Bridges to Excellence®
Chronic Obstructive Pulmonary Disease
Care Recognition Program Guide

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INTRODUCTION

Altarum 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 Altarum. Altarum'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.

The Chronic Obstructive Pulmonary Disease (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 both specialists i.e. pulmonologists as well as primary care physicians (PCPs)—for treatment and management of their Chronic Obstructive Pulmonary Disease. Accordingly, the measures reflect that clinicians should do the following.

- Deliver high-quality care from the outset of patient contact
- Understand and consider previous treatment history to help avoid inappropriate treatment and unnecessary testing
- Make efforts to reduce the risks of preventable illness

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 Chronic Obstructive Pulmonary Disease Care requirements assess clinical measures representing standards of care for patients with Chronic Obstructive Pulmonary Disease. Altarum believes that the BTE 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 due to COPD.

To earn COPD Care Recognition, clinicians and medical practices voluntarily submit medical record data documenting their delivery of care to patients with COPD. Altarum evaluates clinician data based on standard measures to publicly recognize those that meet the BTE Chronic Obstructive Pulmonary Disease Care performance thresholds. Those clinicians not meeting the BTE Chronic Obstructive Pulmonary Disease Care performance thresholds remain anonymous to BTE's health plan licensees. BTE's Chronic Obstructive Pulmonary Disease Care Recognition Program has three performance thresholds which give physicians star ratings, based on their performance compared to their peers.

Clinician Benefits of Recognition

- Clinicians can demonstrate to the public and to their professional peers that they meet the standards of care assessed by the program by issuing a press release, as well as having their recognition achievements posted on BTE's web site www.bridgestoexcellence.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.

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[1]

1. COPD Severity Assessed and Recorded, including Spirometry
2. Inhaled Bronchodilator Therapy: LAMA/LABA as Initial Therapy
3. Inhaled Bronchodilator Therapy: ICS only as Combination Therapy
4. Documentation of Tobacco Status
5. Tobacco use: Cessation Advice and Treatment
6. Assessment of Oxygen Saturation
7. Long Term Oxygen Therapy
8. Influenza Immunization
9. Pneumonia Immunization (PVC 13)
10. Pneumonia Immunization (PCV 23)
11. Follow-Up after Hospital Admission with COPD Exacerbation
12. Lung Cancer Screening with Low Dose CT
13. Advanced Health Care Directives
14. Assessment of COPD Exacerbations

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

[1] *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.*

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 Chronic Obstructive Pulmonary Disease (COPD) Care Recognition Program is designed for clinicians to achieve BTE award status across 3 tiers of recognition based on their performance summed up across all measures.

Assessment for recognition in all 3 tiers is based upon data submitted on the same Chronic Obstructive Pulmonary Disease (COPD) measures (listed above). The BTE program focuses on a clinician-centric view of measurement, looking at individual metrics summed to produce a composite score.

Three Stars: Similar in design to Level I with the exception that the program recognition threshold is set to focus on a clinician-centric view of measurement, looking at individual metrics summed to produce a composite score. Program recognition threshold has been set to focus on above average performance.

Four Stars: Similar in design to Level II with the exception that the program recognition threshold is set to focus on very good performance.

Five Stars: Similar in design to Level III with the exception that the program recognition threshold is set to focus on exceptional performance.

What Recognition Requires

To seek BTE Chronic Obstructive Pulmonary Disease (COPD) Care Recognition, clinician applicants must submit summarized medical record data that demonstrates they meet BTE's Chronic Obstructive Pulmonary Disease (COPD) Care performance requirements. Each measure has an assigned maximum available point value (Table 1). A clinician achieves points for a measure based on the percentage of their patient sample that meets or exceeds the set thresholds for that measure.

Bridges to Excellence (BTE) awards recognition to clinicians who achieve at minimum:

3-Stars:	50^{th} - 64^{th} percentile
4-stars:	65^{th} - 84^{th} percentile
5-stars:	85^{th} percentile and above

Recognition is based on clinician performance relative to their peers. The Star Ratings are determined by overall point score and is graded on a validated bell curve. The Raw Score equivalents will be published on an annual basis.

Table 1: Chronic Obstructive Pulmonary Disease (COPD) Care Measures, Performance Criteria and Scoring

Measure	Total Possible Points	Level of Evidence	Source
COPD Severity Assessed and Recorded, including Spirometry	10	Strong	ACP/ACCP/ATS/ERS
Inhaled Bronchodilator Therapy: LAMA/LABA as Initial Therapy	10	Strong	ACP/ACCP/ATS/ERS
Inhaled Bronchodilator Therapy: ICS only as Combination Therapy	10	Strong	ACP/ACCP/ATS/ERS
Documented Tobacco Status	10	Best Practice	GOLD
Tobacco Use: Cessation Advice and Treatment	15	Best Practice	GOLD
Assessment of Oxygen Saturation	10	Strong	ACP/ACCP/ATS/ERS
Long Term Oxygen Therapy	5	Best Practice	BTE
Influenza Immunization	5	LOE-B	GOLD
Pneumonia Immunization (PCV13)	5	LOE-B	GOLD
Pneumonia Immunization (PCV23)	5	LOE-B	GOLD
Follow-Up after Hospital Admission with COPD Exacerbation	10	Best Practice	NICE 2016
Lung Cancer Screening with Low Dose CT	2.5	LOE- B Moderate	USPSTF
Advanced Health Care Directives	2.5	LOE- B, C	AAFP
Assessment of COPD Exacerbations	0 (Process Measure)	Best Practice	GOLD
Total Possible Points	100		

AAFP= American Academy of Family Physicians
ACP= American College of Physicians
ACCP= American College of Clinical Pharmacy
ATS= American Thoracic Society
BTE = Bridges to Excellence
ERS=European Respiratory Society
GOLD = Global Initiative for Chronic Obstructive Lung Disease
NICE= The National Institute for Health and Care Excellence
USPSTF= US Preventive Services Task Force

Eligibility for Clinician Participation

Clinicians may apply for BTE Chronic Obstructive Pulmonary Disease (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 Chronic Obstructive Pulmonary Disease (COPD) and must 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 BTE 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 Chronic Obstructive Pulmonary Disease (COPD).

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.

Minimum Requirements

To be eligible for recognition, clinicians must have a minimum of 25 patients for the denominator for individual clinician applicants, and a minimum of 10 patients for the denominator for each individual clinician in a practice level applicant, with a minimum practice average of 25 patients per clinician.

Table 1 shows the program measures and the associated point values for scoring clinicians' performance.

How to Submit for Recognition

All Bridges to Excellence (BTE) Recognition Programs must be submitted electronically or via direct data submission through the Bridges to Excellence (BTE) web portal or via an EMR Partner listed below.

