

# **Clinician Guide: Bridges to Excellence**

## **Coronary Artery Disease**

### **Care Recognition Program**

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## Table of Contents

<b>INTRODUCTION</b>	<b>2</b>
<b>OVERVIEW</b>	<b>3</b>
<b>CLINICIAN BENEFITS OF RECOGNITION</b>	<b>4</b>
<b>BACKGROUND ON THE MEASUREMENT CRITERIA</b>	<b>4</b>
<b>RECOGNITION PROGRAM STRUCTURE</b>	<b>6</b>
<b>WHAT RECOGNITION REQUIRES</b>	<b>7</b>
TABLE 1: CAD CARE LEVEL I MEASURES, PERFORMANCE CRITERIA AND SCORING	8
TABLE 2: CAD CARE LEVEL II MEASURES, PERFORMANCE CRITERIA AND SCORING	9
TABLE 3: CAD CARE LEVEL III MEASURES, PERFORMANCE CRITERIA AND SCORING	10
<b>ELIGIBILITY FOR CLINICIAN PARTICIPATION</b>	<b>11</b>
<b>BTE CAD CARE RECOGNITION CLINICAL MEASURES</b>	<b>12</b>
BLOOD PRESSURE CONTROL	13
BLOOD PRESSURE SUPERIOR CONTROL	15
LIPID CONTROL	17
LIPID SUPERIOR CONTROL	19
EVALUATION OF ACTIVITY LEVEL AND ANGINAL SYMPTOMS	21
TOBACCO STATUS AND CESSATION ADVICE AND TREATMENT	22
COMPLETE LIPID PROFILE	24
LDL DRUG THERAPY	26
USE OF ASPIRIN OR OTHER ANTIPLATELET THERAPY	28
ACE-I/ARB THERAPY	30
PERSISTENT BETA BLOCKER TREATMENT AFTER AN ACUTE MYOCARDIAL INFARCTION (AMI)	33
BETA BLOCKER TREATMENT WITH A PRIOR ACUTE MYOCARDIAL INFARCTION (AMI)	36
BODY MASS INDEX	39
<b>PATIENT ELIGIBILITY CRITERIA</b>	<b>41</b>
TABLE 1: CODES TO IDENTIFY A PATIENT WITH A DIAGNOSIS OF CORONARY ARTERY DISEASE	42
TABLE 2: CODES/NOTATIONS TO IDENTIFY PATIENTS WITH EXCLUSIONS	42
<b>APPLYING FOR RECOGNITION</b>	<b>44</b>
<b>DURATION OF RECOGNITION</b>	<b>45</b>
CHANGES IN RECOGNITION LEVELS	46
<b>REPORTING RESULTS TO HCI3 AND ITS PARTNERS</b>	<b>48</b>
<b>TERMS OF RECOGNITION</b>	<b>48</b>

## Introduction

The Health Care Incentives Improvement Institute (HCI3) is excited to offer the opportunity for clinicians to participate in the Bridges to Excellence (BTE) recognition program and 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. HCI3'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 BTE incentives through participating health plans, employers and coalitions.

HCI3 has partnered with CECity as the Performance Assessment Organization (PAO) for all Bridges to Excellence (BTE) Recognition Programs submitted electronically or direct data submission through CECity's cloud-based MedConcert® platform. Clinicians will be provided with real-time performance assessments, feedback reports, and access to dynamically linked improvement tools and resources to help them close performance gaps.

### **About CECity**

Pittsburgh, PA-based CECity is the health care industry's leading platform-as-a-service provider of cloud-based applications and distribution networks for performance improvement, quality reporting, and lifelong learning. Health care professionals and healthcare organizations, including QIOs, health plans, hospitals, chain pharmacies, professional medical certifying and licensing boards, publishers, professional societies, and academic medical centers, count on CECity to power their solutions for continuous performance improvement, performance assessment, clinical registries, professional development, patient safety, medication adherence, care coordination, population health informatics, and quality reporting.

### **About MedConcert®**

MedConcert, healthcare's first social cloud platform for continuous performance improvement and lifelong learning, provides one convenient, integrated solution to help all stakeholders answer the question, "How Do We Improve?" Through MedConcert, providers, practices, and healthcare organizations engage in building secure social networks to share best practices and connect in meaningful ways to address a variety of critical needs driven by healthcare reform. Through the MedConcert App Store, individuals and health systems access a wide variety of applications for pay for performance, performance dashboards, population health management, clinical integration, performance improvement, professional certification, patient surveys, care coordination, patient registries, enterprise-wide benchmarking, and much more.

## Overview

The Health Care Incentive Improvement Institute 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 providers 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 Coronary Artery Disease (CAD) Care Recognition Program is a BTE Clinician Recognition Program intended to identify clinicians who deliver high-value coronary artery disease 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), cardiologists, nephrologists, and others —for treatment and management of their coronary artery disease. 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 CAD Care requirements assess clinical measures representing standards of care for patients with coronary artery disease. HCI3 believes that the CAD Care Recognition program has the potential to significantly improve the quality of care experienced by patients with coronary artery disease and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn CAD Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with coronary artery disease. HCI3 has partnered with an objective third-party independent Performance Assessment Organization (PAO) to evaluate clinician data based on standard measures to publicly recognize those that meet the BTE CAD Care performance thresholds. Those clinicians not meeting the BTE CAD Care performance thresholds remain anonymous to BTE and its health plan licensees. BTE's CAD Care Recognition 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 HCI3's web site [www.hci3.org](http://www.hci3.org), 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 criteria and take steps to improve quality of care.
- Where applicable, clinicians can establish eligibility for pay-for-performance bonuses or differential reimbursement or other incentives from payers and health plans.
- Clinicians who achieve CAD Care Recognition by submitting data through a CCHIT-certified<sup>1</sup> 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 measures***<sup>2</sup>

1. Blood pressure (BP) control
2. LDL control
3. Complete lipid profile
4. Evaluation of activity level and anginal symptoms
5. LDL drug therapy
6. Use of aspirin or other antiplatelet therapy
7. ACE inhibitor/ARB therapy

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<sup>1</sup> 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/>.

<sup>2</sup> *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 a specified percentage of the sample meeting the requirement (numerator) for the measure (pass/fail).

8. Documented Body Mass Index
9. Documentation of tobacco status and cessation advice and treatment
10. Betablocker treatment after a heart attack

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

## Recognition Program Structure

Given the evidence in the literature advocating the creation of clinician quality reward programs that promote continuous quality improvement amongst its participants, the BTE CAD 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 cardiac measures (listed above).

*Level I:* Focuses on a clinician-centric<sup>3</sup> view of measurement, looking at individual metrics summed to produce a composite score, with the inclusion of “minimum” performance requirements for all intermediate outcome control measures, both poor and superior (i.e., BP control and LDL control). Thresholds have been set to focus on above average performance.

*Level II:* Focuses on a combination of clinician and patient-centric<sup>4</sup> measurements. Level II includes the measurement of individual metrics summed to produce a composite score, with the inclusion of “minimum” performance requirements for all intermediate outcome control measures. Also looks at the defect rate of care delivery across poor control 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 superior control 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.

