

**Clinician Guide:  
Bridges to Excellence  
Chronic Obstructive Pulmonary Disease  
Care Recognition Program  
Program**

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## 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 (HCI3) 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 COPD Care Recognition Program is a BTE Clinician Recognition Program intended to identify clinicians who deliver high-value COPD care to adult patients. The program is designed with an understanding that adult patients may seek the care of various types of practitioners— primary care (PCPs), pulmonologists, allergy and immunologists, and others —for treatment and management of their COPD. Accordingly, the measures reflect that clinicians should do the following.

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

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

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

BTE's COPD Care requirements assess clinical measures representing standards of care for patients with COPD. HCI3 believes that the COPD Care Recognition program has the potential to significantly improve the quality of care experienced by patients with COPD and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn COPD Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with COPD. HCI3 has partnered with an objective third-party independent Performance Assessment Organizations (PAO) to evaluate clinician data based on standard measures to publicly recognize those that meet the BTE COPD Care performance thresholds. Those clinicians not meeting the BTE COPD Care performance thresholds remain anonymous to BTE and its health plan licensees. BTE's COPD Care 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 COPD 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. Lung Function/Spirometry Evaluation
2. Inhaled Bronchodilator Therapy
3. Tobacco Cessation Advice and Treatment
4. Assessment of COPD Exacerbations
5. COPD Exacerbation Therapy
6. Assessment of Oxygen Saturation

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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 the percentage of the sample (denominator) which meet or comply (numerator) with the measure threshold.

7. Long-Term Oxygen Therapy
8. Pneumococcal Immunization
9. Influenza Immunization
10. . Documented Body Mass Index (BMI)

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

## Recognition Program Structure

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

*Level I:* Focuses on a clinician-centric<sup>3</sup> view of measurement, looking at individual metrics summed to produce a composite score. Thresholds have been set to focus on above average performance.

*Level II:* Focuses on a combination of clinician and patient-centric<sup>4</sup> measurements. Level II includes the measurement of individual metrics summed to produce a composite score. Also looks at the defect rate of care delivery across pairs of measures on a per patient basis. Thresholds have been set to focus on very good performance.

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

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

<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 (e.g. combining Pneumococcal and Influenza Immunizations into 1 single measure), which is applied on a per patient basis. The results provide a picture of an individual patient's performance on a set of measures which make up the composite measure. Since the process leads to patient-focused results it is said to be "patient-centric."

## What Recognition Requires

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

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

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

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

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

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

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Lung Function/ Spirometry Evaluation	N/A	N/A	10
Inhaled Bronchodilator Therapy <sup>5</sup>	N/A	N/A	10
Tobacco Cessation Advice and Treatment	N/A	N/A	20
Assessment of COPD Exacerbations	N/A	N/A	10
COPD Exacerbation Therapy <sup>5</sup>	N/A	N/A	10
Assessment of Oxygen Saturation <sup>5</sup>	N/A	N/A	10
Long-Term Oxygen Therapy <sup>5</sup>	N/A	N/A	15
Pneumococcal Immunization	N/A	N/A	5
Influenza Immunization	N/A	N/A	10
Documented BMI	N/A	N/A	0
<b>Total Points</b>			100
<b>Percentage of Total Points Needed to Achieve Recognition</b>			60

<sup>5</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: COPD Care Level II Measures, Performance Criteria and Scoring**

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

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Lung Function/ Spirometry Evaluation	N/A	N/A	20
Inhaled Bronchodilator Therapy <sup>5,6</sup>	N/A		
Tobacco Cessation Advice and Treatment	N/A	N/A	20
Assessment of COPD Exacerbations	N/A	N/A	20
COPD Exacerbation Therapy <sup>5,6</sup>	N/A		
Assessment of Oxygen Saturation <sup>5,6</sup>	N/A	N/A	25
Long-Term Oxygen Therapy <sup>5,6</sup>	N/A		
Pneumococcal Immunization	N/A	N/A	5
Influenza Immunization	N/A	N/A	10
Documented BMI	N/A	N/A	0
<b>Total Points</b>			100
<b>Percentage of Total Points Needed to Achieve Recognition</b>			60

<sup>5</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.

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

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

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

Clinical Measures	Threshold	Minimum Criteria	Maximum Points
Lung Function/ Spirometry Evaluation	N/A	N/A	20
Inhaled Bronchodilator Therapy <sup>5,6</sup>	N/A		
Tobacco Cessation Advice and Treatment	N/A	N/A	20
Documented BMI	N/A	N/A	0
Assessment of COPD Exacerbations	N/A	N/A	20
COPD Exacerbation Therapy <sup>5,6</sup>	N/A		
Assessment of Oxygen Saturation <sup>5,6</sup>	N/A	N/A	25
Long-Term Oxygen Therapy <sup>5,6</sup>	N/A		
Pneumococcal Immunization	N/A	N/A	15
Influenza Immunization	N/A		
<b>Total Points</b>			100
<b>Percentage of Total Points Needed to Achieve Recognition</b>			60

<sup>5</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.