EMR Partners

Altarum has worked with many EMR Vendors to streamline the process for users wishing to submit their data for BTE recognition. Contact information for EMR companies who have completed certification as a Data Aggregator can be found below:

Vendor	Contact Information
Athena Health	bte@athenahealth.com
eClinicalWorks	incentiveprograms@eclinicalworks.com
Meridios	info@meridios.com
MediTab	info@meditab.com

BTE Chronic Obstructive Pulmonary Disease (COPD) Care Recognition Clinical Measures

The following examples illustrate the format used for clinical measures.

Evaluation Program Title: Chronic Obstructive Pulmonary Disease (COPD) 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.

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

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

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 the clinical measures and is listed under "Patient Eligibility Criteria", beginning on page 39.

Chronic Obstructive Pulmonary Disease (COPD) Care Recognition Program Measurement Set

COPD Severity Assessed and Recorded, including Spirometry

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and who had documentation of a spirometry evaluation and a GOLD level severity 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/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 and GOLD severity assessment (or FEV1% of predicted) for the numerator.

Explanation: The ACP/ACCP/ATS/ERS, and GOLD groups all strongly recommend that patients with COPD diagnosis have, in their medical chart, documented spirometry results and severity assessment based on GOLD levels or FEV1% of predicted. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator who had COPD severity assessment or a spirometry evaluation, unless a physical inability exists.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD and has documentation of a performed *spirometry evaluation*. Two methods are provided to identify patients documented spirometry evaluation and/or physical inability: claims and medical record data.

Most recent Spirometry (FEV) Results:

Gold 1: Mild	≥80%
Gold 2: Moderate	50%-80%
Gold 3: Severe	30%-50%
Gold 4: Very Severe	<30

Most recent documentation over the last 5 years from last day of the reporting period, as evidenced through claims data and medical record data. Below is a list of codes to identify spirometry evaluation:

COPD symptom assessment: HCPCS code: 1015F

Spirometry:
CPT-I codes: 94010, 94014, 94015, 94016, 94060, 94070, 94150, 94620
CPT-II codes: 3023F, 3025F, 3027F, 3040F, 3042F

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

This includes those patients with COPD who had one of the following:

1. Documentation indicating the date and spirometry results (FEV1 and FEV1/FVC) AND COPD severity assessment.

2. Documentation of spirometry evaluation AND COPD severity assessment 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:

- Patient self-reporting

Frequency: Most recent documentation over the last 5 years from last day of the reporting period.

Scoring: (Numerator/Denominator) * Total Points available

Source and Level of Evidence: ACP/ACCP/ATS/ERS, LOE: Strong

Inhaled Bronchodilator Therapy: LAMA/LABA for Patients with FEV1 <60% Predicted

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Forced Expiratory Volume (FEV1) of < 60% predicted, and at least one COPD symptom, should be prescribed or dispensed at least one long-acting anti-muscarinic (LAMA) OR long-acting beta agonist (LABA) OR a LAMA/LABA combination 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, Forced Expiratory Volume (FEV1) < 60% predicted, and COPD symptoms for the denominator, and claims/encounter, pharmacy or medical record data for inhaled bronchodilator prescription for LAMA OR LABA OR a combination of the two information for the numerator.

Explanation: The ACP/ACCP/ATS/ERS, and GOLD groups all strongly recommend that patients with COPD, who have an FEV1 <60% predicted and are symptomatic use an inhaled bronchodilator. They strongly recommend that these patients use a LAMA OR LABA OR a combination of the 2 classes for initial management of COPD. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40) AND who have documentation of an FEV1 < 60% predicted and at least one COPD symptom (i.e., dyspnea, cough, sputum, wheezing).

Two methods are provided to identify patients' FEV1 < 60% predicted and COPD symptoms: claims and medical record data.

DATA Collection: The patient is denominator compliant if the patient has a diagnosis of COPD, documentation of an FEV1 < 60% predicted and at least one of the following COPD symptoms: dyspnea, cough, sputum, wheezing, during the reporting period, as identified by administrative claims data. The following codes may be used to identify a documentation of FEV1 < 60% predicted AND COPD symptoms:

<u>Spirometry test results demonstrate FEV1/FVC < 70%, FEV < 60% predicted and patient has COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)</u>
HCPCS: G8924

Or a Combination of the following codes:

<u>Spirometry Test Results of FEV1 < 60% predicted</u>
CPT-II Codes: 3025F, 3040F

<u>Dyspnea</u>:
ICD-9 Codes: 786.00, 786.01, 786.02, 786.05, 786.06, 786.09
ICD-10 Codes: R06.9, R06.4, R06.01, R06.02, R06.82, R06.00, R06.09, R06.3, , R06.89

HCPCS: 1019F

Cough:
ICD-9 Codes:, 491.0, 491.8, 491.9,786.2
ICD-10 Codes:, J41.0, J41.1, J41.8, R05

Sputum:
ICD-9 Codes: 786.4
ICD-10 Codes: R09.3

Wheezing:
ICD-9 Codes: 786.07
ICD-10 Codes: R06.2

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

1. Documentation indicating the date of an FEV1 < 60% predicted

2. Dated documentation of an FEV1 < 60% predicted 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.

Numerator: Patients in the denominator who were prescribed or dispensed at least one inhaled bronchodilator of the LAMA or LABA classes, in the absence of contraindications. (Medications may be found starting on page 41 under "Relevant Medication Lists for COPD Care Measurement Set") unless allergy or contraindication is recorded in chart.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD, documentation of an FEV1 < 60% predicted and at least one of the following COPD symptoms (dyspnea, cough, sputum, wheezing, during the reporting period), and were prescribed or dispensed at least one inhaled bronchodilator of the LAMA or LABA classes, in the absence of contraindications.

Three methods are provided to identify patients documented with appropriate COPD medication use: pharmacy, medical claims and medical record data, have documentation of a Forced Expiratory Volume (FEV1) < 60% predicted and at least one COPD symptom.

Electronic Collection: The patient is numerator compliant if he or she has documented evidence of inhaled bronchodilator medication (LAMA or LABA) use or contraindication to inhaled bronchodilator medications in these classes, as identified by pharmacy or claims data. This includes those patients with COPD, FEV1 < 60% and at least one COPD symptom who had one of the following:

1. Inhaled bronchodilator medication(s) (LAMA or LABA) prescribed or dispensed during the reporting period.

2. Evidence of contraindication or previous adverse reaction to inhaled bronchodilator medications (LAMA or LABA)

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, 995.27 with E945.8, and 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

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

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:

- Patient self-reporting

Exclusions: Documentation of medical reason(s) for not prescribing an inhaled bronchodilator (4025F with 1P)
OR
Patient Performance Exclusion: Documentation of patient reason(s) for not prescribing an inhaled bronchodilator (4025F with 2P)
OR
System Performance Exclusion: Documentation of system reason(s) for not prescribing an inhaled bronchodilator (4025F with 3P)
AND
Spirometry test results demonstrate FEV1 < 60% predicted and patient has COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) (G8924)

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

Scoring: (Numerator/Denominator) * Total Points available

Source and Level of Evidence: ACP/ACCP/ATS/ERS, LOE: Strong

Inhaled Bronchodilator Therapy: Inhaled Corticosteroid Therapy only in Combination with LAMA/LABA

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who had a FEV1 < 60% predicted, and at least one COPD symptom, who were prescribed or dispensed an inhaled corticosteroid (ICS) only in addition to another therapy, such as LAMA/LABA long-acting anti-muscarinic / long-acting beta agonist).