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<sup>3</sup> Clinician-centric refers to performance assessment involving evaluation of clinician performance based upon discrete measures (i.e. BP <140/90), 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.”

<sup>4</sup> 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 (i.e. combining BP <140/90 and LDL <100mg/dl 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 CAD Care Recognition, clinician applicants must submit medical record data that demonstrates they meet BTE's CAD Care performance requirements. Each measure has an assigned maximum available point value; the total of all the measures 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 Organization (PAO) 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 submit data sufficient to score 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.

To achieve points for the discrete intermediate outcomes control measures (i.e., BP, LDL), as well as some process measures, applicants must meet certain minimum criteria. Applicants who fail to meet the minimum criteria on a measure will receive 0 points for that measure. 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: CAD 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, with the inclusion of minimum requirements for intermediate outcome control measures (i.e., BP control and LDL control). Thresholds have been set to focus on above average performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
<i>Poor Control Measures<sup>5</sup></i>			
Blood Pressure Control	≥ 145/95	≤ 45% of pts in sample	20
LDL Control	≥ 130 mg/dl	≤ 40% of pts in sample	20
<i>Superior Control Measures</i>			
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	10
LDL Superior Control	< 100 mg/dl	≥ 25% of pts in sample	10
<i>Process Measures</i>			
Evaluation of Activity and Anginal Symptoms	N/A	≥ 65% of pts in sample	5
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	5
Complete Lipid Profile	N/A	N/A	2.5
LDL Drug Therapy	N/A	N/A	2.5
Use of Aspirin or Other Antiplatelet Therapy	N/A	≥ 50% of pts in sample	5
ACE Inhibitor/ARB Therapy <sup>6</sup>	N/A	≥ 75% of pts in sample	7.5
Beta-Blocker Treatment After a Heart Attack <sup>6</sup>	N/A	≥ 75% of pts in sample	7.5
Continued Beta-Blocker Therapy <sup>6</sup>	N/A	≥ 75% of pts in sample	5
Body Mass Index	N/A		0
<b>Total Points</b>			100
<b>Percentage of Total Points Needed to Achieve Recognition</b>			60

<sup>5</sup> Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by  $(1 - \text{the percentage of patients meeting the threshold}) \times \text{the maximum points for that measure}$ .

<sup>6</sup> 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: CAD 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, with the inclusion of “minimum” requirements for all intermediate outcome control measures. Also looks at the defect rate of care delivery across poor control measures on a per patient basis. Thresholds have been set to focus on very good performance.

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
<i>Poor Control Composite Measure<sup>5</sup></i>			
Blood Pressure Control	≥ 145/95	N/A	40
LDL Control	≥ 130 mg/dl		
<i>Superior Control Measures</i>			
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	10
LDL Superior Control	< 100 mg/dl	≥ 25% of pts in sample	10
<i>Process Measures</i>			
Evaluation of Activity and Anginal Symptoms	N/A	≥ 65% of pts in sample	5
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	5
Complete Lipid Profile	N/A	N/A	2.5
LDL Drug Therapy	N/A	N/A	2.5
Use of Aspirin or Other Antiplatelet Therapy	N/A	≥ 50% of pts in sample	5
ACE Inhibitor/ARB Therapy <sup>6</sup>	N/A	≥ 75% of pts in sample	7.5
Beta-Blocker Treatment After a Heart Attack <sup>6</sup>	N/A	≥ 75% of pts in sample	7.5
Continued Beta-Blocker Therapy <sup>6</sup>	N/A	≥ 75% of pts in sample	5
Body Mass Index	N/A		0
<b>Total Points</b>			100
<b>Percentage of Total Points Needed to Achieve Recognition</b>			60

<sup>5</sup> Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by (1 – the percentage of patients meeting the threshold) x the maximum points for that measure.

<sup>6</sup> 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 3: CAD 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 poor control and superior control 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	Criteria	Maximum Points
<i>Poor Control Composite Measure<sup>5</sup></i>			
Blood Pressure Control	≥ 145/95	N/A	40
LDL Control	≥ 130 mg/dl		
<i>Superior Control Composite Measure</i>			
Blood Pressure Superior Control	< 140/90	N/A	20
LDL Superior Control	< 100 mg/dl		
<i>Process Measures</i>			
Evaluation of Activity and Anginal Symptoms	N/A	≥ 65% of pts in sample	5
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	5
Complete Lipid Profile	N/A	N/A	2.5
LDL Drug Therapy	N/A	N/A	2.5
Use of Aspirin or Other Antiplatelet Therapy	N/A	≥ 50% of pts in sample	5
ACE Inhibitor/ARB Therapy <sup>6</sup>	N/A	≥ 75% of pts in sample	7.5
Beta-Blocker Treatment After a Heart Attack <sup>6</sup>	N/A	≥ 75% of pts in sample	7.5
Continued Beta-Blocker Therapy <sup>6</sup>	N/A	≥ 75% of pts in sample	5
Body Mass Index	N/A		0
<b>Total Points</b>			100
<b>Percentage of Total Points Needed to Achieve Recognition</b>			60

<sup>5</sup> Poor control measures, both discrete and composite, are measures of poor care. A lower percentage is

representative of good care. The number of points awarded to the applicant for a poor control measure is calculated by  $(1 - \text{the percentage of patients meeting the threshold}) \times \text{the maximum points for that measure}$ .

<sup>6</sup> 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.

## **Eligibility for Clinician Participation**

Clinicians may apply for BTE CAD 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. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.).
- Applicants must provide continuing care for patients with coronary artery disease 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 clinician practicing in any setting who provides continuing care for patients with coronary artery disease<sup>7</sup>.

### ***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.

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<sup>7</sup> **Eligible Coronary Artery Disease patients** are 18-75 years of age, with a documented diagnosis of coronary artery disease (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 coronary artery disease 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.

## **BTE CAD Care Recognition Clinical Measures**

### **Evaluation Program Title: Coronary Artery Disease Care Recognition Program**

#### **Clinical Measures**

Clinical measures are specific 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 patients in the applicant's eligible patients (domain 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 a clinical measure.

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

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## ***Blood Pressure Control:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who had most recent blood pressure in poor control (greater than or equal to 145/95 mmHg).

**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 coronary artery disease (CAD) for the denominator, and medical record data for blood pressure information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommend treatment for patients with a BP  $\geq$  145/95 mmHg.

This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and most recent systolic blood pressure measurement of  $\geq$  145 mmHg OR diastolic blood pressure of  $\geq$  95 mmHg. See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD. The steps below should be followed to determine the representative blood pressure reading.

1. *Identify the most recent visit to the doctor’s office or clinic in which a BP reading was noted.* BP reading is acceptable if representative BP was obtained during a visit to the clinician’s office or non-emergency outpatient facility, such as clinic or urgent care center.
2. *Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record.* If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The patient is numerator compliant if the most recent systolic blood pressure measurement is  $\geq$  145 mmHg or missing, OR the most recent diastolic blood pressure measurement is  $\geq$  95 mmHg or missing, OR if the BP reading was not done during the reporting period. The patient is NOT numerator compliant if the most recent systolic blood pressure measurement during the reporting period is  $<$ 145 mmHg AND the most recent diastolic blood pressure measurement is  $<$ 95 mmHg.

