DM AUDIT ASPIRIN DRUGS

- **Other antiplatelet medication codes**

  - Defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy

- **Contraindications to ASA or other antiplatelet**

  Defined as any of the following occurring ever unless otherwise noted:

  - Patients with prescription for Warfarin (Coumadin) using site-populated BGP CMS WARFARIN MEDS taxonomy during the period admission or visit date through the 180 days after discharge or visit date
  - Hemorrhage diagnosis (POV ICD-9: 459.0; ICD-10: R58)
  - NMI refusal for any aspirin at least once during the period admission or visit date through the 180 days after discharge or visit date
  - CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) (old code) at least once during the period admission or visit date through the 180 days after discharge or visit date

- **Adverse drug reaction, documented ASA, or other antiplatelet allergy**

  Defined as any of the following occurring anytime up to the 180 days after discharge or visit date:

  - POV ICD-9: 995.0 through 995.3 *and* E935.3; ICD-10: T39.015*, T39.095*
  - Aspirin entry in ART (Patient Allergies File)
  - ASA or aspirin contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ACEI/ARB Numerator Logic

- **Ace Inhibitor (ACEI) medication codes**

  Defined with medication taxonomy BGP HEDIS ACEI MEDS.

  - **ACEI medications are:** Angiotensin Converting Enzyme Inhibitors (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).

- **Antihypertensive Combinations:** (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Trandolapril-verapamil).

- **Contraindications to ACEI** defined as any of the following:

  - **Pregnancy:** See the definition that follows

  - **Breastfeeding:** defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the period admission or visit date through the 180 days after discharge or visit date
  - **Diagnosis ever for moderate or severe aortic stenosis**
    - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
  - **NMI refusal** for any ACEI at least once during the period admission or visit date through the 180 days after discharge or visit date.
- **Adverse drug reaction or documented ACEI allergy**

  Defined as any of the following occurring ever:
  - POV ICD-9: 995.0 through 995.3 *and* E942.6; ICD-10: T46.4X5*
  - Ace inhibitor or ACEI entry in ART (Patient Allergies File)
  - Ace i* or ACEI contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8
- **ARB (Angiotensin Receptor Blocker) medication codes**

  Defined with medication taxonomy BGP HEDIS ARB MEDS
  - **ARB medications are:** Angiotensin II Inhibitors (Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan)
- **Antihypertensive Combinations**
  - Aliskiren-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-olmesartan, Amlodipine-Telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan
- **Contraindications to ARB** defined as any of the following:
  - **Pregnancy:** See the definition that follows
  - **Breastfeeding:** defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the period admission or visit date through the 180 days after discharge or visit date
  - **Diagnosis ever for moderate or severe aortic stenosis**
    - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
  - **NMI refusal** for any ARB at least once during the period admission or visit date through the 180 days after discharge or visit date.

- **Adverse drug reaction or documented ARB allergy**

  Defined as any of the following occurring anytime up to the 180 days after discharge or visit date:

  – POV ICD-9: 995.0 through 995.3 *and* E942.6
  – Angiotensin Receptor Blocker or ARB entry in ART (Patient Allergies File)
  – Angiotensin Receptor Blocker or ARB contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Statins Numerator Logic

- **Statin medication codes**
  – Defined with medication taxonomy BGP PQA STATIN MEDS
  – **Statin medications are:** Atorvostatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altocor, Altoprev, Mevacor), Pravastatin (Pravachol), Pitavastatin (Livalo), Simvastatin (Zocor), Rosuvastatin (Crestor).
- **Statin Combination Products**
  – Niacin-lovastatin, Niacin-simvastatin, Ezetimibe-simvastatin, Amlodipine-Atorvastatin, Sitagliptin-simvastatin, Ezetimibe-atorvastatin, Aspirin-pravastatin.
- **Contraindications to Statins:** Defined as any of the following:
  – **Pregnancy**: See the definition that follows
  – **Breastfeeding:** Defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, BF-N during the period admission or visit date through the 180 days after discharge or visit date
  – **Acute Alcoholic Hepatitis**: Defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the period admission or visit date through the 180 days after discharge or visit date
  – **NMI (not medically indicated) refusal** for any statin at least once during the period admission or visit date through the 180 days after discharge or visit date.
- **Adverse drug reaction or documented statin allergy**

  Defined as any of the following:

  – ALT or AST greater than three times the ULN (i.e., Reference High) on two or more consecutive visits during the period admission or visit date through the 180 days after discharge or visit date

- Creatine Kinase (CK) levels greater than 10 times ULN or CK greater than 10,000 IU/L during the period admission or visit date through the 180 days after discharge or visit date
- Myopathy or Myalgia, defined as any of the following during the period admission or visit date through the 180 days after discharge or visit date:
  - POV ICD-9: 359.0 through 359.9, 729.1, 710.5, 074.1; ICD-10: G71.14, G71.19, G72.0, G72.2, G72.89, G72.9, M35.8, M60.80 through M60.9, M79.1
- Any of the following occurring anytime up to the 180 days after discharge or visit date:
  - POV ICD-9: 995.0 through 995.3 *and* E942.9
  - Statin or Statins entry in ART (Patient Allergies File)
  - Statin or Statins contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Pregnancy Definition

At least two visits during the period admission/visit date through the 180 days after discharge/visit date with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through

O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the time period, CRS will use the first two visits in the time period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit.

- **Miscarriage definition:**
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
- **Abortion definition:**
  - POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
  - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
  - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

All Medications Numerator Logic

To be included in this numerator, a patient must have a prescription or a contraindication for *all* of the 4 medication classes (i.e., beta-blocker, ASA or other anti-platelet, ACEI/ARB, *and* statin).

Test Definitions

- **ALT**
  - Site-populated taxonomy DM AUDIT ALT TAX
  - LOINC taxonomy
- **AST**
  - Site-populated taxonomy DM AUDIT AST TAX
  - LOINC taxonomy
- **Creatine Kinase**
  - Site-populated taxonomy BGP CREATINE KINASE TAX
  - LOINC taxonomy

2.7.13.6 Patient List

List of patients with AMI, with persistent medication therapy, if any.

2.7.14 Appropriate Medication Therapy in High Risk Patients

Changes from CRS v14.0 are noted

2.7.14.1 Owner and Contact

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

2.7.14.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.14.3 Denominators

1. Active CHD patients ages 22 and older, defined as all Active Clinical patients diagnosed with CHD prior to the report period, *and* at least two visits during the report period, *and* two CHD-related visits ever.

   A. Active CHD patients age 22 and older who are not Active Diabetic.

   B. Active CHD patients age 22 and older who are Active Diabetic.

2.7.14.4 Numerators

1. Patients with a 180-day course of treatment with beta-blockers during the report period, or who have a contraindication or previous adverse reaction to beta-blocker therapy.

   Note: This numerator does *not* include refusals.

   A. Patients with 180-day treatment with beta-blockers.

   B. Patients with a contraindication or previous adverse reaction to beta-blockers.

2. Patients with a 180-day course of treatment with ASA (aspirin) or other antiplatelet agent during the report period, or who have a contraindication or previous adverse reaction to ASA or antiplatelet therapy.

   Note: This numerator does *not* include refusals.

   A. Patients with 180-day treatment with ASA (aspirin) or other anti-platelet agent.

B. Patients with a contraindication or previous adverse reaction to ASA (aspirin) or other antiplatelet agent.

3. Patients with a 180-day course of treatment with ACEIs/ARBs during the report period, or who have a contraindication or previous adverse reaction to ACEI/ARB therapy.

Note: This numerator does *not* include refusals.

A. Patients with 180-day treatment with ACEIs/ARBs.

B. Patients with a contraindication or previous adverse reaction to ACEIs/ARBs.

4. Patients with a 180-day course of treatment with statins during the report period, or who have a contraindication or previous adverse reaction to statin therapy.

Note: This numerator does *not* include refusals.

A. Patients with 180-day treatment with statins.

B. Patients with a contraindication or previous adverse reaction to statins.

5. Patients with a 180-day course of treatment for all medications (i.e., beta-blocker, aspirin or antiplatelet, ACEI/ARB, *and* statin) during the report period or who have a contraindication or previous adverse reaction.

Note: This numerator does *not* include refusals.

2.7.14.5 Definitions

CHD

- POV ICD-9: 410.0 through 413.*, 414.0 through 414.9, 429.2; ICD-10: I20.0 through I22.8, I24.0 through I25.83, I25.89, I25.9
- One or more Coronary Artery Bypass Graft (CABG) or Percutaneous Coronary Interventions (PCI) procedures, defined as any of the following:
  - CABG Procedure
    - POV ICD-9: V45.81; ICD-10: Z95.1
    - CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209
    - Procedure ICD-9: 36.1*, 36.2*; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
  - PCI Procedure

- POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
- CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290
- Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**

Diabetes

Diagnosed with diabetes (first POV in V POV with ICD-9: 250.00 through 250.93 or ICD-10: E10.* through E13.*) prior to the current report period, *and* at least two visits during the current report period, *and* two DM-related visits ever. Patients not meeting these criteria are considered non-diabetics.

To be included in the numerators:

A patient must meet one of the two conditions that follow:

- Prescription(s) for the indicated medication with a total days' supply of 180 days or more during the Report Period. Medications must not have a comment of RETURNED TO STOCK.
- Have a contraindication or previous adverse reaction to the indicated medication.

A contraindication or previous ADR or allergies are only counted if a patient did not have a prescription for the indicated medication. Patients without a prescription who have a contraindication, ADR, or allergy will be counted in sub-numerator B.

For prescriptions, the days' supply requirement may be met with a single prescription or from a combination of prescriptions for the indicated medication that were filled during the report period and prescriptions filled prior to the report period but which are still active (i.e., prior active prescription). Prior active prescriptions can be included if the treatment days fall within the report period. Prior active prescription defined as most recent prescription for the indicated medication (see the codes that follow) prior to report period start date with the number of days' supply equal to or greater than the report period start date minus the prescription date.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

Example of patient included in the beta-blocker numerator with prior active prescription:

- Report period: July 1, 2013 through June 30, 2014
- Must have 180 days' supply of indicated medication June 30, 2014 (end of report period)
- Prior Beta-Blocker Rx Date: June 1, 2013
- Number of Days Prescribed: 60 (treats patient through July 31, 2013)
- Report Period Start Date minus Rx Date:

  $July\ 1, 2013 - June\ 1, 2013 = 30\ days$

  $Number\ of\ Days\ Prescribed = 60\ and\ 60 \geq 30\ so:$

  Prescription is considered Prior Active Rx

- July 31, 2013 falls within the report period of July 1, 2013 to June 30, 2014, thus the remainder of the Prior Active Rx can be counted toward 180 days' supply
- Number of Remaining Days Prescribed from Prior Active Rx:

  $Days\ Prescribed - (Report\ Period\ Start\ Date - Prior\ Rx\ Date)$

  $60 - (July\ 1, 2013 - June\ 1, 2013)$

  $60 - 30 = 30$

- Second Prescription: August 5, 2013
- Number of Days Prescribed: 90
- Third Prescription: January 10, 2013
- Number of Days Prescribed: 90
- Total Days' Supply Prescribed between July 1, 2013 and June 30, 2014, including prior active prescription:

$$30 + 90 + 90 = 210$$

Numerator Logic

In the logic that follows, "ever" is defined as anytime through the end of the Report Period.

