HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE®

Fair, Evidence-based Solutions. Real and Lasting Change.

Clinician Guide:
Bridges to Excellence
Hypertension Care Recognition 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 Incentives 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 Hypertension Care Recognition Program is a BTE Clinician Recognition Program intended to identify clinicians who deliver high-value hypertension 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 hypertension. 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 Hypertension Care requirements assess clinical measures representing standards of care for patients with hypertension. HCI3 believes that the Hypertension Care Recognition program has the potential to significantly improve the quality of care experienced by patients with hypertension and to reduce the financial and human burden of unnecessary hospitalizations and complications.

To earn Hypertension Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with hypertension. 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 Hypertension Care performance thresholds. Those clinicians not meeting the BTE Hypertension Care performance thresholds remain anonymous to BTE and its health plan licensees. BTE's Hypertension 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, 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 Hypertension Care Recognition by submitting data through a CCHIT-certified[1] 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[2]
1. Blood pressure (BP) control
2. LDL control
3. Complete lipid profile
4. Use of aspirin
5. Documentation of urine protein test
6. Documentation of annual serum creatinine test

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

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

7. Documentation of tobacco status and cessation advice and treatment
8. Documentation of Body Mass Index (BMI)
9. Documentation of counseling for diet and physical activity

Clinicians who demonstrate high-quality performance based on these measures are awarded BTE Hypertension 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 Hypertension 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 hypertension measures (listed above).

Level I: Focuses on a clinician-centric[3] 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[4] 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.

[3] 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."

[4] Patient centric refers to performance assessment involving evaluation of clinician performance based upon composite measures, created by combining 2 or more separate discrete measures into a single measure (i.e. combining BP <140/90 and LDL <130mg/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 Hypertension Care Recognition, clinician applicants must submit medical record data that demonstrates they meet BTE's Hypertension 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 attain at least 60 percent of the total of 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) and 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: Hypertension 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
Poor Control Measures[5]			
Blood Pressure Control	≥ 160/100	≤ 45% of pts in sample	15
LDL Control	≥ 160 mg/dl	≤ 40% of pts in sample	15
Superior Control Measures			
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	10
LDL Superior Control	< 130 mg/dl	≥ 25% of pts in sample	10
Process Measures			
Complete Lipid Profile	N/A	N/A	5
Use of Aspirin[6]	N/A	≥ 65% of pts in sample	10
Urine Protein Test	N/A	N/A	10
Annual Serum Creatinine Test	N/A	N/A	10
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	10
Documented BMI	N/A	N/A	0
Counseling for Diet and Physical Activity	N/A	N/A	5
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

[5] 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.

[6] 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: Hypertension 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
Poor Control Composite Measure[5]			
Blood Pressure Control	≥ 160/100	N/A	30
LDL Control	≥ 160 mg/dl		
Superior Control Measures			
Blood Pressure Superior Control	< 140/90	≥ 20% of pts in sample	10
LDL Superior Control	< 130 mg/dl	≥ 25% of pts in sample	10
Process Measures			
Complete Lipid Profile	N/A	N/A	5
Use of Aspirin[6]	N/A	≥ 65% of pts in sample	10
Urine Protein Test	N/A	N/A	10
Annual Serum Creatinine Test	N/A	N/A	10
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	10
Documented BMI	N/A	N/A	0
Counseling for Diet and Physical Activity	N/A	N/A	5
		Total Points	100
		Percentage of Total Points Needed to Achieve Recognition	60

[5] 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.

[6] 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: Hypertension 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 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
Poor Control Composite Measure[5]			
Blood Pressure Control	≥ 160/100	N/A	30
LDL Control	≥ 160 mg/dl		
Superior Control Composite Measure			
Blood Pressure Superior Control	< 140/90	N/A	20
LDL Superior Control	< 130 mg/dl		
Process Measures			
Complete Lipid Profile	N/A	N/A	5
Use of Aspirin[6]	N/A	≥ 65% of pts in sample	10
Urine Protein Test	N/A	N/A	10
Annual Serum Creatinine Test	N/A	N/A	10
Tobacco Status and Cessation Advice and Treatment	N/A	N/A	10
Documented BMI	N/A	N/A	0
Counseling for Diet and Physical Activity	N/A	N/A	5
Total Points			100
Percentage of Total Points Needed to Achieve Recognition			60

[5] 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.