The following are not acceptable forms of documentation of blood pressure:

1. Use of terms “VS within normal limits,” “VS WNL,” or “Vital signs normal”
2. BP measurements obtained on the same day as a diagnostic or surgical procedure or at an emergency room visit
3. Patient self-reporting

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

**Scoring:** If [numerator/denominator]  $\leq$  minimum criteria, then Earned Points =  $[1 - (\text{numerator/denominator})] \times$  maximum available points for the measure

If [numerator/denominator]  $>$  minimum criteria, then Earned Points = 0

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## ***Blood Pressure Superior Control:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who had most recent blood pressure in superior control (less than 140/90 mmHg).

**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 coronary artery disease (CAD) for the denominator, and medical record data for blood pressure information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommend a blood pressure management target of < 140/90 mmHg for patients with no coexisting conditions.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and most recent systolic blood pressure measurement of < 140 mmHg AND diastolic blood pressure of < 90 mmHg. See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD. The steps below should be followed to determine the representative blood pressure reading.

1. *Identify the most recent visit to the doctor’s office or clinic in which a BP reading was noted.* BP reading is acceptable if the representative BP was obtained during a visit to the clinician’s office or non-emergency outpatient facility, such as clinic or urgent care center.
2. *Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record.* If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The patient is numerator compliant if the most recent systolic blood pressure measurement during the reporting period is < 140 mmHg AND the most recent diastolic blood pressure measurement during the reporting period is <90 mmHg. The patient is NOT numerator compliant if the most recent systolic blood pressure measurement is  $\geq 140$  mmHg or missing, OR the most recent diastolic blood pressure measurement is  $\geq 90$  mmHg or missing, OR if the BP reading was not done during the reporting period.



The following are not acceptable forms of documentation of blood pressure:

1. Use of terms “VS within normal limits,” “VS WNL,” or “Vital signs normal”
2. BP measurements obtained on the same day as a diagnostic or surgical procedure or at an emergency room visit
3. Patient self-reporting

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

**Scoring:** If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator]  $<$  minimum criteria, then Earned Points = 0

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## ***Lipid Control:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who had most recent LDL-C level in poor control (greater than or equal to 130 mg/dl).

**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 coronary artery disease (CAD) for the denominator, and laboratory or medical record data for LDL-C test information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommend treatment for patients with an LDL-C level of  $\geq 130$  mg/dl.

This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care). It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and most recent LDL-C level  $\geq 130$  mg/dl. See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD.

***Electronic Collection:*** The patient is numerator compliant if the laboratory result of the most recent LDL-C test is  $\geq 130$  mg/dl, is missing, or if the test was not done during the reporting period. The patient is NOT numerator compliant if the laboratory result of the most recent LDL-C test during the reporting period is  $< 130$  mg/dl.

***Medical Record Collection:*** The patient is numerator compliant if the result of the most recent LDL-C test is  $\geq 130$  mg/dl, is missing, or if the test was not done during the reporting period. The patient is NOT numerator compliant if the result of the most recent LDL-C test during the reporting period is  $< 130$  mg/dl.

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are  $\leq 400$  mg/dl

$$\text{LDL-C} = (\text{total cholesterol}) - (\text{HDL}) - (\text{Triglycerides}/5)$$

If the triglycerides are > 400 mg/dl and LDL-C levels cannot be calculated using the Friedewald equation, LDL-C levels should be entered as a value of 500 and the date of the test documented.

The following is not acceptable documentation of LDL-C test results:

1. LDL-to-HDL ratio
2. Patient self-reporting

**Frequency:** Most recent test result over the last 12 months from the last day of the reporting period.

**Scoring:** If [numerator/denominator] ≤ minimum criteria, then Earned Points = [1 – (numerator/denominator)] x maximum available points for the measure

If [numerator/denominator] > minimum criteria, then Earned Points = 0

### ***Lipid Superior Control:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who had most recent LDL-C level in superior control (less than 100 mg/dl).

**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 coronary artery disease (CAD) for the denominator, and laboratory or medical record data for LDL-C test information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommends a lipid management target LDL-C < 100 mg/dl.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and most recent LDL-C level < 100 mg/dl. See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD.

***Electronic Collection:*** The patient is numerator compliant if the laboratory result of the most recent LDL-C test during the reporting period is < 100 mg/dl. The patient is NOT numerator compliant if the laboratory result of the most recent LDL-C test is ≥ 100 mg/dl, is missing, or if the test was not done during the reporting period.

***Medical Record Collection:*** The patient is numerator compliant if the result of the most recent LDL-C test during the reporting period is < 100 mg/dl. The patient is NOT numerator compliant if the result of the most recent LDL-C test is ≥ 100 mg/dl, is missing, or if the test was not done during the reporting period.

At a minimum, documentation in the medical record must include a note indicating the date on which the LDL-C test was performed and the result. LDL-C levels may be calculated from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are ≤ 400 mg/dl:

$$\text{LDL-C} = (\text{total cholesterol}) - (\text{HDL}) - (\text{Triglycerides}/5)$$

If the triglycerides are > 400 mg/dl and LDL-C levels cannot be calculated using the Friedewald equation, LDL-C levels should be entered as a value of 500 and the date of the test documented.

The following is not acceptable documentation of LDL-C test results:

1. LDL-to-HDL ratio
2. Patient self-reporting

**Frequency:** Most recent test result over the last 12 months from the last day of the reporting period.

**Scoring:** If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points =  
[numerator/denominator] x maximum available points for the measure

If [numerator/denominator]  $<$  minimum criteria, then Earned Points = 0

### ***Evaluation of Activity Level and Anginal Symptoms:***

**Description:** Percentage of patients aged 18 through 75 years with a diagnosis of coronary artery disease (CAD) who were evaluated for both level of activity and anginal symptoms.

**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 coronary artery disease (CAD) for the denominator, and medical record data for activity level and anginal symptoms information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with chronic stable angina recommend regular assessment of patients' anginal symptoms and levels of activity. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and documentation of evaluation for both level of activity and anginal symptoms. See "Patient Eligibility Criteria" for further information on codes to identify patients with CAD.

***Medical Record Collection:*** A patient is numerator compliant if the medical record includes dated documentation of one of the following during the reporting period:

1. The patient's level of activity and anginal symptoms
2. Grading of the patient's angina using the Canadian cardiovascular society classification system
3. Patient completed symptom and/or activity questionnaire (e.g. Seattle Angina Questionnaire)

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

**Scoring:** If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator]  $<$  minimum criteria, then Earned Points = 0

### ***Tobacco Status and Cessation Advice and Treatment:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who have documentation of tobacco status, and if a tobacco user, 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 pharmacy or medical record data for identification of patients with coronary artery disease (CAD) for the denominator, and medical record data for documentation of tobacco status, and if a tobacco user, pharmacy or medical record data for documentation of cessation counseling or treatment information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommend inquiring on patients' tobacco status and tobacco cessation and counseling intervention when applicable. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and documentation of tobacco status, and if a tobacco user, date of cessation counseling or treatment. See "Patient Eligibility Criteria" for further information on codes to identify patients with CAD.

