



**Chronic Obstructive
Pulmonary Disease
Care Recognition
Clinician Assessment**

Policies and Procedures

Manual for Data Aggregator

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Bridges to Excellence
13 Sugar Street
Newtown, CT 06470

bteinformation@bridgestoexcellence.org
<http://www.bridgestoexcellence.org>

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INTRODUCTION

Bridges to Excellence (BTE) is excited to offer this opportunity for physicians to pilot its automated EMR/registry performance assessment system. The BTE EMR/registry performance assessment system allows for rapid and independent medical record-based clinician performance evaluations by connecting local and national medical record data sources to a network of performance assessment organizations. BTE's goals are to: reduce the reporting burden for clinicians; leverage existing reporting/data aggregation initiatives; reduce data collection and reporting costs; facilitate the connection between quality improvement and incentives; and speed up cycle times between reporting, improvement and reporting. Clinicians who meet BTE performance thresholds may be eligible for incentives through participating health plans, employers and coalitions.

This Policies and Procedures Manual provides information on the BTE Chronic Obstructive Pulmonary Disease Care Recognition Program Clinician Assessment process as well as instructions for data aggregators on how to submit clinician data to a Performance Assessment Organization (PAO) through electronic data submissions in order to qualify these clinicians for BTE recognition in the Chronic Obstructive Pulmonary Disease Care Recognition Program. All data must be submitted electronically to a PAO through the methods described here, whether the data is manually entered through chart reviews or submitted through an electronic system, such as an electronic health record, patient registry or decision support tool. Paper submissions will not be accepted.

Measurement results will be determined by collecting denominator (population) and numerator (measurement results) information, for the most recent date of care in order to calculate a result for each clinician or medical practice applicant.

Data aggregators are vendors or organizations that are data sources for clinicians' electronic medical record data (e.g. EMR vendors, patient registry vendors, health information exchanges, community initiatives). Data aggregator roles and responsibilities include: interfacing with clinicians via the electronic data, extracting de-identified medical record data in accordance with BTE's eligibility and measures specifications(as identified in this manual), sending extracted medical record data and clinician identifiers to a PAO quarterly in a standardized electronic format for performance measurement, and communicating performance assessment results and opportunities for improvement back to participating clinicians.

BTE is partnering with two PAOs to implement its automated EMR/registry performance assessment system: Minnesota Community Measurement (MNCM) and IPRO.

MN Community Measurement (MNCM) was formed in 2002 by several local health plans as a collaborative to collect performance data. By aggregating health plan claims data and collecting clinical information from physician offices, MNCM publicly reports physicians' performance results in Minnesota. MNCM's goals include improving care and supporting the quality initiatives of providers, reducing reporting-related expenses for medical groups, health plans, and

regulators through more efficient and effective regulation, and communicating findings in a fair, usable and reliable way to medical groups, regulators, purchasers and consumers.

IPRO is one of the nation's largest and most experienced not-for-profit quality assessment and improvement organizations. IPRO's mission is to improve the quality and value of health care services, and does so by supporting the development and implementation of performance measures; increasing the capacity of providers and government agencies for performance improvement; and fostering an environment through transparency and payment reform efforts, that rewards high-quality, high-value care. With 400 staff, IPRO performs work in over 30 states, serving federal, state and local government, and private clients.

Overview

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps in the quality of care by recognizing and rewarding health care clinicians who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

The Chronic Obstructive Pulmonary Disease Care Recognition Program is a BTE Clinician Recognition Program intended to identify clinicians who deliver high-value COPD care to adult patients. The program is designed with an understanding that adult patients may seek the care of various types of practitioners—primary care (PCPs), pulmonologists, allergy and immunologists, and others—for treatment and management of their COPD. Accordingly, the measures reflect that clinicians should do the following.

- Deliver high-quality care from the outset of patient contact
- Understand and consider previous treatment history to help avoid inappropriate treatment

The program comprises a set of measures, based on available clinical evidence, that promote a model of care that includes the following criteria.

- Comprehensive patient assessment and reassessment
- Patient education
- Shared decision making

BTE's COPD Care requirements assess process measures representing standards of care for patients with COPD. BTE believes that the COPD Care Recognition program has the potential to significantly improve the quality of care experienced by patients with COPD and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn COPD Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with COPD. BTE has partnered with two objective third-party independent Performance Assessment Organizations (PAOs) to

evaluate clinician data based on standard measures to publicly recognize those that meet the BTE COPD Care performance thresholds. Those clinicians not meeting the BTE COPD Care performance thresholds remain anonymous to BTE and its health plan licensees. BTE's COPD Care Program has three performance thresholds.

Clinician Benefits of Recognition

- Clinicians can demonstrate to the public and to their professional peers that they meet the standards of care assessed by the program by issuing a press release, as well as having their recognition achievements posted on BTE's consumer portal, HealthGrades (www.healthgrades.com), and communicated to both health plans and employers.
- Clinicians may use the BTE Recognition to demonstrate that they meet the standards of care assessed by the program when contracting with health organizations and purchasers of health services.
- Clinicians can identify areas of their practice that vary from the performance requirements and take steps to improve quality of care.
- Where applicable, clinicians can establish eligibility for pay-for-performance bonuses, differential reimbursement or other incentives from payers and health plans.
- Clinicians who achieve COPD Care Recognition by submitting data through a CCHIT-certified¹ electronic health record or through an electronic health record certified to meet the federally-defined Meaningful Use criteria will also receive BTE Level II Physician Office Link (POL) recognition.

Background on the Measurement Criteria

Eligible clinicians and medical practices voluntarily apply for BTE Recognition by submitting information on how they treat and manage their patients with regard to the following.

Clinical measures²

1. Lung Function/Spirometry Evaluation
2. Inhaled Bronchodilator Therapy
3. Smoking Cessation Advice and Treatment
4. Assessment of COPD Exacerbations
5. COPD Exacerbation Therapy
6. Assessment of Oxygen Saturation

¹ The Certification Commission for Healthcare Information Technology or CCHIT is a recognized certification body for electronic health records and their networks, and an independent, voluntary, private-sector initiative, whose mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. A list of CCHIT-certified products can be found at <http://cchit.org/>.

² *Clinical measures* evaluate performance based on care provided to a sample of individual patients and documented in the medical records of those patients. Clinical measures are scored based on the percentage of the sample (denominator) which meet or comply (numerator) with the measure threshold.

7. Long-Term Oxygen Therapy
8. Pneumococcal Immunization
9. Influenza Immunization

Clinicians who demonstrate high-quality performance based on these measures are awarded BTE COPD Care Recognition.

Recognition Program Structure

Given the evidence in the literature advocating the creation of clinician quality programs that promote continuous quality improvement amongst its participants, the BTE Chronic Obstructive Pulmonary Disease Care Recognition Program is designed to include 3 levels or tiers of recognition. Assessment for recognition in all 3 tiers is based upon data submitted on the same COPD Care measures (listed above).

Level I: Focuses on a clinician-centric³ view of measurement, looking at individual metrics summed to produce a composite score. Thresholds have been set to focus on above average performance.

Level II: Focuses on a combination of clinician and patient-centric⁴ measurements. Level II includes the measurement of individual metrics summed to produce a composite score. Also looks at the defect rate of care delivery across pairs of measures on a per patient basis. Thresholds have been set to focus on very good performance.

Level III: Focuses on patient-centric view of measurement, looking at the defect rate of care delivery across pairs of discrete measures on a per patient basis. Clinicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

³ Clinician-centric refers to performance assessment involving evaluation of clinician performance based upon discrete measures (e.g. Lung Function/Spirometry Evaluation), which is applied across the eligible patient panel. The results provide a picture of a clinician's performance on a given measures across his or her eligible patient panel. Since the process leads to clinician-focused results it is said to be "clinician-centric."

⁴ Patient centric refers to performance assessment involving evaluation of clinician performance based upon composite measures, created by combining 2 or more separate discrete measures into a single measure (e.g. combining Pneumococcal and Influenza Immunizations into 1 single measure), which is applied on a per patient basis. The results provide a picture of an individual patient's performance on a set of measures which make up the composite measure. Since the process leads to patient-focused results it is said to be "patient-centric."

What Recognition Requires

To seek BTE COPD Care Recognition, clinician applicants must submit medical record data that demonstrates they meet BTE's COPD Care performance requirements. Each measure has an assigned maximum available point value; the total of all the measures and standards is the same across all levels of recognition. A clinician achieves points for a measure based on the percentage of his or her patient sample that meets or exceeds the set thresholds for that measure.

Performance Assessment Organizations (PAOs) award recognition to clinicians who achieve at least:

- Level I:* 60% of the total possible points
- Level II:* 60% of the total possible points
- Level III:* 60% of the total possible points

Minimum Requirements

To be eligible for recognition, clinicians must attain at least 60 percent of the total possible points. In the case of clinical measures, this means a minimum of 25 patients for the denominator of each measure for individual clinician applicants, and a minimum of 10 patients for the denominator of each measure for each individual clinician in a practice level applicant, with a minimum practice average of 25 patients per clinician.

Applicants must qualify for each level of recognition before they can be assessed for a subsequent level (e.g., must pass Level I to be assessed for Level II).

Tables 1, 2 and 3 show the program measures and the associated point values for scoring clinicians' performance.

Table 1: COPD Care Level I Measures, Performance Criteria and Scoring

Level I focuses on a clinician-centric view of measurement, looking at individual metrics summed to produce a composite score. Thresholds have been set to focus on above average performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Lung Function/ Spirometry Evaluation	N/A	N/A	10
Inhaled Bronchodilator Therapy ⁵	N/A	N/A	10
Smoking Cessation Advice and Treatment	N/A	N/A	20
Assessment of COPD Exacerbations	N/A	N/A	10
COPD Exacerbation Therapy ⁵	N/A	N/A	10
Assessment of Oxygen Saturation ⁵	N/A	N/A	10
Long-Term Oxygen Therapy ⁵	N/A	N/A	15
Pneumococcal Immunization	N/A	N/A	5
Influenza Immunization	N/A	N/A	10
Total Points			100
Percentage of Total Points Needed to Achieve Recognition			60

⁵ Measure is applicable to a subset of the eligible patient population only and requires a minimum of 25 eligible patients for the denominator subset. Applicants who do not meet this measure-specific patient minimum will not be scored on this measure, and the maximum points for the measure will be removed from the total possible points. 60 percent of the total possible points are needed to achieve recognition in these cases.