[6] 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 Hypertension 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 hypertension 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 hypertension[7].

Medical practice applicant

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

[7] **Eligible Hypertension patients** are 18-75 years of age, with a documented diagnosis of essential hypertension (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 hypertension 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 Hypertension Care Recognition Clinical Measures

The following examples illustrate the format used for clinical measures.

Evaluation Program Title: Hypertension Care Recognition Program

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

The following items are listed for each clinical measure.

Description: A statement of what is being measured specifically.

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

Explanation: Additional information about the clinical measure.

Numerator: A description of patients in 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".

Blood Pressure Control:

Description: Percentage of patients aged 18 through 75 years with essential hypertension who had most recent blood pressure in poor control (greater than or equal to 160/100 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 essential hypertension for the denominator, and medical record data for blood pressure information for the numerator.

Explanation: The Seventh Report of the Joint National Committee (JNC 7) guidelines on prevention, detection, evaluation, and treatment of high blood pressure suggest a doubling of mortality risk for patients with essential hypertension for every 20 mmHg systolic and 10 mmHg diastolic increase above 140 mmHg systolic and 90 mmHg control targets.

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 essential hypertension will submit this measure.

Numerator: Patients aged 18-75 years with the diagnosis of essential hypertension and most recent systolic blood pressure measurement of ≥ 160 mmHg OR diastolic blood pressure of ≥ 100 mmHg. See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension. 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 is ≥ 160 mmHg or missing, OR the most recent diastolic blood pressure measurement is ≥ 100 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 < 160 mmHg AND the most recent diastolic blood pressure measurement during the reporting period is < 100 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] ≤ minimum criteria, then Earned Points = [1 – (numerator/denominator)] x maximum available points for the measure

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

Blood Pressure Superior Control:

Description: Percentage of patients aged 18 through 75 years with essential hypertension 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 essential hypertension for the denominator, and medical record data for blood pressure information for the numerator.

Explanation: The Seventh Report of the Joint National Committee (JNC 7) guidelines on prevention, detection, evaluation, and treatment of high blood pressure suggest a doubling of mortality risk for patients with essential hypertension for every 20 mmHg systolic and 10 mmHg diastolic increase above 140 mmHg systolic and 90 mmHg control targets.

Numerator: Patients aged 18-75 years with the diagnosis of essential hypertension 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 essential hypertension. 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 ≥ 140 mmHg or missing, OR the most recent diastolic blood pressure measurement is ≥ 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] ≥ minimum criteria, then Earned Points = [numerator/denominator] x maximum available points for the measure

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

Lipid Control:

Description: Percentage of patients aged 18 through 75 years with essential hypertension who had most recent LDL-C level in poor control (greater than or equal to 160 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 essential hypertension for the denominator, and laboratory or medical record data for LDL-C test information for the numerator.

Explanation: The Third report of the National Cholesterol Education Program Expert Panel (NCEP) on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III—ATP III) recommends treatment for patients with hypertension and other major risk factors to a target LDL < 160 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 essential hypertension will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension and most recent LDL-C level ≥ 160 mg/dl. See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent LDL-C test is ≥ 160mg/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 < 160 mg/dl.

Medical Record Collection: The patient is numerator compliant if the result of the most recent LDL-C test is ≥ 160mg/dl, is missing, or if the test was not done during the reporting period. The patient NOT is numerator compliant if the result of the most recent LDL-C level during the reporting period is < 160mg/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 ≤ 400mg/dl:

LDL-C = (total cholesterol) – (HDL) – (Triglycerides/5)

If the clinician/medical practice is manually extracting the data and 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.

If the clinician/medical practice is submitting through an EMR and if the triglycerides are > 400 mg/dl and LDL-C levels cannot be calculated using the Friedewald equation, the clinician/medical practice may enter LDL-C levels as a value of 500 and the date of the test documented if programming allows this option. However, this is not required.

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 essential hypertension who had most recent LDL-C level in superior control (less than 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 essential hypertension for the denominator, and laboratory or medical record data for LDL-C test information for the numerator.