Beta-Blocker Numerator Logic:

- **Beta-blocker medication codes**
  - Defined with medication taxonomy BGP HEDIS BETA BLOCKER MEDS
  - Medications are:
    - Noncardioselective Beta Blockers: Carvedilol, Labetalol, Nadolol, Penbutolol, Pindolol, Propranolol, Timolol, Sotalol
    - Cardioselective Beta Blockers: Acebutolol, Atenolol, Betaxolol, Bisoprolol, Metoprolol, Nebivolol
    - Antihypertensive Combinations: Atenolol-chlorthalidone, Bendroflumethiazide-nadolol, Bisoprolol-hydrochlorothiazide, Hydrochlorothiazide-metoprolol, and Hydrochlorothiazide-propranolol
- **Contraindications to beta-blockers**

  Defined as any of the following occurring ever unless otherwise noted:
  - **Asthma**. Two diagnoses (POV) of ICD-9: 493*; ICD-10: J45.20 through J45.52 on different visit dates
  - **Hypotension**. One diagnosis of ICD-9: 458*; ICD-10: I95.*
  - **Heart block greater than 1 degree**. One diagnosis of ICD-9: 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, 426.7; ICD-10: I44.1, I44.2, I45.2, I45.3, I45.6
  - **Sinus bradycardia**. One diagnosis of ICD-9: 427.81; ICD-10: I49.5, R00.1
  - **COPD**. Two diagnoses on different visit dates of ICD-9: 491.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8, or a combination of any of these codes, such as one visit with 491.20 and one with 496
  - NMI refusal for any beta-blocker at least once during the Report Period
  - CPT G8011 (Clinician documented that AMI patient was not an eligible candidate for beta-blocker at arrival) (old code) at least once during the Report Period.
- **Adverse drug reaction or documented beta blocker allergy**

  Defined as any of the following occurring ever:
  - POV ICD-9: 995.0 through 995.3 *and* E942.0

- Beta block* entry in ART (Patient Allergies File)
- Beta block*, bblock* or b block* contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ASA (aspirin) or Other Antiplatelet Numerator Logic

- **ASA medication codes**
  - Defined with medication taxonomy DM AUDIT ASPIRIN DRUGS.
- **Other anti-platelet medication codes**
  - Defined with medication taxonomy site-populated BGP ANTI-PLATELET DRUGS taxonomy.
- **Contraindications to ASA or other antiplatelet**

  Defined as any of the following occurring ever unless otherwise noted:
  - Patients with a 180-day course of treatment for Warfarin (Coumadin) during the Report Period, using site-populated BGP CMS WARFARIN MEDS taxonomy
  - Hemorrhage diagnosis (POV ICD-9: 459.0; ICD-10: R58)
  - NMI refusal for any aspirin at least once during the Report Period
  - CPT G8008 (Clinician documented that AMI patient was not an eligible candidate to receive aspirin at arrival) (old code) at least once during the report period
- **Adverse drug reaction, documented ASA, or other anti-platelet allergy**

  Defined as any of the following occurring ever:
  - POV ICD-9: 995.0 through 995.3 *and* E935.3; ICD-10: T39.015*, T39.095*
  - Aspirin entry in ART (Patient Allergies File)
  - ASA or aspirin contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

ACEI/ARB Numerator Logic

- **Ace Inhibitor (ACEI) medication codes**

  Defined with medication taxonomy BGP HEDIS ACEI MEDS
  - **ACEI medications are:** Angiotensin Converting Enzyme Inhibitors (Benazepril, Captopril, Enalapril, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolopril).

- **Antihypertensive Combinations:** (Amlodipine-benazepril, Benazepril-hydrochlorothiazide, Captopril-hydrochlorothiazide, Enalapril-hydrochlorothiazide, Fosinopril-hydrochlorothiazide, Hydrochlorothiazide-lisinopril, Hydrochlorothiazide-moexipril, Hydrochlorothiazide-quinapril, Trandolapril-verapamil).
- **Contraindications to ACEI** defined as any of the following:
  - **Pregnancy:** See the definition that follows
  - **Breastfeeding:** Defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period
  - **Diagnosis ever for moderate or severe aortic stenosis**
  - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
  - **NMI refusal** for any ACEI at least once during the Report Period.
- **Adverse drug reaction or documented ACEI allergy**

  Defined as any of the following occurring anytime through the end of the report period:
  - POV ICD-9: 995.0 through 995.3 *and* E942.6; ICD-10: T46.4X5*
  - Ace inhibitor or ACEI entry in ART (Patient Allergies File)
  - Ace i* or ACEI contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8
- **ARB (Angiotensin Receptor Blocker) medication codes**

  Defined with medication taxonomy BGP HEDIS ARB MEDS
  - **ARB medications are:** Angiotensin II Inhibitors (Azilsartan, Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan)
- **Antihypertensive Combinations**
  - Aliskiren-valsartan, Amlodipine-hydrochlorothiazide-olmesartan, Amlodipine-hydrochlorothiazide-valsartan, Amlodipine-olmesartan, Amlodipine-Telmisartan, Amlodipine-valsartan, Azilsartan-chlorthalidone, Candesartan-hydrochlorothiazide, Eprosartan-hydrochlorothiazide, Hydrochlorothiazide-Irbesartan, Hydrochlorothiazide-Losartan, Hydrochlorothiazide-olmesartan, Hydrochlorothiazide-Telmisartan, Hydrochlorothiazide-Valsartan
- **Contraindications to ARB** defined as any of the following:
  - **Pregnancy:** See the definition that follows

  - **Breastfeeding:** Defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period
  - **Diagnosis ever for moderate or severe aortic stenosis**
  - POV ICD-9: 395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22
  - **NMI refusal** for any ARB at least once during the Report Period.
- **Adverse drug reaction or documented ARB allergy**

  Defined as any of the following occurring anytime through the end of the Report Period:

  - POV ICD-9: 995.0 through 995.3 *and* E942.6
  - Angiotensin Receptor Blocker or ARB entry in ART (Patient Allergies File)
  - Angiotensin Receptor Blocker or ARB contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Statins Numerator Logic

- **Statin medication codes**
  - Defined with medication taxonomy BGP PQA STATIN MEDS
  - **Statin medications are**: Atorvostatin (Lipitor), Fluvastatin (Lescol), Lovastatin (Altocor, Altoprev, Mevacor), Pravastatin (Pravachol), Pitavastatin (Livalo), Simvastatin (Zocor), Rosuvastatin (Crestor).
- **Statin Combination Products**
  - Niacin-lovastatin, Niacin-simvastatin, Ezetimibe-simvastatin, Amlodipine-Atorvastatin, Sitagliptin-simvastatin, Ezetimibe-atorvastatin, Aspirin-pravastatin.
- **Contraindications to Statins:** Defined as any of the following:
  - **Pregnancy:** See the definition that follows
  - **Breastfeeding**: Defined as POV ICD-9: V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period
  - **Acute Alcoholic Hepatitis**: Defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period
  - **NMI refusal** for any statin at least once during the report period
- **Adverse drug reaction or documented statin allergy**

Defined as any of the following:

- ALT or AST greater than (>) 3 times the ULN (i.e., Reference High) on two or more consecutive visits during the Report Period
- CK levels greater than (>) 10 times ULN or CK greater than 10,000 IU/L during the Report Period
- Myopathy or Myalgia, defined as any of the following during the Report Period:
  - POV ICD-9: 359.0 through 359.9, 729.1, 710.5, 074.1; ICD-10: G71.14, G71.19, G72.0, G72.2, G72.89, G72.9, M35.8, M60.80 through M60.9, M79.1
- Any of the following occurring anytime through the end of the Report Period:
  - POV ICD-9: 995.0 through 995.3 *and* E942.9
  - Statin or Statins entry in ART (Patient Allergies File)
  - Statin or Statins contained within Problem List or in Provider Narrative field for any POV ICD-9: 995.0 through 995.3, V14.8; ICD-10: Z88.8

Pregnancy Definition

At least two visits during the Report Period with POV or Problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3, 661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354,

O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, CRS will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit.

- **Miscarriage definition:**
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
- **Abortion definition:**
  - POV ICD-9: 635*, 636* 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
  - CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267,
  - Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

All Medications Numerator Logic

To be included in this numerator, a patient must have a prescription or a contraindication for *all* of the four medication classes (i.e., beta-blocker, ASA or other anti-platelet, ACEI/ARB, *and* statin).

Test Definitions

- **ALT**
  - Site-populated taxonomy DM AUDIT ALT TAX
  - LOINC taxonomy
- **AST**
  - Site-populated taxonomy DM AUDIT AST TAX
  - LOINC taxonomy
- **Creatine Kinase**
  - Site-populated taxonomy BGP CREATINE KINASE TAX
  - LOINC taxonomy

2.7.14.6 Patient List

List of CHD patients 22 and older with 180-day medication therapy during the report period, if any.

2.7.15 Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed at Discharge for Atrial Fibrillation

No changes from Version 14.0

2.7.15.1 Owner and Contact

Dr. Dena Wilson and Mark Veazie

2.7.15.2 Denominators

1. Number of visits for User Population patients ages 18 and older who were hospitalized during the report period with ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation.

2.7.15.3 Numerators

1. Number of visits where patients received a prescription for anticoagulant at discharge.

2. Number of visits where patients did not receive anticoagulation therapy.

2.7.15.4 Definitions

Ischemic Stroke or TIA with Atrial Fibrillation:

Non-CHS inpatient visit (Type not equal to C and Service Category equals H) and POV of any of the following: (ICD-9: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9; ICD-10: G45.0 through G45.2, G45.8, G45.9, G46.0 through G46.2, I63.*) and POV ICD-9: 427.31; ICD-10: I48.0 through I48.2, I48.91 (atrial fibrillation). The patient must be admitted to the hospital during the report period with one of these conditions but the discharge may occur after the report period.

Anticoagulant Therapy

Patient must meet one of the following conditions to be counted as receiving anticoagulant therapy:

- Active prescription for Warfarin, aspirin, or other antiplatelet as of discharge date. “Active” prescription defined as:

$$Rx\ Days'Supply \geq (Discharge\ Date - Rx\ Date)$$

Where the prescription has not been discontinued as of the discharge date.

- Prescription for Warfarin, aspirin, or other antiplatelet on discharge date.

For all prescriptions, medications must not have a comment of RETURNED TO STOCK.

Warfarin Medication

Any medication in site-populated BGP CMS WARFARIN MEDS taxonomy.

Aspirin Medication

Any medication in site-populated DM AUDIT ASPIRIN DRUGS taxonomy.

Other Anti-Platelet or Anticoagulant Medication

Any medication in the site-populated BGP ANTI-PLATELET DRUGS taxonomy, any medication with VA Drug Class BL700.

No Anticoagulant Therapy

Patients who did not have an active prescription for anticoagulant therapy at time of discharge and did not receive anticoagulant therapy at discharge.

2.7.15.5 Patient List

List of patients with stroke or TIA and atrial fibrillation with anticoagulant therapy, if any.

2.7.16 Cholesterol Management for Patients with Cardiovascular Conditions

Changes from CRS v14.0 are noted

2.7.16.1 Owner and Contact

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

2.7.16.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.16.3 Denominators

1. Active Clinical patients ages 18 to 75 who, during the year prior to the beginning of the report period, were diagnosed with AMI, coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI), or who were diagnosed with IVD during the report period and the year prior to the report period (changed timeframe for IVD). Broken down by gender.