Table 2: COPD Care Level II Measures, Performance Criteria and Scoring

Level II focuses on a combination of clinician and patient-centric measurements. Level II includes the measurement of individual metrics summed to produce a composite score. Also looks at the defect rate of care delivery across pairs of measures on a per patient basis. Thresholds have been set to focus on very good performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Lung Function/ Spirometry Evaluation	N/A	N/A	20
Inhaled Bronchodilator Therapy ^{5,6}	N/A		
Smoking Cessation Advice and Treatment	N/A	N/A	20
Assessment of COPD Exacerbations	N/A	N/A	20
COPD Exacerbation Therapy ^{5,6}	N/A		
Assessment of Oxygen Saturation ^{5,6}	N/A	N/A	25
Long-Term Oxygen Therapy ^{5,6}	N/A		
Pneumococcal Immunization	N/A	N/A	5
Influenza Immunization	N/A	N/A	10
Total Points			100
Percentage of Total Points Needed to Achieve Recognition			60

⁵ Measure is applicable to a subset of the eligible patient population only and requires a minimum of 25 eligible patients for the denominator subset. Applicants who do not meet this measure-specific patient minimum will not be scored on this measure, and the maximum points for the measure will be removed from the total possible points. 60 percent of the total possible points are needed to achieve recognition in these cases.

⁶ When a measure with a denominator subset is included in a bundled or composite measure and the measure-specific patient minimum is not met for one of the two bundled measures, the maximum points for the discrete measure with the patient minimum not met (as allotted in Level I scoring) will be removed from the total possible points. Applicants will be scored on the remaining discrete measure for which the measure-specific patient minimum is met. The remaining discrete measure will be assigned the same number of maximum points it was allotted in Level I scoring. Maximum points assigned to discrete measures in Level I scoring are identified in Table 1: COPD Care Level I Measures, Performance Criteria and Scoring.

Table 3: COPD Care Level III Measures, Performance Criteria and Scoring

Level III focuses on patient-centric view of measurement, looking at the defect rate of care delivery across pairs of measures on a per patient basis. Clinicians must demonstrate that they are using advanced processes and delivering all the right care on a per patient basis. Thresholds have been set to focus on exceptional performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Lung Function/ Spirometry Evaluation	N/A	N/A	20
Inhaled Bronchodilator Therapy ^{5,6}	N/A		
Smoking Cessation Advice and Treatment	N/A	N/A	20
Assessment of COPD Exacerbations	N/A	N/A	20
COPD Exacerbation Therapy ^{5,6}	N/A		
Assessment of Oxygen Saturation ^{5,6}	N/A	N/A	25
Long-Term Oxygen Therapy ^{5,6}	N/A		
Pneumococcal Immunization	N/A	N/A	15
Influenza Immunization	N/A		
Total Points			100
Percentage of Total Points Needed to Achieve Recognition			60

For a sample clinician scoring report, see Appendix B.

⁵ Measure is applicable to a subset of the eligible patient population only and requires a minimum of 25 eligible patients for the denominator subset. Applicants who do not meet this measure-specific patient minimum will not be scored on this measure, and the maximum points for the measure will be removed from the total possible points. 60 percent of the total possible points are needed to achieve recognition in these cases.

⁶ When a measure with a denominator subset is included in a bundled or composite measure and the measure-specific patient minimum is not met for one of the two bundled measures, the maximum points for the discrete measure with the patient minimum not met (as allotted in Level I scoring) will be removed from the total possible points. Applicants will be scored on the remaining discrete measure for which the measure-specific patient minimum is met. The remaining discrete measure will be assigned the same number of maximum points it was allotted in Level I scoring. Maximum points assigned to discrete measures in Level I scoring are identified in Table 1: COPD Care Level I Measures, Performance Criteria and Scoring.

POLICIES AND PROCEDURES

Eligibility for Clinician Participation

Clinicians may apply for BTE COPD Care Recognition as individuals or part of a medical practice. To be eligible, applicants must meet the following criteria.

- Applicants must be licensed as a medical doctor (M.D., D.O.), nurse practitioner (N.P.), or physician assistant (P.A.).
- Applicants must provide continuing care for people with COPD and be able to meet the minimum patient sample sizes.
- Applicants must complete all application materials and agree to the terms of the program by executing a data use agreement and authorization with a data aggregator partner.
- Applicants must submit the required data documenting their delivery of care for all eligible patients in their full patient panel.
- Applicants must use PAO-supplied or approved methods for submitting data electronically.

Individual clinician applicant

An individual clinician applicant represents one licensed clinicians practicing in any setting who provides continuing care for patients with COPD⁷.

Medical Practice applicant

A medical practice applicant represents any practice with three or more licensed clinicians who, by formal arrangement, share responsibility for a common panel of patients and practice at the same site, defined as a physical location or street address. For purposes of this assessment process practices of two clinicians or less must apply as individual applicants.

⁷ **COPD patients** are 18-75 years of age, with a documented diagnosis of COPD (as defined by criteria labeled “Patient Eligibility Criteria”) for at least 12 months AND have been under the care of the applicant clinician or practice for at least 12 months. This is defined by documentation of two face-to-face visits for COPD care between the clinician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

Applying for Recognition

Clinician applicants opt to voluntarily submit their data to a PAO for performance assessment through the Chronic Obstructive Pulmonary Disease Care Recognition Program. Participating clinicians must execute a data use agreement with the data aggregator partner through which they plan to submit data for BTE’s automated performance assessment process. All data aggregator partners have data use agreements executed with their partnering PAO. All necessary steps will be taken by the data aggregator and PAO to protect the confidentiality of patient data, as required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist with clinician compliance with HIPAA, the data aggregator partner provides a Business Associate addendum referenced in the data use agreement, which states that both the data aggregator and the clinician applicant will comply with HIPAA requirements.

Clinicians considering applying for recognition should:

1. Determine eligibility. See “Eligibility for Clinician Participation” for more information.
2. Familiarize themselves with the BTE COPD Care measures and specifications. See “What Recognition Requires” and “Requirements for Chronic Obstructive Pulmonary Disease Care Recognition Program” for more information.
3. Determine whether to apply as an individual clinician or medical practice.

The following outlines the submission process for applicants with electronic data collection systems:

Clinicians submitting through a data aggregator partner are required to submit medical record data for all eligible patients across their full patient population. Data aggregators will submit the most recent patient level data for each participating clinician’s full panel of eligible patients on a quarterly calendar schedule. Files are due by the end of the month following the end of the calendar quarter. The following illustrates the submission cycle due dates for sample reporting periods. Note that these are outside deadlines. Individual file submission dates will be agreed to between the data aggregator and PAO based on the estimates time needed by the data aggregator to prepare the quarterly data submission.

Reporting Period	Submission Deadline
January 1, 2009 – December 31, 2009	January 31, 2010
April 1, 2009 – March 31, 2010	April 30, 2010
July 1, 2009 – June 30, 2010	July 31, 2010
October 1, 2009 – September 30, 2010	October 31, 2010

Clinicians are required to continue submitting data for all eligible patients each quarter unless they cease using the data aggregator's electronic system.

Clinicians that are new to an electronic data aggregator partner's system, where the system is not yet fully integrated in the clinicians' office and patient records have not been backloaded, are required to prospectively enter all eligible patients from their full patient panel into the data aggregator's electronic system. For individual applicants, clinician assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for the minimum requirement of 25 eligible patients. For practice level applicants, assessment will automatically be triggered after all required data is submitted through the data aggregator's electronic system for 10 patients per individual clinician and a practice average of 25 patients per clinician. It is assumed that after one full year of usage of the data aggregator's electronic system that all eligible patients will be included.

Once a clinician or medical practice has opted to send their data to a PAO, the necessary data elements, including de-identified patient information for each COPD Care measure as well as clinician identifiers, will be transmitted from the data aggregator partner to the pre-identified PAO. Clinical information and clinician identifiers will be maintained in separate files to ensure that the identities of the clinicians remain unknown during scoring. Clinical data should be linked to the treating clinician through a unique coded clinician identifier assigned by the data aggregator. For practice applications, the clinical patient data should be linked to the individual clinician practice members so that the PAOs can verify that all members of the practice meet the eligibility requirements. Clinical information must be transmitted at the individual patient level so that numerators and denominators presented in any summary data submission can be validated. Clinician identifiers to be submitted include:

- Responsible clinician identifier (unique coded clinician identifier assigned by the data aggregator)
- Clinician name (first, middle, last)
- Clinician address
- Clinician degree
- Clinician specialty
- Clinician gender
- Clinician date of birth
- Medical license number
- DEA number
- Clinician NPI
- Whether data submission occurred through a CCHIT or Meaningful Use certified system

It is the responsibility of the data aggregator to ensure that the responsible clinician identifier assigned to each clinician remains the same over time. This is necessary for the PAO to be able to track recognition status and apply changes to recognition level appropriately.

Medical practices may apply for recognition as a practice or as individual clinicians. However, individual clinician identifiers must be provided for each clinician included in a practice level

recognition application. Two additional identifiers are also included for clinicians applying for recognition as part of a practice:

- Practice identifier (unique coded practice identifier assigned by the data aggregator)
- Practice name

Relevant de-identified medical record data should be submitted from the data aggregator partner to the pre-identified PAO for each eligible patient in the clinician applicant's patient. As part of their agreement with the selected data aggregator, clinicians will be asked to sign an attestation verifying that all eligible patients are being entered into the data aggregator's electronic system as they are seen, and verify whether all eligible patients are included in the system at the time of submission. The clinician identifier file contains an additional field for data aggregators to indicate whether data submitted represents all eligible patients treated by the clinician (full patient panel). For instructions on completing medical record abstraction, see the "Required Standards for Chronic Obstructive Pulmonary Disease Care Recognition" section in this document.

PAOs will provide data aggregators with standard file formats for both the clinical data and clinician identifier data files.

Evaluation Process

The PAO reviews and assesses the completeness of clinician data submitted each quarter and notifies the data aggregator partner if additional information is required. The PAO runs and provides the data aggregator with a file load summary either accepting or rejecting the data aggregator file if invalid or incomplete information is submitted. The load summary will identify which records contain invalid or incomplete data. It is the data aggregator's responsibility to correct or remove the problematic data and resubmit the file(s) to the PAO. The PAO is not required to make any changes to the files submitted by the data aggregators. Completed applications are processed for compliance with performance requirements, and applicant-specific reports with results for all COPD Care measures are produced within 30 days.

