

***Measure #28: Aspirin at Arrival for Acute Myocardial Infarction (AMI)**

DESCRIPTION:

Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

INSTRUCTIONS:

This measure is to be reported each time during the reporting period a patient has been discharged from the emergency department with a diagnosis of AMI. Patients who are discharged from the emergency department with a diagnosis of AMI should have documentation in the medical record of having received aspirin 24 hours before emergency department arrival or during emergency department stay. It is anticipated that clinicians who provide care in the emergency department will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

Numerator Coding:

Aspirin Received or Taken 24 hours Before Emergency Department Arrival or During Emergency Department Stay

CPT II 4084F: Aspirin received within 24 hours before emergency department arrival or during emergency department stay

OR

Aspirin not Received or Taken 24 hours Before Emergency Department Arrival or During Emergency Department Stay for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4084F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay
- **2P:** Documentation of patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay

OR

Aspirin not Received or Taken 24 hours Before Emergency Department Arrival or During Emergency Department Stay, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4084F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Aspirin was not received within 24 hours before emergency department arrival or during emergency department stay, reason not otherwise specified

DENOMINATOR:

All patients with an emergency department discharge diagnosis of acute myocardial infarction

Denominator Coding:

An ICD-9 emergency department discharge diagnosis code and a CPT E/M service code to identify patients with a diagnosis of AMI are required for denominator inclusion.

ICD-9 diagnosis codes: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

AND

CPT E/M service codes: 99281-99285, 99291

RATIONALE:

The emergency physician should document that the patient received aspirin no matter where or when the aspirin was taken.

CLINICAL RECOMMENDATION STATEMENTS:

Aspirin should be chewed by patients who have not taken aspirin before presentation with STEMI. The initial dose should be 162 mg (*Level A*) to 325 mg (*Level C*). Although some trials have used enteric-coated aspirin for initial dosing, more rapid buccal absorption occurs with non-enteric-coated aspirin formulations. (ACC/AHA)

▲ Measure #29: Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)

DESCRIPTION:

Percentage of patients with a diagnosis of AMI who had documentation of receiving beta-blocker within 24 hours before or after hospital arrival

INSTRUCTIONS:

This measure is to be reported once during a hospital stay for each occurrence of an AMI during the reporting period. Patients should receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the hospital inpatient setting. It is anticipated that clinicians who provide services in the hospital inpatient setting will submit this measure.

This measure can be reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

NUMERATOR: Acute myocardial infarction patients who received beta blocker within 24 hours before or after hospital arrival

Numerator Coding:

Beta-blocker Received

G8009: Acute myocardial infarction: patient documented to have received beta-blocker at arrival

OR

Beta-blocker not Received for Documented Reasons

G8011: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

OR

Beta-blocker not Received

G8010: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival

DENOMINATOR:

Patients with acute myocardial infarction who present to hospital inpatient setting or are hospitalized

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with acute myocardial infarction are required for denominator inclusion.

ICD-9 diagnosis codes: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

AND

CPT E/M service codes: 99221-99223 (initial inpatient), 99218-99220, 99234-99236 (observation), 99291, 99292 (critical care)

RATIONALE:

The early use of beta blockers in patients with acute myocardial infarction reduces mortality and morbidity (ISIS-1, 1986; Goldstein, 1996; and MIAMI, 1985) and has demonstrated effectiveness in a wide range of AMI patients (Krumholz, 1998). National guidelines strongly recommend early beta blockers for patients hospitalized with AMI (Braunwald, 2002 and Antman, 2004). Despite these recommendations, beta blockers remain under-utilized in eligible older patients hospitalized with AMI (Jencks, 2000).

CLINICAL RECOMMENDATIONS:

Long-Term Beta-blocker Therapy Recommendations in Survivors of Myocardial Infarction (ACC/AHA Revised Recommendations, 1999)

Class IIa

2. Survivors of non–ST-elevation MI.

Class IIb

1. Patients with moderate or severe LV failure or other relative contraindication to β -adrenoceptor blocker therapy, provided patients can be monitored closely.

Class III

No recommendation

When citing this document, the American College of Cardiology and the American Heart Association request that the following citation format be used: Ryan TJ, Antman EM, Brooks NH, Califf RM, Hillis LD, Hiratzka LF, Rapaport E, Riegel B, Russell RO, Smith EE III, Weaver WD. 1999 update: ACC/AHA guidelines for the management of patients with acute myocardial infarction: executive summary and recommendations: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Management of Acute Myocardial Infarction). *Circulation*. 1999;100:1016–1030.