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 < 60% predicted, and COPD symptoms, as well as a prescription for ICS for the denominator, and claims/encounter, pharmacy or medical record data for inhaled bronchodilator prescription for - LAMA OR LABA OR a combination of the two for the numerator.

Explanation: The ACP/ACCP/ATS/ERS, and GOLD groups all strongly recommend that patients with COPD, who have an FEV1<60% predicted use an inhaled bronchodilator. They strongly recommend that these patients use a LAMA OR LABA OR a combination of the 2 classes for initial management of COPD. Only patients who are already prescribed a LAMA/LABA or combination should be prescribed an ICS. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40) and who have documentation of an FEV1 < 60% predicted, at least one COPD symptom (i.e., dyspnea, cough, sputum, wheezing) who have been prescribed or dispensed an ICS. (Medications may be found starting on page 41 under "Relevant Medication Lists for COPD Care Measurement Set") unless allergy or contraindication is recorded in chart.

The following codes may be used to identify FEV1 < 60% predicted AND COPD symptoms:

G8924 or a Combination of the following codes

Spirometry Test Results of FEV1 < 60% predicted
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
HCPCS code: 1019F

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

The following code may be used to identify patients that were prescribed an inhaled corticosteroid:

Inhaled corticosteroids prescribed (Asthma)
CPT-II Code: 4140F

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

1. Documentation indicating the date of an FEV1 <60% predicted . *This does not need to be in the reporting period, but needs to be in the chart.*

2. Dated documentation of an FEV1 <60% predicted 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.

Numerator: Patients in the denominator who were prescribed or dispensed a LAMA/LABA inhaled bronchodilator (Medications may be found starting on page 48 under "Relevant Medication Lists for COPD Care Measurement Set") unless allergy or contraindication is recorded in chart.

DATA Collection: Three methods are provided to identify patients documented to have appropriate COPD medication use: pharmacy, medical claims and medical record data.

Medical Record Collection: Evidence of one of the following is present in the eligible patients to identify a prescription of an ICS in patient's chart:

1. Inhaled bronchodilator medication(s) (ICS) prescribed or dispensed during the reporting period.

2. Evidence of contraindication or previous adverse reaction to inhaled bronchodilator medications (ICS)

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

Inhaled bronchodilator prescribed (COPD): 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 (ICS) use OR previous adverse reaction or contraindication to inhaled bronchodilator medications in this classes. This includes those patients with COPD, a FEV1 < 60% predicted and at least one COPD symptom who had one of the following:

4. Documentation indicating the date on which an inhaled bronchodilator ICS medication was prescribed during the reporting period.

5. Dated documentation of a prescription for an inhaled bronchodilator medication from another treating clinician during the reporting period.

6. 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:

- Patient self-reporting

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

Scoring: (Numerator/Denominator) * Total Points available

Source and Level of Evidence: ACP/ACCP/ATS/ERS, LOE: Strong

Documentation of Tobacco Status

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), who have documentation of tobacco use status.

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 COPD for the denominator, and medical record data for documentation of tobacco use status information for the numerator.

Explanation: The 2017 GOLD guidelines strongly recommend that COPD patients do not use tobacco products and that those who do received cessation counseling and treatment. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator with documentation of tobacco use status.

DATA Collection: The patient is numerator compliant if he or she has tobacco use status documented.

Below is a list of codes that can also be used to identify patients that had tobacco use assessed:

HCPCS codes: 1000F, 1031F, 1034F, 1035F, 1036F

The patient is NOT numerator compliant if:

1. His or her tobacco use status documentation is missing

OR

2. His or her tobacco status was not asked

Frequency: Most recent tobacco use status over the last 12 months from the last day of the reporting period.

Scoring: (Numerator/Denominator) * Total Points Possible = Points awarded

Source and Level of Evidence: GOLD, Best practice

Documentation of Tobacco Cessation Counseling if user – and Treatment

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who use tobacco and have received cessation counseling or treatment during the reporting period.

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 COPD that use tobacco for the denominator, and medical record data for documentation of cessation counseling or treatment information for the numerator.

Explanation: The 2017 GOLD guidelines strongly recommend that COPD patients do not use tobacco products and that those who do received cessation counseling and treatment. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40) AND who are users of tobacco products.

Numerator: Patients in the denominator who are tobacco users and have received cessation counseling and/or treatment.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD and is a tobacco user is a tobacco user and has documented date of receipt of cessation counseling and/or treatment during the reporting period, as identified by medical claims data or medical record data. The following codes may be used to identify smoking cessation counseling and/or treatment:

CPT I codes: 99406, 99407

CPT II codes: 4000F, 4001F, 4004F

HCPCS codes: S9453, G0436, G0437, G9458

For a list of numerator compliant medications, see Table 8, page under "Tobacco Cessation Medications", page 42.

Medical Record Collection: 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 tobacco user, the patient is NOT numerator compliant if:

1. His or her status documentation is missing.
   OR
2. His or her tobacco user 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 available during the reporting period.

Frequency: Most recent counseling/treatment within the 12 months prior to the last day of the reporting period.

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: GOLD 2017, Best Practice

Assessment of Oxygen Saturation

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and who had 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.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40) 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.

DATA Collection: The patient is denominator compliant if the patient has a diagnosis of COPD and 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.

<u>FEV1 < 40% of Predicted Value</u>
CPT-II codes: 3040F

<u>Respiratory Failure</u>
ICD-9 codes: 518.83, 518.84
ICD-10 codes: J96.10-J96.12, J96.20-J96.22

<u>Right Heart Failure</u>
ICD-9 codes: 428.0, 428.3
ICD-10 codes: I50.20, I50.30
Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

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.

Numerator: Patients in the denominator with documentation of oxygen saturation assessment in the last 12 months, from the last day of the reporting period.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD and has documentation of an FEV1 < 40% of predicted value, respiratory failure, or right heart failure, AND documentation of an oxygen saturation assessment..

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.

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

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

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.

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

- Patient self-reporting

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

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: ACP/ACCP/ATS/ERS, LOE: Strong

Long Term Oxygen Therapy

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and who had a resting oxygen saturation level of ≤ 88% or a PaO2 ≤ 55 mmHg, who have been prescribed long-term oxygen therapy.