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

## Eligibility for Clinician Participation

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

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

### *Individual clinician applicant*

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

## **BTE COPD Care Recognition Clinical Measures**

### **Clinical Measures**

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

The following items are listed for each clinical measure.

**Description:** A statement of what is being measured specifically.

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

**Explanation:** Additional information about the clinical measure.

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

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

**Frequency:** Time frames associated with the numerator requirements.

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

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

## ***Lung Function / Spirometry Evaluation***

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

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

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

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

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

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

**CPT-II codes:** 3023F

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

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

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

1. Patient self-reporting

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

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

## ***Inhaled Bronchodilator Therapy***

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

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

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

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

***Electronic Collection:*** The patient is numerator compliant if he or she has documented evidence of inhaled bronchodilator medication ( $\beta$ 2 agonist or anticholinergic) use or contraindication to inhaled bronchodilator medications, as identified by pharmacy or claims data. This includes those patients with COPD, FEV1/FVC < 70% and at least one COPD symptom who had one of the following:

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

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

**CPT-II Code:** 4025F

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

**ICD-9 Codes:**

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

**ICD-10 Codes:**

Adverse Reaction to Inhaled Bronchodilators: T50.995A with T48.6X5A or T48.6X5D or T48.6X5S, T78.40XA with T48.6X5A or T48.6X5D or T48.6X5S

***Medical Record Collection:*** The patient is numerator compliant if he or she has documentation in the medical record of inhaled bronchodilator medication ( $\beta_2$  agonist or anticholinergic) use OR previous adverse reaction or contraindication to inhaled bronchodilator medications. This includes those patients with COPD, a FEV1/FVC < 70% and at least one COPD symptom who had one of the following:

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

The following is not acceptable documentation for inhaled bronchodilator therapy:

1. Patient self-reporting



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

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

**Spirometry Test Results of FEV1/FVC < 70%:**

**CPT-II Codes:** 3025F

**Dyspnea:**

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

**ICD-10 Codes:** R06.9, R06.4, R06.01, R06.02, R06.82, R06.00, R06.09, R06.3, R06.83, R06.89

**Cough:**

**ICD-9 Codes:** 786.2, 491.0

**ICD-10 Codes:** R05, J41.0

**Sputum:**

**ICD-9 Codes:** 786.3, 786.4

**ICD-10 Codes:** R04.2, R04.9, R09.3

**Wheezing:**

**ICD-9 Codes:** 786.07

**ICD-10 Codes:** R06.2

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

1. Documentation indicating the date of an FEV1/FVC < 70% during the reporting period.

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

AND one of the following:

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

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

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

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

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

**Description:** Percentage of patients aged 18- through 75 years with COPD 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 or medical record data for identification of patients with COPD for the denominator, and medical record data for documentation of tobacco status, and if a tobacco user, claims or medical record data for documentation of cessation counseling or treatment information for the numerator.

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

**Numerator:** Patients aged 18-75 years with a diagnosis of COPD and documentation of 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 COPD.

***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 tobacco 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

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 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

## ***Assessment of COPD Exacerbations***

- Description:** Percentage of patients aged 18 through 75 years old with COPD and documentation of the number of exacerbations.
- Data source:** Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter data or medical record data for identification of patients with COPD for the denominator, and claims/encounter or medical record data for exacerbations information for the numerator.
- Explanation:** According to the American Thoracic Society (ATS) and European Respiratory Society (ERS), exacerbations are a common cause of morbidity and mortality in patients with COPD and those with frequent exacerbations are more likely to have recurrent symptoms and hospital readmission within 14 days of the original episode. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.
- Numerator:** Patients aged 18-75 years with a diagnosis of COPD and documentation of the number of exacerbations during the reporting period. See “Patient Eligibility Criteria” for further information on codes to identify patients with COPD.

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

**ICD-9 codes:** 491.22

**ICD-10 codes:** J44.0

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

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

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

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

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

## ***COPD Exacerbation Therapy***

**Description:** Percentage of patients aged 18 through 75 years old with COPD and a history of an exacerbation who were prescribed or dispensed at least one inhaled bronchodilator (long-acting  $\beta$ 2 agonist or anticholinergic) and/or one inhaled corticosteroid, in the absence of contraindications.

**Data source:** Electronic data (visit, lab, encounter data or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter data or medical record data for identification of patients with COPD and history of an exacerbation for the denominator, and claims/encounter data, pharmacy or medical record data for inhaled bronchodilator (long-acting  $\beta$ 2 agonist or anticholinergic) and inhaled corticosteroid prescription information for the numerator.