***Measure #30: Perioperative Care: Timing of Prophylactic Antibiotic – Administering Physician**

DESCRIPTION:

Percentage of surgical patients aged 18 and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

INSTRUCTIONS:

This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo surgical procedures with an order for prophylactic antibiotics. It is anticipated that clinicians who provide anesthesia care for surgical procedures will submit this measure.

This measure can be reported using CPT Category II codes:

CPT Category II codes and patient demographics (age, gender, etc) are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Surgical patients for whom administration of a prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Numerator Coding:

Table 2A: The antimicrobial drugs listed below are considered prophylactic antibiotics for the purposes of this measure.

<ul style="list-style-type: none"> • Ampicillin/sulbactam • Aztreonam • Cefazolin • Cefmetazole • Cefotetan 	<ul style="list-style-type: none"> • Cefoxitin • Cefuroxime • Ciprofloxacin • Clindamycin • Erythromycin base • Gatifloxacin 	<ul style="list-style-type: none"> • Gentamicin • Levofloxacin • Metronidazole • Moxifloxacin • Neomycin • Vancomycin
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Prophylactic Antibiotic Given

CPT II 4048F: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

Prophylactic Antibiotic not Given, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4048F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Antibiotic was not given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified

DENOMINATOR:

All surgical patients aged 18 years and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Denominator Instructions: For denominator inclusion, there must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral antibiotic is to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

Denominator Coding:

A CPT Category II code to identify patients who have an order for a parenteral antibiotic is required for denominator inclusion.

CPT II 4047F: Documentation of order for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

RATIONALE:

The appropriate timing of administration of prophylactic antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Available evidence suggests that although most surgical patients receive a prophylactic antibiotic, many do not receive the drug within one hour before incision as recommended.

CLINICAL RECOMMENDATION STATEMENTS:

The anti-infective drug should ideally be given within 30 minutes to 1 hour before the initial incision to ensure its presence in an adequate concentration in the targeted tissues. For most procedures, scheduling administration at the time of induction of anesthesia ensures adequate concentrations during the period of potential contamination. Exceptions: cesarean procedures (after cross clamping of the umbilical cord); colonic procedures (starting 19 hours before the scheduled time of surgery). (ASHP)

Infusion of the first antimicrobial dose should begin within 60 minutes before incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 minutes before incision to prevent antibiotic-associated reactions. Although research has demonstrated that administration of the antimicrobial at the time of anesthesia induction is safe and results in adequate serum and tissue drug levels at the time of incision, there was no consensus that the infusion must be completed before incision. (SIPGWW)

***Measure #32: Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA who were prescribed antiplatelet therapy at discharge

INSTRUCTIONS:

This measure is to be reported for patients under active treatment for ischemic stroke or TIA at or after discharge from a hospital, emergency department or rehabilitation facility during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting will submit this measure. It is possible that this measure may be reported multiple times, potentially by more than one provider, for a single episode of care (e.g. in the hospital and in the rehab setting).

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed antiplatelet therapy at discharge

Definition: Antiplatelet therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine

Numerator Coding:

Antiplatelet Therapy Prescribed

CPT II 4073F: Oral antiplatelet therapy prescribed at discharge

OR

Antiplatelet Therapy Prescription not Prescribed for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4073F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing antiplatelet therapy at discharge, including identification from medical record that patient on anticoagulation therapy
- **2P:** Documentation of patient reason(s) for not prescribing antiplatelet therapy at discharge

OR

Antiplatelet Therapy Prescription not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4073F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Oral antiplatelet therapy was not prescribed at discharge, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA)

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA) and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0-435.3, 435.8, 435.9, 436, 438.2, 438.89, 438.9, 997.02

AND

CPT E/M service codes: 99218-99220 (initial observation care), 99221-99223 (initial inpatient), 99231-99233 (inpatient), 99238, 99239 (hospital discharge), 99251-99255 (inpatient consult), 99281-99285 (ED services), 99291 (critical care)

RATIONALE:

Following a stroke, patients should be prescribed antiplatelet therapy to decrease the risk of additional strokes.