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

Explanation: The ACP/ACCP/ATS/ERS, and GOLD groups all strongly recommend that patients whose disease is stable on a full medical regimen, with an oxygen saturation level of ≤ 88% or PaO2 < 55 mmHg, should receive long-term oxygen therapy. Along with smoking cessation, oxygen therapy has shown significant decrease in morbidity and mortality when used in these patients. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40) AND documentation of an oxygen saturation level of ≤ 88% or a PaO2 ≤ 55 mmHg.. Two methods are provided to identify patients' oxygen saturation or PaO2 level: claims and medical record data.

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

CPT-II codes: 3035F

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

1. Documentation indicating an oxygen saturation level of ≤ 88% or a PaO2 ≤ 55 mmHg during the reporting period.

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

Numerator: Patients in the denominator 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.

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.

Long-term oxygen therapy prescribed (more than 15 hours per day) (COPD)
CPT-II code: 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 ≤ 88% or a PaO2 ≤ 55 mmHg who had one of the following:

1. Documentation indicating the date on which long-term oxygen therapy (defined as > 15 hours per day) was prescribed during the reporting period.

2. Dated documentation of a prescription for long-term oxygen therapy (defined as > 15 hrs. per day) from another treating clinician.

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

- Patient self-reporting

Exclusions: Patients are excluded from the denominator if they are actively smoking or live with active smokers due to an increased risk of fire and explosion.

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

Scoring: (Numerator/Denominator) * Total Points available

Source and Level of Evidence: ACP/ACCP/ATS/ERS, LOE: Strong

Influenza Immunization

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) for whom influenza immunization was recommended, administered or previously received during the reporting year.

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). In addition, the GOLD guidelines recommend this vaccine annually in these patients. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator who received an influenza immunization OR who reported previous receipt of an influenza immunization. Influenza immunization administered or previously received (G8482).

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD, and had documentation of having ever received the influenza vaccine as identified by claims data. Below is a list of codes to identify the administration of influenza vaccine:

CPT-I codes: 90682, 90685, 90686, 90687, 90688
CPT-II codes: 4037F

Exclusions: Documentation of medical reason(s) for not administering influenza immunization (e.g. patient allergic reaction, patient refusal, vaccine not available – G8483).

Frequency: This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of COPD seen during the reporting period.

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: GOLD LOE-B

Pneumonia Immunization (PCV 13)

Description: Percentage of patients over 66 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who received the pneumonia vaccination (PCV-13).

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 PCV-13 vaccination information for the numerator.

Explanation: The GOLD guidelines recommend that patients with COPD all receive the PCV-13 pneumonia vaccine at age 66 or sooner. If covered by insurance, this vaccine should be given at a younger age. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: Patients aged 66 and older with a diagnosis of COPD. See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator with documentation of having ever received the PCV-13 vaccine.

DATA Collection: The patient is numerator compliant if the patient is 66 years of age or older (during the reporting period), has a diagnosis of COPD, and had documentation of having ever received the PCV-13 vaccine as identified by claims data. Below is a list of codes to identify the administration of PCV-13 vaccine:

CPT-I codes: 90670
CPT-II codes: 4040F

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

1. Documentation indicating the PCV-13 vaccine was administered to the patient during his or her lifetime.

2. Documentation of administration of the PCV-13 vaccine by another treating clinician during his or her lifetime.

The following is not acceptable documentation:

- Patient self-reporting

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

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: GOLD LOE- B

Pneumonia Immunization (PCV 23)

Description: Percentage of patients over 67 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who received the pneumonia vaccination (PCV-23).

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 PCV-23 vaccination information for the numerator.

Explanation: The GOLD guidelines recommend that patients with COPD all receive the PCV-23 pneumonia vaccine at age 67 or sooner. If covered by insurance, this vaccine should be given at a younger age. This vaccine is typically administered 1 year after PCV-13. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: Patients aged 67 and older with a diagnosis of COPD. See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator with documentation of having ever received the PCV-23 vaccine.

DATA Collection: The patient is numerator compliant if the patient is 67 years of age or older (during the reporting period), has a diagnosis of COPD, and whom had documentation of having ever received the PCV-23 vaccine as identified by claims data. Below is a list of codes to identify the administration of PCV-23 vaccine:

CPT-I codes: 90732
CPT-II codes: 4040F

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

1. Documentation indicating the PCV-23 vaccine was administered to the patient during his or her lifetime.

2. Documentation of administration of the PCV-23 vaccine by another treating clinician during his or her lifetime.

The following is not acceptable documentation:

- Patient self-reporting

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

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: GOLD LOE- B

Follow-Up after Hospital Admission with COPD exacerbation

Description: Percentage of patients 18 through 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) requiring hospitalization who have followed up with their PCP, pulmonologist, or have been referred to pulmonary rehab within 30 days of hospital discharge.

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, or medical record data to show documentation of follow-up visit after hospitalization.

Explanation: According to the National Institute for Health and Care Excellence (NICE) 2016 clinical practice guidelines, patients who are discharge from the hospital following a COPD exacerbation should have prompt outpatient follow-up. The NICE guidelines recommend follow-up with PCP, pulmonologist, or referral to pulmonary rehab within 4 weeks (30 days) of hospital discharge. This has been shown to significantly decrease hospital readmission and future exacerbations. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: Patients aged 18 through 80 years of age with a diagnosis of COPD AND documentation of at least one exacerbation in last 12 months. See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

DATA Collection: The patient is denominator compliant if the patient has a diagnosis of COPD and has had at least one exacerbation in last 12 months. The following codes may be used to identify a documented COPD exacerbation (may need to adjust codes if we want to capture only those exacerbations that lead to IP stay):

ICD-9 codes: 491.21, 493.22
ICD-10 codes: J44.1
CPT-I codes: 99281, 99282, 99283, 99284, 99285 (must be accompanied by ICD-9 code 491, 492 or 496)
CPT-II code: 4033F

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

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

Numerator: Patients in the denominator who have a history of a COPD exacerbation requiring hospitalization within the last 12 months, who were seen for an outpatient follow-up

appointment with their PCP, pulmonologist, or pulmonary rehab within 30 days of hospital discharge.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD, was hospitalized for at least one exacerbation in last 12 months and has documented evidence of outpatient follow-up appointment with their PCP, pulmonologist, or pulmonary rehab within 30 days of hospital discharge as evidenced by medical record or claims data.

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

- Documentation of the patient having an outpatient follow-up appointment with their PCP, pulmonologist, or pulmonary rehab within 30 days of hospital discharge.

Frequency: Most recent COPD exacerbation requiring hospitalization within the past 12 months.

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: NICE 2016, Best Practice

Lung Cancer Screening with Low Dose CT

Description: Percentage of patients 55 to 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) with at least a 30-pack year history and who continue to smoke or have quit within the past 15 years should be offered a low dose CT to screen for lung cancer.