All applicants must meet the COPD Care program eligibility requirements to be scored. For practice level applicants, all individual clinicians included in the practice application must meet the COPD Care program eligibility requirements to be scored. If a clinician included in a practice application does not meet the requirements, his or her designated patients' data will be excluded from the scoring. If the remaining members of the practice still meet the eligibility requirements without the backed out clinician and his or her patients, then the PAO can proceed to score the remaining members of the application as a practice. Only clinicians included in the scoring will be sent to BTE's Recognition Data Exchange (RDE) upon a Recognition determination. If the remaining members of the practice do not meet the eligibility requirements without the backed out clinician and his or her patients, then these clinicians will be assessed as individual applicants, if they meet the individual applicant eligibility requirements. (For an example, see "Minimum Patient Requirements.") The PAO will inform the data aggregator in its

results reports which applicants, if any, were not scored due to inability to meet the eligibility requirements.

Clinician assessment will be ongoing for continuous data submissions. Assessment will be conducted quarterly based on the most current medical record data submitted for each eligible patient (see measures specifications for further details). For patients with no new data submitted in the current quarter, data aggregators will look back for the most recent patient information to be included in the current data submission for performance assessment.

Audit

The PAO is responsible for conducting three levels of audit pertaining to applicant submissions for BTE COPD Care Recognition. The first level of audit is the data aggregator data extraction code review, the second level of audit is the data validation or load summary, and the third level of audit is the clinician chart audit.

Level 1 – Audit of data aggregator data extraction: The PAO will conduct an audit of each data aggregator’s data extraction process prior to accepting applications. The PAO will review the code that the data aggregator is using to extract the clinician data and verify that all eligible patients are accurately included in the denominator. The DA must also clinician the PAO with documentation of the code or logic used to extract numerator data to ensure that all data submitted is in accordance with BTE’s measure specifications. Each data aggregator needs to pass the extraction audit before numerator data is abstracted for submission to the PAO. This level of review will also be conducted biannually and upon any changes to the data aggregator data extraction code. Data aggregators are responsible for informing the PAO when any changes are made. See Appendix A for a list of requirements each data aggregator needs to supply to the PAO for the data extraction audit.

Level 2 – Data validation: As stated above, the PAO runs and provides the data aggregator with a file load summary for each file submission, ensuring that each data field contains a valid data value that meets the data field specifications and makes sense in relation to itself and related data fields. The load summary will identify which records contain incomplete or invalid data values and designate them as errors or warnings. There is a zero tolerance policy for errors on required data fields and data values that do not meet data field specifications. It is the data aggregator’s responsibility to correct or remove the problematic data identified as errors and resubmit the file to the PAO. Files will not be rejected for invalid data values in clinical measures fields, but will be counted as a numerator miss for scoring purposes (with the exception of the poor control measures for which it will be counted as a numerator hit). Invalid data values in clinical measures fields are however identified as warnings in the load summary to the data aggregator, which is responsible for reporting this information back to the applicant in order to improve data collection. See Appendix A for the list of data validation checks used by the PAO.

Level 3 – Clinician chart audit: Additionally, BTE reserves the right to complete an audit of any individual or practice application for Recognition. PAOs or specified local organization subcontractors conduct audits of at least 5 percent of applicants from each data aggregator partner each year. COPD Care audits may be completed by fax, mail, electronically or on site, as

determined by the PAO. Any data identified by the PAO as irregular will be subject to audit. The remainder of the 5 percent will be selected through a random sampling methodology.

The PAO will notify the data aggregator which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission. Failure to pass an audit results in no further consideration for the COPD Care program for six months to two years (depending on the audit score) from the date of submission of the application. For further information on clinician chart audit methodology and scoring, see Appendix A.

Scoring

The PAO makes a decision on whether to award Recognition on the basis of the applicant's overall performance against the criteria. Decisions are based on a numeric score. The COPD Care program evaluates performance based upon an aggregate score achieved across the clinical measures. Clinical measures are scored based upon the percentage of the sample which meets or complies with the measure threshold or standard (numerator/denominator) multiplied by the maximum points assigned to the measure to determine the applicant's points total for that measure. These clinical measure scores are summed to determine the applicant's final score which is used to assess the applicant's recognition status.

Example 1: For Level I, there is a maximum of 10 points for the Lung Function/Spirometry Evaluation measure. If 20 percent of the patient sample is compliant with the measure, then the clinician receives 20% of the total 10 points [$0.20 \times 10 = 2$] or 2 points. If 50 percent of the patient sample is compliant with the measure, then the clinician receives 50% of the total 10 points [$0.50 \times 10 = 5$] or 5 points.

Example 2: For Level II and III, there is a maximum of 20 points for the composite measure bundle Lung Function/Spirometry Evaluation and Inhaled Bronchodilator Therapy. If 20 percent of the patient sample is compliant with the Lung Function/Spirometry Evaluation measure and 40 percent of the patient sample is compliant with the Inhaled Bronchodilator Therapy measure, then the clinician receives the product of both compliance rates [$0.20 \times 0.40 \times 20 = 1.6$] or 1.6 points.

Final Status Determinations

The PAO completes, reviews and makes COPD Care Recognition status determinations. Applicants may, however, appeal a determination of Not Recognized, as described below under Reconsiderations.

The scoring thresholds are shown in the tables below. For COPD Care Recognition, there are two statuses for each level: Recognized and Not Recognized.

COPD Care Recognition	Percentage of Total Possible Points
Recognized	60-100
Not Recognized	0-59

“Recognized” indicates the applicant meets or exceeds the requirements acceptable for the standards and that COPD Care Recognition at that level has been achieved. COPD Care Recognitions achieved on or before December 31, 2009 will be effective for three years. Beginning January 1, 2010, the COPD Care Recognition term will be shortened to two years.

“Not Recognized” indicates that the applicant does not meet the requirements acceptable for the standards. PAOs do not release the identities of clinicians or practices who do not achieve at least Level I COPD Care Recognition. Applicants who do not achieve Level I Recognition but continue to submit data on a quarterly basis will be reassessed each quarter and awarded recognition upon two consecutive quarters of successful recognition achievement.

Reconsideration

An applicant may request Reconsideration of a Recognition status decision of Not Recognized for any level. The Data Aggregator must receive a request for Reconsideration within 30 days after an applicant is notified of their recognition status. The request must list the measures or other information for which reconsideration is being requested. The clinician or practice may not submit additional documentation at this time, but may state how it believes the PAO misinterpreted the original documentation.

The first level of appeals is conducted at the data aggregator level. The data aggregator partner through which the recognition application was submitted will review the applicant’s data included in the request to ensure that the data submitted to the PAO was extracted in accordance with the BTE COPD Care measures and specifications. If no issues are found, the data aggregator will then verify the data with the PAO, and the PAO will review the scoring of the applicant’s data. In the case of a deadlock, the appeal will be referred to BTE for reconsideration. If necessary, final determination will be made by the physician members of the BTE Board.

The reconsideration decision is final and is provided in writing to the clinician or practice requesting Reconsideration.

Reporting Results

As part of BTE’s mission to identify and promote quality, PAOs report results to the following:

- To the data aggregator partner through which the recognition application was submitted. The data aggregator is required to share results reports with the clinician applicant to facilitate quality improvement. See Appendix B for a sample results report.

- To BTE: Only Recognized statuses are reported to BTE for display on BTE's consumer portal for recognition information hosted by HealthGrades and transmission to BTE-licensed health plans for associated incentives. Once the final decision is made, the PAO will reveal the identity, program name and program level of the recognized clinicians only. No clinical data is shared with BTE at any point in the process.

PAOs are responsible for monitoring and reporting to BTE through the BTE Recognition Data Exchange (RDE) which COPD Care Recognized clinicians submitted data for assessment through a CCHIT or Meaningful Use certified data aggregator product. These clinicians will automatically receive a Level II Physician Office Link (POL) recognition.

Certificates

BTE issues an official certificate to each recognized clinician.

Duration of Recognition

For COPD Care Recognitions achieved on or before December 31, 2009, Recognition status remains in effect for **3 years** from the date on which a PAO awards recognition. Beginning January 1, 2010, the COPD Care Recognition duration will be shortened to **2 years** from the date on which a PAO awards recognition. For continuously assessed applicants who maintain their current level of recognition, new begin and end recognition dates will be assigned at the time of the most recent assessment. Recognition determinations are made on the basis of a specific patient population. Recognition status remains in effect for the duration of recognition as long as the clinician maintains his or her current practice and patient base. Clinicians are responsible for informing the data aggregator within 30 days who will inform the PAO if they move or change practices.

Changes in Recognition Levels

Continuous data submission applicants are eligible for changes in recognition level. Clinicians who achieve at least Level I COPD Care Recognition will maintain their COPD Care Recognition for the duration of recognition outlined above. However, during this time it is possible for the recognition status to move between program levels (I, II and III) based on changes in clinical data from quarter to quarter. Changes to program level and recognition dates occur according to the following rules:

- Clinicians who achieve a higher level of recognition for two consecutive assessment periods will have their recognition status changed effective the date of the most recent assessment.
- Clinicians recognized at Level II or III can drop in levels of recognition based on lower scoring results for two consecutive assessment periods.

- Each time a clinician’s recognition status changes levels in either direction a new begin recognition date is assigned for the date of the most recent assessment and a new end recognition date is calculated.
- Clinicians who drop below Level I for two consecutive quarterly assessments will be assigned or maintain Level I COPD Care Recognition status and maintain their current begin and end recognition dates.