CLINICAL RECOMMENDATION STATEMENTS:

We recommend that every patient who has experienced a noncardioembolic (atherothrombotic, lacunar, or cryptogenic) stroke or TIA and has no contraindication receives an antiplatelet agent regularly to reduce the risk of recurrent stroke and other vascular events. Aspirin, 50 to 325 mg qd; the combination of aspirin, 25 mg, and extended-release dipyridamole, 200 mg bid; or clopidogrel, 75 mg qd, are all acceptable options for initial therapy. (Albers, ACCP, 2001) (Grade 1A)

For patients with noncardioembolic ischemic stroke or TIA, antiplatelet agents rather than oral anticoagulation are recommended to reduce the risk of recurrent stroke and other cardiovascular events. (Sacco, ASA, 2006) (Class I, Level of Evidence: A)

Aspirin (50 to 325 mg/d), the combination of aspirin and extended-release dipyridamole, and clopidogrel are all acceptable options for initial therapy (Sacco, ASA, 2006) (Class IIa, Level of Evidence: A)

***Measure #33: Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

INSTRUCTIONS:

This measure is to be reported for patients under active treatment for ischemic stroke or TIA with documented atrial fibrillation at or after discharge from a hospital, emergency department or rehabilitation facility during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting will submit this measure. It is possible that this measure may be reported multiple times, potentially by more than one provider, for a single episode of care (e.g. in the hospital and in the rehab setting).

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed an anticoagulant at discharge

Definitions:

- Persistent Atrial Fibrillation: recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically.
- Paroxysmal Atrial Fibrillation: recurrent atrial fibrillation, self-terminating
- Permanent Atrial Fibrillation: long-standing atrial fibrillation (>1 year), cardioversion failed or not attempted

Numerator Coding:

Anticoagulant Prescribed

CPT II 4075F: Anticoagulant therapy prescribed at discharge

AND

CPT II 1060F: Documentation of permanent OR persistent OR paroxysmal atrial fibrillation

OR

Anticoagulant Prescription not Received for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4075F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P**: Documentation of medical reason(s) for not prescribing anticoagulant therapy at discharge
- **2P**: Documentation of patient reason(s) for not prescribing anticoagulant therapy at discharge

AND

CPT II 1060F: Documentation of permanent OR persistent OR paroxysmal atrial fibrillation

OR

If patient does not meet denominator inclusion because patient does not have permanent, persistent, or paroxysmal atrial fibrillation, report:

CPT II 1061F: Documentation of absence of permanent AND persistent AND paroxysmal atrial fibrillation

OR

Anticoagulant Prescription not Received, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4075F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P**: Anticoagulant therapy was not prescribed at discharge, reason not otherwise specified

AND

CPT II 1060F: Documentation of permanent OR persistent OR paroxysmal atrial fibrillation

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or transient ischemic attack (TIA) and atrial fibrillation and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0-435.3, 435.8, 435.9, 436, 438.2, 438.89, 438.9, 997.02

AND

ICD-9 diagnosis code: 427.31 (atrial fibrillation)

AND

CPT E/M service codes: 99218-99220 (initial observation care), 99221-99223 (initial inpatient), 99231-99233 (inpatient), 99238, 99239 (hospital discharge), 99251-99255 (inpatient consult), 99281-99285 (ED), 99291 (critical care)

RATIONALE:

Patients with atrial fibrillation (permanent, persistent, or paroxysmal) and stroke should be prescribed an anticoagulant to prevent recurrent strokes.

CLINICAL RECOMMENDATION STATEMENTS:

Administer antithrombotic therapy (oral anticoagulation or aspirin) to all patients with AF, except those with lone AF, to prevent thromboembolism. (ACC/AHA/ESC, 2001)(Class I, Level of Evidence: A)

We recommend that clinicians use long-term oral anticoagulation (target INR of 2.5; range, 2.0 to 3.0) for prevention of stroke in atrial fibrillation patients who have suffered a recent stroke or TIA. Oral anticoagulation is also beneficial for prevention of recurrent stroke in patients with several other high-risk cardiac sources. (Albers, ACCP, 2001) (Grade 1A)

For patients with ischemic stroke or TIA with persistent or paroxysmal AF, anticoagulation with adjusted-dose warfarin (target INR, 2.5; range 2.0 to 3.0) is recommended. (Sacco, ASA, 2006) (Class I, Level of Evidence: A)

***Measure #34: Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA)
Considered**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration

INSTRUCTIONS:

This measure is to be reported each time during a hospital stay when a patient is under active treatment for ischemic stroke during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke in the hospital setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD 9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients who were considered for t-PA administration (given t-PA or documented reasons for patient not being a candidate for therapy)

Definition: For purposes of this measure, patients "considered for t-PA administration" includes patients to whom t-PA was given or patients for whom reasons for not being a candidate for t-PA therapy are documented.