2. User Population patients ages 18 to 75 who, during the year prior to the beginning of the report period, were diagnosed with AMI, coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI), or who were diagnosed with IVD during the report period and the year prior to the report period (changed timeframe for IVD). Broken down by gender.

2.7.16.4 Numerators

1. Patients with LDL completed during the report period, regardless of result.

   A. Patients with LDL less than 100, completed during the report period.

   B. Patients with LDL 100 through 130, completed during the report period.

   C. Patients with LDL greater than 130, completed during the report period

2.7.16.5 Definitions

AMI

- POV ICD-9: 410.*0, 410.*1; ICD-10: I21.*

PCI

- Procedure ICD-9: 00.66, 36.01 (old code), 36.02 (old code), 36.05, (old code), 36.06 through 36.07; ICD-10: 02703**, 02704**, 02713**, 02714**, 02723**, 02724**, 02733**, 02734**
- POV ICD-9: V45.82; ICD-10: Z95.5, Z98.61
- CPT 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, G0290

CABG

- Procedure ICD-9: 36.1*, 36.2; ICD-10: 02100**, 021049*, 02104A*, 02104J*, 02104K*, 02104Z*, 02110**, 021149*, 02114A*, 02114J*, 02114K*, 02114Z*, 02120**, 021249*, 02124A*, 02124J*, 02124K*, 02124Z*, 02130**, 021349*, 02134A*, 02134J*, 02134K*, 02134Z*
- POV ICD-9: V45.81; ICD-10: Z95.1
- CPT 33510 through 33514, 33516 through 33519, 33521 through 33523, 33533 through 33536, S2205 through S2209

IVD

- POV ICD-9: 411.*, 413.*, 414.0*, 414.2, 414.8, 414.9, 429.2, 433.* through 434.*, 440.1, 440.2*, 440.4, 444.*, 445.*; ICD-10: I20.*, I24.*, I25.1*, I25.5 through I25.812, I70.201 through I70.299, I70.92, I75.*

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 defined as:

- 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

2.7.16.6 Patient List

List of patients with AMI, CABG, PCI, or IVD with LDL value, if any.

2.7.17 Heart Failure and Evaluation of LVS Function

No changes from Version 14.0

2.7.17.1 Owner and Contact

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

2.7.17.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.7.17.3 Denominators

1. Active Clinical ages 18 or older discharged with heart failure during the report period.

2.7.17.4 Numerators

1. Patients whose left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge.

2.7.17.5 Definitions

Age

Age of the patient is calculated as of the hospital admission date

Heart Failure

- POV primary diagnosis code of ICD-9: 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9, 429.1, 997.1; ICD-10: I11.0, I13.0, I13.2, I50.* *and* with Service Category H (hospitalization).

Note:	If a patient has multiple admissions matching these criteria during the report period, the earliest admission will be used.

Denominator Exclusions

Defined as any of the following:

- Patients receiving comfort measures only (i.e., patients who received palliative care and usual interventions were not received because a medical decision was made to limit care).
- Patients with a Discharge Type of Transferred or Irregular or containing "Death."
- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospitalization.

Comfort Measures

- POV ICD-9: V66.7 (Encounter for palliative care); ICD-10: Z51.5 documented during hospital stay

LVAD or Heart Transplant

Any of the following during hospital stay:

- Procedure ICD-9: 33.6, 37.41, 37.51 through 37.54, 37.61 through 37.66, 37.68; ICD-10: 02HA**Z, 02PA*RZ, 02RK0JZ, 02RL0JZ, 02UA4JZ, 02WA0JZ, 02WA0QZ, 02WA0RZ, 02WA3QZ, 02WA3RZ, 02WA4QZ, 02WA4RZ, 02YA0Z*, 5A02*10, 5A02*16, 5A02*1D

Evaluation of LVS Function

Any of the following:

- An ejection fraction ordered or documented anytime 1 year prior to discharge date, defined as any of the following:
  - Measurement "CEF"
  - Procedure ICD-9: 88.53, 88.54; ICD-10: B205*ZZ, B206*ZZ, B215*ZZ, B216*ZZ
  - CPT 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314 through 93318, 93350, 93543, 93555
- RCIS (Referred Care Information System) order for Cardiovascular Disorders referral that is ordered during the hospital stay but no later than the hospital discharge date. (RCIS referral defined as:
  - ICD Diagnostic Category Cardiovascular Disorders combined with any of the following CPT Categories: Evaluation or Management, Non-surgical Procedures, or Diagnostic Imaging.)
- Any of the following documented anytime one year prior to discharge date:
  - Echocardiogram: Procedure ICD-9: 88.72, 37.28, 00.24; ICD-10: B245YZZ, B245ZZ4, B245ZZZ, B246YZZ, B246ZZ4, B246ZZZ, B24BYZZ, B24BZZ4, B24BZZZ
  - Nuclear Medicine Test: Procedure ICD-9: 92.2*
  - Cardiac Catheterization with a Left Ventriculogram: Procedure ICD-9: 37.22, 37.23, 88.53, 88.54; ICD-10: 4A02*N7, 4A02*N8, B205*ZZ, B206*ZZ, B215*ZZ, B216*ZZ

2.7.17.6 Patient List

List of Active Clinical heart failure patients 18 and older who received evaluation of LVS function, if any.

2.8 STD-Related Group

2.8.1 HIV Screening

No changes from Version 14.0

2.8.1.1 Owner and Contact

Lisa Neel, MPH and Dr. Marie Russell

2.8.1.2 National Reporting

NATIONAL (included in National GPRA/GPRAMA Report; reported to OMB and Congress)

2.8.1.3 Denominators

1. GPRA**:** All pregnant Active Clinical patients with no documented miscarriage or abortion during the past 20 months and no recorded HIV diagnosis ever.
2. GPRA Developmental: User Population patients ages 13 through 64 with no recorded HIV diagnosis prior to the Report Period.

2.8.1.4 Numerators

1. GPRA**:** Patients who were screened for HIVduring the past 20 months.
2. Patients with documented HIV screening refusal during the past 20 months
3. GPRA Developmental: Patients who were screened for HIV during the Report Period.

> **Note:** This numerator does *not* include refusals.

4. Patients with documented HIV screening refusal during the report period.
5. GPRA Developmental: Number of HIV screens provided to User Population patients during the report period, where the patient was not diagnosed with HIV any time prior to the screen.

> **Note**: This numerator does *not* include refusals. No denominator and is a total count only, not a percentage.

2.8.1.5 Definitions

HIV

- Any of the following documented any time prior to the end of the report period
  - POV or Problem List entry where the status is not Inactive or Deleted ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73

Pregnancy:

- At least two visits with POV or problem diagnosis ICD-9: 640.*3, 641.*3, 642.*3, 643.*3, 644.*3, 645.*3, 646.*3, 647.*3, 648.*3, 649.*3, 651.*3, 652.*3, 653.*3, 654.*3, 655.*3, 656.*3, 657.*3, 658.*3, 659.*3, 660.*3,

661.*3, 662.*3, 663.*3, 665.*3, 668.*3, 669.*3, 671.*3, 673.*3, 674.*3, 675.*3, 676.*3, 678.*3, 679.*3, V22.0 through V23.9, V28.81, V28.82, V28.89, V72.42, V89.01 through V89.09; ICD-10: O09.00 through O10.02, O10.111 through O10.12, O10.211 through O10.22, O10.311 through O10.32, O10.411 through O10.42, O10.911 through O10.92, O11.1 through O15.1, O15.9 through O24.02, O24.111 through O24.12, O24.311 through O24.32, O24.41*, O24.811 through O24.82, O24.911 through O24.92, O25.10 through O25.2, O26.00 through O26.62, O26.711 through O26.72, O26.811 through O26.93, O29.011 through O30.93, O31.* through O48.*, O60.0*, O61.* through O66.*, O68, O69.*, O71.00 through O71.1, O71.89, O71.9, O74.0 through O75.81, O75.89, O75.9, O76 through O77.*, O88.011 through O88.02, O88.111 through O88.12, O88.211 through O88.22, O88.311 through O88.32, O88.811 through O88.82, O90.3, O91.011 through O91.019, O91.111 through O91.119, O91.211 through O91.219, O92.011 through O92.019, O92.20, O92.29, O98.011 through O98.02, O98.111 through O98.12, O98.211 through O98.22, O98.311 through O98.32, O98.411 through O98.42, O98.511 through O98.52, O98.611 through O98.62, O98.711 through O98.72, O98.811 through O98.82, O98.911 through O98.92, O99.011 through O99.02, O99.111 through O99.12, O99.210 through O99.214, O99.280 through O99.284, O99.310 through O99.314, O99.320 through O99.324, O99.330 through O99.334, O99.340 through O99.344, O99.350 through O99.354, O99.411 through O99.42, O99.511 through O99.52, O99.611 through O99.62, O99.711 through O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 through O99.844, O99.89, O9A.111 through O9A.12, O9A.211 through O9A.22, O9A.311 through O9A.32, O9A.411 through O9A.42, O9A.511 through O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36 during the past 20 months from the end of the Report Period, where the primary provider is not a CHR (Provider code 53). Pharmacy-only visits (Clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the past 20 months, CRS will use the first two visits in the 20-month period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit. In addition, the patient must have at least one pregnancy-related visit occurring during the reporting period. The time period is extended to include patients who were pregnant during the report period but whose initial diagnoses (and HIV test) were documented prior to report period.

– **Miscarriage**: Occurring after the second pregnancy POV and during the past 20 months.
  - POV ICD-9: 630, 631, 632, 633*, 634*; ICD-10: O03.9
  - CPT 59812, 59820, 59821, 59830
– **Abortion**: Occurring after the second pregnancy POV and during the past 20 months.

- POV ICD-9: 635*, 636*, 637*; ICD-10: O00.*, O01.*, O03.1, O03.31 through O03.33, O03.6, O03.81 through O03.83, O04.6, O04.81 through O04.83, Z33.2
- CPT 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260 through S2267
- Procedure ICD-9: 69.01, 69.51, 74.91, 96.49; ICD-10: 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z

HIV Screening

- CPT 86689, 86701 through 86703, 87390, 87391, 87534 through 87539
- LOINC taxonomy
- Site-populated taxonomy BGP HIV TEST TAX
- Refusal of any laboratory test in site-populated taxonomy BGP HIV TEST TAX. For the number of HIV screens provided to User Population patients numerator (count only), a maximum of one HIV screen per patient per day will be counted
- HIV Screening Refusals: Refusal of any laboratory test in site-populated taxonomy BGP HIV TEST TAX

Note: The time frame for both screening and refusals for the pregnant patient's denominator is anytime during the past 20 months and for User Population patients 13 through 64 years of age is anytime during the report period. Refusals are allowed during the past 20 months for pregnant patients (vs. only during the report period) in the event the patient is at the end of her pregnancy at the beginning of the report period and refused the HIV test earlier in her pregnancy during the previous year.

2.8.1.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 89.1% for the proportion of pregnant patients who are screened for HIV.

2.8.1.7 Patient List

List of pregnant patients or User Population patients with documented HIV test or refusal, if any.

2.8.2 HIV Quality of Care

No changes from Version 14.0

2.8.2.1 Owner and Contact

Lisa Neel, MPH, Dr. Marie Russell, and Jonathan Iralu

2.8.2.2 National Reporting

Not reported nationally

2.8.2.3 Denominators

1. User Population patients 13 and older with at least two direct care visits, (i.e., not contract or CHS) during the report period with HIV diagnosis *and* one HIV visit in last 6 months.