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, significant smoking history and smoking status for the denominator, and claims/encounter data, or medical record data to show documentation of CT scan being offered to patient.

Explanation: According to the United States Preventative Service Task Force (USPSTF), patients with significant smoking history as described above should be offered annual lung cancer screening with low dose CT annually. Lung cancer is significantly more common in patients with COPD and a smoking history, and low dose CT screening has been shown to significantly increase survival in asymptomatic patients who screen positively. This test is not recommended after an individual has quit smoking for over 15 years or has limited life expectancy. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: Number of patients 55 to 80 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) with at least a 30-pack year history and who continue to smoke or have quit within the past 15 years. See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator who were offered a low dose CT to screen for lung cancer within the reporting period.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD and whom had documentation of a low dose CT to screen for lung cancer was performed or was offered to the patient.

The following codes may be used to identify Low Dose CT (LDCT) Scan:

HCPCS: G0296, G0297

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

1. Documentation of a performed low dose CT to screen for lung cancer.
2. Documentation of a low dose CT to screen for lung cancer was offered to the patient.

Frequency: Annually

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: USPSFT, LOE- B

Advance Health Care Directives for Patients with Severe COPD

Description: Percentage of patients over 60 years of age with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) who had a GOLD Level 3 or 4 (severe or very severe) diagnosis, should have advanced health care directives documented in their chart.

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 Gold Level 3 or 4 COPD diagnosis, and documentation of advanced health care directives.

Explanation: According to the American Academy of Family Physicians (AAFP), patients with diagnoses which can limit life expectancy and increase morbidity and mortality, such as COPD, should have an advanced health care directive documented in their chart. Having these advanced directives has been shown to improve end-of-life care, patient satisfaction, and family stress. It is anticipated that clinicians who provide services for the primary management of COPD will submit this measure.

Denominator: Patients aged 60 years of age or older and have a diagnosis of COPD. See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator with a Gold 3 or 4 (severe or very severe) COPD diagnosis who have documentation of advance health care directives in their medical chart.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of Gold 3 or 4 (severe or very severe) COPD diagnosis and whom have documentation of advanced health care directives in their medical chart. The following codes may be used to identify a documented Advance Care Planning:

CPTII: 1123F, 1124F, 1123 with 8P modifier

Medical Record Collection: Evidence of one of the following is present in the eligible patient's chart:

- Documentation of the patient having an advanced health care directive in their medical chart.

Frequency: Once

Scoring: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: AAFP, LOE- B

Assessment of COPD Exacerbations

Description: Percentage of patients with a diagnosis of Chronic Obstructive Pulmonary Disease (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 ACP/ACCP/ATS/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.

Denominator: See "Patient Eligibility Criteria", beginning on page 39, for information on codes to identify patients with COPD (Table 3, page 40).

Numerator: Patients in the denominator who have documentation of the number of exacerbations during the reporting period.

DATA Collection: The patient is numerator compliant if the patient has a diagnosis of COPD and has documentation of the number of exacerbations during the reporting period. The following codes may be used to identify a documented exacerbation during the reporting period, as identified through claims and/or ED encounter data with a principal diagnosis of COPD:

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: Evidence of one of the following is present in the eligible patient's chart:

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: (Numerator/Denominator) * Total Possible Points

Source and Level of Evidence: GOLD, Best Practice

Recognition Process

Applying for Recognition

Clinician applicants opt to voluntarily submit their data to BTE 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 Altarum. All necessary steps will be taken by the data aggregator and BTE 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 applicantwill 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 an electronic 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 back loaded, 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 award 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. BTE 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 mail, electronically or on site, as determined by BTE. 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.

BTE will notify the data aggregator, which will notify the applicant if their application is chosen for audit, ascertain that audit personnel have no conflict of interest with the audited organization and provide instructions on audit requirements. Obtaining final Recognition results takes longer than usual for applicants chosen for audit. For those applicants selected for audit, final Recognition determination will be made within 60 days of the date of data submission. Upon passing an audit, the applicant's recognition dates are assigned retroactively to the date the applicant's data was scored. Failure to pass an audit or failure to respond to an audit request and complete the audit within 30 days results in no further consideration for the 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 their current practice and patient base. Clinicians are responsible for informing the data aggregator within 30 days who will inform BTE 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 Three Star 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 (3, 4, or 5 Stars) 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 Four Stars or Five Stars 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 Three Stars for two consecutive quarterly assessments will be assigned or maintain Three Star COPD Care Recognition status and maintain their current begin and end recognition dates.

Example 1

- A provider submitted for Q1 and was assessed at a 3 Star Rating
  - The providers 'Current Recognition' Level is a 3 Star Rating
- The provider was submitted in Q2 and was assessed at a 5 Star Rating
  - The providers 'Current Recognition' Level is a 3 Star Rating
- The provider was submitted in Q3 and was assessed at a 4 Star Rating
  - The providers 'Current Recognition' Level is now a 4 Star Rating

How this works:

If a provider's assessment level increases for 2 consecutive assessments, the new recognition level equals the lower of the 2 most recent assessment levels.

Assessment Date	Assessed Rating	Recognition Rating	Recognition Dates
Q1	3	3	01/21/2013 - 01/20/2015
Q2	5	3	04/21/2013 - 04/20/2015
Q3	4	4	07/21/2013 -07/20/2015

Example 2

- A provider submitted in Q1 and was assessed at a 5 Star Rating
  - The providers 'Current Recognition' Level is a 5 Star Rating
- The provider submitted in Q2 and was assessed at a 4 Star Rating
  - The providers 'Current Recognition' Level is a 5 Star Rating
- The provider submitted in Q3 and was assessed at a 3 Star Rating
  - The providers 'Current Recognition' Level is now a 4 Rating

How this works:

If a provider's assessment level decreases for 2 consecutive assessments, the new recognition level equals the higher of the 2 most recent assessment levels.

Assessment Date	Assessed Rating	Recognition Rating	Recognition Dates
Q1	5	5	01/21/2013 - 1/20/2015
Q2	4	5	04/21/2013 - 04/20/2015
Q3	3	4	07/21/2013 - 07/20/2015

Example 3

- A provider submitted for Q1, Q2, and Q3, and was assessed at a 5 Star Rating all three submissions
  - The providers 'Current Recognition' Level remains unchanged and will be a 5 Star Rating

How it works:

If a provider's assessment level remains the same for 2 consecutive assessments, the recognition level is unchanged.

Assessment Date	Assessed Rating	Recognition Rating	Recognition Dates
Q1	5	5	01/21/2013 - 1/20/2015
Q2	5	5	04/21/2013 - 04/20/2015
Q3	5	5	07/21/2013 - 07/20/2015

Reporting Results to BTE and Its Partners

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

- To the data aggregator partner through which the recognition application was submitted. The data aggregator is required to share results reports with the clinician applicant to facilitate quality improvement.
- To BTE: Only Recognized statuses are reported to BTE for display on Altarum's BTE web site: www.bridgestoexcellence.org and transmission to BTE-licensed health plans for associated rewards payments. Once the final decision is made, Altarum will reveal the identity, program name and program rating 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

BTE 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.