***Electronic Collection:*** The patient is numerator compliant if he or she has tobacco status documented (see Medical Record Collection below) AND if tobacco user, 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;

**CPT II:** G0436, G0437, 100F, 1032F, 1033F, 1034F, 1035F, 1036F  
**HCPCS Codes:** S9453

***Medical Record Collection:*** The patient is numerator compliant if he or she has tobacco status documented AND if a tobacco user, 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 tobacco cessation
4. Drug therapy

For a list of numerator compliant medications, see Table 3 under “Relevant Medications Lists for CAD Care 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-tobacco user, the patient is NOT numerator compliant if:

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

If the patient is a tobacco user, the patient is NOT numerator compliant if:

1. His or her tobacco status documentation is missing  
OR
2. His or her tobacco status was not asked  
OR
3. His or her documentation on receiving cessation counseling and/or treatment is missing  
OR
3. 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-tobacco user: most recent tobacco status.

If tobacco user: most recent 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



## ***Complete Lipid Profile:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who had a full lipid profile completed.

**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 coronary artery disease (CAD) for the denominator, and laboratory or medical record data for lipid profile information for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommend routine lipid profile which should include total cholesterol, high-density lipoprotein (HDL-C), low-density lipoprotein (LDL-C), and triglycerides. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and documentation of full lipid profile completed. A full lipid profile includes all of the following:

1. Total serum Cholesterol (TC)
2. Serum Triglycerides (TRIG)
3. High- Density Lipoprotein (HDL)
4. Low- Density Lipoprotein (LDL)

See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD.

***Electronic Collection:*** The patient is numerator compliant if he or she has laboratory documentation of the results of at least 3 of the 4 lipid profile components listed above during the reporting period. The patient is NOT numerator compliant if 2 or more of the lipid profile components are missing results or were not done during the reporting period.

***Medical Record Collection:*** The patient is numerator compliant if he or she documentation of the results of at least 3 of the 4 lipid profile components listed above during the reporting period. The patient is NOT numerator compliant if 2 or more of the lipid profile components are missing results or were not done during the reporting period.

The following is not acceptable documentation for full lipid profile:

1. LDL-to-HDL ratio
2. Patient self-reporting

**Frequency:** Most recent test results 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

## ***LDL Drug Therapy:***

**Description:** Percentage of patients aged 18 through 75 years old with coronary artery disease (CAD) and documented evidence of low density lipid (LDL) lowering therapy use, if not contraindicated.

**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 coronary artery disease (CAD) for the denominator, and claims/encounter, pharmacy or medical record data for documentation of use of LDL-lowering medication(s) or contraindications for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommend that patients with a baseline LDL  $\geq$  130 mg/dl be started on a cholesterol lowering drug, simultaneously with therapeutic lifestyle changes and control of non-lipid factors. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and documented evidence of LDL-lowering medication use, if not contraindicated. Three methods are provided to identify patients documented LDL-lowering medication use and/or contraindications: pharmacy, claims, and medical record data. See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD.

***Electronic Collection:*** The patient is numerator compliant if he or she has documented evidence of LDL-lowering medication(s) use or contraindication to LDL-lowering medications, as identified by pharmacy or claims data. This includes those patients with CAD who had one of the following:

1. LDL-lowering medication(s) dispensed during the reporting period.
2. Evidence of contraindication or previous adverse reaction to LDL-lowering therapy

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to LDL-lowering medications:

ICD-9 CODES	ICD-10 CODES
<b>LDL-lowering therapy allergy or intolerance:</b> 995.0 and E942.2, 995.1 and E942.2, 995.27 and E942.2, 995.29 and E942.2	<b>LDL-lowering therapy allergy or intolerance:</b> T782XXA, T783XXA, T50995A, T360X5A – T369X5A
<b>Pregnancy:</b> V22.0 – V23.9	<b>Pregnancy:</b> Z34.00, Z34.80, Z34.90, Z33.1, O09.00, O09.10, O09.291, O09.40, O09.30, O09.90 – O09.93
<b>LOINC Codes WITH associated LDL &lt; 130 mg/dl:</b> 12773-8, 13457-7, 18262-6, 2089-1, 22748-8, 24331-1-1, 39469-2	<b>LOINC Codes WITH associated LDL &lt; 130 mg/dl:</b> 12773-8, 13457-7, 18262-6, 2089-1, 22748-8, 24331-1-1, 39469-2
<b>CPT (C4) Codes WITH associated LDL &lt; 130 mg/dl:</b> 80061, 83700, 83701, 83704, 83721	<b>CPT (C4) Codes WITH associated LDL &lt; 130 mg/dl:</b> 80061, 83700, 83701, 83704, 83721

**Medical Record Collection:** The patient is numerator compliant if he or she has documentation in the medical record of use of a LDL-lowering medication OR previous adverse reaction or contraindication to LDL-lowering medications. This includes those patients with coronary artery disease who had one of the following:

1. Documentation indicating the date on which a LDL-lowering medication was prescribed during the reporting period.
2. Documentation of a prescription for a LDL-lowering 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 use of LDL-lowering therapy:
  - LDL-lowering medication allergy or intolerance
  - Most recent LDL value (within the last 12 months from the last day of the reporting period) is < 130 mg/dl
  - Pregnancy

The following is not acceptable documentation for LDL-lowering medication use or contraindication:

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

### ***Use of Aspirin or Other Antiplatelet Therapy:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) who have documentation of use of aspirin or other antiplatelet therapy, if not contraindicated.

**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 coronary artery disease (CAD) for the denominator, and pharmacy or medical record data for documentation of use of aspirin or another antiplatelet for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommends antiplatelet therapy in the absence of contraindications. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and documentation of use of aspirin or another antiplatelet, if not contraindicated. Two methods are provided to identify patients with documented use of aspirin or another antiplatelet: pharmacy data or medical record data.

See “Patient Eligibility Criteria” for further information on codes to identify patients with CAD.

***Electronic Collection:*** The patient is numerator compliant if pharmacy data documents he or she was dispensed aspirin (75 to 325 mg daily) or another antiplatelet during the reporting period, on an ambulatory basis.

Other antiplatelets include:

1. Clopidogrel (Plavix)
2. Dipyridamole (w/aspirin = Aggrenox)

***Medical Record Collection:*** The patient is numerator compliant if he or she has documentation in the medical record of use of aspirin or another antiplatelet OR contraindication to aspirin or another antiplatelet. This includes those patients with coronary artery disease who had one of the following:

1. Documentation indicating the date on which aspirin or another antiplatelet was prescribed during the reporting period.
2. Documentation of a prescription for aspirin or another antiplatelet from another treating clinician during the reporting period.
3. Documentation of diagnosis of or medical treatment for one of the following in which use of aspirin or another antiplatelet is contraindicated:
  - Active peptic ulcer
  - History of recent<sup>4</sup> GI bleeding
  - History of intracranial hemorrhage (ICH)
  - Allergy or hypersensitivity to Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
  - Bleeding disorders including hemophilia, von Willebrand's disease, thrombocytopenia and severe liver disease

Other antiplatelets include:

1. Clopidogrel (Plavix)
2. Dipyridamole (w/aspirin = Aggrenox)

For a list of numerator compliant aspirin medications and other antiplatelets, see Tables 5 and 6 under "Relevant Medication Lists for CAD 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 aspirin or other antiplatelet therapy use:

1. Patient self-reporting

**Frequency:** If patient with diagnosis of or treatment for condition for which aspirin or another antiplatelet is contraindicated: during patient lifetime (unless more specific frequency is indicated above).

