

# Technical Specifications for AMA Physician Consortium for Performance Improvement™ measures endorsed by the National Quality Forum

Current as of August 4, 2005

Specifications for AMA/Consortium measures endorsed by the NQF are contained within this table.  
Additional clinical and technical specifications will be made available shortly.

Measure Specifications: The Physician Consortium for Performance Improvement (Consortium) provides specifications for obtaining the required data elements for its clinical performance measures based on the selected data source.

## *Specifications For Electronic Medical Records*

Physicians utilizing an electronic health record system (EHRS) may be able to search their electronic database using standardized codes to identify patients and patient data for a performance measure. Some data elements may be entered into the electronic medical record by a physician or other clinician during a patient visit. Other data elements may be electronically imported or manually entered into the EHRS from laboratory reports, radiology reports, and other reports from healthcare institutions where a patient receives care.

We provide here standardized codes that are available for use in querying an EHRS for the required data elements. We also provide an algorithm that describes how to query and calculate the measure numerator and denominator from the EHRS data.

In some cases, standardized codes do not yet exist for required data elements. The AMA, on behalf of the Consortium, and CMS are working with code developers to fill the gaps. The AMA and CMS also continue to encourage EHRS vendors to provide functionality in their products to enable physicians to query the system and create the numerators and denominators for the measures. Standardized coding will be useful for EHRS vendors to achieve this goal. Vendors are encouraged to complete the Consortium measures license agreement application.

Specifications for EHRS users that will be made available shortly:

- Algorithm for measures calculation
- Coding specifications (CPT® Category I, CPT® Category II, ICD-9, SNOMED CT®, LOINC®, NDC)

## *Specifications For Paper Medical Records*

Physicians utilizing paper medical records may obtain the data elements for the Consortium performance measures by either abstracting data from existing records or using a flowsheet to prospectively gather data. Several tools are provided to assist physicians with paper records.

A prospective flowsheet is provided; the flowsheet is intended to be attached to the top of a patient's medical record and used to collect data from a given date forward, generally for a one-year period. A retrospective data abstraction tool is available to assist in retrieving data from a medical record from a given date back in time. Data abstraction definitions are provided to help an abstractor to find the required data elements in a medical record. We also provide an algorithm that describes how to construct the measure numerator and denominator from the data elements and calculate the measures.

Specifications for paper medical records that will be made available shortly:

- Prospective data collection flowsheet
- Retrospective data abstraction tool
- Data abstraction definitions (including synonyms)
- Algorithm for measures calculation

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*Specifications For Administrative Data (Paper or Electronic)*

All of the required data for obtaining the Consortium measures can be obtained from billing data (CMS 1500 paper form or ASC X12N 837 electronic transaction standard for claims) only by using CPT® Category II codes. These new, non-reimbursable codes enable the capture of the appropriate inclusions and exclusions for a measure and therefore provide complete data.

Some implementers who have access to administrative claims data may choose to query claims data to identify which patients may be appropriate for the denominator of a measure and therefore which patients' medical records should be pulled for abstraction. For this reason, we also provide CPT® Category I and ICD-9 codes. However, these codes alone do not provide for all of the exclusions specified for all measures and therefore cannot be used alone.

Specifications for administrative data that will be made available shortly:

- CPT® Category II Codes
- CPT® Category I Codes and ICD-9 Codes

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<b>ASTHMA AND RESPIRATORY ILLNESS</b>					
<b>MEASURE</b>	<b>IP OWNER</b>	<b>NUMERATOR</b>	<b>DENOMINATOR</b>	<b>EXCLUSIONS</b>	<b>DATA SOURCE</b>
Asthma Assessment	AMA PCPI*	<p>Patients who were evaluated during at least one office visit during the reporting year for the frequency (numeric) of daytime and nocturnal asthma symptoms*</p> <p>*To be counted in calculations of this measure, symptom frequency must be numerically quantified. Measure may also be met by physician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tools may include the QualityMetric Asthma Control Test™; NAEPP Asthma Symptoms and Peak Flow Diary.</p>	<p>All patients aged 5-40 years with asthma</p> <p>Patient Selection:                      ICD-9-CM Codes for asthma:                      493.00-493.92  <i>And</i>                      CPT codes for patient visit:                      99201-99205, 99212-99215,                      99241-99245, 99354-99355,                      99383-99385, 99393-99395,                      99401-99404  <i>And</i>                      Patient's age is between 5 and 40 years</p>	None	EHRS, Retrospective paper medical records, Prospective flow sheet

\* Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

**THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND**

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Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

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ASTHMA AND RESPIRATORY ILLNESS					
MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Asthma: Pharmacologic Therapy	AMA PCPI*	Patients who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines) (drug list available)	All patients aged 5-40 years with mild, moderate, or severe <i>persistent</i> asthma  Patient Selection: ICD-9-CM Codes for asthma: 493.00-493.92 <i>And</i> Additional individual medical record review must be completed to identify those patients with mild, moderate, or severe <i>persistent</i> asthma <i>And</i> Patient's age is between 5 and 40 years	Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment	EHRS, Retrospective paper medical records, Prospective flow sheet