Explanation: The Third report of the National Cholesterol Education Program Expert Panel (NCEP) on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III—ATP III) recommends patients with hypertension and one or more major risk factor have an LDL < 130 mg/dl.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension and most recent LDL-C level < 130 mg/dl. See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

Electronic Collection: The patient is numerator compliant if the laboratory result of the most recent LDL-C test during the reporting period is < 130 mg/dl. The patient is NOT numerator compliant if the laboratory result of the most recent LDL-C test is ≥ 130 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 < 130 mg/dl. The patient is NOT numerator compliant if the result of the most recent LDL-C test is ≥ 130 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:

LDL-C = (total cholesterol) – (HDL) – (Triglycerides/5)

If the clinician/medical practice is manually extracting the data and 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.

If the clinician/medical practice is submitting through an EMR and if the triglycerides are > 400 mg/dl and LDL-C levels cannot be calculated using the Friedewald equation, the clinician/medical practice may enter LDL-C levels as a value of 500 and the date of the test documented if programming allows this option. However, this is not required.

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 = [numerator/denominator] x maximum available points for the measure

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

Complete Lipid Profile:

Description: Percentage of patients aged 18 through 75 years with essential hypertension who had a full lipid profile completed.

Data source: Electronic data (visit, lab, encounter 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 essential hypertension for the denominator, and laboratory or medical record data for lipid profile information for the numerator.

Explanation: According to the U.S. Preventive Services Task Force (USPSTF) recommendations for high blood pressure, the relationship between systolic blood pressure and diastolic blood pressure and cardiovascular risk is continuous and graded. Clinicians should consider the patient's overall cardiovascular risk profile, including smoking, diabetes, abnormal blood lipid values, age, sex, sedentary lifestyle, and obesity.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension 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)

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See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

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 has 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

Use of Aspirin:

Description: Percentage of male patients aged 45 through 75 years and female patients aged 55 through 75 years with essential hypertension who have documentation of use of aspirin, if not contraindicated.

Data source: Electronic data (visit, laboratory, 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 essential hypertension for the denominator, and medical record data for documentation of use of aspirin for the numerator.

Explanation: According to the U.S. Preventive Services Task Force (USPSTF) recommendations on the use of aspirin for the Prevention of Cardiovascular Disease in the presence of hypertension, the USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage and for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

Numerator: Male patients aged 45-75 years and female patients aged 55-75 years with a diagnosis of essential hypertension and documentation of use of aspirin, if not contraindicated. Two methods are provided to identify patients documented use of aspirin: pharmacy data or medical record data.

See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

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

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

1. Documentation indicating the date on which aspirin was prescribed during the reporting period.
2. Documentation of a prescription for aspirin 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 is contraindicated:

   - Active peptic ulcer
   - History of recent[4] 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

The following is not acceptable documentation for use:

1. Patient self-reporting

Denominator Subset: Male patients age 45-75 years and female patients age 55-75 years with the domain denominator diagnosis (i.e., essential hypertension). Information on the domain's denominator diagnosis can be found under the "Patient Eligibility Criteria" section of the document.

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

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

Scoring: If denominator subset ≥ 25 patients, then**:**

If [numerator/denominator] ≥ 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.

4.

[4] Over the last six months, from the last day of the reporting period.

Urine Protein Test:

Description: Percentage of patients aged 18 through 75 years with essential hypertension who had a urine protein test (to screen for nephropathy or evidence of nephropathy).

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 essential hypertension for the denominator, and claims/encounter, pharmacy, laboratory or medical record data for urine protein test, nephropathy diagnosis or medical treatment information for the numerator.

Explanation: The American Heart Association (AHA) advocates for routine urinalysis and microalbuminuria testing for adult patients with hypertension to detect nephropathy. It is anticipated that clinicians who provide services for the primary management of essential hypertension will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension and documentation of urine protein test or evidence of nephropathy. See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

Electronic Collection: The patient is numerator compliant if he or she has a urine protein test or evidence of nephropathy, as identified by claims or pharmacy data. This includes those patients with hypertension who had one of the following:

1. Urine protein test (for nephropathy screening) during the reporting period.
2. Evidence of nephropathy diagnosis or medical treatment during the patient's lifetime.