Example 1: Clinician A

<i>Assessment period</i>	<i>Assessment date</i>	<i>Assessed (Scored) Level⁸</i>	<i>Recognition Level⁹</i>	<i>Recognition Dates</i>
10/1/07-9/30/08	10/22/08	Level III	Level III	10/22/08-10/22/2011
1/1/08-12/31/09	1/21/09	Level III	Level III	1/21/09-1/21/2012
4/1/08-3/31/09	4/18/09	Level III	Level III	4/18/09-4/18/2012
7/1/08-6/30/09	7/25/09	Level II	Level III	4/18/09-4/18/2012
10/1/08-9/30/09	10/16/09	Level II	Level II	10/16/09-10/16/2012

Example 2: Clinician B

<i>Assessment period</i>	<i>Assessment date</i>	<i>Assessed (Scored) Level</i>	<i>Recognition Level</i>	<i>Recognition Dates</i>
10/1/08-9/30/09	10/22/09	Not Pass	N/A	N/A
1/1/09-12/31/09	1/21/10	Level II	N/A	N/A
4/1/09-3/31/10	4/18/10	Level II	Level II	4/18/10-4/18/2012
7/1/09-6/30/10	7/25/10	Not Pass	Level II	4/18/10-4/18/2012
10/1/09-9/30/10	10/16/10	Not Pass	Level I	4/18/10-4/18/2012

PAOs are responsible for managing changes to clinician’s start and end recognition dates and submitting updated recognition level and recognition dates to the BTE Recognition Data Exchange (RDE) on a monthly basis. PAOs are responsible for alerting data aggregators when applicants’ assessment scores drop in level for one quarter. Data aggregators are responsible for alerting applicants that a second consecutive lower score will result in a change to their recognition level.

⁸ A clinician’s Assessed Level is the BTE level at which the clinician’s data is scored for the current measurement period.

⁹ A clinician’s Recognition Level is the BTE level at which the clinician is currently recognized and the level that is distributed to BTE’s health plan licensees and the BTE consumer portal at HealthGrades. A clinician’s Recognition Level may or may not be the same as a clinician’s Assessed Level.

Terms of Recognition

When communicating with patients, third-party payers, managed care organizations (MCOs) and others, clinicians or practices who receive BTE COPD Care Recognition may represent themselves as BTE-recognized and meeting NQF/AQA quality measure requirements; however, clinicians or practices may not characterize themselves as “NQF/AQA-Approved” or “NQF/AQA-Endorsed.” The use of this mischaracterization or other similarly inappropriate statements will be grounds for revocation of status.

Revoking Recognition

PAOs may revoke a Recognition decision if any of the following occurs:

- The clinician or practice submits false data or does not collect data according to the procedures outlined in this manual, as determined by discussion with the clinician or practice or audit of application data and materials.
- The clinician or practice misrepresents the credentials of any of its clinicians.
- The clinician or practice misrepresents its Recognition status.
- The clinician or any of the practice’s clinicians experience a suspension or revocation of medical licensure.
- The clinician or practice has been placed in receivership or rehabilitation and is being liquidated.
- State, federal or other duly authorized regulatory or judicial action restricts or limits the clinician or practice’s operations.
- BTE identifies a significant threat to patient safety or care.

Data Use Terms

Data use terms are outlined in the data use agreement that the applicant signs with the selected data aggregator partner.

BTE COPD Care Recognition Clinical Measures

The following examples illustrate the format used for clinical measures.

Evaluation Program Title: Chronic Obstructive Pulmonary Disease Care Recognition Program

Clinical Measures

Clinical measures are standard measures with a numerator and denominator that reflect performance across a sample of eligible patients based on medical record documentation.

The following items are listed for each clinical measure.

Description: A statement of what is being measured specifically.

Data source: A list of the data sources accepted for the clinical measure.

Explanation: Additional information about the clinical measure.

Numerator: A description of the applicant's eligible patients (denominator) who meet the measure threshold or standard.

Denominator Subset: A description of a subset of the applicant's eligible patients (domain denominator) for whom a particular measure is relevant (measure denominator).

Frequency: Time frames associated with the numerator requirements.

Scoring: Performance level (percentage of patients meeting or complying with the measure) translated to points total for the clinical measure.

Information on the Domain Denominator is consistent across all of the clinical measures and is listed under "Patient Eligibility Criteria".

REQUIREMENTS FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE CARE RECOGNITION PROGRAM

Chronic Obstructive Pulmonary Disease Care Program Measurement Set

Clinical Measures Specifications:

1. Lung Function/Spirometry Evaluation:

Description: Percentage of patients aged 18 through 75 years old with COPD and documentation of a spirometry evaluation.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with COPD for the denominator, and claims/encounter data or medical record data for spirometry information for the numerator.

Explanation: The National COPD Education and Prevention Program Expert Panel Report 2 (NAEPP-EPR-2) guidelines recommend monitoring pulmonary function (spirometry; peak flow monitoring) to determine whether goals of COPD therapy are being met. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and documentation of a spirometry evaluation, unless a physical inability exists.. Two methods are provided to identify patients documented spirometry evaluation and/or physical inability: claims and medical record data. See “Patient Eligibility Criteria” for further information on codes to identify patients with COPD.

Electronic Collection: The patient is numerator compliant if he or she has documentation of spirometry evaluation during the reporting period, as evidenced through claims data. Below is a list of codes to identify spirometry evaluation:

CPT-I codes: 94010, 94014, 94015, 94016, 94060, 94070, 94620

CPT-II codes: 3023F

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of spirometry results OR a physical inability to perform spirometry. This includes those patients with COPD who had one of the following:

1. Documentation indicating the date and spirometry results (FEV1 and FEV1/FVC) during the reporting period.
2. Documentation of spirometry evaluation and results from another treating clinician during the reporting period.
3. Documentation of a physical inability to perform spirometry.

The following is not acceptable documentation for spirometry evaluation and results:

1. Patient self-reporting

Frequency: Most recent documentation over the last 12 months from last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

2. Inhaled Bronchodilator Therapy:

Description: Percentage of patients aged 18 through 75 years old with COPD, an FEV1/FVC < 70%, and at least one COPD symptom, who were prescribed or dispensed at least one inhaled bronchodilator, in the absence of contraindications.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with COPD, an FEV1/FVC < 70%, and COPD symptoms for the denominator, and claims/encounter, pharmacy or medical record data for inhaled bronchodilator prescription information for the numerator.

Explanation: The National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization recognize bronchodilator medications as central to the symptomatic management of patients with Chronic Obstructive Pulmonary Disease (COPD). It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD, an FEV1/FVC < 70% and at least one COPD symptom, who were prescribed or dispensed at least one inhaled bronchodilator, in the absence of contraindications. Three methods are provided to identify patients' documented appropriate COPD medication use: pharmacy, claims and medical record data. See "Denominator Subset" section below for further information on codes to identify patients with COPD, an FEV1/FVC < 70% and at least one COPD symptom.

Electronic Collection: The patient is numerator compliant if he or she has documented evidence of inhaled bronchodilator medication (β_2 agonist or anticholinergic) use or contraindication to inhaled bronchodilator medications, as identified by pharmacy or claims data. This includes those patients with COPD, an FEV1/FVC < 70% and at least one COPD symptom who had one of the following:

1. Inhaled bronchodilator medication(s) (β_2 agonist or anticholinergic) prescribed or dispensed during the reporting period.
2. Evidence of contraindication or previous adverse reaction to inhaled bronchodilator medications (β_2 agonist or anticholinergic)

Inhaled Bronchodilator Medications: For a list of numerator compliant inhaled bronchodilator medications, see Tables 3 and 4 under "Relevant Medication Lists for COPD Care Measurement Set." These lists are provided as an example, but do not constitute exhaustive lists of appropriate medications.

Below is a list of codes that can also be used to identify the dispensing of an inhaled bronchodilator medication.

CPT-II Code: 4025F

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to inhaled bronchodilator medications:

ICD-9 Codes:

Adverse Reaction to Inhaled Bronchodilators: 995.27 with E945.7, 995.3 with E945.7, 995.27 with E941.1, and 995.3 with E941.1)

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of inhaled bronchodilator medication (β 2 agonist or anticholinergic) use OR previous adverse reaction or contraindication to inhaled bronchodilator medications. This includes those patients with COPD, an FEV1/FVC < 70% and at least one COPD symptom who had one of the following:

1. Documentation indicating the date on which an inhaled bronchodilator medication was prescribed during the reporting period.
2. Dated documentation of a prescription for an inhaled bronchodilator medication from another treating clinician during the reporting period.
3. Documentation of diagnosis of or medical treatment for one of the following indicating a previous adverse reaction or contraindication to inhaled bronchodilator medications:
 - Adverse reaction to inhaled bronchodilators

For a list of numerator compliant inhaled bronchodilator medications, see Tables 3 and 4 under “Relevant Medication Lists for COPD Care Measurement Set.” These lists are provided as an example, but do not constitute exhaustive lists of appropriate medications.

The following is not acceptable documentation for inhaled bronchodilator therapy:

1. Patient self-reporting

Denominator Subset: Patients aged 18-75 years with the domain denominator diagnosis (i.e., COPD) AND documentation of an FEV1/FVC < 70% and at least one COPD symptom (i.e., dyspnea, cough, sputum, wheezing). Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document. Two methods are provided to identify patients' FEV1/FVC and COPD symptoms: claims and medical record data.

Electronic Collection: The patient is denominator compliant if he or she has documentation of an FEV1/FVC < 70% and at least one of the following COPD symptoms: dyspnea, cough, sputum, wheezing, during the reporting period, as identified by administrative claims data. Below is a list of eligible codes to identify an FEV1/FVC < 70% AND COPD symptoms:

Spirometry Test Results of FEV1/FVC < 70%:

CPT-II Codes: 3025F

Dyspnea:

ICD-9 Codes: 786.00, 786.01, 786.02, 786.05, 786.06, 786.09, 493.2

Cough:

ICD-9 Codes: 786.2, 491.0

Sputum:

ICD-9 Codes: 786.3, 786.4

Wheezing:

ICD-9 Codes: 786.07

Medical Record Collection: The patient is denominator compliant if he or she has documentation in the medical record of an FEV1/FVC < 70% and the presence of at least one of the following COPD symptoms: dyspnea, cough, sputum, or wheezing. This includes those patients with COPD who had one of the following:

1. Documentation indicating the date of an FEV1/FVC < 70% during the reporting period.
2. Dated documentation of an FEV1/FVC < 70% from another treating clinician during the reporting period.

AND one of the following:

3. Documentation indicating the date of the presence of at least one of the following COPD symptoms: dyspnea, cough, sputum, or wheezing, during the reporting period.
4. Dated documentation of the presence of at least one of the following COPD symptoms: dyspnea, cough, sputum, or wheezing, from another treating clinician during the reporting period.

Frequency: Most recent prescription over the last 12 months from the last day of the reporting period.

Scoring: If denominator subset ≥ 25 patients, then Earned Points =
[numerator/denominator] x maximum available points for the measure

If denominator subset < 25 patients, then measure is not scored.