Patient Eligibility Criteria

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

1. Is between 18 and 80 years of age.[2]

2. Has had a documented diagnosis of COPD (as defined in Table 3 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 one or care between the clinician and the patient: one within 12 months of the last day of the reporting period.

There are two accepted data sources that can be used to identify patients with COPD:

Claims/Encounter data: Patient is denominator compliant if the patient is 18-80 years of age during the measurement period, with a documented diagnosis of COPD listed on the problem list, has had at least one (1) face-to-face encounter in an ambulatory setting and has been under the care of the applicant for at least 12 months. See Table 3 for further information on diagnoses to identify patients with COPD and Table 2 for further information on procedural codes to identify a face-to-face visit.

Medical Record data: Patient is denominator compliant if the patient is 18-80 years of age during the measurement period, with a documented diagnosis of COPD listed on the problem list, has had at least one (1) face-to-face encounter in an ambulatory setting and has been under the care of the applicant for at least 12 months. See Table 3 for further information on diagnoses to identify patients with COPD and Table 2 for further information on procedural codes to identify a face-to-face visit.

Exclusions: Patients in hospice or palliative care are excluded from the denominator. See Table 4 below for further information on codes to identify patients with exclusions.

[2] As of the last day of the reporting period. Patients known to be deceased should be excluded.

Relevant Procedural and Diagnosis Codes for COPD Care Measurement Set

Table 2: Face-to-Face Visits

Procedural Codes
CPT: 99201-99215 Value Set Authority-Value Set Name - Office Visit - 2.16.840.1.113883.3.464.1003.101.12.1001 CPT: 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350 Value Set Authority-Value Set Name - Home Healthcare Services - 2.16.840.1.113883.3.464.1003.101.12.1016 HCPCS: G0438, G0439 Value Set Authority-Value Set Name - Annual Wellness Visit -2.16.840.1.113883.3.526.3.1240 CPT: 99385, 99386, 99387 Value Set Authority-Value Set Name - Preventive Care Services-Initial Office Visit, 18 and Up - 2.16.840.1.113883.3.464.1003.101.12.1023 CPT: 99395,99396,99397 Value Set Authority-Value Set Name - Preventive Care Services - Established Office Visit, 18 and Up - 2.16.840.1.113883.3.464.1003.101.12.1025

Table 3: Codes to Identify Patients with a COPD

Diagnosis Codes
ICD-9: 493.20, 493.21, 493.22, 496 ICD-10: J44.0, J44.1, J44.9 Value Set Authority-Value Set Name - Chronic Obstructive Pulmonary Disease - 2.16.840.1.113883.3.464.1003.102.12.1007

Table 4: Codes/Notations to Identify Patients with Exclusions

Procedural & Diagnosis Codes / Notations
Hospice Care CPT: 99377, 99378 Value Set Authority-Value Set Name-Hospice Care CPT-OID 2.16.840.1.113883.3.3157.1004.19 Palliative Care ICD-9: V66.7 ICD-10: Z51.5 Value Set Authority-Value Set Name- Palliative Care-OID 2.16.840.1.113762.1.4.1125.3

Relevant Medication Lists for COPD Care Measurement Set

Table 5: Corticosteroids, Inhaled (ICS)

Drug Names	Generic Names
Advair Diskus	Fluticasone propionate/salmeterol inhaled
Advair HFA	Fluticasone propionate/salmeterol inhaled
AeroBid	Flunisolide Inhaled
Aerospan	Flunisolide Inhaled
Alvesco	Ciclesonide Inhaled
Arnuity Ellipta	Fluticasone Furoate Inhaled
Asmanex HFA	Mometasone Inhaled
Asmanex Twisthaler	Mometasone Inhaled
Breo Ellipta	Fluticasone Furoate/Vilanterol Inhaled
Budesonide Inhaled	Generic
Dulera	Mometasone/Formoterol Inhaled
Flovent Diskus	Fluticasone Propionate Inhaled
Flovent HFA	Fluticasone Propionate Inhaled
Pulmicort Flexhaler	Budesonide Inhaled
Pulmicort Respules	Budesonide Inhaled
Qvar	Beclomethasone Dipropionate Inhaled
Symbicort	Budesonide/Formoterol Inhaled

Table 6: Beta-2 Agonists: Long-acting Inhaled (LABAs)

Drug Names	Generic Names
Advair Diskus	Fluticasone Propionate/Salmeterol Inhaled
Advair HFA	Fluticasone Propionate/Salmeterol Inhaled
Anoro Ellipta	Umeclidinium/Vilanterol Inhaled
Arcapta Neohaler	Indacaterol Inhaled
Bevespi Aerosphere	Glycopyrrolate/Formoterol Fumarate Inhaled
Breo Ellipta	Fluticasone Furoate/Vilanterol Inhaled
Brovana	Arformoterol Inhaled
Dulera	Mometasone/Formoterol Inhaled

Foradil Aerolizer	Formoterol Inhaled
Perforomist	Formoterol Inhaled
Serevent Diskus	Salmeterol Inhaled
Stiolto Respimat	Tiotropium/Olodaterol Inhaled
Striverdi Respimat	Olodaterol Inhaled
Symbicort	Budesonide/Formoterol Inhaled
Utibron Neohaler	Indacaterol/Glycopyrrolate Inhaled

Table 7: Long-Acting Muscarinic Antagonists (LAMA) - Anticholinergics, Inhaled

Drug Names	Generic Names
Anoro Ellipta	Umeclidinium/Vilanterol Inhaled
Atrovent HFA	Ipratropium Bromide Inhaled
Bevespi Aerosphere	Glycopyrrolate/Formoterol Fumarate Inhaled
Combivent	Ipratropium Bromide/Albuterol Inhaled
Combivent Respimat	Ipratropium Bromide/Albuterol Inhaled
DuoNeb	Ipratropium Bromide/Albuterol Inhaled
Incruse Ellipta	Umeclidinium Inhaled
Ipratropium Bromide Inhaled	Generic
Ipratropium Bromide/Albuterol Inhaled	Generic
Spiriva HandiHaler	Tiotropium Inhaled
Spiriva Respimat	Tiotropium Inhaled
Stiolto Respimat	Tiotropium/Olodaterol Inhaled
Tudorza Pressair	Aclidinium Bromide Inhaled
Utibron Neohaler	Indacaterol/Glycopyrrolate Inhaled

Table 8: Tobacco Cessation Medications

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

APPENDICES

Appendix A: Audit Methodology

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

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

Detailed audit policies are included in the *Recognition Process* section of this guide.