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<b>OSTEOARTHRITIS</b>					
<b>MEASURE</b>	<b>IP OWNER</b>	<b>NUMERATOR</b>	<b>DENOMINATOR</b>	<b>EXCLUSIONS</b>	<b>DATA SOURCE</b>
Osteoarthritis: Assessment for use of Anti-inflammatory or Analgesic OTC Medications	CMS/ AMA PCPI/ AAOS*	Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented (drug list is available)	All visits for patients with OA $\geq$ 21 years of age:  Patient Selection: ICD-9-CM codes for OA: 715.00-715.98 <i>And</i> CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>And</i> Patient's age is $\geq$ 21 years	None	EHRs, Retrospective paper medical records, Prospective flow sheet
Osteoarthritis: Functional and Pain Assessment	CMS/ AMA PCPI/ AAOS*	Patient visits with assessment for function and pain documented	All visits for patients with OA $\geq$ 21 years of age  Patient Selection: ICD-9-CM codes for OA: 715.00-715.98 <i>And</i> CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>And</i> Patient's age is $\geq$ 21 years	None	EHRs, Retrospective paper medical records, Prospective flow sheet

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HEART DISEASE MEASURE		IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Coronary Artery Disease (CAD): Symptom and Activity Assessment	AMA PCPI/ ACC/AHA*	<p>Patients evaluated for both level of activity and anginal symptoms during one or more office visits</p> <p>Medical record must include documentation of the patient's level of activity and anginal symptoms</p> <p><i>And/Or</i></p> <p>Grading of Angina by the Canadian Cardiovascular Society Classification System</p> <p><i>And/Or</i></p> <p>the patient completed a symptom and/or activity questionnaire (eg, Seattle Angina Questionnaire)</p>	<p>All patients with CAD <math>\geq</math> 18 years of age</p> <p>Patient Selection:                      ICD-9-CM codes for CAD:                      414.00-414.07, 414.8, 414.9,                      410.00-410.92, 412, 411.0-                      411.89, 413.0-413.9, V45.81,                      V45.82;</p> <p><i>Or</i></p> <p>CPT Diagnosis codes: 92980-                      92982, 92984, 92995, 92996,                      33140, 33510-33514, 33516-                      33519, 33521-33523, 33533-                      33536</p> <p><i>And</i></p> <p>CPT codes for patient visit:                      99201-99205, 99212-99215,                      99241-99245, 99354-99355,                      99385-99387, 99395-99397,                      99401-99404</p> <p><i>And</i></p> <p>Patient's age is <math>\geq</math> 18 years</p>	None	EHRs, Retrospective paper medical records, Prospective flow sheet	
CAD: Lipid Profile	AMA PCPI/ ACC/AHA*	<p>Patients who received at least one lipid profile (or ALL component tests) during the reporting year</p> <p>CPT laboratory codes for lipid testing: 80061, 83721, 83716, 82465, 83718, 84478;</p> <p><i>Or</i></p> <p>LOINC codes for lipid testing:                      24331-1, 13457-7, 18262-6, 18261-8, 22748-8, 2093-3, 14647-2, 2085-</p>	<p>All patients with CAD <math>\geq</math> 18 years of age</p> <p>Patient Selection:                      ICD-9-CM codes for CAD:                      414.00-414.07, 414.8, 414.9,                      410.00-410.92, 412, 411.0-                      411.89, 413.0-413.9, V45.81,                      V45.82;</p> <p><i>Or</i></p>	None	EHRs, Retrospective paper medical records, Prospective flow sheet	

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HEART DISEASE MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
		9, 14646-4, 18263-4, 2571-8, 14927-8, 1644-4, 3043-7, 3048-6, 30524-3	CPT Diagnosis codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536 <i>And</i> Patient's age is $\geq$ 18 years		
CAD: Drug Therapy for Lowering LDL Cholesterol (LDL-C)	AMA PCPI/ ACC/AHA*	Patients who were prescribed lipid-lowering therapy (based on current ACC/AHA guidelines) (drug list is available)	All patients with CAD $\geq$ 18 years of age  Patient Selection: ICD-9-CM codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82; <i>Or</i> CPT codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536 <i>And</i> Patient's age is $\geq$ 18 years	<ul style="list-style-type: none"> <li>Documentation that lipid-lowering therapy was not indicated (LDL-C &lt;100); <i>Or</i></li> <li>Other medical reason(s) documented by the practitioner for not prescribing lipid-lowering therapy; <i>Or</i></li> <li>Patient reason(s) (eg, economic, social, religious)</li> </ul>	EHRS, Retrospective paper medical records, Prospective flow sheet
CAD: Antiplatelet Therapy	CMS/AMA PCPI/ ACC/AHA*	Patients who were prescribed antiplatelet therapy (aspirin, clopidogrel or combination of aspirin and dipyridamole) (drug list is available)	All patients with CAD $\geq$ 18 years of age  Patient Selection: ICD-9-CM codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82; <i>Or</i> CPT codes: 92980-92982, 92984, 92995, 92996, 33140,	<ul style="list-style-type: none"> <li>Active bleeding in the previous six months, which required hospitalization(s) or transfusion(s); <i>Or</i></li> <li>Aspirin/clopidogrel allergy/intolerance ICD-9-CM exclusion codes: 995.0 and E935.3, 995.1 and</li> </ul>	EHRS, Retrospective paper medical records, Prospective flow sheet