Numerator Coding:

t-PA Administration or Consideration Documented

CPT II 4077F: Documentation that tissue plasminogen activator (t-PA) administration was considered

AND

CPT II 1065F: Ischemic stroke symptom onset of less than 3 hours prior to arrival

OR

If patient does not meet denominator inclusion because ischemic stroke symptom onset \geq 3 hours prior to arrival at hospital, report:

CPT II 1066F: Ischemic stroke symptom onset greater than or equal to 3 hours prior to arrival

OR

t-PA Administration or Consideration not Documented, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4077F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Tissue plasminogen activator (t-PA) administration was not considered, reason not otherwise specified

AND

CPT II 1065F: Ischemic stroke symptom onset of less than 3 hours prior to arrival

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours.

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 997.02

AND

CPT E/M service codes: 99218-99220 (initial observation care), 99221-99223 (initial inpatient), 99251-99255 (inpatient consult), 99281-99285 (ED services), 99291 (critical care)

RATIONALE:

Patients who arrive at the hospital within 3 hours of stroke symptom onset should be considered for t-PA therapy.

CLINICAL RECOMMENDATION STATEMENTS:

We recommend administration of IV tPA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 minutes for eligible patients, provided that treatment is initiated within 3 hours of clearly defined symptom onset. We recommend strict adherence to eligibility criteria for the use of IV tPA based on the NINDS trial protocol. (Inclusion Criteria: Age \geq 18 years, clinical diagnosis of stroke with a clinically meaningful neurologic deficit, clearly defined time of onset of $<$ 180 minutes before treatment, and a baseline CT showing no evidence of intracranial hemorrhage. (Albers, ACCP, 2001) (Grade 1A)

Intravenous rtPA (0.9 mg/kg, maximum dose 90 mg) is strongly recommended for carefully selected patients who can be treated within 3 hours of onset of ischemic stroke. (Adams, ASA, 2003) (Grade A)

***Measure #35: Stroke and Stroke Rehabilitation: Screening for Dysphagia**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

INSTRUCTIONS:

This measure is to be reported each time during a hospital stay when a patient is under active treatment for ischemic stroke or intracranial hemorrhage during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure. It is possible that this measure may be reported multiple times, potentially by more than one provider, for a single episode of care (e.g. in the hospital and in the rehab setting).

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

Definition: Dysphagia Screening: use of a tested and validated dysphagia screening tool (e.g. Burke dysphagia screening test, 3 oz. water swallow test, Mann assessment of swallowing ability [MASA], standardized bedside swallowing assessment [SSA]) OR a dysphagia screening tool approved by the hospital's speech/language pathology (SLP) services.

Numerator Instructions: For purposes of this measure, patients "who receive any food, fluids or medication by mouth" may be identified by the absence of an NPO (nothing by mouth) order

Numerator Coding:

Dysphagia Screening Conducted

CPT II 6010F: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth

AND

CPT II 6015F: Patient receiving or eligible to receive food, fluids or medication by mouth

OR

Dysphagia Screening not Conducted for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **6010F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth

AND

CPT II 6015F: Patient receiving or eligible to receive food, fluids or medication by mouth

OR

If patient does not meet denominator inclusion because patient is NPO, report:

CPT II 6020F: NPO (nothing by mouth) ordered

OR

Dysphagia Screening not Conducted, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **6010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dysphagia screening was not conducted prior to order for or receipt of any foods, fluids or medication by mouth, reason not otherwise specified

AND

CPT II 6015F: Patient receiving or eligible to receive food, fluids or medication by mouth

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.9, 436, 438.2, 438.89, 438.9, 997.02

AND

CPT E/M service codes: 99218-99220 (initial observation care), 99281-99285 (ED services), 99221-99223 (initial inpatient), 99231-99233 (inpatient), 99251-99255 (inpatient consult)

RATIONALE:

All patients should have their swallowing evaluated prior to receiving food, fluids or oral medications to help prevent aspiration. The evaluation should be performed with a validated or hospital-approved dysphagia screening tool; a routine cranial nerve examination is not sufficient.