3. Smoking Status and Cessation Advice and Treatment:

Description: Percentage of patients aged 18- through 75 years with COPD who have documentation of smoking status, and if a smoker, received cessation counseling or treatment.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with COPD for the denominator, and medical record data for documentation of smoking status, and if a smoker, claims or medical record data for documentation of cessation counseling or treatment information for the numerator.

Explanation: The United States Preventive Services Task Force (USPTF) recommends periodic screening for all patients. The USPTF also recommends cessation counseling for all patients that smoke. According to the American Thoracic Society (ATS) and European Respiratory Society (ERS) COPD guidelines, quitting smoking can slow the progressive loss of lung function and can reduce symptoms at any point in time. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and documentation of smoking status, and if a smoker, date of cessation counseling or treatment. See “Patient Eligibility Criteria” for further information on codes to identify patients with COPD.

Electronic Collection: The patient is numerator compliant if he or she has smoking status documented (see Medical Record Collection below) AND if smoker has documented date of receipt of cessation counseling and/or treatment during the reporting period, as identified by claims data. The following codes may be used to identify smoking cessation counseling and/or treatment:

CPT I Codes: 99406, 99407;

HCPCS Codes: S9075, S9453.

Medical Record Collection: The patient is numerator compliant if he or she has smoking status documented AND if a smoker, has documented date of receipt of cessation counseling and/or treatment during the reporting period. Acceptable forms of cessation counseling and treatment methods/resources include dated documentation of patient receiving/participating in at least one of the following:

1. 1:1 teaching

2. Written or web-based risk-based educational materials
3. Group education class focused on smoking cessation
4. Drug therapy

For a list of numerator compliant medications, see Table 6 under “Relevant Medication Lists for COPD Measurement Set.” The list is provided as an example, but does not constitute an exhaustive list of appropriate medications.

If the patient is a non-smoker, the patient is NOT numerator compliant if:

1. His or her smoking status documentation is missing
OR
2. His or her smoking status was not asked

If the patient is a smoker, the patient is NOT numerator compliant if:

1. His or her smoking status documentation is missing
OR
2. His or her smoking status was not asked
OR
3. His or her documentation on receiving cessation counseling and/or treatment is missing
OR
4. He or she has not received cessation counseling and/or treatment
OR
5. He or she has not received cessation counseling and/or treatment during the reporting period
OR
6. His or her documentation on receiving cessation counseling and/or treatment is not during the reporting period

Frequency: If non-smoker: most recent smoking status.

If smoker: most recent smoking status and counseling/treatment over the last 12 months from last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

4. Assessment of COPD Exacerbations:

Description: Percentage of patients aged 18 through 75 years old with COPD and documentation of the number of exacerbations.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter data or medical record data for identification of patients with COPD for the denominator, and claims/encounter or medical record data for exacerbations information for the numerator.

Explanation: According to the American Thoracic Society (ATS) and European Respiratory Society (ERS), exacerbations are a common cause of morbidity and mortality in patients with COPD and those with frequent exacerbations are more likely to have recurrent symptoms and hospital readmission within 14 days of the original episode. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and documentation of the number of exacerbations during the reporting period. See “Patient Eligibility Criteria” for further information on codes to identify patients with COPD.

Electronic Collection: The patient is numerator compliant if he or she has documentation of all exacerbations during the reporting period, as identified through claims and/or ED encounter data with a principal diagnosis of COPD. Below is a list of codes to identify COPD exacerbations:

ICD-9 codes: 491.22, 491.22

CPT-I codes (must be accompanied by ICD-9 code 491, 492 or 496): 99281, 99282, 99283, 99284, 99285

Medical Record Collection: The patient is numerator compliant if: he or she has documentation in the medical record of all exacerbations. This includes those patients with COPD who had one of the following:

1. Documentation of notes indicating all exacerbations during the reporting period.
2. Dated documentation of notes indicating all exacerbations during the reporting period from another treating clinician.

Frequency: Most recent documentation over the last 12 months from the last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

5. COPD Exacerbation Therapy:

Description: Percentage of patients aged 18 through 75 years old with COPD and a history of an exacerbation who were prescribed or dispensed at least one inhaled bronchodilator (long-acting β_2 agonist or anticholinergic) and/or one inhaled corticosteroid, in the absence of contraindications.

Data source: Electronic data (visit, lab, encounter data or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter data or medical record data for identification of patients with COPD and history of an exacerbation for the denominator, and claims/encounter data, pharmacy or medical record data for inhaled bronchodilator (long-acting β_2 agonist or anticholinergic) and inhaled corticosteroid prescription information for the numerator.

Explanation: According to the American Thoracic Society (ATS) and European Respiratory Society (ERS) COPD clinical practice guidelines, long-acting bronchodilators improve health status as well as reduce symptoms, rescue medication use and increase time between exacerbations. Furthermore, the National Heart Lung and Blood Institute (NHLBI) and the World Health Organization (WHO) state that treatment with inhaled corticosteroids reduces the frequency of exacerbations in symptomatic, severe COPD patients with repeated exacerbations. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and a history of an exacerbation in the last 12 months, who were prescribed or dispensed at least one inhaled bronchodilator (long-acting β_2 agonist or anticholinergic) and/or one inhaled corticosteroid, in the absence of contraindications. Three methods are provided to identify patients' documented appropriate COPD exacerbation therapy use: pharmacy, claims and medical record data. See "Denominator Subset" section below for further information on identifying patients with exacerbations.

Electronic Collection: The patient is numerator compliant if:he or she has documented evidence of inhaled bronchodilator (long-acting β_2 agonist or anticholinergic) and/or inhaled corticosteroid medication use or contraindication to inhaled bronchodilator and/or inhaled corticosteroid medications, , as evidenced by pharmacy or claims data. This includes those patients with COPD and a history of exacerbation in the last 12 months who had one of the following:

1. Inhaled bronchodilator (long-acting β 2 agonist or anticholinergic) and/or inhaled corticosteroid medication(s) prescribed or dispensed during the reporting period.
2. Evidence of contraindication or previous adverse reaction to inhaled bronchodilator (long-acting β 2 agonist or anticholinergic) and inhaled corticosteroid medications.

Inhaled Bronchodilator and/or Inhaled Corticosteroid Medications: For a list of numerator compliant inhaled bronchodilator and inhaled corticosteroid medications, see Tables 4 and 5 under “Relevant Medication Lists for COPD Care Measurement Set.” These lists are provided as an example, but do not constitute exhaustive lists of appropriate medications.

Below is a list of codes that can also be used to identify the dispensing of an inhaled bronchodilator or inhaled corticosteroid medication.

CPT-II Codes:

Inhaled Bronchodilator: 4025F

Inhaled Corticosteroid: 4135F

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to inhaled bronchodilator and inhaled corticosteroid medications:

ICD-9 Codes:

Adverse Reaction to Inhaled Bronchodilators: 995.27 with E945.7, 995.3 with E945.7, 995.27 with E941.1, and 995.3 with E941.1

Adverse Reaction to Inhaled Corticosteroids: 995.27 with E945.8, 995.3 with E945.8

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of inhaled bronchodilator (long-acting β 2 agonist or anticholinergic) and/or inhaled corticosteroid medication use OR previous adverse reaction or contraindication to inhaled bronchodilator or corticosteroid medications. This includes those patients with COPD and a history of exacerbation over the last 12 months who had one of the following:

1. Documentation indicating the date on which an inhaled bronchodilator or and/or inhaled corticosteroid medication was prescribed during the reporting period.
2. Dated documentation of a prescription for an inhaled bronchodilator and/or inhaled corticosteroid medication from another treating clinician during the reporting period.
3. Documentation of diagnosis of or medical treatment for the following indicating a previous adverse reaction or contraindication to inhaled bronchodilator and inhaled corticosteroid medications:
 - Adverse reaction to inhaled bronchodilators
 - Adverse reaction to inhaled corticosteroids

For a list of numerator compliant inhaled bronchodilator and inhaled corticosteroid medications, see Tables 4 and 5 under “Relevant Medication Lists for COPD Care Measurement Set.” These lists are provided as an example, but do not constitute exhaustive lists of appropriate medications.

The following is not acceptable documentation for COPD exacerbation therapy:

1. Patient self-reporting

Denominator Subset: Patients aged 18-75 years with the domain denominator diagnosis (i.e., COPD) AND documentation of at least one exacerbation in last 12 months. Information on the domain’s denominator diagnosis can be found under the “Patient Eligibility Criteria” section of the document. Two methods are provided to identify patients’ exacerbation history: claims and medical record data.

Electronic Collection: The patient is denominator compliant if he or she has documentation of at least one exacerbation during the reporting period, as identified by claims and/or ED encounter data with a principal diagnosis of COPD. Below is a list of codes to identify COPD exacerbations:

ICD-9 codes: 491.22, 491.22

CPT-I codes (must be accompanied by ICD-9 code 491, 492 or 496): 99281, 99282, 99283, 99284, 99285

Medical Record Collection: The patient is denominator compliant if he or she has documentation in the medical record indicating the occurrence of at least

one of exacerbation during the reporting period. This includes those patients with COPD who had one of the following:

1. Documentation of an occurrence of at least one exacerbation during the reporting period.
2. Dated documentation from another treating clinician of an occurrence of at least one exacerbation during the reporting period.

Frequency: Most recent prescription over the last 12 months from the last day of the reporting period.

Scoring: If denominator subset ≥ 25 patients, then Earned Points = [numerator/denominator] x maximum available points for the measure

If denominator subset < 25 patients, then measure is not scored.

6. Assessment of Oxygen Saturation:

Description: Percentage of patients aged 18 through 75 years old with COPD and at least one of the following: (1) FEV1 < 40% of predicted value, (2) respiratory failure, or (3) right heart failure, with documentation of oxygen saturation assessment.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims or medical record data for identification of patients with COPD and at least one of the following: FEV1 < 40% of predicted value, respiratory failure, or right heart failure, for the denominator, and claims/encounter data or medical record data for oxygen saturation information for the numerator.

Explanation: The American Thoracic Society (ATS) and European Respiratory Society (ERS) COPD clinical practice guidelines recommend the measurement of arterial blood gases in COPD patients in both the moderate and severe stages. This includes oxygen saturation for use in initiation and trending of long-term oxygen therapy, as well as maintaining the important therapeutic goal of safe oxygen saturation levels during rest, sleep and exertion. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years old with a diagnosis of COPD and at least one of the following: (1) FEV1 < 40% of predicted value, (2) respiratory failure, or (3) right heart failure, with documentation of oxygen saturation assessment in the last 12 months, from the last day of the reporting period. See “Denominator Subset” section below for further information on identifying patients with FEV1 < 40% of predicted value, respiratory failure, or right heart failure.