Urine Protein Test (Nephropathy Screening): The following codes may be used to identify urine protein tests (microalbuminuria and/or macroalbuminuria test):

CPT I Codes:

Microalbuminuria Test: 82042, 82043, 82044, 83518, 84156, 84160*, 84166*, 84165*.
Codes marked by an asterisk (*) must be accompanied by CPT I code 81050 indicating test was a urinalysis.

Macroalbuminuria Test: 81000-81003*, 81005*.
Codes marked by an asterisk (*) must be accompanied by CPT II code 3062F indicating a positive macroalbuminuria result.

Evidence of Nephropathy: The following codes may be used to identify nephropathy diagnosis or treatment:

CPT I Codes: 36145, 36800, 36810, 36815, 36818, 36819, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512;
ICD-9-CM Codes: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4,403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 585.3, 584-586, 588, 753.0, 753.1, 791.0;
V-Codes: V42.0, V45.1, V56, UB-92;
Revenue Codes: 0367, 080X, 082X-085X, 088X;
DRGs: 316, 317.

ICD-10 Codes: N14.0 – N14.4, N15.0, N13.71, N07.0 – N07.9, E08.21, E09.21, E10.21, E11.21, E13.21, A36.84

Medical Record Collection: The patient is numerator compliant if he or she has a urine protein test or evidence of nephropathy. This includes those patients with hypertension who had one of the following:

1. Urine protein test (for nephropathy screening) during the reporting period.
2. Evidence of nephropathy diagnosis or medical treatment during the patient's lifetime.
3. Evidence of drug therapy for nephropathy during the reporting period.

Urine Protein Test (Nephropathy Screening): Documentation in the medical record must include the date on which the urine protein test (microalbuminuria and/or macroalbuminuria test) was performed, and the test result, over the past 12 months, from the last day of the reporting period. Notation of the following may count for microalbuminuria screening test:

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for micro albumin
- Microalbumin/Creatine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

Notation of the following may count for macroalbuminuria screening test:

- Positive result on urine dipstick

Note: A negative result on urine dipstick is insufficient for numerator compliance.
Evidence of Nephropathy: Documentation in the medical record must include diagnosis of or medical treatment for one of the following during the patient's lifetime:

- Diabetic nephropathy
- Diabetic kidney disease
- Diffuse diabetic or nodular glomerularsclerosis
- Kimmesstiel-Wilson lesion
- Papillary necrosis
- Arterionephrosclerosis
- End-stage renal disease (ESRD)
- Chronic renal failure (CRF)
- Chronic Renal insufficiency
- Chronic renal disorder
- Renal Dialysis
- Acute renal failure
- Proteinuria
- Azotemia
- Microalbuminuria

Nephropathy Drug Therapy: Documentation in the medical record must indicate the patient was dispensed or prescribed an Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin II Receptor Blocker (ARB) medication over the past 12 months, from the last day of the reporting period.

The following is not acceptable documentation:

1. Patient Self-Reporting

Frequency: If patient with drug therapy treatment for nephropathy or urine protein test: most recent prescription or test result over the last 12 months from last day of the reporting period.

2. If patient with diagnosis of or medical treatment for nephropathy: during patient lifetime.

3.

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

Serum Creatinine Test:

Description: Percentage of patients aged 18 through 75 years with essential hypertension who had a serum creatinine test (to screen for nephropathy or evidence of nephropathy).

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 essential hypertension for the denominator, and claims/encounter, pharmacy, laboratory or medical record data for serum creatinine test, nephropathy diagnosis or medical treatment information for the numerator.

Explanation: The American Heart Association (AHA) suggests routine serum creatinine testing for adult patients with hypertension to monitor for renal dysfunction. It is anticipated that clinicians who provide services for the primary management of essential hypertension will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension and documentation of serum creatinine test, including date and value or evidence of nephropathy. See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

Electronic Collection : The patient is numerator compliant if he or she has a serum creatinine test, including date and value, or evidence of nephropathy, as identified by claims or pharmacy data. This includes those patients with hypertension who had one of the following:

1. Serum creatinine test (for nephropathy screening) during the reporting period.

2. Evidence of nephropathy diagnosis or medical treatment during the patient's lifetime.

Serum Creatinine Test (Nephropathy Screening): The following codes may be used to identify serum creatinine tests:

CPT I Codes: 82565, 80050, 80053, 80048, 82575;

LOINC Codes: 2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 24321-2, 24322-0, 24323-8, 24320-4, 24362-6, 26752-6, 33558-8, 34555-3, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4.