CLINICAL RECOMMENDATION STATEMENTS:

Recommend that all patients have their swallow screened before initiating oral intake of fluids or food, utilizing a simple valid bedside testing protocol. (VA/DoD, 2003) (Evidence II-2, Grade B)

***Measure #36: Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented

INSTRUCTIONS:

This measure is to be reported each time during a hospital stay when a patient is under active treatment for ischemic stroke or intracranial hemorrhage during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients for whom consideration of rehabilitation services (ordered rehabilitation or documented that rehabilitation was not indicated) is documented

Definition: For purposes of this measure, "consideration of rehabilitation services" includes an order for rehabilitation services or documentation that rehabilitation was not indicated.

Numerator Coding:

Rehabilitation Services Ordered or Considered

CPT II 4079F: Documentation that rehabilitation services were considered

OR

Rehabilitation Services not Ordered or Considered, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4079F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Rehabilitation services were not considered, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage

Denominator Coding:

An ICD-9 diagnosis code to identify patients with a diagnosis of ischemic stroke or intracranial hemorrhage and a CPT E/M service code are required for denominator inclusion.

ICD-9 diagnosis codes: 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.9, 997.02

AND

CPT E/M service codes: 99217(obsv discharge), 99220 (initial obsv), 99221-99223 (initial inpatient), 99231-99233 (inpatient), 99234-99236(obsv/inpatient), 99238, 99239 (hospital discharge), 99251-99255 (inpatient consult)

RATIONALE:

All patients should be considered for rehabilitation services to meet the individual patient needs.

CLINICAL RECOMMENDATION STATEMENTS:

Strongly recommend that patients in need of rehabilitation services have access to a setting with a coordinated and organized rehabilitation care team that is experienced in providing stroke services. The coordination and organization of inpatient post-acute stroke care will improve patient outcome. (VA/DoD, 2003)

***Measure #47: Advance Care Plan**

DESCRIPTION:

Percentage of patients aged 65 years and older with documentation of a surrogate decision-maker or advance care plan in the medical record

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is appropriate for use in all healthcare settings. It is anticipated that clinicians who provide primary care services for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

CPT E/M service codes and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed CPT E/M service codes and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients with documentation of a surrogate decision maker or advance care plan in the medical record

Numerator Coding:

Surrogate Decision Maker or Advance Care Plan Documented

CPT II 1080F: Surrogate decision maker or advance care plan documented in the medical record

OR

Surrogate Decision Maker or Advance Directive not Documented for Patient Reasons

Append a modifier (**2P**) to CPT Category II code **1080F** to report documented circumstances that appropriately exclude patients from the denominator.

- **2P:** Documentation of patient reason(s) for no documentation of a surrogate decision maker or advance care plan in the medical record (e.g., patient does not wish to discuss advance care planning)

OR

Surrogate Decision Maker or Advance Directive not Documented, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1080F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Surrogate decision maker or advance care plan not documented in the medical record, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

A CPT E/M service code to identify patients aged 65 years and older who were seen by the clinician is required for denominator inclusion.

CPT E/M service codes: 99201-99205, 99212-99215, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99241-99245, 99281-99285, 99291, 99292, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354, 99355, 99387, 99397, 99401-99404

RATIONALE:

It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity.

CLINICAL RECOMMENDATION STATEMENTS:

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site (www.caringinfo.org). This web site provides resources and information on end-of-life care, including a national repository of state by state advance directives.

***Measure #54: Electrocardiogram Performed for Non-Traumatic Chest Pain**

DESCRIPTION:

Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an electrocardiogram (ECG) performed

INSTRUCTIONS:

This measure is to be reported each time a patient has been discharged from the emergency department with a discharge diagnosis of non-traumatic chest pain during the reporting period. Patients who were discharged from an emergency department with a diagnosis of non-traumatic chest pain should have documentation in the medical record of having an ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who had an ECG performed

Numerator Coding:

ECG Performed

CPT II 3120F: 12-Lead ECG performed

OR

ECG not Performed for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **3120F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing an ECG
- **2P:** Documentation of patient reason(s) for not performing an ECG

OR

ECG not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3120F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** 12-Lead ECG not performed, reason not otherwise specified

DENOMINATOR:

All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain

Denominator Coding:

An ICD-9 emergency department discharge diagnosis code and a CPT E/M service code to identify patients with a diagnosis of non-traumatic chest pain are required for denominator inclusion.