If patient with aspirin or antiplatelet use: most recent prescription over the last 12 months from the last day of the reporting period.

**Scoring:** If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

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<sup>4</sup> Over the last six months, from the last day of the reporting period.

## ***ACE-I/ARB Therapy:***

**Description:** Percentage of patients aged 18 through 75 years with coronary artery disease (CAD) and left ventricular systolic dysfunction (LVSD) who have documented evidence of angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) therapy use, if not contraindicated.

**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 coronary artery disease (CAD) and left ventricular systolic dysfunction (LVSD) for the denominator, and claims/encounter, pharmacy or medical record data for documentation of ACE-I or ARB medication(s) use for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) recommends that patients with left ventricular systolic dysfunction (LVSD) be started on an ACE-I or ARB in the absence of contraindications. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and left ventricular systolic dysfunction (LVSD) with documented evidence of ACE-I or ARB medication use, if not contraindicated. Three methods are provided to identify patients' documented ACE-I or ARB medication use: pharmacy, claims, and medical record data. See "Denominator Subset" section below for further information on identifying patients with CAD and LVSD.

***Electronic Collection:*** The patient is numerator compliant if he or she has documented evidence of ACE-I or ARB medication(s) use or contraindication to ACE-I or ARB medications, as identified by pharmacy or claims data. This includes those patients with coronary artery disease and LVSD who had one of the following:

1. ACE-I or ARB medication(s) dispensed during the reporting period.
2. Evidence of contraindication or previous adverse reaction to ACE-I or ARB therapy

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to ACE-I and/or ARB medications:

ICD-9 CODES	ICD-10 CODES
<b>ACE-I or ARB therapy allergy or intolerance:</b> 995.0 and E942.2, 995.1 and E942.2, 995.27 and E942.2, 995.29 and E942.2	<b>ACE-I or ARB therapy allergy or intolerance:</b> T782XXA, T783XXA, T50995A, T360X5A – T369X5A
<b>Anuric renal failure:</b> V56.0, V56.8, 39.95, 54.98, 788.5, 586, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 584.5 – 584.9, 585.5, 585.6	<b>Anuric renal failure:</b> Z49.31, Z49.32, R34, N19, I12.0, I13.11, I13.2, N17.0 – N17.2, N17.8, N17.9, N18.5, N18.6
<b>Moderate or severe aortic stenosis:</b> 440.1, 395.0, 396.0, 396.2, 396.8, 425.1, 747.22	<b>Moderate or severe aortic stenosis:</b> I70.1, I06.0, I08.0, I08.8, Q25.2, Q25.3
<b>Pregnancy:</b> V22.0 – V23.9	<b>Pregnancy:</b> Z34.00, Z34.80, Z34.90, Z33.1, O09.00, O09.10, O09.291, O09.40, O09.30, O09.90 – O09.93

**Medical Record Collection:** The patient is numerator compliant if he or she has documentation in the medical record of use of ACE-I or ARB medication OR previous adverse reaction or contraindication to ACE-I or ARB medications. This includes those patients with coronary artery disease and LVSD who had one of the following:

1. Documentation indicating the date on which an ACE-I or ARB medication was prescribed during the reporting period.
2. Documentation of a prescription for an ACE-I or ARB 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 use of ACE-I and/or ARB therapy:
  - ACE-I or ARB medication allergy or intolerance
  - Anuric renal failure
  - Moderate or severe aortic stenosis
  - Pregnancy

The following is not acceptable documentation:

1. Patient self-reporting

**Denominator Subset:** Patients aged 18-75 years with the domain denominator diagnosis (i.e coronary artery disease [CAD]) AND evidence of left ventricular systolic dysfunction (LVSD). LVSD is defined as a most recent left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed



left ventricular systolic function. Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document.

**Electronic Collection:** Patient is denominator compliant if he or she has undergone left ventricular function (LVF) testing, as documented by administrative claims data AND documentation in the medical record of an ejection fraction < 40% or moderately or severely depressed left ventricular systolic function. Below is a list of eligible codes to identify left ventricular function (LVF) testing:

Left Ventricular Function (LVF) Testing

**CPT-I Codes:** 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93543

**Medical Record Collection:** Patient is denominator compliant if he or she has documentation of one of the following on the problem list:

1. Left ventricular systolic dysfunction (LVSD)
2. Left ventricular ejection fraction (LVEF) < 40%
3. Moderate or severely depressed left ventricular systolic function

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

**Scoring:** If denominator subset  $\geq$  25 patients, then:

If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

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

### ***Persistent Beta Blocker Treatment After An Acute Myocardial Infarction (AMI):***

**Description:** Percentage of patients aged 18 through 75 years old with coronary artery disease (CAD) and an acute myocardial infarction (AMI) in the past 6-18 months who have documented evidence of persistent beta blocker treatment, if not contraindicated.

**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 coronary artery disease (CAD) with prior acute myocardial infarction (AMI) for the denominator, and claims/encounter, pharmacy or medical record data for documentation of days' supply of beta blocker(s) prescribed for the numerator.

**Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) and prior myocardial infarction recommends beta blocker therapy in the absence of contraindications. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and an acute myocardial infarction (AMI) in the past 6-18 months (look back starts 6 months from the last day of the reporting period and ends 18 months from the last day of the reporting period), with documented evidence of persistent beta blocker treatment in the past 180 days (from the last day of the reporting period), if not contraindicated. Three methods are provided to identify patients' documented days' supply of beta blocker(s): pharmacy, claims, and medical record data. See "Denominator Subset" section below for further information on identifying patients with CAD and AMI.

***Electronic Collection:*** The patient is numerator compliant if he or she has documented evidence of beta blocker treatment or contraindication to beta blocker therapy, as identified by pharmacy or claims data. This includes those patients with coronary artery disease and AMI within the past 6-18 months who had one of the following:

1.  $\geq$  135 days' supply of beta blocker(s) dispensed in the past 180 days from the last day of the reporting period
2. Evidence of contraindication or previous adverse reaction to beta blocker therapy

Beta blocker treatment: Persistence of treatment for this measure is defined as at least 75% of the days' supply filled.