Evidence of Nephropathy: The following codes may be used to identify nephropathy diagnosis or treatment:

CPT I Codes: 36145, 36800, 36810, 36815, 36818, 36819, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512;
ICD-9-CM Codes: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0;
V-Codes: V42.0, V45.1, V56, UB-92;
Revenue Codes: 0367, 080X, 082X-085X, 088X;
DRGs: 316, 317.

ICD-10 Codes: N14.0 – N14.4, N15.0, N13.71, N07.0 – N07.9, E08.21, E09.21, E10.21, E11.21, E13.21, A36.84

Medical Record Collection: A patient is numerator compliant if he or she has documentation of a serum creatinine test, including date and value, or evidence of nephropathy. This includes those patients with hypertension who had one of the following:

1. Serum creatinine test (for nephropathy screening during the reporting period.

2. Evidence of nephropathy diagnosis or medical treatment during the patient's lifetime.

3. Evidence of drug therapy for nephropathy during the reporting period.

Serum Creatinine Test (Nephropathy Screening): Documentation in the medical record must include the date on which the serum creatinine test was performed, and the test result, over the past 12 months, from the last day of the reporting period.

Evidence of Nephropathy: Documentation in the medical record must include diagnosis of or medical treatment for one of the following during the patient's lifetime:

- Diabetic nephropathy
- Diabetic kidney disease
- Diffuse diabetic or nodular glomerularsclerosis
- Kimmesstiel-Wilson lesion
- Papillary necrosis

- Arterionephrosclerosis
- End-stage renal disease (ESRD)
- Chronic renal failure (CRF)
- Chronic Renal insufficiency
- Chronic renal disorder
- Renal Dialysis
- Acute renal failure
- Proteinuria
- Azotemia
- Microalbuminuria

Nephropathy Drug Therapy: Documentation in the medical record must indicate the patient was dispensed or prescribed an Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin II Receptor Blocker (ARB) medication over the past 12 months, from the last day of the reporting period.

The following is not acceptable documentation:

1. Patient self-reporting

Frequency: If patient with drug therapy treatment for nephropathy or serum creatinine test: most recent prescription or test result over the last 12 months from last day of the reporting period.

If patient with diagnosis of or medical treatment for nephropathy: during patient lifetime.

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

Tobacco Status and Cessation Advice and Treatment:

Description: Percentage of patients aged 18 through 75 years with essential hypertension 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 essential hypertension 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: According to the U.S. Preventive Services Task Force (USPSTF) recommendations for high blood pressure, the relationship between systolic blood pressure and diastolic blood pressure and cardiovascular risk is continuous and graded. Clinicians should consider the patient's overall cardiovascular risk profile, including tobacco user, diabetes, abnormal blood lipid values, age, sex, sedentary lifestyle, and obesity.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension 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 essential hypertension.

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 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

4 He or she has not received cessation counseling and/or treatment

OR

5. He or she has not received cessation counseling and/or treatment during the reporting period

OR

6. His or her documentation on receiving cessation counseling and/or

treatment is not during the reporting period

Frequency: If non-tobacco user: most recent status.

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

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

Counseling for Diet and Physical Activity:

Description: Percentage of patients aged 18 through 75 years with essential hypertension who have documentation of having received dietary and physical activity counseling.

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 essential hypertension for the denominator, and medical record data for documentation of dietary counseling, activity status, and physical activity counseling for the numerator.

Explanation: The American Heart Association (AHA) and American College of Cardiology (ACC) strongly recommend the adoption of a healthy diet and lifestyle, including physical activity, for all individuals with hypertension. It is anticipated that clinicians who provide services for the primary management of essential hypertension will submit this measure.

Numerator: Patients aged 18-75 years with a diagnosis of essential hypertension and documentation of physical activity status and date of dietary and physical activity counseling. See "Patient Eligibility Criteria" for further information on codes to identify patients with essential hypertension.

Medical Record Collection: The patient is numerator compliant if he or she has documented date of receipt of dietary counseling during the reporting period AND activity status documented AND if inactive, documented date of receipt of counseling for exercise or physical activity during the reporting period.