ICD-9 diagnosis codes: 786.50-786.52, 786.59, 413.0, 413.1, 413.9

AND

CPT E/M service codes: 99281-99285, 99291

RATIONALE:

All patients in the age group for which CAD/ACS is part of the differential diagnosis, should have an ECG performed.

CLINICAL RECOMMENDATION STATEMENTS:

A 12-lead ECG should be performed and shown to an experienced emergency physician within 10 minutes of ED arrival for all patients with chest discomfort (or anginal equivalent) or other symptoms of STEMI. (ACC/AHA)(Class I, Level C)

If pain is severe or pressure or substernal or exertional or radiating to jaw, neck, shoulder or arm, then the following are recommended:

- ECG (Rule)
- IV access, supplemental oxygen, cardiac monitor, serum cardiac markers (e.g., CKMB), CXR, nitrates, management of ongoing pain, admit (ACEP)

***Measure #55: Electrocardiogram Performed for Syncope**

DESCRIPTION:

Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed

INSTRUCTIONS:

This measure is to be reported each time a patient has been discharged from the emergency department with a discharge diagnosis of syncope during the reporting period. Patients who experienced syncope should have documentation in the medical record of having an ECG performed. It is anticipated that clinicians who provide care in the emergency department will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who had an ECG performed

Numerator Coding:

ECG Performed

CPT II 3120F: 12-Lead ECG performed

OR

ECG not Performed for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **3120F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not performing an ECG
- **2P:** Documentation of patient reason(s) for not performing an ECG

OR

ECG not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3120F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** 12-Lead ECG not performed, reason not otherwise specified

DENOMINATOR:

All patients aged 60 years and older with an emergency department discharge diagnosis of syncope

Denominator Coding:

An ICD-9 discharge diagnosis code and a CPT E/M service code to identify patients with a diagnosis of syncope are required for denominator inclusion.

ICD-9 diagnosis codes: 780.2

AND

CPT E/M service codes: 99281-99285, 99291

RATIONALE:

ECG can occasionally pick up potentially life-threatening conditions such as pre-excitation syndromes, prolonged QT syndromes, or Brugada's syndrome in otherwise healthy appearing young adults. ECG testing is performed inconsistently, even in high risk patients; the largest study to date of ECG testing variation in ED syncope visits using a 9 year national sample illustrated that ECG testing was documented in only 59% of ED syncope visits.

CLINICAL RECOMMENDATION STATEMENTS:

Obtain a standard 12-lead ECG in patients with syncope when history and physical examination do not reveal a diagnosis. (ACEP) (Level A)

- A patient with normal ECG has a low likelihood of dysrhythmias as a cause of syncope
- Abnormal ECG has been associated as being the most important predictor of serious outcomes and a multivariate predictor for arrhythmia or death within 1 year after the syncopal episode

***Measure #56: Vital Signs for Community-Acquired Bacterial Pneumonia**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

INSTRUCTIONS:

This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. All patients 18 years and older with a diagnosis of community acquired bacterial pneumonia should have documentation in the medical record of having vital signs recorded and reviewed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definition: Medical record may include one of the following: clinician documentation that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician

Numerator Coding:

Vital Signs Documented and Reviewed

CPT II 2010F: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

OR

Vital Signs not Documented and Reviewed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0-482.2, 482.30-482.32, 482.39, 482.40, 482.41, 482.49, 482.81-482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

AND

CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245, 99281-99285, 99291

RATIONALE:

Each of the vital signs should be recorded in the emergency department. While vital signs may be routinely recorded, there likely is a gap in care on acting on those values that warrant further evaluation. Moreover, it is important for physicians to review the vital signs to ensure continuous quality improvement and consistent patient care.