Electronic Collection: The patient is numerator compliant if he or she has documentation of an oxygen saturation assessment or long-term oxygen therapy as identified through claims data. This includes those patients with COPD and FEV1 < 40% of predicted value, respiratory failure, or right heart failure who had one of the following:

1. Oxygen saturation assessment (based upon an arterial blood gas or pulse oximetry) during the reporting period.
2. Long-term oxygen therapy (defined as > 15 hours per day) prescribed during the reporting period.

Oxygen Saturation Assessment: Below is a list of codes that may be used to identify oxygen saturation assessment.

CPT-I Codes: 82803, 82805, 82810, 94760, 94761, 94762

CPT-II Codes: 3028F, 3035F, 3037F

Long-Term Oxygen Therapy: Below is a list of codes that may be used to identify prescription of long-term oxygen therapy.

CPT-II codes: 4030F

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of an oxygen saturation assessment or long-term oxygen therapy. This includes those patients with COPD and FEV1 < 40% of predicted value, respiratory failure, or right heart failure who had one of the following:

1. Documentation of oxygen saturation results (based upon an arterial blood gas or pulse oximetry) during the reporting period.
2. Dated documentation of oxygen saturation results (based upon an arterial blood gas or pulse oximetry) during the reporting period from another treating clinician.
3. Documentation indicating the date on which long-term oxygen therapy (defined as > 15 hours per day) was prescribed during the reporting period.
4. Dated documentation of a prescription for long-term oxygen therapy (defined as > 15 hrs per day) from another treating clinician.

The following is not acceptable documentation for assessment of oxygen saturation:

1. Patient self-reporting

Denominator Subset: Patients aged 18-75 years with the domain denominator diagnosis (i.e., COPD) AND documentation of at least one of the following: (1) FEV1 < 40% of predicted value, (2) respiratory failure, or (3) right heart failure. Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document. Two methods are provided to identify patients in the above 3 categories: claims and medical record data.

Electronic Collection: The patient is denominator compliant if he or she has documentation of an FEV1 < 40% of predicted value, respiratory failure, or right heart failure, as identified by claims data. Below is a list of eligible codes to identify the above 3 categories.

FEV1 < 40% of Predicted Value

CPT-II Codes: 3040F

Respiratory Failure

ICD-9 codes: 518.83, 518.84

Right Heart Failure

ICD-9 codes: 428.0, 428.3

Medical Record Collection: The patient is denominator compliant if he or she has documentation in the medical record of FEV1 < 40% of predicted value, respiratory failure, or right heart failure. This includes those patients with COPD who had one of the following:

1. Documentation indicating at least one of the following: (1) FEV1 < 40% predicted value, (2) respiratory failure, or (3) right heart failure.
2. Dated documentation of at least one of the following: (1) FEV1 < 40% predicted value, (2) respiratory failure, or (3) right heart failure from another treating clinician.

Frequency: Most recent documentation over the last 12 months from the last day of the reporting period.

Scoring: If denominator subset ≥ 25 patients, then Earned Points =
[numerator/denominator] x maximum available points for the measure

If denominator subset < 25 patients, then measure is not scored.

7. Long-Term Oxygen Therapy:

Description: Percentage of patients aged 18 through 75 years old with COPD and an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg, who have been prescribed long-term oxygen therapy.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter data or medical record data for identification of patients with COPD and an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg, for the denominator, and claims/encounter data or medical record data for oxygen therapy prescription information for the numerator.

Explanation: According to the American Thoracic Society (ATS) and European Respiratory Society (ERS) COPD clinical practice guidelines, patients whose disease is stable on a full medical regimen, with an oxygen saturation level of $\leq 88\%$ or PaO₂ < 55 mmHg, should receive long-term oxygen therapy. The National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization advise that long-term administration of oxygen (> 15 hrs per day) to patients with chronic respiratory failure has been shown to increase survival. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and documentation of an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg, who have been prescribed long-term oxygen therapy. Two methods are provided to identify patients with prescribed long-term oxygen therapy: claims and medical record data. See “Denominator Subset” section below for further information on identifying patients with an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg.

Electronic Collection: The patient is numerator compliant if he or she has documentation of having received a prescription for long-term oxygen therapy (defined as > 15 hrs per day) during the reporting period as identified by claims data. Below is a list of codes to identify patients receiving long-term oxygen therapy.

CPT-II codes: 4030F

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of long-term oxygen therapy. This includes those patients with COPD and an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg who had one of the following:

1. Documentation indicating the date on which long-term oxygen therapy (defined as > 15 hours per day) was prescribed during the reporting period.
2. Dated documentation of a prescription for long-term oxygen therapy (defined as > 15 hrs per day) from another treating clinician.

The following is not acceptable documentation for long-term oxygen therapy:

1. Patient self-reporting

Denominator Subset: Patients aged 18-75 years with the domain denominator diagnosis (i.e., COPD) AND documentation of an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg. Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document. Two methods are provided to identify patients' oxygen saturation or PaO₂ level: claims and medical record data.

Electronic Collection: The patient is denominator compliant if he or she has documentation of an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg during the reporting period, as identified by claims data. Below is a list of eligible codes to identify O₂ Saturation $\leq 88\%$ or a PaO₂ ≤ 55 mmHg.

CPT-II Codes: 3035F

Medical Record Collection: The patient is denominator compliant if he or she has documentation in the medical record of an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg. This includes those patients with COPD who had one of the following:

1. Documentation indicating an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg during the reporting period.
2. Dated documentation of an oxygen saturation level of $\leq 88\%$ or a PaO₂ ≤ 55 mmHg during the reporting period from another treating clinician.

Frequency: Most recent prescription over the last 12 months from the last day of the reporting period.

Scoring: If denominator subset ≥ 25 patients, then Earned Points =
[numerator/denominator] x maximum available points for the measure

If denominator subset < 25 patients, then measure is not scored.

8. Pneumococcal Immunization:

Description: Percentage of patients aged 18 through 75 years old with COPD who received the pneumococcal vaccination.

Data source: Electronic data (visit, lab, encounter data or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims or medical record data for identification of patients with COPD for the denominator, and claims/encounter data or medical record data for pneumococcal vaccination information for the numerator.

Explanation: The Centers for Disease Control (CDC) Advisory Committee on Immunization Practices recommend that all patients with chronic diseases of the pulmonary system be vaccinated. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and documentation of having ever received the pneumococcal vaccine. See “Patient Eligibility Criteria” for further information on codes to identify patients with COPD.

Electronic Collection: The patient is numerator compliant if he or she has documentation of having ever received the pneumococcal vaccine as identified by claims data. Below is a list of codes to identify the administration of pneumococcal vaccine:

CPT-I codes: 90732

CPT-II codes: 1022F, 4040F

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of having ever received the pneumococcal vaccine. This includes those patients with COPD who had one of the following:

1. Documentation indicating the pneumococcal vaccine was administered to the patient during his or her lifetime.
2. Documentation of administration of the pneumococcal vaccine by another treating clinician during his or her lifetime.

The following is not acceptable documentation:

1. Patient self-reporting

Frequency: Most recent documentation over the lifetime of the patient.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

9. Influenza Immunization:

Description: Percentage of patients aged 18 through 75 years old with COPD who received the influenza vaccination, in the absence of contraindications.

Data source: Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims or medical record data for identification of patients with COPD for the denominator, and claims/encounter data or medical record data for influenza vaccination information for the numerator.

Explanation: According to the National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization, influenza vaccines can reduce serious illness and death by about 50% in patients with Chronic Obstructive Pulmonary Disease (COPD). It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of COPD and documentation of having received the influenza vaccine, in the absence of contraindications. Two methods are provided to identify patients documented influenza vaccine; claims and medical record data. See “Patient Eligibility Criteria” for further information on codes to identify patients with COPD.

Electronic Collection: The patient is numerator compliant if he or she has documented evidence of having received the influenza vaccine or contraindication to the influenza vaccine, as identified by claims data. This includes those patients with COPD who had one of the following:

1. Influenza vaccine administered during the reporting period.
2. Evidence of contraindication or previous adverse reaction to the influenza vaccine

Influenza Vaccine: The following codes may be used to identify the administration of the influenza vaccine:

ICD-9 codes: V04.81

CPT-I codes: 90656, 90658, 90660

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to the administration of the influenza vaccine:

ICD-9 Codes:

Egg allergy: 693.1, V15.03, 995.68

Adverse reaction to the influenza vaccine: 995.0 with E949.6, 995.1 with E949.6, and 995.2 with E949.6

Medical Record Collection: The patient is numerator compliant if he or she has documentation in the medical record of having received the influenza vaccine OR previous adverse reaction or contraindication to the influenza vaccine. This includes those patients with COPD who had one of the following:

1. Documentation indicating the date on which the influenza vaccine was administered to the patient during the reporting period.
2. Documentation of administration of the influenza vaccine by another treating clinician during the reporting period.
3. Documentation of diagnosis or medical treatment for one of the following indicating a contraindication to the administration of the influenza vaccine.
 - Egg allergy
 - Adverse reaction to the influenza vaccine

The following is not acceptable documentation for influenza vaccine:

1. Patient self-reporting

Frequency: Most recent documentation over the last 12 months from the last day of the reporting period.

Scoring: Earned Points = [numerator/denominator] x maximum available points for the measure

Patient Eligibility Criteria

An **eligible** COPD patient is one who meets **all three** criteria:

1. Is between 18 and 75 years of age.¹⁰
2. Has had a documented diagnosis of COPD (as defined in Table 1 below) for at least 12 months, from the last day of the reporting period.
3. Has been under the care of the applicant for at least 12 months. This is defined by documentation of two face-to-face visits for COPD care between the clinician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

There are two accepted data sources that can be used to identify patients with COPD: claims/encounter data and medical record data.

Claims/Encounter data: Patient is denominator compliant if he or she is aged 18-75 and has had at least 2 face-to-face encounters for COPD care, in an ambulatory setting: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months. See Table 1 below for further information on codes to identify patients with COPD.

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of COPD listed on the problem list AND has been under the care of the applicant for at least 12 months. See Table 1 below for further information on diagnoses to identify patients with COPD.