2.8.2.4 Numerators

1. Patients who received CD4 test only (without HIV viral load) during the report period.
2. Patients who received HIV Viral load only (without CD4), during the report period.
3. Patients who received both CD4 and HIV viral load tests during the report period.
4. Total Numerators 1, 2, and 3.
5. Patients who received at least one prescription for an Antiretroviral medication.

2.8.2.5 Definitions

HIV

POV ICD-9: 042, 042.0 through 044.9 (old codes), 079.53, V08, 795.71; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73

Lab Test CD4

- CPT 86359, 86360, 86361
- LOINC taxonomy
- Site-populated taxonomy BGP CD4 TAX

HIV Viral Load

- CPT 87536, 87539
- LOINC taxonomy
- Site-populated taxonomy BGP HIV VIRAL TAX

Antiretroviral Medication

Defined with medication taxonomy BGP PQA ANTIRETROVIRAL MEDS. Medications must not have a comment of RETURNED TO STOCK.

2.8.2.6 Patient List

List of patients 13 and older diagnosed with HIV, with CD4 test, viral load or antiretroviral Rx, if any.

2.8.3 Hepatitis C Screening

No changes from Version 14.0

2.8.3.1 Owner and Contact

Brigg Reilley

2.8.3.2 Denominators

1. User Population patients born between 1945 and 1965 with no recorded Hepatitis C diagnosis. Broken down by gender.

2.8.3.3 Numerators

1. Patients screened for Hepatitis C ever.

2.8.3.4 Definitions

Hepatitis C Diagnosis

Any of the following documented any time prior to the end of the Report Period:

- POV or Problem List entry where the status is not Inactive or Deleted: ICD-9: 070.41, 070.44, 070.51, 070.54, 070.70 through 070.71; ICD-10: B17.10, B17.11, B18.2, B19.20, B19.21

Hepatitis C Screening

- CPT 86803
- LOINC taxonomy
- Site-populated taxonomy BGP HEP C TEST TAX

2.8.3.5 Patient List

List of patients with documented Hepatitis C screening ever, if any.

2.8.4 Chlamydia Testing

No changes from Version 14.0

2.8.4.1 Owner and Contact

Epidemiology Program: Scott Tulloch

2.8.4.2 National Reporting

Not reported nationally

2.8.4.3 Denominators

1. Female Active Clinical patients ages 16 through 25 years, broken down into age groups 16 through 20 years and 21 through 25 years.
2. Female User Population patients ages 16 through 25 years, broken down into age groups 16 through 20 years and 21 through 25 years.

2.8.4.4 Numerators

1. Patients tested for Chlamydia trachomatis during the report period.

2.8.4.5 Definitions

Chlamydia

- POV ICD-9: V73.88, V73.98
- CPT 86631, 86632, 87110, 87270, 87320, 87490 through 87492, 87810, 3511F
- Site-populated taxonomy BGP GPRA CHLAMYDIA TESTS
- LOINC taxonomy

2.8.4.6 Patient List

List of patients with documented Chlamydia screening, if any.

2.8.5 Sexually Transmitted Infection (STI) Screening

No changes from Version 14.0

2.8.5.1 Owner and Contact

Scott Tulloch

2.8.5.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; *not* reported to OMB and Congress)

2.8.5.3 Denominators

1. Number of key STI incidents for Active Clinical patients that occurred during the period 60 days prior to the beginning of the report period through the first 300 days of the report period. Key STIs defined as Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Two or more key STIs on the same visit will be counted once. Broken down by gender.

2. Chlamydia screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.

3. Gonorrhea screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.

4. HIV/AIDS screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.

5. Syphilis screenings needed for key STI incidents for Active Clinical patients that occurred during the defined period. Broken down by gender.

6. Number of key STI incidents for User Population patients that occurred during the period 60 days prior to the beginning of the report period through the first 300 days of the report period. Key STIs defined as Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Two or more key STIs on the same visit will be counted once. Broken down by gender.

7. Chlamydia screenings needed for key STI incidents for User Population patients that occurred during the defined period. Broken down by gender.

8. Gonorrhea screenings needed for key STI incidents for User Population patients that occurred during the defined period. Broken down by gender.

9. HIV/AIDS screenings needed for key STI incidents for User Population patients that occurred during the defined period. Broken down by gender.

10. Syphilis screenings needed for key STI incidents for User Population patients that occurred during the defined period. Broken down by gender.

2.8.5.4 Numerators

1. No denominator; count only. The total count of Active Clinical patients who were diagnosed with one or more key STIs during the period 60 days prior to the report period through the first 300 days of the report period. Broken down by gender.

2. No denominator; count only. The total count of separate key STI incidents for Active Clinical patients during the defined period. Broken down by gender.

3. For use with denominator #1 and 6: Number of complete screenings, defined as all screenings necessary for a specific STI incidents, performed from 1 month prior to the date of relevant STI incident through 2 months after.

   Note: This numerator does *not* include refusals.

4. For use with denominator #2 and 7: Number of needed Chlamydia screenings performed from 1 month prior to the date of first STI diagnosis of each incident through 2 months after.

   Note: This numerator does *not* include refusals.

5. For use with denominator #3 and 8: Number of needed Gonorrhea screenings performed from 1 month prior to the date of first STI diagnosis of each incident through 2 months after.

   Note: This numerator does *not* include refusals.

6. For use with denominator #4 and 9: Number of needed HIV/AIDS screenings performed from 1 month prior to the date of first STI diagnosis of each incident through 2 months after.

   Note: This numerator does *not* include refusals.

7. For use with denominator #5 and 10: Number of needed Syphilis screenings performed from 1 month prior to the date of first STI diagnosis of each incident through 2 months after.

   Note: This numerator does *not* include refusals.

2.8.5.5 Definitions

Key STIs

Chlamydia, gonorrhea, HIV/AIDS, and syphilis. Key STIs defined with the following POVs:

- Chlamydia: ICD-9: 079.88, 079.98, 099.41, 099.50 through 099.59; ICD-10: A56.*, A74.81 through A74.9
- Gonorrhea: ICD-9: 098.0 through 098.89; ICD-10: A54.*, O98.2*
- HIV/AIDS: ICD-9: 042, 042.0 through 044.9, 079.53, 795.71, V08; ICD-10: B20, B97.35, R75, Z21, O98.711 through O98.73
- Syphilis: ICD-9: 090.0 through 093.9, 094.1 through 097.9; ICD-10: A51.* through A53.*

Logic for Identifying Patients Diagnosed with Key STI (Numerator #1)

Any patient with one or more diagnoses of any of the key STIs defined previously during the period 60 days prior to the beginning of the report period through the first 300 days of the report period.

Logic for Identifying Separate Incidents of Key STIs (Numerator #2)

One patient may have one or multiple occurrences of one or multiple STIs during the year, except for HIV. An occurrence of HIV is only counted if it is the initial HIV diagnosis for the patient ever. Incidents of an STI are identified beginning with the date of the first key STI diagnosis (see the previous definition) occurring between 60 days prior to the beginning of the report period through the first 300 days of the report period. A second incident of the same STI (other than HIV) is counted if another diagnosis with the same STI occurs 2 months or more after the initial diagnosis. A different STI diagnosis that occurs during the same 60-day time period as the first STI counts as a separate incident.

Table 2-3: Logic for Identifying Separate Incidents of Key STIs

Date	Visit	Total Incidents
August 1, 2013	Patient screened for Chlamydia	0
August 8, 2013	Patient diagnosed with Chlamydia	1
October 15, 2013	Patient diagnosed with Chlamydia	2
October 25, 2013	Follow-up for Chlamydia	2
November 15, 2013	Patient diagnosed with Chlamydia	2
March 1, 2014	Patient diagnosed with Chlamydia	3

Denominator Logic for Needed Screenings (Denominator #1)

One patient may need multiple screening tests based on one or more STI incidents occurring during the time period.

To be included in the needed screening tests denominator, the count will be derived from the number of separate STI incidents and the type(s) of screenings recommended for each incident. The recommended screenings for each key STI are listed in the following table.

Table 2-4: Recommended Screenings for each Key STI

STI	Screenings Needed
Chlamydia	Gonorrhea, HIV/AIDS, Syphilis
Gonorrhea	Chlamydia, HIV/AIDS, Syphilis
HIV/AIDS	Chlamydia, Gonorrhea, Syphilis
Syphilis	Chlamydia, Gonorrhea, HIV/AIDS

"Needed" screenings are recommended screenings that are further evaluated for contraindications. The following are reasons that a recommended screening is identified as not needed (i.e., contraindicated).

- The patient has a documented STI diagnosis corresponding to the screening type in the same time period. For example, a patient with both a Chlamydia and a Gonorrhea diagnosis on the same visit does not need the recommended Chlamydia screening based on the gonorrhea diagnosis.
- Only one screening for each type of STI is needed during the relevant time period, regardless of the number of different STI incidents identified. For example, if a patient is diagnosed with Chlamydia and Gonorrhea on the same visit, only one screening each is needed for HIV/AIDS and Syphilis.
- A patient with HIV/AIDS diagnosis prior to any STI diagnosis that triggers a recommended HIV/AIDS screening does not need the screening ever.

Numerator Logic

To be counted in the numerator, each needed screening in the denominator must have a corresponding lab test or test refusal documented in the period from 1 month prior to the relevant STI diagnosis date through 2 months after the STI incident.

- **Chlamydia Screening**

  Any of the following during the specified time period:

  – POV ICD-9: V73.88, V73.98

  - CPT 86631 through 86632, 87110, 87270, 87320, 87490 through 87492, 87810, 3511F
  - Site-populated taxonomy BGP CHLAMYDIA TESTS TAX
  - LOINC taxonomy
- **Gonorrhea Screening**

  Any of the following during the specified time period:
  - CPT 87590 through 87592, 87850, 3511F
  - Site-populated taxonomy BKM GONORRHEA TEST TAX
  - LOINC taxonomy
- **HIV/AIDS Screening**

  Any of the following during the specified time period:
  - CPT 86689, 86701 through 86703, 87390 through 87391, 87534 through 87539
  - Site-populated taxonomy BGP HIV TEST TAX
  - LOINC taxonomy
- **Syphilis Screening**

  Any of the following during the specified time period:
  - CPT 86592 through 86593, 86781, 87285, 3512F
  - Site-populated taxonomy BKM FTA-ABS TESTS TAX or BKM RPR TESTS TAX
  - LOINC taxonomy

Logic Examples

- Example of Patient with Single Diagnosis of Single STI
  - August 1, 2013: Patient screened for Chlamydia
  - August 8, 2013: Patient diagnosed with Chlamydia; three screens needed: Gonorrhea, HIV/AIDS, Syphilis
  - August 13, 2013: Patient screened for Gonorrhea, HIV/AIDS, Syphilis
  - Result:
    - Denominator: One key STI incident
    - Numerator: One complete screening
- Example of Patient with Multiple Diagnoses of Single STI
  - August 1, 2013: Patient screened for Chlamydia
  - August 8, 2013: Patient diagnosed with Chlamydia (Incident #1); three screens needed: Gonorrhea, HIV/AIDS, Syphilis

  - August 13, 2013: Patient screened for Gonorrhea, HIV/AIDS, Syphilis
  - February 1, 2013: Patient screened for Chlamydia
  - December 8, 2013: Patient diagnosed with Chlamydia (Incident #2); three screens needed: Gonorrhea, HIV/AIDS, Syphilis
  - Result:
    - Denominator: Two key STI incidents,
    - Numerator: One complete screening (one each of three types)
- Example of Patient with Single Diagnosis of Multiple STIs
  - October 15, 2013: Patient screened for Chlamydia, Gonorrhea, HIV/AIDS, Syphilis
  - October 18, 2013: Patient diagnosed with Chlamydia; three screens needed: Gonorrhea, HIV/AIDS, Syphilis
  - October 20, 2013: Patient diagnosed with Syphilis; removes needed screen for Syphilis (see previous)
  - Result:
    - Denominator: Two key STI incidents
    - Numerator: One complete screening (prior to triggering diagnoses but within timeframe)
- Example of Patient with Multiple Diagnoses of Multiple STIs
  - June 15, 2005: Patient diagnosed with HIV/AIDS
  - August 1, 2013: Patient screened for Chlamydia and Gonorrhea
  - August 8, 2013: Patient diagnosed with Chlamydia and Gonorrhea (Incident #1); One screen needed: Syphilis (HIV/AIDS not needed since prior diagnosis)
  - August 8, 2013: Patient screened for HIV/AIDS and Syphilis - since only the Syphilis screen is needed, the HIV/AIDS screen is not counted at all
  - February 1, 2013: Patient screened for Chlamydia
  - December 8, 2013: Patient diagnosed with Chlamydia (Incident #2; two screens needed: Gonorrhea and Syphilis
  - December 10, 2013: Patient screened for Syphilis
  - Result: Denominator:
    - Two key STI incidents
    - Numerator: One complete screening

2.8.5.6 Patient List

List of patients diagnosed with one or more STIs during the defined time period with related screenings.