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

Clinician Identifier Data

Data Field	Data Field Specifications and Acceptable/Valid Data Range(s)
Clinician_RespID	(Required field) Alphanumeric value up to 26 characters in length
Clinician_NPI	(Required field) Numeric value 10 characters in length
Clinician_DEA	Alphanumeric value 9 characters in length First letter must be “A”, “B”, “F” or “M”.
Clinician_MedicalLicense	Alphanumeric value up to 10 characters in length
Clinician_LastName	(Required field) Alpha value up to 50 characters in length
Clinician_FirstName	(Required field) Alpha value up to 50 characters in length
Clinician_MiddleName	Alpha value up to 30 characters in length
Clinician_Degree	(Required field) Numeric value 01 = M.D. 02 = D.O. 03 = N.P. 04 = P.A.
Clinician_PracticeAddress1	(Required field) Alphanumeric value up to 100 characters in length
Clinician_PracticeAddress2	Alphanumeric value up to 100 characters in length
Clinician_PracticeCity	(Required field) Alpha value up to 100 characters in length

Clinician_PracticeState	(Required field) Alpha value 2 characters in length
Clinician_PracticeZipCode	Numeric value 5 (#####), 9 (#########) or 10 characters (#####-####) in length
Clinician_emailaddress	Example smith@email.com
Clinician_PracticePhone	Alphanumeric value up to 30 characters in length
Clinician_DateofBirth	Numeric value: MM/DD/YYYY
Clinician_Gender	F = Female M = Male U = Unknown
Clinician_Specialty	01 = Allergy/Immunology 02 = Cardiology 03 = Critical Care Services 04 = Dermatology 05 = Endocrinology 06 = Gastroenterology 07 = Gen/Fam Practice 08 = Geriatric Medicine 09 = Hematology 10 = Infectious Disease 11 = Internal Medicine 12 = Nephrology 13 = Neurology 14 = Neurosurgery 15 = Obstetrics/Gynecology 16 = Occ. Medicine 17 = Oncology 18 = Ophthalmology 19 = Orthopedics 20 = Otolaryngology 21 = Pediatrics 22 = Phys/Rehab Medicine 23 = Psychiatry 24 = Psychopharmacology 25 = Pulmonary Medicine 26 = Rheumatology 27 = Surgery 28 = Urology 29 = Other – not listed
Practice ID	(Required field) Alphanumeric value up to 26 characters in length
PracticeName	(Required field) Alpha value up to 100 characters in length

Individual_Group	(Required Field) Alpha value "I" - Individual Scoring or "G" - Group Scoring
Group_GroupID	If yes, Provide the Group ID that the Individual Provider wishes to be associated with. Numeric value 10 characters in length
Data Submission through CCHIT /Meaningful Use Certified System	Yes/No
Full Patient Panel	Yes/No

Clinical Measures Data

Data field	Data field specifications	Data Values
ResponsibleProviderID	Internal provider ID that matches with the ID in the physician file	Any unique combination of characters and numbers
NPI	Responsible Provider NPI	Alphanumeric value 10 characters in length
groupID	The unique identifier that will identify the providers within a group applying for recognition together.	Alphanumeric value up to 50 characters in length
individualGroup	G if the provider is applying as part of a group for recognition. I if the provider is applying individually.	I or G - blank will default to I
ChartID	Unique patient or chart ID	Alphanumeric value up to 50 characters in length
lastVisitDate	The date of the last face-to face encounter/visit for the patient	MM/DD/YYYY - cannot be after the end of the reporting period
PatientDOB	The date of birth, or year of birth, of the patient	MM/DD/YYYY - or YYYY
patientGender	Patient's Gender	Female, Male
medicarePartB	Is the patient a Medicare Part B Fee-For-Service (FFS) beneficiary (includes Railroad Retirement Board, Medicare Secondary Payer, and Critical Access Hospitals method II; does not include Medicare Advantage beneficiaries)?	YES, NO
COPDDiagnosis	Does the patient have a diagnosis of COPD?	YES, NO
COPDSymptoms	Is the patient experiencing any COPD symptoms?	YES, NO

SpirometryEvalResults	Most recent Spirometry (FEV) Results: Gold 1: Mild ≥80% Gold 2: Moderate 50%-80% Gold 3: Severe 30%-50% Gold 4: Very Severe <30	numeric value (0-100)
SpirometryEvalDate	Most recent Spirometry evaluation date	MM/DD/YYYY - cannot be after the end of the reporting period
InhaledBronchodilatorPrescribedDATE	Was the patient prescribed a Long-Acting Anti-Muscarinic (LAMA), Long-Acting Beta Agonist (LABA) or a LAMA/LABA combination?	MM/DD/YYYY - cannot be after the end of the reporting period
InhaledCorticosteroidDispensedDate	Inhaled Corticosteroid Therapy dispense date?	MM/DD/YYYY - cannot be after the end of the reporting period
InhaledCorticosteroidPrescribedDate	Inhaled Corticosteroid Therapy prescription date?	MM/DD/YYYY - cannot be after the end of the reporting period
tobaccoStatus	Is the patient a tobacco user?	Tobacco Free Smoking Reduced Light Smoker (1-9 cigs/day) Moderate smoker (10-19 cigs/day) Heavy smoker (20-39 cigs/day) Very heavy smoker (40+ cigs/day)
tobaccoStatusAssessmentDate	Date the patient's tobacco use status was most recently assessed	MM/DD/YYYY - cannot be after the end of the reporting period
tobaccoCessationAdviceOrTreatmentDate	Date the patient was most recently given tobacco cessation counseling or treatment	MM/DD/YYYY - cannot be after the end of the reporting period
RespiratoryFailureDiagnosis	Does the patient have a diagnosis of Respiratory Failure?	YES, NO
RightHeartFailureDiagnosis	Does the patient have a diagnosis of Right Heart Failure?	YES, NO
OxygenSaturationLevel	Patient's most recent Oxygen Saturation Level	numeric value
OxygenSaturationLevelDate	Date of patient's most recent Oxygen Saturation Level	MM/DD/YYYY - cannot be after the end of the reporting period
PaO2Level	Patient's most recent PaO2 Level	numeric value
PaO2LevelDate	Date of patient's most recent PaO2 Level	MM/DD/YYYY - cannot be after the end of the reporting period
LongTermOxygenTherapyDate	Was the patient prescribed Long-Term Oxygen Therapy?	MM/DD/YYYY - cannot be after the end of the reporting period