Exclusions: Patients in hospice or palliative care are excluded from the denominator. See Table 2 below for further information on codes to identify patients with exclusions.

Table 1: Codes to Identify a Patient with a Diagnosis of COPD

Diagnosis Codes
COPD
ICD-9 codes: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496

¹⁰ As of the last date of the reporting period. Patients known to be deceased should be excluded.

Table 2: Codes to Identify Patients with Exclusions

Diagnosis Codes
Hospice and Palliative Care ICD-9: V66.7 CPT: 99377, 99378

Relevant Medication Lists for COPD Care Measurement Set

Table 3: Short-Acting Inhaled Bronchodilators: β_2 Agonists and Anti-Muscarinics

Albuterol	Alupent	Atrovent	Bricanyl
Combivent	DuoNeb	Ipratropium Bromide	Levalbuterol
Levosalbutamol	Maxair	Maxair Autohaler	Metaproterenol
Piropbuterol	Proventil	Proventil HFA	Salbutamol
Terbutaline	Tiotropium	Ventolin	Ventolin Rotocaps
Xopenex			

Table 4: Long-Acting Inhaled Bronchodilators: β_2 Agonists and Anti-Muscarinics

Advair	Budesonide/Formoterol	Fluticasone/Salmeterol	Foradil
Salmeterol	Servent	Spiriva	Symbicort
Theophylline	Tiotropium Bromide		

Table 5: Inhaled Corticosteroids

Advair	Azmacort	Flovent Rotadisk	Qvar
Aerobid	Beclovent	Pulmicort	Vanceril
Aerobid-M	Flovent	Pulmicort Respules	Vanceril DS
Asmanex Twisthaler			

Table 6: Smoking Cessation Medications

Buproban Oral	Habitrol (TD)	Nicotine TD	NTS Step 1 TD
Bupropion SR	INTS Step 3 TD	Nicotine Transdermal TD	NTS Step 2 TD
Brupopion XL	Medic Nicotine TD	Nicotrol (PDR)	NTS Step 3 TD
Chantix (varenicline)	NicoDerm CQ	Nicotrol Inhaler (PDR)	Prostep TD
CVS NTS Step 1 TD	Nicoderm CQ TD	Nicotrol NS (PDR)	Wellbutrin
CVS NTS Step 2 TD	Nicoderm TD	Nicotrol NS Nasl	Zyban (PDR)
CVS NTS Step 3 TD	Nicotine Nasl	Nicotrol TD	Zyban Oral
Habitrol (PDR)	Nicotine Patches (PDR)	Nicotrol Td TD	

Minimum Patient Requirements

Applicants must abide by the minimum patient panel requirements as outlined below. Clinicians must elect and inform their data aggregator whether they are applying as an individual clinician or a medical practice. Clinicians are prohibited from applying as both individuals and part of a practice.

Individual clinician applicants: Individual clinician applicants must submit data on a minimum of 25 different eligible patients with COPD.

Medical practice applicants: For practice level applicants, the total number of COPD patients submitted must include:

- A minimum of 10 COPD patients per individual clinician
- A minimum practice average of 25 COPD patients per clinician

Example 1: Medical Practice A

- Clinician 1 has 25 eligible patients.
- Clinician 2 has 55 eligible patients.
- Clinician 3 has 10 eligible patients.
- Total number of eligible patients for Practice A is 90.
- Practice average per clinician for Practice A is 30.

Each clinician in Practice A meets the individual minimum of 10 COPD patients. Practice A also meets the minimum practice average of 25 COPD patients per clinician.

Example 2: Medical Practice B

- Clinician 1 has 25 eligible patients.
- Clinician 2 has 30 eligible patients.
- Clinician 3 has 7 eligible patients.
- Clinician 4 has 26 eligible patients.
- Total number of eligible patients for Practice B is 88.
- Practice average per clinician for Practice B is 22.

Clinician 3 in Practice B does not meet the individual minimum of 10 COPD patients. Additionally, Practice B does not meet the minimum practice average of 25 COPD patients per clinician. Clinician 3 and his or her patients will be removed from the assessment and the remaining clinicians (Clinicians 1, 2, and 4) will be scored as a practice, since they now have a practice average per clinician of 27 COPD patients.

Example 3: Medical Practice C

- Clinician 1 has 25 eligible patients.
- Clinician 2 has 55 eligible patients.
- Clinician 3 has 7 eligible patients.
- Total number of eligible patients for Practice C is 87.
- Practice average per clinician for Practice C is 29.

Clinician 3 does not meet the individual minimum of 10 eligible patients for practice level assessment. Since there are only 2 remaining eligible clinicians in this practice they will be scored as individuals. Each remaining clinician (Clinician 1 and Clinician 2) meets the individual clinician applicant minimum of 25 patients. Clinicians 1 and 2 can proceed with assessment as individuals.

APPENDICES

Appendix A: Audit Methodology

The PAO is responsible for conducting three levels of audit pertaining to applicant submissions for BTE COPD Care Recognition:

- Level 1: Data Aggregator (DA) Data Extraction code review
- Level 2: Data Validation (Load Summary)
- Level 3: Clinician Chart Audit

Level 1 Audit – Data Aggregator Data Extraction

The PAO will conduct an audit of each data aggregator’s COPD Care data extraction process prior to accepting applications. The PAO will review the code that the data aggregator is using to extract the clinician data and verify that all eligible patients are accurately included in the denominator. The DA must also provide the PAO with documentation of the code or logic used to extract numerator data to ensure that all data submitted is in accordance with BTE’s measures specifications. Each data aggregator needs to pass the extraction audit before numerator data is abstracted for submission to the PAO. This level of review will also be conducted biannually and upon any changes to the data aggregator data extraction code. Data aggregators are responsible for informing the PAO when any changes are made.

Data aggregators are required to supply the PAO with the following information in order for the PAO to certify the denominators and numerator data submitted by the data aggregator:

- Patient lists produced by following the clinical measures specifications and patient eligibility requirements outlined in this document
- Source code used to produce denominator lists
- Patient attribution methodology documentation
- Exclusion criteria
- Source code used to extract numerator data for each COPD Care measure

Level 2 Audit – Data Validation (Load Summary)

The PAO runs and provides the data aggregator with a file load summary for each file submission within 3 days of receipt of the file, ensuring that each data field contains a valid data value that meets the data field specifications and makes sense in relation to itself and related data fields. The load summary will identify which records contain incomplete or invalid data values

and designate them as errors or warnings. There is a zero tolerance policy for errors on required data fields and data values that do not meet data field specifications. It is the data aggregator's responsibility to correct or remove the problematic data identified as errors and resubmit the file to the PAO. Files will not be rejected for invalid data values in clinical measures fields, but will be counted as a numerator miss for scoring purposes (with the exception of the poor control measures for which it will be counted as a numerator hit). Invalid data values in clinical measures fields are however identified as warnings in the load summary to the data aggregator, which is responsible for reporting this information back to the applicant in order to improve data collection.

The following data validation checks are used in creating the load summary provided to the data aggregator after each data file submission to identify any missing or invalid data values:

Data Validation Checks for Clinical Measures Data Fields			
Data field	Data field specifications	Acceptable Data Value Range	Notes
Resp. Clinician ID	(Required Field) Alphanumeric value up to 26 characters in length		
Chart ID	(Required Field) Alphanumeric value		
Last Visit Date	(Required Field) Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
Patient Year/Date of Birth	(Required Field) Numeric value: YYYY or MM/DD/YYYY	(Current Year/Date -75 years) - (Current Year/Date -18 years)	Current year/date anchored to last day of reporting period
Spirometry Evaluation Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
Physical Inability to Perform Spirometry	Alpha value	"YES", "NO"	
Exacerbation Count	Numeric value		
Last Exacerbation Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
FEV1/FVC <70%	Alpha value	"YES", "NO"	
COPD Symptom(s) Present	Alpha value	"YES", "NO"	

Inhaled Bronchodilator Medication Prescription Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
Inhaled Bronchodilator Medication Contraindications	Alpha value	“YES”, “NO”	
Inhaled Corticosteroid Medication Prescription Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
Inhaled Corticosteroid Medication Contraindications	Alpha value	“YES”, “NO”	
Smoking Status	Alpha value	“SMOKER”, “NON-SMOKER”, “NOT KNOWN”	
Smoking Status Assessment Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period..</i>	
Smoking Cessation and/or Treatment Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
FEV1 < 40% of predicted value	Alpha value	“YES”, “NO”	
Respiratory Failure Diagnosis	Alpha value	“YES”, “NO”	
Right Heart Failure Diagnosis	Alpha value	“YES”, “NO”	
Oxygen Saturation Assessment Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
Long-term Oxygen Prescription Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	
Oxygen Saturation ≤ 88% or PaO2 ≤ 55mmHg	Alpha value	“YES”, “NO”	
Pneumococcal Vaccination	Alpha value	“YES”, “NO”	
Influenza Vaccination Date	Numeric value: MM/DD/YYYY	01-12/01-31/2000-Current Year <i>Date submitted is INVALID if it is a future date based upon the last day of the reporting period.</i>	