2.9 Other Clinical Measures Group

2.9.1 Osteoporosis Management

No changes from Version 14.0

2.9.1.1 Owner and Contact

Dr. Lisa Sumner

2.9.1.2 National Reporting

Not reported nationally

2.9.1.3 Denominators

1. Female Active Clinical patients ages 67 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.

2.9.1.4 Numerators

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

2.9.1.5 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 the codes that follow) or receiving any osteoporosis therapy medication (see the codes that follow).
- 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 six 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.

2.9.1.6 Patient List

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

2.9.2 Osteoporosis Screening in Women

No changes from Version 14.0

2.9.2.1 Owner and Contact

Dr. Lisa Sumner

2.9.2.2 National Reporting

Not reported nationally

2.9.2.3 Denominators

1. Female Active Clinical patients ages 65 and older without a documented history of osteoporosis.

2.9.2.4 Numerators

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

Note: This numerator does *not* include refusals.

2.9.2.5 Definitions

Patients without Osteoporosis

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

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

2.9.2.6 Patient List

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

2.9.3 Rheumatoid Arthritis Medication Monitoring

No changes from Version 14.0

2.9.3.1 Owner and Contact

Dr. Lisa Sumner

2.9.3.2 National Reporting

Not reported nationally

2.9.3.3 Denominators

1. Active Clinical patients ages 16 and older diagnosed with rheumatoid arthritis (RA) prior to the report period and with at least two RA-related visits any time during the report period who were prescribed maintenance therapy medication chronically during the report period.

2.9.3.4 Numerators

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

2.9.3.5 Definitions

RA

Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted) ICD-9: 714.*; ICD-10: M05.*-M06.*, M08.0*, M08.2-M08.99, M12.0* prior to the report period, and at least two RA POVs during the report period.

Maintenance Therapy Medications and Monitoring

For all maintenance therapy medications *except* intramuscular gold, 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 is greater than or equal to 348. This means the patient must have been on the medication at least 75% of the medication period. The following two examples illustrate this logic. All 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 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:

$90 + 90 + 90 = 270$ *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:

  - Sulfasalazine:
    - 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:

    $90 + 90 + 180 = 360$ *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 a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

For intramuscular gold, the patient must have 12 or more injections during the report period.

Appropriate Monitoring of Rheumatoid Arthritis Medications

Appropriate monitoring is defined with laboratory tests and varies by medication, as shown in Table 2-5. If patient is prescribed two or more types of medications, patient must meet criteria for all of the medications.

Maintenance Therapy Medications

Medications shown in Table 2-5 *except* for Gold, Intramuscular, all medications requiring more than one of each type of test during the report period, there must be a minimum of 10 days between tests. For example, if a Sulfasalazine test was performed on March 1, March 7, and March 21, 2014, the March 7 test will not be counted since it was performed only 6 days after the March 1 test.

Table 2-5: Maintenance Therapy Medications

Medication	Required Monitoring Test(s) and Frequency
Gold, Intramuscular	Complete Blood Count (CBC) and Urine Protein on same day as each injection during report period.
Azathrioprine or Sulfasalazine	Four CBCs during the report period.
Leflunomide or Methotrexate	Six each of CBC, Serum Creatinine, and Liver Function Test during the report period.
Cyclosporin	CBC, Liver Function Tests, and Potassium within past 180 days from report period end date. 12 Serum Creatinine tests during the report period
Gold, Oral or Penicillamine	Four each of CBC and Urine Protein during the report period.
Mycophenolate	CBC within past 180 days from report period end date.

The medications in the previous table are defined with medication taxonomies:

- BGP RA IM GOLD MEDS
- BGP RA AZATHIOPRINE MEDS

- BGP RA LEFLUNOMIDE MEDS
- BGP RA METHOTREXATE MEDS
- BGP RA CYCLOSPORINE MEDS
- BGP RA ORAL GOLD MEDS
- BGP RA MYCOPHENOLATE MEDS
- BGP RA PENICILLAMINE MEDS
- BGP RA SULFASALAZINE MEDS

NSAID Medications

- All of the following NSAID medications must have Creatinine, Liver Function Tests, and CBC during the report period:
  - Diclofenac, Etodolac, Indomethacin, Ketorolac, Sulindac, Tolmetin, Meclofenamate, Mefanamic Acid, Nabumetone, Meloxicam, Piroxicam, Fenoprofen, Flurbiprofen, Ibuprofen, Ketoprofen, Naproxen, Oxaprozin, Aspirin, Choline Magnesium Trisalicylate, Diflunisil, Magnesium Salicylate, Celocoxib.
  - 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

Glucocorticoid Medications

- Dexamethasone, Methylprednisolone, Prednisone, Hydrocortisone, Betamethasone, Prednisonolone, Triamcinolone
- These medications defined with medication taxonomy BGP RA GLUCOCORTICOIDS MEDS
- Glucocorticoids must have a glucose test, which must be performed during the report period

Example of Patient Not Included in Numerator

Medications Prescribed and Required Monitoring:

- Gold, Oral, last prescription June 15, 2014. Requires CBC and Urine Protein within past 90 days of report period end date.
- CBC performed on December 1, 2014, which is within past 90 days of report period end date of December 31, 2014. No Urine Protein performed during that period.
- Patient is not in numerator.

Example of Patient Included in Numerator

Medications Prescribed and Required Monitoring:

- Diclofenac, last prescription September 1, 2014. Requires LFT and CBC during report period.
- Mycophenolate, last prescription March 10, 2014. Requires CBC within past 180 days from report period end date.
- LFT and CBC performed during report period. CBC performed November 1, 2014, which is within past 180 days of report period end date of December 31, 2014.
- Patient is in numerator.

Monitoring Test Definitions

CBC

- CPT 85025, 85027
- Site-populated taxonomy BGP CBC TESTS
- LOINC taxonomy

Urine Protein

- Site-populated taxonomy DM AUDIT URINE PROTEIN TAX
- LOINC taxonomy

Serum Creatinine

- CPT 82540, 82565 through 75
- Site-populated taxonomy DM AUDIT CREATININE TAX
- 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, or
- LOINC taxonomy

Glucose

- CPT 82947, 82948, 82950, 82951, 82952, 82962
- Site-populated taxonomy DM AUDIT GLUCOSE TESTS TAX
- LOINC taxonomy

Potassium

- CPT 84132
- Site-populated taxonomy BGP POTASSIUM
- LOINC taxonomy

2.9.3.6 Patient List

List of RA patients 16 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:". The chronic medications and all laboratory tests the patient *did* have are displayed.

2.9.4 Osteoarthritis Medication Monitoring

No changes from Version 14.0

2.9.4.1 Owner and Contact

Dr. Lisa Sumner

2.9.4.2 National Reporting

Not reported nationally

2.9.4.3 Denominators

1. Active Clinical patients ages 40 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.

2.9.4.4 Numerators

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

2.9.4.5 Definitions

Osteoarthritis

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 day's supply is greater than or equal to 348. 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 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:

    $90 + 90 + 90 = 270$ *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:

  $90 + 90 + 180 = 360$ *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 a 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 the subsections that follow.

Maintenance Therapy Medications

- NSAID Medications: All of the following NSAID medications must have Creatinine, Liver Function Tests, and CBC during the report period:

  - Diclofenac, Etodolac, Indomethacin, Ketorolac, Sulindac, Tolmetin, Meclofenamate, Mefanamic Acid, Nabumetone, Meloxicam, Piroxicam, Fenoprofen, Flurbiprofen, Ibuprofen, Ketoprofen, Naproxen, Oxaprozin, Aspirin, Choline Magnesium Trisalicylate, Diflunisil, Magnesium Salicylate, Celocoxib
  - 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 prescription 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 prescription 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 (Complete Blood Count)**:
  - 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

2.9.4.6 Patient List

List of OA patients 40 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 laboratory tests the patient *did* have are displayed.

2.9.5 Asthma

No changes from Version 14.0

2.9.5.1 Owner and Contact

Chris Lamer, PharmD

2.9.5.2 National Reporting

Not reported nationally

2.9.5.3 Denominators

1. Active Clinical patients, broken down by age groups: younger than 15 years, 15 through 34 years, 35 through 64 years, 65 years and older.

2. Numerator 1 (Patients who have had two asthma-related visits during the report period or with persistent asthma) broken down by age groups: younger than 15 years, 15 through 34 years, 35 through 64 years, 65 years and older.

2.9.5.4 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.

B. Patients from Numerator 1 who have visited the ER or Urgent Care for asthma during the Report Period.

C. Patients from Numerator 1 who have a Severity of 1.

D. Patients from Numerator 1 who have a Severity of 2.

E. Patients from Numerator 1 who have a Severity of 3.

F. Patients from Numerator 1 who have a Severity of 4.

G. Patients from Numerator 1 who have no documented Severity.

2.9.5.5 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.

Severity

Severity is defined as a Severity of 1, 2, 3 or 4 in an active entry in the PCC Problem List for ICD-9: 493.*; ICD-10: J45.20 through J45.52 or in V Asthma.

Hospitalizations

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

ER and Urgent Care

ER and Urgent Care visits are defined as Clinic codes 30 or 80 with primary POV ICD-9: 493.*; ICD-10: J45.20 through J45.52.

2.9.5.6 Patient List

List of patients diagnosed with asthma and any asthma-related hospitalizations, ER, or Urgent Care visits.

2.9.6 Asthma Assessments

Changes from CRS v14.0 are noted

2.9.6.1 Owner and Contact

Chris Lamer, PharmD

2.9.6.2 National Reporting

Not reported nationally

2.9.6.3 Denominators

1. Active Clinical patients ages five and older with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or chronic obstructive pulmonary disease (COPD), broken down by age groups: 5 through 14 years, 15 through 34 years, 35 through 64 years, and 65 years and older.