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to beta blocker therapy:

ICD-9 CODES	ICD-10 CODES
<b>History of Asthma:</b> 493.00 – 493.02, 493.10 – 493.12, 493.80 – 493.82, 493.90 – 493.92	<b>History of Asthma:</b> J45.20 – J45.22, J45.990, J45.991, J45.901, J45.902, J45.909, J45.998
<b>History of Hypertension:</b> 458.0, 458.1, 458.21, 458.29, 458.8, 458.9	<b>History of Hypertension:</b> I95.1 – I95.3, I95.9, I95.81, I95.89
<b>History of heart block &gt; 1 degree:</b> 426.0, 426.12, 426.13, 426.2, 426.4, 426.50, 426.51, 426.52, 426.53, 426.54, 426.6, 426.7	<b>History of heart block &gt; 1 degree:</b> I44.1, I44.2, I44.4, I44.5, I44.60, I44.69, I45.10, I44.30, I44.39, I45.4, I45.2, I45.3, I45.5, I45.6
<b>History of sinus bradycardia:</b> 427.81	<b>History of sinus bradycardia:</b> I49.5, R001
<b>History of Chronic Obstructive Pulmonary Disease (COPD):</b> 491.20, 491.21, 491.22, 493.20, 493.21, 493.22, 496	<b>History of Chronic Obstructive Pulmonary Disease (COPD):</b> J44.0, J44.1, J44.9

Pharmacy data documenting a prescription for an inhaled corticosteroid during the reporting period may also be used to identify a contraindication to beta blocker therapy.

**Medical Record Collection:** The patient is numerator compliant if he or she has documentation in the medical record of use of beta blockers OR previous adverse reaction or contraindication to beta blocker therapy. This includes those patients with coronary artery disease and AMI within the past 6-18 months who had one of the following:

1. Documentation indicating the patient was dispensed  $\geq$  135 days' supply of beta blocker(s) in the past 180 days from the last day of the reporting period.
2. Documentation indicating the patient was dispensed  $\geq$  135 days' supply of beta blocker(s) from another treating clinician in the past 180 days from the last day of the reporting period.
3. Documentation of diagnosis of or medical treatment for one of the following indicating a previous adverse reaction or contraindication to use of beta blocker therapy:

- History of asthma or prescription for an inhaled corticosteroid over the past 12 months, from the last day of the reporting period
- History of hypotension
- History of heart block > 1 degree -  
History of sinus bradycardia
- History of Chronic Obstructive Pulmonary Disease (COPD) -  
History of Class IV Congestive Heart Failure (CHF)

The following is not acceptable documentation:

1. Patient self-reporting

**Denominator Subset:** Patients aged 18-75 years with the domain denominator diagnosis (i.e coronary artery disease [CAD]) AND diagnosis of an acute myocardial infarction (AMI) in the past 6-18 months (from the last day of the reporting period). Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document.

***Electronic Collection:*** Patient is denominator compliant if he or she has had at least one acute myocardial infarction (AMI) event in the past 6-18 months, from the last day of the reporting period, as documented by administrative claims data. Below is a list of eligible codes to identify an acute myocardial infarction (AMI):

Acute Myocardial Infarction (AMI)

**ICD-9 Codes:** 410, 414.0, 410.00, 410.01, 410.02, 410.1, 410.10, 410.11, 410.12, 410.2, 410.20, 410.21, 410.22, 410.3, 410.30, 410.31, 410.32, 414, 410.40, 410.41, 410.42, 410.5, 410.50, 410.51, 410.52, 410.6, 410.60, 410.61, 410.62, 410.7, 410.70, 410.71, 410.72, 410.8, 410.80, 410.81, 410.82, 410.9, 410.90, 410.91, 410.92, 411, 411.0, 411.1

**ICD-10 Codes:** I21.09, I21.19, I21.11, I21.29, I21.4, I21.3, I24.1, I20.0

***Medical Record Collection:*** Patient is denominator compliant if he or she has a diagnosis of acute myocardial infarction (AMI) listed on the problem list dated in the past 6-18 months, from the last day of the reporting period.

**Frequency:** Most recent documentation over the last 180 days from the last day of the reporting period.

**Scoring:** If denominator subset  $\geq$  25 patients, then:

If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points =  
[numerator/denominator] x maximum available points for the measure

If [numerator/denominator] < minimum criteria, then Earned Points = 0

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

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### ***Beta Blocker Treatment with a Prior Acute Myocardial Infarction (AMI):***

- Description:** Percentage of patients aged 18 through 75 years old with coronary artery disease (CAD) and a prior acute myocardial infarction (AMI) who have documented evidence of beta blocker use, if not contraindicated.
- 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 coronary artery disease (CAD) with prior acute myocardial infarction (AMI) for the denominator, and claims/encounter, pharmacy or medical record data for documentation of beta blocker(s) use for the numerator.
- Explanation:** The American Heart Association (AHA) and American College of Cardiology (ACC) guidelines for the management of patients with coronary artery disease (CAD) and prior myocardial infarction recommends beta blocker therapy in the absence of contraindications. It is anticipated that clinicians who provide services for the primary management of coronary artery disease (CAD) will submit this measure.
- Numerator:** Patients aged 18-75 years with a diagnosis of coronary artery disease (CAD) and a prior acute myocardial infarction (AMI) with documented evidence of beta blocker treatment use, if not contraindicated. Three methods are provided to identify patients' documented beta blocker use: pharmacy, claims, and medical record data. See "Denominator Subset" section below for further information on identifying patients with CAD and AMI.

***Electronic Collection:*** The patient is numerator compliant if he or she has documented evidence of beta blocker treatment or contraindication to beta blocker therapy, as identified by pharmacy or claims data. This includes those patients with coronary artery disease and a prior AMI who had one of the following:

1. Beta blocker(s) dispensed during the reporting period
2. Evidence of contraindication or previous adverse reaction to beta blocker therapy

Evidence of Contraindication or Previous Adverse Reaction: The following codes may be used to identify contraindications to beta blocker therapy:

ICD-9 CODES	ICD-10 CODES
<b>History of Asthma:</b> 493.00 – 493.02, 493.10 – 493.12, 493.80 – 493.82, 493.90 – 493.92	<b>History of Asthma:</b> J45.20 – J45.22, J45.990, J45.991, J45.901, J45.902, J45.909, J45.998
<b>History of Hypertension:</b> 458.0, 458.1, 458.21, 458.29, 458.8, 458.9	<b>History of Hypertension:</b> I95.1 – I95.3, I95.9, I95.81, I95.89
<b>History of heart block &gt; 1 degree:</b> 426.0, 426.12, 426.13, 426.2, 426.4, 426.50, 426.51, 426.52, 426.53, 426.54, 426.6, 426.7	<b>History of heart block &gt; 1 degree:</b> I44.1, I44.2, I44.4, I44.5, I44.60, I44.69, I45.10, I44.30, I44.39, I45.4, I45.2, I45.3, I45.5, I45.6
<b>History of sinus bradycardia:</b> 427.81	<b>History of sinus bradycardia:</b> I49.5, R001
<b>History of Chronic Obstructive Pulmonary Disease (COPD):</b> 491.20, 491.21, 491.22, 493.20, 493.21, 493.22, 496	<b>History of Chronic Obstructive Pulmonary Disease (COPD):</b> J44.0, J44.1, J44.9,

Pharmacy data documenting a prescription for an inhaled corticosteroid during the reporting period may also be used to identify a contraindication to beta blocker therapy.