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

**Numerator:** Patients aged 18-75 years with a diagnosis of COPD and a history of an exacerbation in the last 12 months, who were prescribed or dispensed at least one inhaled bronchodilator (long-acting  $\beta$ 2 agonist or anticholinergic) and/or one inhaled corticosteroid, in the absence of contraindications. Three methods are provided to identify patients' documented appropriate COPD exacerbation therapy use: pharmacy, claims and medical record data. See "Denominator Subset" section below for further information on identifying patients with exacerbations.

***Electronic Collection:*** The patient is numerator compliant if: he or she has documented evidence of inhaled bronchodilator (long-acting  $\beta$ 2 agonist or anticholinergic) and/or inhaled corticosteroid medication use or contraindication to inhaled bronchodilator and/or inhaled corticosteroid medications, as evidenced by pharmacy or claims data. This includes those patients with COPD and a history of exacerbation in the last 12 months who had one of the following:

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

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

**CPT-II Codes:**

Inhaled Bronchodilator: 4025F

Inhaled Corticosteroid: 4135F

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

**ICD-9 Codes:**

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

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

**ICD-10 Codes:**

Adverse Reaction to Inhaled Bronchodilators: T50.995A with T48.6X5A or T48.6X5D or T48.6X5S, T78.40XA with T48.6X5A or T48.6X5D or T48.6X5S

Adverse Reaction to Inhaled Corticosteroids: T50.995A with T88.6XXA or T88.6XXD or T88.6XXS, T78.40XA with T88.6XXA or T88.6XXD or T88.6XXS



**Medical Record Collection:** The patient is numerator compliant if he or she has documentation in the medical record of inhaled bronchodilator (long-acting  $\beta_2$  agonist or anticholinergic) and/or inhaled corticosteroid medication use OR previous adverse reaction or contraindication to inhaled bronchodilator or corticosteroid medications. This includes those patients with COPD and a history of exacerbation over the last 12 months who had one of the following:

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

The following is not acceptable documentation for COPD exacerbation therapy:

1. Patient self-reporting

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

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

**ICD-9 codes:** 491.22  
**ICD-10 codes:** J44.0

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

***Medical Record Collection:*** The patient is denominator compliant if he or she has documentation in the medical record indicating the occurrence of at least one of exacerbation during the reporting period. This includes those patients with COPD who had one of the following:

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

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

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

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

## ***Assessment of Oxygen Saturation***

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

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

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

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

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

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

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

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

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

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

**CPT-II codes:** 4030F

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

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

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

1. Patient self-reporting

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

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

FEV1 < 40% of Predicted Value

**CPT-II Codes:** 3040F

Respiratory Failure

**ICD-9 codes:** 518.83, 518.84

**ICD-10 codes:** J96.10-J96.12, J96.20-J96.22

Right Heart Failure

**ICD-9 codes:** 428.0, 428.3

**ICD-10 code:** I50.20, I50.30

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

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

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

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

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

## ***Long Term Oxygen Therapy***

**Description:** Percentage of patients aged 18 through 75 years old with COPD and an oxygen saturation level of  $\leq 88\%$  or a  $\text{PaO}_2 \leq 55$  mmHg, who have been prescribed long-term oxygen therapy.

**Data source:** Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter data or medical record data for identification of patients with COPD and an oxygen saturation level of  $\leq 88\%$  or a  $\text{PaO}_2 \leq 55$  mmHg, for the denominator, and claims/encounter data or medical record data for oxygen therapy prescription information for the numerator.

**Explanation:** According to the American Thoracic Society (ATS) and European Respiratory Society (ERS) COPD clinical practice guidelines, patients whose disease is stable on a full medical regimen, with an oxygen saturation level of  $\leq 88\%$  or  $\text{PaO}_2 < 55$  mmHg, should receive long-term oxygen therapy. The National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization advise that long-term administration of oxygen ( $> 15$  hrs per day) to patients with chronic respiratory failure has been shown to increase survival. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

**Numerator:** Patients aged 18-75 years with a diagnosis of COPD and documentation of an oxygen saturation level of  $\leq 88\%$  or a  $\text{PaO}_2 \leq 55$  mmHg, who have been prescribed long-term oxygen therapy. Two methods are provided to identify patients with prescribed long-term oxygen therapy: claims and medical record data. See “Denominator Subset” section below for further information on identifying patients with an oxygen saturation level of  $\leq 88\%$  or a  $\text{PaO}_2 \leq 55$  mmHg.

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

**CPT-II codes:** 4030F

***Medical Record Collection:*** The patient is numerator compliant if he or she has documentation in the medical record of long-term oxygen therapy.