2.9.6.4 Numerators

1. Patients with asthma management plan during the Report Period.
2. Patients with severity documented at any time before the end of the Report Period.
3. Patients with control documented during the Report Period.
4. Patients who were assessed for number of symptom free days during the Report Period.
5. Patients with number of symptom free days score of 0 through 5.
6. Patients with number of symptom free days score of 6 through 12.
7. Patients with number of symptom free days score of 13 through 14.
8. Patients who were assessed for number of school or work days missed during the Report Period.
9. Patients with number of school or work days missed score of 0 through 2.
10. Patients with number of school or work days missed score of 3 through 7.
11. Patients with number of school or work days missed score of 8 through 14.

2.9.6.5 Definitions

Denominator Exclusions

Patients diagnosed with emphysema or COPD at any time on or before the end of the report period are excluded from the denominator.

Emphysema

Any visit at any time on or before the end of the report period with POV codes: ICD-9: 492.*, 506.4, 518.1, 518.2; ICD-10: J43.*, J68.4, J68.8, J98.2, J98.3.

COPD

Any visit at any time on or before the end of the report period with POV codes: ICD-9: 491.20, 491.21, 491.22, 493.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8.

Persistent Asthma

Meeting any of the following four criteria that follow within the year prior to the beginning of the report period and during the report period:

- At least one visit to Clinic code 30 (Emergency Medicine) with primary diagnosis ICD-9: 493.*; ICD-10: J45.20 through J45.52 (asthma)
- At least one acute inpatient discharge with primary diagnosis ICD-9: 493.*; ICD-10: J45.20 through J45.52 Acute inpatient discharge defined as Service Category of H
- At least four outpatient visits, defined as Service Categories A, S, or O, with primary or secondary diagnosis of ICD-9: 493.*; ICD-10: J45.20 through J45.52 and at least two asthma medication dispensing events (see the definition that follows)
- At least four asthma medication dispensing events (see the definition that follows). If the sole medication was leukotriene modifiers, then must also have at least one visit with POV ICD-9: 493.*; ICD-10: J45.20 through J45.52 in the same year as the leukotriene modifier (i.e., during the report period or within the year prior to the beginning of the report period.), or

Meeting any of the following criteria:

- 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.

Dispensing Event

One prescription of an amount lasting 30 days or less. For prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to 3 dispensing events:

$$100 \div 30 = 3.33, rounded\ down\ to\ 3$$

Also, two different prescriptions dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

- Asthma medication codes for denominator defined with medication taxonomies:
  - BGP HEDIS ASTHMA MEDS
  - BGP HEDIS ASTHMA LEUK MEDS
  - BGP HEDIS ASTHMA INHALED MEDS
  - Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline), Antibody Inhibitor (Omalizumab), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol, Formoterol-Mometasone), Inhaled Corticosteroids (Belclomethasone, Budesonide, Ciclesonide CFC Free, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Long-Acting, Inhaled Beta2 Agonists (Aformoterol, Formoterol, Salmeterol), Mast Cell Stabilizers (Cromolyn), Methylxanthines (Aminophylline, Dyphylline, Theophylline), Short-Acting, Inhaled Beta2 Agonists (Albuterol, Levalbuterol, Pirbuterol. Medications must not have a comment of RETURNED TO STOCK.

Asthma Management Plan

Defined as Patient Education code ASM-SMP.

Severity

Severity documented defined as meeting any of the following criteria:

- 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.

Control

Control documented defined as ICD-9: 493.*; ICD-10: J45.20 through J45.52 with Asthma Control recorded in the V POV file.

Symptom Free Days

Number of symptom free days defined as the most recent V Measurement documented during the Report Period.

School or Work Days Missed

Number of school or work days missed defined as the most recent V Measurement documented during the Report Period.

2.9.6.6 Patient List

List of asthmatic patients with assessments, if any.

2.9.7 Asthma Quality of Care

Changes from CRS v14.0 are noted

2.9.7.1 Owner and Contact

Chris Lamer, PharmD

2.9.7.2 National Reporting

Not reported nationally

2.9.7.3 Denominators

1. Active Clinical patients ages 5 through 56 years with persistent asthma within the year prior to the beginning of the report period and during the report period, without a documented history of emphysema or COPD.

   A. Active Clinical patients ages 5 through 9 years.

B. Active Clinical patients ages 10 through 17 years.

C. Active Clinical patients ages 18 through 56 years.

2.9.7.4 Numerators

1. Patients who had at least one dispensed prescription for preferred asthma therapy medication during the report period.

2.9.7.5 Definitions

Denominator Exclusions

Patients diagnosed with emphysema or COPD at any time on or before the end of the report period are excluded from the denominator.

Emphysema

Any visit at any time on or before the end of the report period with POV codes: ICD-9: 492.*, 518.1, 518.2; ICD-10: J43.*, J98.2, J98.3.

COPD

Any visit at any time on or before the end of the report period with POV codes: ICD-9: 491.20, 491.21, 491.22, 493.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8.

Persistent Asthma:

Meeting any of the following four criteria that follow within the year prior to the beginning of the report period *and* during the report period:

- At least one visit to Clinic code 30 (Emergency Medicine) with primary diagnosis ICD-9: 493.*; ICD-10: J45.20 through J45.52 (asthma)
- At least one acute inpatient discharge with primary diagnosis ICD-9: 493.*; ICD-10: J45.20 through J45.52 Acute inpatient discharge defined as Service Category of H
- At least four outpatient visits on different dates of service, defined as Service Categories A, S, or O, with primary or secondary diagnosis of ICD-9: 493.*; ICD-10: J45.20 through J45.52 *and* at least two asthma medication dispensing events (see the definition that follows)
- At least four asthma medication dispensing events (see the definition that follows). If the sole medication was leukotriene modifiers, then *must* also have at least one visit with POV ICD-9: 493.*; ICD-10: J45.20 through J45.52 in the same year as the leukotriene modifier (i.e., during the report period or within the year prior to the beginning of the report period.), *or*

Meeting any of the following criteria that follow:

- 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.

Dispensing Event

One prescription of an amount lasting 30 days or less. For prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to 3 dispensing events:

$$100 \div 30 = 3.33, rounded\ down\ to\ 3$$

Also, 2 different prescriptions dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

- **Asthma medication codes for denominator defined** with medication taxonomies:
  - BGP HEDIS ASTHMA MEDS
  - BGP HEDIS ASTHMA LEUK MEDS
  - BGP HEDIS ASTHMA INHALED MEDS
  - Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline), Antibody Inhibitor (Omalizumab), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol, Formoterol-Mometasone), Inhaled Corticosteroids (Belclomethasone, Budesonide, Ciclesonide CFC Free, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Long-Acting, Inhaled Beta2 Agonists (Aformoterol, Formoterol, Salmeterol), Mast Cell Stabilizers (Cromolyn), Methylxanthines (Aminophylline, Dyphylline, Theophylline), Short-Acting, Inhaled Beta2 Agonists (Albuterol, Levalbuterol, Pirbuterol. Medications must not have a comment of RETURNED TO STOCK.

Preferred Asthma Therapy

To be included in the numerator, patient must have a nondiscontinued prescription for preferred asthma therapy (see the list of medications that follows) during the report period.

- **Preferred asthma therapy medication codes for numerator defined with medication taxonomy**: BGP HEDIS PRIMARY ASTHMA MEDS.
  - Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline), Antibody Inhibitor (Omalizumab), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol, Formoterol-Mometasone), Inhaled Corticosteroids (Belclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Mast Cell Stabilizers (Cromolyn), Methylxanthines (Aminophylline, Dyphylline, Theophylline). Medications must not have a comment of RETURNED TO STOCK.

2.9.7.6 Patient List

List of asthmatic patients with preferred asthma therapy medications, if any.

2.9.8 Medication Therapy for Persons with Asthma

Changes from CRS v14.0 are noted

2.9.8.1 Owner and Contact

Chris Lamer, PharmD

2.9.8.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.8.3 Denominators

1. Active Clinical patients ages 5 through 50 with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or COPD.

2. Active Clinical patients ages five and older with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or COPD, broken down into age groups: 5 through 14 years, 15 through 34 years, 35 through 64 years, and 65 years and older.

3. Active Clinical patients ages five and older with persistent asthma within the year prior to the beginning of the Report Period and during the Report Period, without a documented history of emphysema or COPD who had two or more prescriptions for a Long-Acting Beta2 Agonist (LABA) medication during the Report Period, broken down into age groups: 5 through 14 years, 15 through 34 years, 35 through 64 years, and 65 years and older.

2.9.8.4 Numerators

1. Suboptimal Control: Patients who were dispensed more than three canisters of a short-acting Beta2 Agonist inhaler during the same 90-day period during the Report Period.

2. Absence of Controller Therapy: Patients who were dispensed more than three canisters of short acting Beta2 Agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.

3. Patients who were prescribed two or more controller therapy medications during the Report Period.

4. Patients who were prescribed 2 or more inhaled corticosteroid medications during the Report Period.

5. Patients who were not prescribed 2 or more inhaled corticosteroid medications during the Report Period.

2.9.8.5 Definitions

Denominator Exclusions

Patients diagnosed with emphysema or COPD at any time on or before the end of the report period are excluded from the denominator.

Emphysema

Any visit at any time on or before the end of the report period with POV codes: ICD-9: 492.*, 506.4, 518.1, 518.2; ICD-10: J43.*, J68.4, J68.8, J98.2, J98.3.

COPD

Any visit at any time on or before the end of the report period with POV codes: ICD-9: 491.20, 491.21, 491.22, 493.2*, 496, 506.4; ICD-10: J44.*, J68.4, J68.8.

Persistent Asthma

Meeting any of the following four criteria that follow within the year prior to the beginning of the report period and during the report period:

- At least one visit to Clinic code 30 (Emergency Medicine) with primary diagnosis ICD-9: 493.*; ICD-10: J45.20 through J45.52 (asthma)
- At least one acute inpatient discharge with primary diagnosis ICD-9: 493.*; ICD-10: J45.20 through J45.52 Acute inpatient discharge defined as Service Category of H
- At least 4 outpatient visits, defined as Service Categories A, S, or O, with primary or secondary diagnosis of ICD-9: 493.*; ICD-10: J45.20 through J45.52 and at least 2 asthma medication dispensing events (see the definition that follows)
- At least four asthma medication dispensing events (see the definition that follows). If the sole medication was leukotriene modifiers, then must also have at least one visit with POV ICD-9: 493.*; ICD-10: J45.20 through J45.52 in the same year as the leukotriene modifier (i.e., during the report period or within the year prior to the beginning of the report period.), or

Meeting any of the following criteria:

- 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.

Dispensing Event

One prescription of an amount lasting 30 days or less. For prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to 3 dispensing events:

$$100 \div 30 = 3.33, rounded\ down\ to\ 3$$

Also, 2 different prescriptions dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

- Asthma medication codes for denominator defined with medication taxonomies:
  - BGP HEDIS ASTHMA MEDS
  - BGP HEDIS ASTHMA LEUK MEDS
  - BGP HEDIS ASTHMA INHALED MEDS
  - Medications are: Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline), Antibody Inhibitor (Omalizumab), Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol, Formoterol-Mometasone), Inhaled Corticosteroids (Belclomethasone, Budesonide, Ciclesonide CFC Free, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone), Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton), Long-Acting, Inhaled Beta2 Agonists (Aformoterol, Formoterol, Salmeterol), Mast Cell Stabilizers (Cromolyn), Methylxanthines (Aminophylline, Dyphylline, Theophylline), Short-Acting, Inhaled Beta2 Agonists (Albuterol, Levalbuterol, Pirbuterol. Medications must not have a comment of RETURNED TO STOCK.