**Medical Record Collection:** Patient is numerator compliant if he or she has documentation in the medical record of use of beta blockers OR previous adverse reaction or contraindication to beta blocker therapy. This includes those patients with coronary artery disease and a prior AMI who had one of the following:

1. Documentation indicating the date on which a beta blocker was prescribed during the reporting period.
2. Documentation of a prescription for a beta blocker 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 use of beta blocker therapy:
  - History of asthma or prescription for an inhaled corticosteroid over the past 12 months, from the last day of the reporting period
  - History of hypotension
  - History of heart block > 1 degree
  - History of sinus bradycardia
  - History of Chronic Obstructive Pulmonary Disease (COPD)
  - History of Class IV Congestive Heart Failure (CHF)

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The following is not acceptable documentation:

1. Patient self-reporting

**Denominator** Patients aged 18-75 years with the domain denominator diagnosis (i.e. coronary artery disease [CAD]) AND diagnosis of a prior acute myocardial infarction (AMI) at any time. Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document.

**Subset:**

***Electronic Collection:*** Patient is denominator compliant if he or she has had at least one prior acute myocardial infarction (AMI) at any time, as documented by administrative claims data. Below is a list of eligible codes to identify an acute myocardial infarction (AMI):

Acute Myocardial Infarction (AMI)

**ICD-9 Codes:** 410, 414.0, 410.00, 410.01, 410.02, 410.1, 410.10, 410.11, 410.12, 410.2, 410.20, 410.21, 410.22, 410.3, 410.30, 410.31, 410.32, 414, 410.40, 410.41, 410.42, 410.5, 410.50, 410.51, 410.52, 410.6, 410.60, 410.61, 410.62, 410.7, 410.70, 410.71, 410.72, 410.8, 410.80, 410.81, 410.82, 410.9, 410.90, 410.91, 410.92, 411, 411.0, 411.1

**ICD-10 Codes:** I21.09, I21.19, I21.11, I21.29, I21.4, I21.3, I24.1, I20.0

***Medical Record Collection:*** Patient is denominator compliant if he or she has a diagnosis of acute myocardial infarction (AMI) listed on the problem list at any time.

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

**Scoring:** If denominator subset  $\geq$  25 patients, then:

If [numerator/denominator]  $\geq$  minimum criteria, then Earned Points =  
[numerator/denominator] x maximum available points for the measure

If [numerator/denominator]  $<$  minimum criteria, then Earned Points = 0

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

## ***Body Mass Index:***

**Description:** Percentage of patients' aged 18 through 75 years with CAD for whom a documented body mass index (BMI) is calculated.

**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, pharmacy or medical record data for identification of patients with ischemic vascular disease for the denominator, and claims/encounter and medical record data for BMI information for the numerator.

**Explanation:** Obesity is becoming a global epidemic in both children and adults. It is associated with numerous comorbidities such as cardiovascular diseases (CVD), type 2 diabetes, hypertension, certain cancers, and sleep apnea/sleep-disordered breathing. In fact, obesity is an independent risk factor for CVD, and CVD risks have also been documented in obese children. Obesity is associated with an increased risk of morbidity and mortality as well as reduced life expectancy. Obesity is an independent risk factor for hypertension, dyslipidemia, and cardiovascular disease, which is the major cause of death in persons with diabetes.

**Numerator:** Patients aged 18-75 years with a diagnosis of ischemic vascular disease and a documented BMI calculated. See "Patient Eligibility Criteria" for further information on codes to identify patients with ischemic vascular disease.

***Electronic Collection:*** The patient is numerator compliant if he or she has a calculation of their BMI documented during the reporting period, as identified by claims data. The following codes may be used to identify a documented BMI:

**CPT II Code:** 3008F

**HCPCS Codes:** G8417-G8420

**ICD-9:** V-Codes: V85.0 BMI less than 19, adult; V85.1 BMI between 19-24, adult; V85.2 BMI between 25-29, adult; V85.3 BMI between 30-39, adult; V85.4 BMI between 40 and over, adult.

**ICD-10:** Z68.1 BMI less than 19, adult; Z68.20 – Z68.24 BMI between 20-24, adult; Z68.25-Z68.29 BMI between 25-29, adult; Z68.30 – Z68.39 BMI between 30-39, adult; Z68.4 BMI between 40 and over, adult.



▪ **Medical Record Collection:** The patient is numerator compliant if he or she has had their BMI calculated and documented. This includes those patients with ischemic vascular disease who had one of the following:

1. Documentation of the result of a BMI calculation during the reporting period
2. Documentation in the medical record must include BMI result and exam date. **Calculated BMI** – Requires that both the height and weight are actually measured by an eligible professional or by their staff.

The following are not acceptable documentation for documented BMI calculation:

1. Patient self-reporting

**Frequency:** Most recent test result over the last 12 months from last day of the reporting period.

**Not Eligible/Not Appropriate for BMI Measurement** – Patients can be considered not eligible in the following situations:

1. If the patient has a terminal illness – life expectancy less than 6 months
2. If the patient is pregnant

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

## Patient Eligibility Criteria

An **eligible** coronary artery disease patient is one who meets **all three** criteria:

1. Is between 18 and 75 years of age.<sup>5</sup>
2. Has had a documented diagnosis of Coronary Artery Disease (CAD) (as defined in Table 1 below) for at least 12 months, from the last day of the reporting period. Eligible diagnosis categories exclude peripheral arterial disease (PAD), cerebrovascular disease (CVD) and diabetes.
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 coronary artery disease (CAD) 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 coronary artery disease (CAD): 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 coronary artery disease (CAD) 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 coronary artery disease.

Also denominator compliant if the patient has documentation of being discharged alive for Anterior wall Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), or Percutaneous Transluminal Coronary Angioplasty (PTCA).

Medical Record data: Patient is denominator compliant if he or she is aged 18-75 with a documented diagnosis of coronary artery disease (CAD) 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 CAD.

Also denominator compliant if the patient has documentation of being discharged alive for Anterior wall Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), or Percutaneous Transluminal Coronary Angioplasty (PTCA).

**Exclusions:** Patients with a diagnosis of peripheral arterial disease (PAD), cerebrovascular disease (CVD) OR diabetes are excluded from the denominator. Patients in hospice or palliative care are also excluded from the denominator. See Table 2 below for further information on codes to identify patients with exclusions.

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<sup>5</sup> As of the last date of the reporting period. Patients known to be deceased should be excluded.