CLINICAL RECOMMENDATION STATEMENTS:

It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydrations and mental status). (ATS) (Level II Evidence)

***Measure #57: Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

INSTRUCTIONS:

This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia would have documentation in the medical record of having oxygen saturation assessed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients with oxygen saturation documented and reviewed

Definition: Medical record may include one of the following: clinician documentation that oxygen saturation was reviewed, dictation by the clinician including oxygen saturation, clinician initials in the chart that oxygen saturation was reviewed, or other indication that oxygen saturation had been acknowledged by the clinician

Numerator Coding:

Oxygen Saturation Documented and Reviewed

CPT II 3028F: Oxygen saturation results documented and reviewed

OR

Oxygen Saturation not Documented and Reviewed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to CPT Category II code **3028F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not documenting and reviewing oxygen saturation
- **2P:** Documentation of patient reason(s) for not documenting and reviewing oxygen saturation

- **3P:** Documentation of system reason(s) for not documenting and reviewing oxygen saturation

OR

Oxygen Saturation not Documented and Reviewed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3028F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Oxygen saturation results not documented and reviewed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0-482.2, 482.30-482.32, 482.39, 482.40, 482.41, 482.49, 482.81-482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

AND

CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245, 99281-99285, 99291

RATIONALE:

The assessment of oxygenation helps to assess the severity of the illness.

CLINICAL RECOMMENDATION STATEMENTS:

It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydrations and mental status). For those patients with chronic heart or lung disease, the assessment of oxygenation by pulse oximetry will help identify the need for hospitalization. (ATS) (Level II Evidence)

***Measure #58: Assessment of Mental Status for Community-Acquired Bacterial Pneumonia**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

INSTRUCTIONS:

This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. All patients 18 years and older with a diagnosis of community acquired bacterial pneumonia should have documentation in the medical record of having mental status assessed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:

Patients for whom mental status was assessed

Definition: Medical record may include documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented).

Numerator Coding:

Mental Status Assessed

CPT II 2014F: Mental status assessed

OR

Mental Status not Assessed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2014F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Mental status not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0-482.2, 482.30-482.32, 482.39, 482.40, 482.41, 482.49, 482.81-482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

AND

CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245, 99281-99285, 99291

RATIONALE:

The assessment of mental status helps to assess the severity of the illness.

CLINICAL RECOMMENDATION STATEMENTS:

It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydrations and mental status). (ATS) (Level II Evidence)

***Measure #59: Empiric Antibiotic for Community-Acquired Bacterial Pneumonia**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

INSTRUCTIONS:

This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. All patients 18 years and older with a diagnosis of community acquired bacterial pneumonia should have documentation in the medical record of having an appropriate empiric antibiotic prescribed. It is anticipated that clinicians who provide care in the emergency department or office setting will submit this measure.

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients with appropriate empiric antibiotic prescribed

Definition: Appropriate empiric antibiotic for treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines).

Numerator Coding:

Appropriate Empiric Antibiotic Prescribed

CPT II 4045F: Appropriate empiric antibiotic prescribed

OR

Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P**, or **3P**) to CPT Category II code **4045F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic
- **2P:** Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
- **3P:** Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4045F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P**: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia

Denominator Coding:

An ICD-9 diagnosis code and a CPT E/M service code to identify patients with a diagnosis of community-acquired bacterial pneumonia are required for denominator inclusion.

ICD-9 diagnosis codes: 481, 482.0-482.2, 482.30-482.32, 482.39, 482.40, 482.41, 482.49, 482.81-482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

AND

CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245, 99281-99285, 99291

RATIONALE:

All patients need to be treated empirically according to the guideline recommendations.

CLINICAL RECOMMENDATION STATEMENTS:

All patients should be treated empirically. Patients treated as outpatients with no cardiopulmonary disease and no modifying factors should be treated with advanced generation macrolide: azithromycin or clarithromycin or doxycycline. Patients treated as an outpatient with cardiopulmonary disease and/or risk factors should be treated with beta lactam plus macrolide or doxycycline or fluoroquinolone alone. Empiric therapy based on the ATS guidelines lead to better outcomes than if the guidelines are not followed. (ATS) (Level II Evidence)

Fluoroquinolones (gatifloxacin, gemifloxacin, levofloxacin, and moxifloxacin) are recommended for initial empiric therapy of selected outpatients with CAP. (Level A Recommendation, Level I Evidence)

Other options (macrolides and doxycycline) are generally preferred for uncomplicated infections in outpatients. (IDSA) (Level A Recommendation, Level I Evidence)

A macrolide is recommended as monotherapy for selected outpatients, such as those who were previously well and not recently treated with antibiotics. (Level A Recommendation, Level I Evidence)

A macrolide plus a beta lactam is recommended for initial empiric treatment of outpatients in whom resistance is an issue. (IDSA) (Level A Recommendation, Level I Evidence)