Dietary Counseling: Any of following is acceptable documentation for dietary counseling:

1. Dietary saturated fat and cholesterol restriction for patients
    a. Taking an LDL-lowering medication
    b. With LDL not under control (as defined by LDL superior control measure above)
    c. Taking an HDL-raising medication
    d. Who are overweight/obese (BMI > 25)

    OR
2. Calorie restriction as part of weight reduction program for overweight patients (BMI > 25)

    OR
3. DASH eating plan

OR

4. Dietary sodium restriction

OR

5. Increased fruits, vegetables and/or soluble fibers

For all patients, the patient is NOT numerator compliant if:

1. His or her documentation on receiving dietary counseling is missing

OR

2. He or she has not received dietary counseling

OR

3. He or she has not received dietary counseling during the reporting period

OR

4. His or her documentation on receiving dietary counseling is not during the reporting period

If the patient is active, the patient is NOT numerator compliant if:

1. His or her activity status documentation is missing

OR

2. His or her activity status was not asked

If the patient is inactive, the patient is NOT numerator compliant if:

1. His or her activity status documentation is missing

OR

2. His or her activity status was not asked

OR

3. His or her documentation on receiving physical activity counseling is missing

OR

3. He or she has not received physical activity counseling

OR

5. He or she has not received physical activity counseling during the reporting period

OR

6. His or her documentation on receiving physical activity counseling is not during the reporting period

Frequency: **If active**: most recent activity status and dietary counseling over the last 12 months from last day of the reporting period.
If inactive: most recent dietary counseling over the last 12 months from last day of the reporting period and most recent physical activity counseling over the last 12 months from 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 with asthma 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 asthma 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 asthma and a documented BMI calculated. See "Patient Eligibility Criteria" for further information on codes to identify patients with asthma.

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 asthma 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** essential hypertension patient is one who meets **all three** criteria:

1. Is between 18 and 75 years of age.[5]

2. Has had a documented diagnosis of essential hypertension (as defined in Table 1 below) for at least 12 months, from the last day of the reporting period. Eligible diagnosis categories exclude all other causes of hypertension, coronary artery disease (CAD) and diabetes. (See Table 2 for complete list of exclusionary codes.)

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 essential hypertension 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 essential hypertension: 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 essential hypertension 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 essential hypertension.

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

Exclusions: Patients with a diagnosis of non-essential hypertension OR coronary artery disease (CAD) OR diabetes. 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.

[5] 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 Essential Hypertension

Diagnosis Codes
Essential Hypertension **ICD-9**: 401, 401.0, 401.1, 401.9 **ICD-10**: I10

Table 2: Codes/Notations to Identify Patients with Exclusions

Diagnosis Codes / Notations
Hypertensive Heart Disease **ICD-9**: 402, 402.0, 402.00, 402.01, 402.1, 402.10, 402.11, 402.9, 402.90, 402.91 **ICD-10:** I11.9, I11.0 **Hypertensive Chronic Kidney Disease** **ICD-9**: 403, 403.0, 403.00, 403.01, 403.1, 403.10, 403.11, 403.9, 403.90, 403.91 **ICD-10**: I12.9, I12.0 **Hypertensive Heart and Chronic Kidney Disease** **ICD-9**: 404, 404.0, 404.00, 404.01, 404.02, 404.03, 404.1, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93 **ICD-10:** I13.0, I13.2, I13.10, I13.11 **Secondary Hypertension** **ICD-9**: 405, 405.0, 405.01, 405.09, 405.1, 405.11, 405.19, 405.9, 405.91, 405.99 **ICD-10:** I15.0, I15.8 **Complications affecting other specified body systems, not elsewhere classified--Hypertension** **ICD-9**: 997.91 **ICD-10:** I97.3

CORONARY ARTERY DISEASE

Coronary Artery Disease
ICD-9: 411, 411.0, 411.1, 411.8, 411.81, 411.89, 414, 414.0, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82
ICD-10: I24.0, I24.8, I25.10, I25.810, I25.811, I25.812, Z95.1, Z98.61

Acute Myocardial Infarction
ICD-9: 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: I21.09, I21.19, I21.11, I21.29, I21.4, I21.3, I24.1, I20.0