**Table 1: Codes to Identify a Patient with a Diagnosis of Coronary Artery Disease**

Diagnosis Codes
<p><b>CORONARY ARTERY DISEASE</b></p> <p><b><u>Coronary Artery Disease</u></b>  <b>ICD-9:</b> 411, 411.0, 411.1, 411.8, 411.81, 411.89, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82  <b>ICD-10:</b> I24.0, I24.8, I25.10, I25.810, I25.811, I25.812, Z95.1, Z98.61</p> <p><b><u>Acute Myocardial Infarction</u></b>  <b>ICD-9:</b> 410, 414.0, 410.00, 410.01, 410.02, 410.1, 410.10, 410.11, 410.12, 410.2, 410.20, 410.21, 410.22, 410.3, 410.30, 410.31, 410.32, 414, 410.40, 410.41, 410.42, 410.5, 410.50, 410.51, 410.52, 410.6, 410.60, 410.61, 410.62, 410.7, 410.70, 410.71, 410.72, 410.8, 410.80, 410.81, 410.82, 410.9, 410.90, 410.91, 410.92, 411, 411.0, 411.1.  <b>ICD-10:</b> I21.09, I21.19, I21.11, I21.29, I21.4, I21.3, I24.1, I20.0</p> <p><b><u>Stable Angina</u></b>  <b>ICD-9:</b> 413, 413.0, 413.1, 413.9  <b>ICD-10:</b> I20.8-I20.9, I20.1</p> <p><b><u>Percutaneous Coronary Intervention</u></b>  <b>CPT:</b> 92980-92981, 92982, 92984, 92995, 92996, 92997, 92998, 33140  <b>ICD-9:</b> 36.06, 36.07, 36.09  <b>ICD-10:</b> 02C, 02C0, 02C1, 02C2, 02C3</p> <p><b><u>CABG</u></b>  <b>CPT:</b> 33510-33514, 33516-33519, 33521-33523, 33533-33536, 33542, 33545, 33572, 35600, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631-35634, 35636-35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 35501, 35506, 35508-35512, 35515, 35516, 35518, 35521-35523, 35525, 35526, 35531, 35533, 35535-35540, 35548, 35549, 35551, 35556, 35558, 35560, 35563, 35565, 35566, 35570, 35571  <b>ICD-9:</b> 36.1, 36.2  <b>ICD-10:</b> 027, 0270, 0271, 0272, 0273</p>

**Table 2: Codes/Notations to Identify Patients with Exclusions**

<b>Diagnosis Codes / Notations</b>
<p><b>PERIPHERAL ARTERIAL DISEASE</b></p> <p><b><u>Lower Extremity Arterial Disease/Peripheral Arterial Disease</u></b>  <b>ICD-9:</b> 440.20-440.24, 440.29, 447.0-447.6, 447.8, 447.9, 444-444.2, 444.8-444.9  <b>ICD-10:</b> I70.209-I70.229, I70.269, I70.299, I77.0-I77.6, I77.9, I77.89, I74.01-I74.11, I74.5, I74.9</p> <p><b>CEREBROVASCULAR DISEASE</b></p> <p><b><u>Ischemia</u></b>  <b>ICD-9:</b> 435, 435.0, 435.1, 435.3, 435.8, 435.9  <b>ICD-10:</b> G45.0, G45.1, G45.8, G45.9, I67.848</p> <p><b><u>Stroke</u></b>  <b>ICD-9:</b> 437.0-437.9, 438.0-438.2, 438.10-438.12, 438.20, 438.21, 438.22, 438.3, 438.30-438.32, 438.4, 438.40-438.42, 438.6-438.8, 438.81-438.85, 438.89, 438.9  <b>ICD-10:</b> I67.1, I67.2, I67.4-I67.9, I67.81, I67.82, I67.89, G45.4</p> <p><b><u>Atheroembolism</u></b>  <b>ICD-9:</b> 444.0, 444.1, 445.0, 445.8, 445.01, 445.02, 445.81, 445.89  <b>ICD-10:</b> I74.11, I75.8, I75.019, I75.029, I75.81, I75.89</p> <p><b>DIABETES</b></p> <p><b><u>Diabetes Mellitus</u></b>  <b>ICD-9:</b> 250, 648.0  <b>ICD-10:</b> E119, O24.319  <b>Notation of:</b> Prescribed insulin, Oral hypoglycemics/anti-hyperglycemics</p> <p><b><u>Diabetic Polyneuropathy</u></b>  <b>ICD-9:</b> 357.2  <b>ICD-10:</b> E08.42, E09.42, E10.42, E11.42, E13.42</p> <p><b><u>Diabetic Retinopathy</u></b>  <b>ICD-9:</b> 362.0  <b>ICD-10:</b> E11.319</p> <p><b><u>Diabetic Cataract</u></b>  <b>ICD-9:</b> 366.41  <b>ICD-10:</b> E08.36, E09.36, E10.36, E11.36, E13.36</p> <p><b><u>Hospice and Palliative Care</u></b>  <b>ICD-9:</b> V66.7  <b>ICD-10:</b> Z51.5  <b>CPT:</b> 99377, 99378</p>

## Applying for Recognition

Clinician applicants opt to voluntarily submit their data to a PAO for performance assessment through the CAD 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 CAD Care measures and specifications. See "What Recognition Requires".
3. Determine whether to apply as an individual clinician or medical practice.

Clinicians submitting through a data aggregator partner are required to submit medical record data for all eligible patients across their full patient population on a quarterly calendar schedule. 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.

Completed applications are processed for compliance with performance requirements, and applicant-specific reports with results for all CAD Care measures are produced within 30

days. The begin recognition date is calculated based on the date that the applicant's data is scored. BTE issues an official certificate to each recognized clinician or medical practice.

Additionally, BTE reserves the right to complete an audit of any individual or practice application for Recognition. PAO or specified local organization subcontractors conduct audits of at least 5 percent of the recognized clinicians from each data aggregator partner each year. Audits may be completed by fax, mail, electronically or on site, as determined by the PAO. The remainder of the five percent will be identified by a single methodology that randomizes the medical groups who submit to the data aggregator and then sequentially selecting medical groups. The number of medical groups selected is dependent on the total number of recognized clinicians in each medical group, enough groups will be selected to account for 5% of total recognized clinicians submitted by the data aggregator.

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. Upon passing an audit, the applicant's recognition dates are assigned retroactively to the date the applicant's data was scored. Failure to pass an audit or failure to respond to an audit request within 30 days results in no further consideration for the CAD Care program for six months to two years (depending on the audit score) from the date of submission of the application.

## **Duration of Recognition**

The Chronic Care Recognition Programs have duration of two years from the date on which the recognition was awarded; regardless of the pathway the clinician achieved the recognition – electronic data submission, direct data manual submission or NCQA. Patient Centered Medical Home Recognitions achieved through the NCQA have a three-year duration.

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.

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## ***Changes in Recognition Levels***

Continuous data submission applicants are eligible for changes in recognition level. Clinicians who achieve at least Level I CAD Care Recognition will maintain their CAD 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 level 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 CAD Care Recognition status and maintain their current begin and end recognition dates.

*Example 1: Clinician A assessment history*

<i>Assessment period</i>	<i>Assessment date</i>	<i>Assessed (Scored) Level<sup>8</sup></i>	<i>Recognition Level<sup>9</sup></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

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*Example 2: Clinician B assessment history*

<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
1/1/09-12/31/10	1/21/10	Level II	N/A	N/A
4/1/09-3/31/10	4/18/10	Level II	Level II	4/18/2010-4/18/2012
7/1/09-6/30/10	7/25/10	Not Pass	Level II	4/18/2010-4/18/2012
10/1/09-9/30/10	10/16/10	Not Pass	Level I	4/18/2010-4/18/2012

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<sup>8</sup> A clinician's Assessed Level is the BTE level at which the clinician's data is scored for the current measurement period.

<sup>9</sup> 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.



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## Reporting Results to HCI3 and Its Partners

As part of BTE's mission to identify and promote quality, PAO 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.
- 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 rewards payments. 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.

## Terms of Recognition

When communicating with patients, third-party payers, managed care organizations (MCOs) and others, clinicians or practices who receive BTE Coronary artery disease 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

PAO 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.