InfluenzaImmunization	Was an influenza immunization recommended, ordered, administered or previously received within the reporting year?	YES, NO, documented allergy or contraindication
InfluenzaImmunizationDate	Date Assessed	MM/DD/YYYY - cannot be after the end of the reporting period
PneumococcalVaccine_PCV13	Was a pneumococcal vaccine administered or previously received?	YES, NO, documented allergy or contraindication
PneumococccalVaccineDate_PCV13	Date Assessed	MM/DD/YYYY - cannot be after the end of the reporting period
PneumococcalVaccine_PCV23	Was a pneumococcal vaccine administered or previously received?	YES, NO, documented allergy or contraindication
PneumococccalVaccineDate_PCV23	Date Assessed	MM/DD/YYYY - cannot be after the end of the reporting period
COPDExacerbationEpisodeCount	How many exacerbation episodes did this patient experience during the reporting period?	numeric value
COPDExacerbationEpisodeDate	Date of Episode	MM/DD/YYYY - cannot be after the end of the reporting period
COPDExacerbationEpisodeStateDATE	Did this patient require hospitalization due to the COPD Exacerbation episode?	MM/DD/YYYY - cannot be after the end of the reporting period
COPDExacerbationEpisodeReferralDate	Was this patient referred and seen by their PCP, pulmonologist, or pulmonary rehab within 30 days of hospital discharge?	MM/DD/YYYY - cannot be after the end of the reporting period
FaceToFaceVisit	Did this patient present for a face-to-face visit with pulmonologist, or pulmonary rehab within 30 days of hospital discharge?	MM/DD/YYYY - cannot be after the end of the reporting period
LowDoseCTDate	Date the patient was screened via a low dose CT to screen for lung cancer	MM/DD/YYYY - cannot be after the end of the reporting period
LowDoseCTReferral	Was the patient referred to an imaging center to be screened via a low dose CT to screen for lung cancer?	YES, NO

LowDoseCTDocumented	Was the patient offered a low dose CT to screen for lung cancer?	YES, NO
AdvancedDirective	What is that status of the patient's advanced care directive?	Active Requested Discussed Unavailable

Measures Specifications

COPD Severity Assessed and Recorded, including Spirometry

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- Patient age = 18 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

SpirometryEvalResults =numeric value is present
AND
SpirometryEvalDate = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Inhaled Bronchodilator Therapy: LAMA/LABA for Patients with FEV1 <60% Predicted

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- Patient age = 18 – 80
- COPDDiagnosis = YES
- SpirometryEvalResults =< 60%
- COPDSymptoms =YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

InhaledBronchodilatorPrescribedDATE = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Inhaled Bronchodilator Therapy: Inhaled Corticosteroid Therapy only in Combination with LAMA/LABA

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- Patient age = 18 – 80
- COPDDiagnosis = YES
- SpirometryEvalResults =< 60%
- COPDSymptoms =YES
- lastVisitDate = date is present and within reporting period (12 months)

  AND
- InhaledCorticosteroidDispensedDATE = date is present and within reporting period (12 months)

  OR
- InhaledCorticosteroidPrescribedDATE = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

InhaledBronchodilatorPrescribedDATE = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Documentation of Tobacco Status

DENOMINATOR REQUIREMENTS:

Patients are included in the denominator when:

- PatientAge = 18 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS:

Patients in the denominator are numerator compliant when:

TobaccoStatus = Tobacco Free, Smoking Reduced, Light Smoker, Moderate Smoker, Heavy Smoker or Very Heavy Smoker

AND

tobaccoStatusAssessmentDate = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Documentation of Tobacco Cessation counseling if user – and Treatment

DENOMINATOR REQUIREMENTS:

Patients are included in the denominator when:

- PatientAge = 18 – 80
- COPDDiagnosis = YES
- TobaccoStatus = Tobacco User, Light Smoker, Moderate Smoker, Heavy Smoker or Very Heavy Smoker
- tobaccoStatusAssessmentDate= date is present and within reporting period (12 months)
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS:

Patients in the denominator are numerator compliant when:

TobaccoCessationAdviceOrTreatmentDate = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Assessment of Oxygen Saturation

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 18 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)
  AND
  - SpirometryEvalResults =< 40%

  And/Or
  - RespiratoryFailureDiagnosis = YES

  And/Or
  - RightHeartFailureDiagnosis = YES

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

OxygenSaturationLevel = numeric value present
AND
OxygenSaturationLevelDate = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Long Term Oxygen Therapy

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 18 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)
  AND
  - SpirometryEvalResults =< 88
    AND
  - SpirometryEvalDate = date is present and within reporting period (12 months)

  OR
  - PaO2Level = < 55
    AND
  - PaO2LevelDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

LongTermOxygenTherapyDate = date is present and within reporting period (12 months)

SCORING:

Score=(numerator/denominator) x Total Possible Points

Influenza Immunization

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 18 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

InfluenzaImmunization = Yes or documented allergy or contraindication
AND
InfluenzaImmunizationDate = date is present and within reporting period (12 months)

SCORING

Score=(numerator/denominator) x Total Possible Points

Pneumonia Immunization (PCV 13)

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge =≥66 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

PneumococccalVaccine_PCV13 = Yes or documented allergy or contraindication
AND
PneumococccalVaccine_PCV13Date = date is present and within reporting period (12 months)

SCORING

Score=(numerator/denominator) x Total Possible Points

Pneumonia Immunization (PCV 23)

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = ≥67 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

PneumococcalVaccine_PCV23 = Yes or documented allergy or contraindication
AND
PneumococcalVaccine_PCV23Date = date is present and within reporting period (12 months)

SCORING

Score=(numerator/denominator) x Total Possible Points

Follow-Up after Hospital Admission with COPD exacerbation

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 18 – 80
- COPDDiagnosis = YES
- COPDExacerbationEpisodeDate = date is present and within reporting period (12 months)
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

COPDExacerbationEpisodeReferralDATE = date is present and within 30 days from the COPDExacerbationEpisodeStateDATE

OR

FaceToFaceVisit = date is present and within 30 days from the COPDExacerbationEpisodeStateDATE

SCORING

Score=(numerator/denominator) x Total Possible Points

Lung Cancer Screening with Low Dose CT

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 55 – 80
- COPDDiagnosis = YES
- TobaccoStatus = Moderate Smoker, Heavy Smoker or Very Heavy Smoker
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

LowDoseCTDate = date is present and within reporting period (12 months)

Or

LowDoseCTReferral = YES

Or

LowDoseCTDocumented = YES

SCORING

Score=(numerator/denominator) x Total Possible Points

Advance Health Care Directives for Patients with Severe COPD

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 60 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

SpirometryEvalResults = <50

AND

SpirometryEvalDate = date is present and within reporting period (12 months)

And

AdvancedDirective = Active

SCORING

Score=(numerator/denominator) x Total Possible Points

Assessment of COPD Exacerbations

DENOMINATOR REQUIREMENTS

Patients are included in the denominator when:

- PatientAge = 60 – 80
- COPDDiagnosis = YES
- lastVisitDate = date is present and within reporting period (12 months)

NUMERATOR REQUIREMENTS

Patients in the denominator are numerator compliant when:

COPDExacerbationEpisodeCount = numeric value present

SCORING

Score=(numerator/denominator) x Total Possible Points