Influenza Vaccination Contraindications	Alpha value	“YES”, “NO”	
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Data Validation Checks for Clinician Identifier Data Fields			
Data field	Data field specifications	Acceptable Data Value Range	Notes
Resp. Clinician ID	(Required field) Alphanumeric value up to 26 characters in length		
NPI	(Required field) NPI: Numeric value 10 characters in length		
DEA Number	Alphanumeric value 9 characters in length	First letter must be “A”, “B”, “F” or “M”.	
Medical License Number	Alphanumeric value up to 10 characters in length		
Clinician Last Name	(Required field) Alpha value up to 50 characters in length		Leading abbreviations like “DR” or “Dr” must be dropped. Generational suffixes (e.g., Sr, Jr, II, III, etc.) should be included in the Last Name field without any punctuation. Suffix should be separated from the last name by a blank (e.g., Smith Jr).
Clinician First Name	(Required field) Alpha value up to 50 characters in length		
Clinician Middle Name	Alpha value up to 30 characters in length		
Clinician Degree	(Required field) Numeric value	“01”, “02”, “03”, “04”.	01 = M.D. 02 = D.O. 03 = N.P. 04 = P.A.
Clinician/ Practice Address 1	(Required field) Alphanumeric value up to 100 characters in length		Should include the street name and number only.
Clinician/ Practice Address 2	Alphanumeric value up to 100 characters in length		Should include additional information such as suite, room, floor, building, etc.
Clinician/ Practice City	(Required field) Alpha value up to 100 characters in length		
Clinician/ Practice State	(Required field) Alpha value 2	U.S. Postal Service abbreviation representing the state of the	

	characters in length	clinician's or practice's address	
Clinician/ Practice Zip Code	(Required field) Numeric value 5 (#####), 9 (#####) or 10 characters (#####- ####) in length		
Clinician/ Practice Phone	Alphanumeric value up to 30 characters in length		Area code is required. Telephone number may be entered with or without punctuation.
Clinician Date of Birth	Numeric value: MM/DD/YYYY		
Clinician Gender	Alpha value	"F", "M", "U"	F = Female M = Male U = Unknown
Clinician Specialty	Numeric value	01-29	01 = Allergy/Immunology 02 = Cardiology 03 = Critical Care Services 04 = Dermatology 05 = Endocrinology 06 = Gastroenterology 07 = Gen/Fam Practice 08 = Geriatric Medicine 09 = Hematology 10 = Infectious Disease 11 = Internal Medicine 12 = Nephrology 13 = Neurology 14 = Neurosurgery 15 = Obstetrics/Gynecology 16 = Occ. Medicine 17 = Oncology 18 = Ophthalmology 19 = Orthopedics 20 = Otolaryngology 21 = Pediatrics 22 = Phys/Rehab Medicine 23 = Psychiatry 24 = Psychopharmacology 25 = Pulmonary Medicine 26 = Rheumatology 27 = Surgery 28 = Urology 29 = Other – not listed
Practice ID	(Required field for practice applicants only) Alphanumeric value up to 26 characters in length		
Practice Name	(Required field for practice applicants		

	<i>only</i> Alpha value up to 100 characters in length		
<i>Data Submission through CCHIT/ Meaningful Use certified System</i>	Alpha value	“Y”, “N”	Y = Yes N = No Blank fields will default to “N”.
<i>Full Patient Panel</i>	Alpha value	“Y”, “N”	Y = Yes N = No Blank fields will default to “N”.

Level 3 Audit – Clinician Chart

BTE reserves the right to complete an audit of any individual or practice application for recognition. PAOs or specified local organization subcontractors conduct audits of at least 5 percent of applicants from each data aggregator partner each year. COPD Care audits may be completed by fax, mail, electronically or on site, as determined by the PAO. Any data identified by the PAO as irregular through a pre-determined list of chart audit triggers is subject to audit. The remainder of the 5 percent is selected through a random sampling methodology. Once selected for an audit, an applicant submitting data continuously cannot be reselected for a subsequent audit through the random sampling methodology for a period of at least one year.

The PAO will notify the data aggregator which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission.

The following chart identifies the components of the clinician chart audit depending on the data source of the patient information (whether the information is housed in an electronic medical record (EMR), patient registry or paper chart).

<i>Patient data source / Audit Component</i>	<i>EMR/EHR</i>	<i>Registry</i>	<i>Paper Chart</i>
<i>1. Verification of data submitted in comparison to data in patient chart</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>
<i>2. Verification of patient selection for entry in electronic system (denominator certification)</i>	<i>N</i>	<i>Y</i>	<i>Y</i>

For each applicant selected for audit, the PAO will identify and notify the data aggregator of 25 charts selected for review. For those clinicians chosen for audit due to an audit trigger, the patient charts containing the irregular data identified are included in the review. For all other audits the patient charts are identified through a random sampling methodology.

The auditor reviews all data fields submitted to the PAO in the clinical measures data file for each patient chart selected. The auditor is required to audit all the way through the 25 charts regardless of early findings to determine the final audit score. Errors are counted at the data field level. Applicants with 85 percent or greater accuracy on the audit will receive a Pass for the audit, and final recognition status will be determined. Failure to pass an audit results in no further consideration for the COPD Care Recognition program for a pre-determined period of time from the date of submission of the application. Applicants with an audit score of 50 to 84 percent will be prohibited from resubmitting data to a PAO for a period of six months. Applicants with an audit score less than 50 will be prohibited from resubmitting data to a PAO for assessment for a period of two years.

Audit Score	Audit Determination	Lockout from Reconsideration
85-100	Pass	None
50-84	Fail	6 months
0-49	Fail	2 years

Applicants with an audit determination of “Fail” are automatically subject to re-audit upon their next data submission to any PAO after the completion of the lockout period. All audit decisions are considered final.

Detailed audit processes and procedures will be provided to data aggregators and selected applicants by the PAO.

Appendix B: Sample Results Report

COLOR KEY

Light Orange = Those values which are numerator compliant for each of the process measures

BTE COPD Care Recognition Sample Data Set Calculation

Clinical Measures	<u>Spirometry Evaluation</u>	<u>Inhaled bronchodilator therapy</u>	<u>Smoking Cessation, Advice & Treatment</u>	<u>COPD Exacerbations</u>	<u>COPD Exacerbation Therapy</u>	<u>O2 sat Assess</u>	<u>O2 Therapy</u>	<u>Pneumo Vaccine</u>	<u>Flu Vaccine</u>
Patient 1	YES	NO	NO	YES	YES	YES	NO	YES	YES
Patient 2	NO	YES	YES	NO	YES	NO	NO	NO	YES
Patient 3	YES	YES	YES	YES	NO	YES	YES	YES	YES
Patient 4	YES	NO	YES	YES	NO	YES	YES	YES	YES
Patient 5	NO	YES	YES	NO	YES	YES	YES	NO	YES
Patient 6	YES	YES	YES	YES	NO	YES	NO	YES	NO
Patient 7	YES	YES	NO	YES	YES	YES	YES	YES	YES
Patient 8	NO	NO	YES	NO	YES	NO	YES	YES	YES
Patient 9	YES	NO	YES	YES	NO	YES	NO	YES	YES
Patient 10	YES	NO	YES	YES	YES	YES	NO	YES	YES
Patient 11	YES	YES	NO	YES	YES	NO	NO	YES	NO
Patient 12	YES	YES	YES	YES	YES	YES	YES	YES	YES
Patient 13	NO	YES	YES	NO	NO	YES	YES	YES	NO
Patient 14	YES	YES	YES	YES	YES	YES	YES	YES	YES
Patient 15	YES	NO	YES	YES	YES	NO	YES	NO	YES
Patient 16	YES	YES	YES	NO	NO	YES	YES	YES	YES
Patient 17	YES	YES	YES	YES	NO	YES	YES	YES	YES
Patient 18	YES	NO	NO	YES	YES	YES	YES	YES	YES
Patient 19	NO	YES	YES	NO	YES	NO	YES	YES	NO
Patient 20	YES	YES	YES	YES	YES	YES	NO	YES	NO
Patient 21	YES	YES	YES	YES	NO	YES	YES	YES	YES
Patient 22	YES	NO	YES	YES	YES	YES	YES	YES	YES
Patient 23	YES	NO	NO	NO	YES	NO	YES	NO	YES
Patient 24	YES	YES	YES	YES	NO	YES	NO	YES	YES
Patient 25	YES	YES	YES	YES	YES	YES	NO	YES	YES

Level I Recognition

Clinical Measures

Lung Function/Spirometry Evaluation
 Inhaled Bronchodilator Therapy
 Smoking Status and Cessation Advice & Tx
 Assessment of COPD Exacerbations
 COPD Exacerbation Therapy
 Assessment of O2 saturation
 Long-term O2 therapy
 Pneumococcal Immunization
 Influenza Immunization

TOTAL POINTS
PERCENTAGE OF TOTAL POINTS NEEDED TO
ACHIEVE RECOGNITION

Threshold	Minimum Criteria	Sample Meeting Threshold	Maximum Available Points	Points Earned
N/A	N/A	20/25 = 80%	10	8.0
N/A	N/A	16/25 = 64%	10	6.4
N/A	N/A	20/25 = 80%	20	16.0
N/A	N/A	18/25 = 72%	10	7.2
N/A	N/A	16/25 = 64%	10	6.4
N/A	N/A	19/25 = 76%	10	7.6
N/A	N/A	16/25 = 64%	15	9.6
N/A	N/A	23/25 = 92%	5	4.6
N/A	N/A	20/25 = 80%	10	8.0
			100	72.2
			60	60

Level II Recognition

Clinical Measures

Lung Function/Spirometry Evaluation
 Inhaled Bronchodilator Therapy
 Smoking Status and Cessation Advice & Tx
 Assessment of COPD Exacerbations
 COPD Exacerbation Therapy
 Assessment of O2 saturation
 Long-term O2 therapy
 Pneumococcal Immunization
 Influenza Immunization

TOTAL POINTS
PERCENTAGE OF TOTAL POINTS NEEDED TO
ACHIEVE RECOGNITION

Threshold	Minimum Criteria	Sample Meeting Threshold	Maximum Available Points	Points Earned
N/A				
N/A	N/A	80% x 64% = 51.2%	20	10.24
N/A	N/A	20/25 = 80%	20	16.0
N/A				
N/A	N/A	72% x 64% = 46.1%	20	9.22
N/A				
N/A	N/A	76% x 64% = 48.6%	25	12.16
N/A	N/A	21/25 = 84%	5	4.6
N/A	N/A	17/25 = 68%	10	8.0
			100	60.22
			60	60

Level III Recognition

Clinical Measures

Lung Function/Spirometry Evaluation
 Inhaled Bronchodilator Therapy
 Smoking Status and Cessation Advice & Tx
 Assessment of COPD Exacerbations
 COPD Exacerbation Therapy
 Assessment of O2 saturation
 Long-term O2 therapy
 Pneumococcal Immunization
 Influenza Immunization

TOTAL POINTS
PERCENTAGE OF TOTAL POINTS NEEDED TO
ACHIEVE RECOGNITION

<u>Threshold</u>	<u>Minimum Criteria</u>	<u>Sample Meeting Threshold</u>	<u>Maximum Available Points</u>	<u>Points Earned</u>
N/A				
N/A	N/A	80% x 64% = 51.2%	20	10.24
N/A	N/A	20/25 = 80%	20	16.0
N/A				
N/A	N/A	72% x 64% = 46.1%	20	9.22
N/A				
N/A	N/A	76% x 64% = 48.6%	25	12.16
N/A				
N/A	N/A	84% x 68% = 57.1%	15	8.57
			100	56.19
			60	60