Numerator Inclusion

To be included in the Suboptimal Control and Absense of Controller Therapy numerators, patient must have one or more non-discontinued prescriptions for short acting Beta2 Agonist inhalers totalling at least four canisters in one 90-day period. Short acting Beta2 Agonist inhaler medications defined with medication taxonomy BGP PQA SABA MEDS. (Medications are: Albuterol, Levalbuterol, Pirbuterol). Medications must not have a comment of RETURNED TO STOCK.

Controller Therapy

At least one non-discontinued prescription of controller therapy medications during the same 90-day period.

Controller Therapy Medications

Controller therapy medications defined with medication taxonomy BGP PQA CONTROLLER MEDS. (Medications are: Beclomethasone, Budesonide, Budesonide-Formoterol, Ciclesonide, Cromolyn, Flunisolide, Fluticasone,

Fluticasone-Salmeterol, Formoterol, Mometasone, Mometasone-Formoterol, Montelukast, Nedocromil, Salmeterol, Theophylline, Triamcinolone, Zafirlukast, Zileuton). Medications must not have a comment of RETURNED TO STOCK.

Inhaled Corticosteroid Medications

Inhaled corticosteroid medications defined with medication taxonomy BGP PQA ASTHMA INHALED STEROIDS. (Medications are: Beclomethasone, Budesonide, Ciclesonide, Fluticasone, Flunisolide, Fluticasone-salmeterol, Mometasone, Triamcinolone, Budesonide-formoterol, Mometasone-formoterol) Medications must not have a comment of RETURNED TO STOCK.

LABA Medications

LABA medications defined with medication taxonomy BGP ASTHMA LABA MEDS. (Medications are: Aformoterol, Formoterol, Salmeterol.) Medications must not have a comment of RETURNED TO STOCK.

2.9.8.6 Patient List

List of patients with asthma with asthma medications, if any.

2.9.9 Chronic Kidney Disease Assessment

No changes from Version 14.0

2.9.9.1 Owner and Contact

Kidney Disease Program: Dr. Andrew Narva

2.9.9.2 Denominators

1. Active Clinical patients ages 18 and older with serum creatinine test during the report period.

2.9.9.3 Numerators

1. Patients with Estimated GFR.

   A. Patients with GFR less than 60.

   B. Patients with normal GFR (i.e., greater than or equal to 60).

2.9.9.4 Definitions:

Creatinine

- CPT 82540, 82565 through 75

- LOINC taxonomy
- Site-populated taxonomy DM AUDIT CREATININE TAX

Estimated GFR

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

For the GFR less than 60 numerator, CRS will include GFR results containing a numeric value less than 60 or with a value of "<60". For the normal GFR (greater than or equal to 60) numerator, CRS will include GFR results containing a numeric value equal to or greater than 60 or with a value of ">60"

2.9.9.5 Patient List:

List of patients with Creatinine test, with GFR and value, if any.

2.9.10 Proportion of Days Covered by Medication Therapy

Changes from CRS v14.0 are noted

2.9.10.1 Owner and Contact

Chris Lamer, PharmD

2.9.10.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.10.3 Denominators

1. Active Clinical patients ages 18 and older who had two or more prescriptions for beta-blockers during the Report Period.
2. Active Clinical patients ages 18 and older who had two or more prescriptions for RAS Antagonists and no documented history of ESRD during the Report Period.
3. Active Clinical patients ages 18 and older who had two or more prescriptions for calcium channel blockers (CCB) during the Report Period.
4. Active Clinical patients ages 18 and older who had two or more prescriptions for biguanides during the Report Period.
5. Active Clinical patients ages 18 and older who had two or more prescriptions for sulfonylureas during the Report Period.

6. Active Clinical patients ages 18 and older who had two or more prescriptions for thiazolidinediones during the Report Period.
7. Active Clinical patients ages 18 and older who had two or more prescriptions for DiPeptidyl Peptidase (DPP)-IV Inhibitors during the Report Period.
8. Active Clinical patients ages 18 and older who had two or more prescriptions for Diabetes All Class medications and no documented history of ESRD during the Report Period.
9. Active Clinical patients ages 18 and older who had two or more prescriptions for statins during the Report Period.
10. Active Clinical patients ages 18 and older who had two or more prescriptions for non-warfarin oral anticoagulants during the Report Period.
11. Active Clinical patients ages 18 and older who had two or more prescriptions for antiretroviral agents during the Report Period.

2.9.10.4 Numerators

1. Patients with proportion of days covered (PDC) greater than or equal to 80% during the Report Period.
2. Patients with a gap in medication therapy greater than or equal to 30 days.
3. For use with denominator #11: Patients with PDC greater than or equal to 90% during the Report Period.

2.9.10.5 Definitions

Denominator Inclusion

Patients must have at least two prescriptions for that particular type of medication on two unique dates of service at any time during the Report Period. Medications must not have a comment of RETURNED TO STOCK.

For the Non-warfarin anticoagulants measures, the two unique dates of service must be at least 180 days apart and the patient must have received greater than 60 days supply of the medication during the Report Period. Patients who received one or more prescriptions for warfarin, low molecular weight heparin (LMWH) or heparin (defined by medication taxonomy BGP PQA WARFARIN) will be excluded from the denominator.

Index Prescription Start Date

The date when the medication was first dispensed within the Report Period. For all measures except Non-warfarin anticoagulants, this date must be greater than 90 days from the end of the Report Period to be counted in the denominator.

Medications

Medications are defined with the following taxonomies: BGP PQA BETA BLOCKER MEDS, BGP PQA RASA MEDS, BGP PQA CCB MEDS, BGP PQA BIGUANIDE MEDS, BGP PQA SULFONYLUREA MEDS, BGP PQA THIAZOLIDINEDIONE MEDS, BGP PQA DPP IV MEDS, BGP PQA DIABETES ALL CLASS, BGP PQA STATIN MEDS, BGP PQA NON-WARFARIN ANTICOAG, BGP PQA WARFARIN, BGP PQA ANTIRETROVIRAL MEDS.

ESRD

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, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), S2065, S9339
- POV ICD-9: 585.6, V45.1 (old code), V45.11 V45.12, V56.*; ICD-10: N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2
- Procedure ICD-9: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*

Each PDC Numerator

Proportion of days covered equals the number of days the patient was covered by at least one drug in the class divided by the number of days in the patient's measurement period.

The patient's measurement period is defined as the number of days between the Index Prescription Start Date and the end of the Report Period. When calculating the number of days the patient was covered by at least one drug in the class, if prescriptions for the same drug overlap, the prescription start date for the second prescription will be adjusted to be the day after the previous fill has ended.

Note: If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

Example of Proportion of Days Covered

Report Period: January 1 through December 31, 2014

- First prescription:
  - Index Rx Start Date: March 1, 2014
  - Days' Supply: 90
  - Prescription covers patient through May 29, 2014
- Second prescription:
  - Rx Date: May 26, 2014
  - Days' Supply: 90
  - Prescription covers patient through August 27, 2014
- Third prescription:
  - Rx Date: September 11, 2014
  - Days' Supply: 180
  - Gap:
    $September\ 11, 2014 - August\ 27. 2014 = 15\ days$
  - Prescription covers patient through March 8, 2015

Patient's measurement period:

$$March\ 1, 2014\ through\ December\ 31, 2014 = 306\ days$$

Days patient was covered:

$$March\ 1, 2014\ through\ August\ 27, 2014 + September\ 11, 2014\ through\ December\ 31, 2014 = 292\ days$$

PDC:

$$292 \div 306 = 95\%$$

Each Gap Numerator

CRS will calculate whether a gap in medication therapy of 30 or more days has occurred between each consecutive medication dispensing event during the

Report Period. A gap is calculated as the days not covered by the days' supply between consecutive medication fills.

Example of Medication Gap greater than or equal to 30 Days:

Report Period: January 1 through December 31, 2014

- First prescription:
  - Rx Date: April 1, 2014
  - Days' Supply: 30
  - Prescription covers patient through April 30, 2014
- Second prescription:
  - Rx Date: July 1, 2014
  - Days' Supply: 90
  - Gap #1:

    $July\ 1, 2014 - April\ 30, 2014 = 61\ days$

  Prescription covers patient through September 28, 2014

- Third prescription:
  - Rx Date: October 1, 2014
  - Days' Supply: 90
  - Gap #2:

    $October\ 1, 2014 - September\ 28 - 2014 = 2\ days$

  Prescription covers patient through December 29, 2014

  $Gap\ \#1 \geq 30\ days$

  Patient will be included in the numerator for that medication.

2.9.10.6 Patient List

List of patients 18 and older prescribed medication therapy medication with proportion of days covered and gap days.

2.9.11 Primary Medication Non-adherence

New topic for Version 14.0

2.9.11.1 Owner and Contact

Chris Lamer, PharmD

2.9.11.2 National Reporting

Not reported nationally

2.9.11.3 Denominators

1. Number of e-prescriptions for newly initiated drug therapy for chronic medications for Active Clinical patients ages 18 and older.

2.9.11.4 Numerators

1. Number of medications returned to stock within 30 days.

2.9.11.5 Definitions

Denominator Inclusion

To be included in the denominator, the e-prescription must be for a chronic medication during the Report Period.

Denominator Exclusions

- Any prescription where there is a prescription dispensing record in the preceding 180 days for the same drug.
- Any duplicate medications, defined as any medication that has been e-prescribed twice in a 30-day period with no prescription fill in between the e-prescriptions.
- Any prescription sent to an outside pharmacy, as it is not possible to know if the medication was returned to stock.

Chronic Medications

Defined by the following taxonomies: BGP PQA ASTHMA INHALED STEROIDS, BGP PQA COPD, BGP PQA DIABETES ALL CLASS, BGP PQA RASA MEDS, BGP PQA STATIN MEDS

Numerator Inclusion

To be included in the numerator, the e-prescription medication must have a comment of RETURNED TO STOCK within 30 days of the prescription date (i.e., visit date).

2.9.11.6 Patient List

List of patients 18 and older with an e-prescription for chronic medications, with returned to stock, if any.

2.9.12 Medications Education

No changes from Version 14.0

2.9.12.1 Owner and Contact

Patient Education Program: Chris Lamer, PharmD

2.9.12.2 National Reporting

Not reported nationally

2.9.12.3 Denominators

1. Active Clinical patients with medications dispensed at their facility during the report period.
2. All User Population patients with Medications dispensed at their facility during the Report Period.

2.9.12.4 Numerators

1. Patients who were provided patient education about their medications in any location.

2.9.12.5 Definitions

Patients receiving medications

Are identified any entry in the VMed file for your facility.

Medication Education

Any Patient Education code containing “M-” or “-M” or Patient Education codes DMC-IN, FP-DPO, FP-OC, *-NEB, *-MDI, or FP-TD.

2.9.12.6 Patient List

List of patients receiving medications with med education, if any

2.9.13 Medication Therapy Management Services

No changes from Version 14.0

2.9.13.1 Owner and Contact

Chris Lamer, PharmD

2.9.13.2 National Reporting

Not reported nationally

2.9.13.3 Denominators

1. Active Clinical patients 18 or older with Medications dispensed at their facility during the Report Period.

2.9.13.4 Numerators

1. Patients who received medication therapy management (MTM) during the Report Period.

2.9.13.5 Definitions

Patients receiving medications

Are identified any entry in the VMed file for your facility.