This includes those patients with COPD and an oxygen saturation level of  $\leq 88\%$  or a  $\text{PaO}_2 \leq 55$  mmHg who had one of the following:

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

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

1. Patient self-reporting

**Denominator** Patients aged 18-75 years with the domain denominator diagnosis (i.e.,  
**Subset:** COPD) AND documentation of an oxygen saturation level of  $\leq 88\%$  or a PaO<sub>2</sub>  $\leq 55$  mmHg. Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document. Two methods are provided to identify patients' oxygen saturation or PaO<sub>2</sub> level: claims and medical record data.

**Electronic Collection:** The patient is denominator compliant if he or she has documentation of an oxygen saturation level of  $\leq 88\%$  or a PaO<sub>2</sub>  $\leq 55$  mmHg during the reporting period, as identified by claims data. Below is a list of eligible codes to identify O<sub>2</sub> Saturation  $\leq 88\%$  or a PaO<sub>2</sub>  $\leq 55$  mmHg.

**CPT-II Codes:** 3035F

**Medical Record Collection:** The patient is denominator compliant if he or she has documentation in the medical record of an oxygen saturation level of  $\leq 88\%$  or a PaO<sub>2</sub>  $\leq 55$  mmHg. This includes those patients with COPD who had one of the following:

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

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

**Scoring:** If denominator subset  $\geq 25$  patients, then Earned Points =  
[numerator/denominator] x maximum available points for the measure  
If denominator subset  $< 25$  patients, then measure is not scored.

## ***Pneumococcal Immunization***

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

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

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

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

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

**CPT-I codes:** 90732

**CPT-II codes:** 1022F, 4040F

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

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

The following is not acceptable documentation:

1. Patient self-reporting



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

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

## ***Influenza Immunization***

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

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

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

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

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

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

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

**ICD-9 codes:** V04.81

**ICD-10 codes:** Z23

**CPT-I codes:** 90656, 90658, 90660

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

**ICD-9 Codes:**

Egg allergy: 693.1, V15.03, 995.68

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

**ICD-10 Codes:**

Egg allergy: L27.2, Z91.012, T78.08XA

Adverse Reaction to the influenza vaccine: T78.2XXA with T50.B95A or T50.B95S; T78.3XXA with T50.B95A or T50.B95S

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

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

The following is not acceptable documentation for influenza vaccine:

1. Patient self-reporting

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

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

## ***Body Mass Index***

**Description:** Percentage of patients' aged 18 through 75 years ischemic vascular disease 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:** The USPSTF (2009) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. The clinical guideline for obesity recommends assessment of BMI at each encounter (National Heart, Lung and Blood Institute).

**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

**ICD9:** 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.
3. **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** COPD patient is one who meets **all three** criteria:

1. Is between 18 and 75 years of age.<sup>4</sup>
2. Has had a documented diagnosis of COPD (as defined in Table 1 below) for at least 12 months, from the last day of the reporting period.
3. Has been under the care of the applicant for at least 12 months. This is defined by documentation of two face-to-face visits for COPD care between the clinician and the patient: one within 12 months of the last day of the reporting period and one that predates the last day of the reporting period by at least 12 months.

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

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

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

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

**Table1: Codes to Identify a Patient with a Diagnosis of COPD**

Diagnosis Codes
<b>COPD</b>
<b>ICD-9 codes:</b> 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496
<b>ICD-10 codes:</b> J41.0, J41.1, J44.9, J44.0, J41.8, J42, J43.9, J44.9

<sup>4</sup> As of the last date of the reporting period. Patients known to be deceased should be excluded.

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**Table2: Codes to Identify Patients with Exclusions**

Diagnosis Codes
<b>Hospice and Palliative Care</b> <b>ICD-9:</b> V66.7 <b>ICD-10:</b> Z51.5 <b>CPT:</b> 99377, 99378

## Applying for Recognition

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

Clinicians considering applying for recognition should:

1. Determine eligibility. See "Eligibility for Clinician Participation" for more information.
2. Familiarize themselves with the BTE COPD care measures and specifications. See "What Recognition Requires".
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 COPD 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 results in no further consideration for the COPD Care program for six months to two years (depending on the audit score) from the date of submission of the application.

## **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.

## Changes in Recognition Levels

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

- Clinicians who achieve a higher level of recognition for two consecutive assessment periods will have their recognition 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 COPD 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

<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.

*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

## 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 HCI3: Only Recognized statuses are reported to BTE for display on HCI3’s web site [www.hci3.org](http://www.hci3.org) 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 COPD Care Recognition may represent themselves as BTE-recognized and meeting NQF/AQA quality measure requirements; however, clinicians or practices may not characterize themselves as “NQF/AQA-Approved” or “NQF/AQA-Endorsed.” The use of this mischaracterization or other similarly inappropriate statements will be grounds for revocation of status.

## Revoking Recognition

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.