Stable Angina
ICD-9: 413, 413.0, 413.1, 413.9
ICD-10: I20.8-I20.9, I20.1

Percutaneous Coronary Intervention
CPT: 92980-92981, 92982, 92984, 92995, 92996, 92997, 92998, 33140
ICD-9: 36.06, 36.07, 36.09
ICD-10: 02C, 02C0, 02C1, 02C2, 02C3

CABG
CPT: 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
ICD-9: 36.1, 36.2
ICD-10: 027, 0270, 0271, 0272, 0273

PERIPHERAL ARTERIAL DISEASE

Lower Extremity Arterial Disease/Peripheral Arterial Disease
ICD-9: 440.20-440.24, 440.29, 447.0-447.6, 447.8, 447.9, 444-444.2, 444.8-444.9
ICD-10: I70.209-I70.229, I70.269, I70.299, I77.0-I77.6, I77.9, I77.89, I74.01-I74.11, I74.5, I74.9

CEREBROVASCULAR DISEASE

Ischemia
ICD-9: 435, 435.0, 435.1, 435.3, 435.8, 435.9
ICD-10: G45.0, G45.1, G45.8, G45.9, I67.848

Stroke
ICD-9: 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
ICD-10: I67.1, I67.2, I67.4-I67.9, I67.81, I67.82, I67.89, G45.4

Atheroembolism
ICD-9: 444.0, 444.1, 445.0, 445.8, 445.01, 445.02, 445.81, 445.89
ICD-10: I74.11, I75.8, I75.019, I75.029, I75.81, I75.89

DIABETES[6]

Diabetes Mellitus
ICD-9: 250, 648.0
ICD-10: E119, O24.319
Notation of: Prescribed insulin7, Oral hypoglycemics/anti-hyperglycemics8

Diabetic Polyneuropathy
ICD-9: 357.2
ICD-10: E08.42, E09.42, E10.42, E11.42, E13.42

Diabetic Retinopathy
ICD-9: 362.0
ICD-10: E11.319

Diabetic Cataract
ICD-9: 366.41
ICD-10: E08.36, E09.36, E10.36, E11.36, E13.36

Hospice and Palliative Care
ICD-9: V66.7
ICD-10: Z51.5
CPT: 99377, 99378

[7] Any mention of routine insulin use during the past 12 months. Includes : Any insulin, including regular insulin, insulin pump, insulin pen, 70/30, CSII (continuous subcutaneous infusion of insulin), Humalog, Humulin, Lente, Lispro, MDI (multiple daily injections), Novolin, Novolin Penfill, NPH Novo Nordisk, Semilente, Ultralente, Velosulin (Note: Insulin given only during hospitalization, or briefly to help a patient through an acute illness, such as with steroid treatment or active infection does not constitute documentation of insulin use for diabetes)

[8] Any mention of oral hypoglycemic or antihyper-glycemic use during the past 12 months in the medical record. Includes: Acarbose, Acetohexamide, Amaryl, Chlorpropamide, Diabeta, Diabinase, Dymelor, Glipizide, Glipizide XL, Glucamide, Glucophage, Glucotrol, Glucotrol XL, Glyburide, Glynase, Metformin, Micronase, Orinase, Orimide, Prandin (Repaglinide), Precose, Tolazamide, Tolamide, Tolbutamide, Tolinase, Troglitazone

Applying for Recognition

Clinician applicants opt to voluntarily submit their data to a PAO for performance assessment through the Hypertension 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 Hypertension 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 Hypertension 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 applicants from each data aggregator partner each year. Hypertension Care audits may be completed by fax, mail, electronically or on site, as determined by the PAO. Any data identified by the PAO as irregular will be subject to audit. The remainder of the 5 percent will be selected through a random sampling methodology.

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

Example 1: Clinician A assessment history

Assessment period	*Assessment date*	*Assessed (Scored) Level*[8]	*Recognition Level*[9]	*Recognition Dates*
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

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

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

Example 2: Clinician B assessment history

Assessment period	*Assessment date*	*Assessed (Scored) Level*	*Recognition Level*	*Recognition Dates*
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
Assessment period	Assessment date	Assessed (Scored) Level	Recognition Level	Recognition Dates
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 HCI3'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 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 Hypertension 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.