Medication Therapy Management

MTM defined as:

- CPT 99605 through 99607
- Clinic codes: D1, D2, D5

2.9.13.6 Patient List

List of patients 18 or older receiving medications with medication therapy management, if any.

2.9.14 Self Management (Confidence)

No changes from Version 14.0

2.9.14.1 Owner and Contact

Chris Lamer, PharmD

2.9.14.2 National Reporting

Not reported nationally

2.9.14.3 Denominators

1. Active Clinical patients assessed for confidence in managing their health problems during the Report Period.

2.9.14.4 Numerators

1. Patients who are very confident in managing their health problems during the Report Period.

2.9.14.5 Definitions

Confidence

Confidence in managing health problems defined as any health factor for category CONFIDENCE IN MANAGING HEALTH PROBLEMS.

Very Confident

Very confident defined as the most recent health factor in the CONFIDENCE IN MANAGING HEALTH PROBLEMS category of VERY SURE.

2.9.14.6 Patient List

List of patients who are confident in managing their health problems.

2.9.15 Public Health Nursing

No changes from Version 14.0

2.9.15.1 Owner and Contact

Tina Tah, RN, BSN, MBA

2.9.15.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.15.3 Denominators

1. User Population patients.
2. Number of visits to User Population patients by PHNs in any setting, including Home
   A. Number of visits to patients age 0 through 28 days (Neonate)
   B. Number of visits to patients age 29 days to 12 months (Infants)
   C. Number of visits to patients ages 1 through 64 years
   D. Number of visits to patients ages 65 and older (Elders)
   E. Number of PHN driver/interpreter (Provider code 91) visits.

3. Number of visits to User Population patients by PHNs in Home setting, broken down into age groups: 0 through 28 days (neonate), 29 days through 12 months (infants), 1 through 64 years, 65 and older (elders).

   A. Number of Home visits to patients age 0 through 28 days (Neonate)

   B. Number of Home visits to patients age 29 days to 12 months (Infants)

   C. Number of Home visits to patients ages 1 through 64 years

   D. Number of Home visits to patients ages 65 and older (Elders)

   E. Number of PHN driver/interpreter (Provider code 91) visits

2.9.15.4 Numerators

1. For User Population only, the number of patients in the denominator served by PHNs in any setting, including Home.

2. For User Population only, the number of patients in the denominator served by a PHN driver/interpreter in any setting

3. For User Population only, the number of patients in the denominator served by PHNs in a HOME setting.

4. For User Population only, the number of patients in the denominator served by a PHN driver/interpreter in a HOME setting.

5. No numerator: Count of visits only.

2.9.15.5 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

2.9.15.6 Patient List

List of patients with PHN visits documented.

Numerator codes in patient list:

- All PHN equals Number of PHN visits in any setting

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

2.9.16 Breastfeeding Rates

No changes from Version 14.0

> **Note:** This measure is used to support the reduction of the incidence of childhood obesity.

2.9.16.1 Owner and Contact

Tina Tah, RN, BSN, MBA

2.9.16.2 National Reporting

OTHER NATIONAL (included in new Other National Measures Report; not reported to OMB and Congress)

2.9.16.3 Denominators

1. Active Clinical patients who are 30 through 394 days old.
2. GPRA: Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 2 months (45 through 89 days).
3. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 6 months (165 through 209 days).
4. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 9 months (255 through 299 days).
5. Active Clinical patients who are 30 through 394 days old who were screened for infant feeding choice at the age of 1 year (350 through 394 days)

2.9.16.4 Numerators

1. Patients who were screened for infant feeding choice at least once.
2. Patients who were screened for infant feeding choice at the age of 2 months (45 through 89 days).
3. Patients were screened for infant feeding choice at the age of 6 months (165 through 209 days).

4. Patients who were screened for infant feeding choice at the age of 9 months (255 through 299 days).
5. Patients who were screened for infant feeding choice at the age of 1 year (350 through 394 days).
6. GPRA: Patients who, at the age of 2 months (45 through 89 days), were either exclusively or mostly breastfed.
7. Patients who, at the age of six months (165 through 209 days), were either exclusively or mostly breastfed.
8. Patients who, at the age of 9 months (255 through 299 days), were either exclusively or mostly breastfed.
9. Patients who, at the age of 1 year (350 through 394 days), were either exclusively or mostly breastfed.

2.9.16.5 Definitions

Patient Age

Since the age of the patient is calculated at the beginning of the Report period, this measure may include patients up to 25 months old if they were within the eligible age range on the first day of the report period, and will not include any patients that were born after the first day of the report period. Patients born after the first day of the report period will be included in the following report period.

Infant Feeding Choice

The documented feeding choice from the file V Infant Feeding Choice that is closest to the exact age that is being assessed will be used. For example, if a patient was assessed at 45 days old as half breastfed and half formula fed and assessed again at 65 days old as mostly breastfed, the mostly breastfed value will be used since it is closer to the exact age of 2 months (i.e., 60 days). Another example is a patient who was assessed at 67 days as mostly breastfed and again at 80 days as mostly formula. In this case, the 67 days value of mostly breastfed will be used. The other exact ages are 180 days for six months, 270 days for nine months, and 365 days for 1 year.

In order to be included in the age-specific screening numerators, the patient must have been screened at the specific age range. For example, if a patient was screened at 6 months and was exclusively breastfeeding but was not screened at 2 months, then the patient will only be counted in the 6 months numerator.

2.9.16.6 GPRA 2014 Description

During FY 2014, achieve the target rate of 29.0% for the proportion of 2-month olds who are mostly or exclusively breastfeeding.

2.9.16.7 Patient List

List of patients 30 through 394 days old, with infant feeding choice value, if any.

2.9.17 Use of High Risk Medications in the Elderly

No changes from Version 14.0

2.9.17.1 Owner and Contact

Dr. Bruce Finke

2.9.17.2 National Reporting

Not reported nationally

2.9.17.3 Denominators

1. Active Clinical patients ages 65 and older, broken down by gender and age groups (65 years and older, 65 through 74 years, 75 through 84 years, and 85 years and older).

2.9.17.4 Numerators

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

2. Patients who received at least two different high risk medications for the elderly during the report period.

2.9.17.5 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, Butabarbital, 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 > 0. If a 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:
$November\ 19, 2014 - November\ 15, 2014 = 4$

Medications must not have a comment of RETURNED TO STOCK.

2.9.17.6 Patient List

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

2.9.18 Functional Status in Elders

No changes from Version 14.0

2.9.18.1 Owner and Contact

Dr. Bruce Finke

2.9.18.2 National Reporting

Not reported nationally

2.9.18.3 Denominators

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

2.9.18.4 Numerators

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

2.9.18.5 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.

2.9.18.6 Patient List

List of patients 55 or 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

2.9.19 Fall Risk Assessment in Elders

No changes from Version 14.0

2.9.19.1 Owner and Contact

Dr. Bruce Finke

2.9.19.2 National Reporting

Not reported nationally

2.9.19.3 Denominators

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

2.9.19.4 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/balance or mobility diagnosis in the past year.

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

2.9.19.5 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/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

2.9.19.6 Patient List

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

2.9.20 Palliative Care

No changes from Version 14.0

2.9.20.1 Owner and Contact

Dr. Bruce Finke

2.9.20.2 National Reporting

Not reported nationally

2.9.20.3 Denominators

1. No denominator, count only.

2.9.20.4 Numerators

1. No denominator; count only. For patients meeting the Active Clinical definition, the total number of patients with at least one palliative care visit during the report period; broken down by age groups (younger than 18 years, 18 through 54 years, 55 years and older).

2. No denominator; count only. For patients meeting the Active Clinical definition, the total number of palliative care visits during the report period; broken down by age groups (younger than 18 years, 18 through 54 years, 55 years and older).

2.9.20.5 Definitions

Palliative Care Visit

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

2.9.20.6 Patient List

List of patients with a palliative care visit, if any.

2.9.21 Annual Wellness Visit

No changes from Version 14.0

2.9.21.1 Owner and Contact

Dr. Bruce Finke

2.9.21.2 National Reporting

Not reported nationally

2.9.21.3 Denominators

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

2.9.21.4 Numerators

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

2.9.21.5 Definitions

Annual Wellness Exam

CPT G0438, G0439, G0402

2.9.21.6 Patient List

List of patients with an annual wellness visit in the past 15 months.

2.9.22 Goal Setting

No changes from Version 14.0

2.9.22.1 Owner and Contact

Patient Education: Chris Lamer, PharmD

2.9.22.2 National Reporting

Not reported nationally

2.9.22.3 Denominators

1. User Population patients.

2.9.22.4 Numerators

1. Number of patients who set at least one goal during the Report Period.
2. Number of patients who met at least one goal during the Report Period.

2.9.22.5 Definition

Patient Goal Numerator Logic

Goal Set

The Goal Setting value must be "Goal Set" and the Goal Start Date must be during the Report Period.

Goal Met

The Goal Status value must be "Goal Met" and the Date/Time Last Modified must be during the Report Period. The patient is not required to have set a goal during the Report Period.

2.9.22.6 Patient List

List of User Population patients with goal setting information during the Report Period

List of Acronyms

ABG	Arterial Blood Gas
ACEI	Angiotensin Converting Enzyme Inhibitors
ADR	Adverse Drug Reactions
AI/AN	American Indian/Alaska Native
AMA	Against Medical Advice
AMI	Acute Myocardial Infarction
APT	Acute Phase Treatment
ARB	Angiotensin Receptor Blocker
ART	Patient Allergies File
ASA	Aspirin (acetylsalicylic acid)
ASBI	Alcohol Screening and Brief Intervention
BH	Behavioral Health
BHS	Behavioral Health System
BMI	Body Mass Index
BNI	Brief Negotiated Interview
BP	Blood Pressure
CABG	Coronary Artery Bypass Graft
CBC	Complete Blood Count
CCB	Calcium Channel Blocker

CHD	Coronary Heart Disease
CHR	Community Health Representative
CHS	Contract Health Service
CK	Creatine Kinase
CONPT	Continuation Phase Treatment
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CVX	Vaccine Code
CRS	Clinical Reporting System
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
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
IFC	Infant Feeding Choice
IHS	Indian Health Service
IMM	Immunization
IPV/DV	Intimate Partner Violence/Domestic Violence
IVD	Ischemic Vascular Disease
LABA	Long-Acting Beta2 Agonist
LDL	Low-density Lipoprotein
LOINC	Logical Observations Identifiers, Names, Codes
LVAD	Left Ventricular Assistive Device
LVS	Left Ventricular Systolic
MAOI	Monoamine Oxidase Inhibitors
MTM	Medication Therapy Management
NMI	Not Medically Indicated
OA	Osteoarthritis
OMB	Office of Management and Budget
OPC	Optimal Practitioner Contact
PCC	Patient Care Component
PCI	Percutaneous Coronary Interventions

PDC	Proportion of Days Covered
PEPC	Patient and Family Education Protocols and Codes
POV	Purpose of Visit
RA	Rheumatoid Arthritis
RAS	Renin Angiotensin System
RCIS	Referred Care Information System
RPMS	Resource and Patient Management System
SNRI	Serotonin-Norepinephrine Reuptake Inhibitors
SSRI	Selective Serotonin Reuptake Inhibitors
STI	Sexually Transmitted Infection
TCA	Tricyclic Antidepressants
TIA	Transient Ischemic Attack
ULN	Upper Limit of Normal
URI	Upper Respiratory Infection

Contact Information

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