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CAD: Beta Blocker Therapy – Prior Myocardial Infarction (MI)	AMA PCPI/ ACC/AHA*	Patients who were prescribed beta blocker therapy (drug list is available)	33510-33514, 33516-33519, 33521-33523, 33533-33536 <i>And</i> Patient's age is $\geq$ 18 years	E935.3, 995.2 and E935.3, 995.0, and E934.8, 995.1 and E934.8, 995.2 and E934.8; Or • Patients prescribed ticlopidine or dipyridamole alone; Or • Other medical reason(s) documented by the practitioner for not prescribing antiplatelet therapy; Or • Patient reason(s) (eg, economic, social, religious)	EHRs, Retrospective paper medical records, Prospective flow sheet
			All patients with CAD who also have prior MI at any time $\geq$ 18 years of age  Patient Selection: ICD-9-CM codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82; Or CPT codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536;	<ul style="list-style-type: none"> <li>• Documentation of bradycardia &lt; 50 bpm (without beta-blocker therapy) on two consecutive readings, history of Class IV (congestive) heart failure, history of second- or third-degree atrioventricular (AV) block without permanent pacemaker. ICD-9-CM exclusion codes: 493.xx, 458.xx, 426.0</li> </ul>	

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HEART DISEASE MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
CAD: ACE Inhibitor/ARB Therapy	AMA PCPI/ ACC/AHA *	Patients who were prescribed ACE inhibitor or ARB therapy (drug list is available)	<p><i>And</i>                      ICD-9-CM codes for MI: 410.00-410.92, 412;  <i>And</i>                      Patient's age is <math>\geq</math> 18 years</p>	<p>without V45.01, 426.12 without V45.01, 426.13 without V45.01, 427.81, 427.89;  <i>Or</i></p> <ul style="list-style-type: none"> <li>Other medical reason(s) documented by the practitioner for not prescribing beta blocker therapy;</li> <li><i>Or</i></li> <li>Patient reason(s) (e.g., economic, social, religious)</li> </ul>	EHRS, Retrospective paper medical records, Prospective flow sheet
			<p>All patients with CAD <math>\geq</math> 18 years of age who also have diabetes and/or LVSD</p> <p>Patient Selection:                      [ICD-9-CM codes for CAD:                      414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82;  <i>Or</i>                      CPT codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536]  <i>And</i>                      [ICD-9-CM codes for diabetes:                      250.xx, 357.2, 362.01, 362.02, 366.41, 648.0x]  <i>Or</i></p>	<p>without V45.01, 426.12 without V45.01, 426.13 without V45.01, 427.81, 427.89;  <i>Or</i></p> <ul style="list-style-type: none"> <li>Allergy or intolerance to ACE inhibitor or ARB;</li> <li><i>Or</i></li> <li>ACE inhibitor contraindications including angioedema, anuric renal failure, moderate or severe aortic stenosis or pregnancy ICD-9-CM exclusion codes: 440.1, V56.0, V56.8, 39.95, 54.98, 788.5, 586, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 584.x, 585, 395.0, 395.2, 396.0,</li> </ul>	EHRS, Retrospective paper medical records, Prospective flow sheet

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HEART DISEASE MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
CAD: Smoking Cessation	AMA PCPI/ ACC/AHA*	Patients who were queried one or more times about cigarette smoking	<p>[CPT procedure codes for testing LVSD: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93543</p> <p><i>And</i></p> <p>Additional individual medical record review must be completed to identify patients who had documentation of an ejection fraction &lt;40% (use most recent value)]</p> <p><i>And</i></p> <p>Patient's age is <math>\geq 18</math> years</p>	<p>396.2, 396.8, 425.1, 747.22, V22.0-V23.9, 277.6;</p> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>Other medical reason documented by the practitioner for not prescribing ACE inhibitor or ARB therapy;</li> <li><i>Or</i></li> <li>Patient reason (e.g., economic, social, religious)</li> </ul>	EHRS, Retrospective paper medical records, Prospective flow sheet
			<p>All patients with CAD <math>\geq 18</math> years of age</p> <p>Patient Selection:                      ICD-9-CM codes for CAD:                      414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, V45.82;</p> <p><i>Or</i></p> <p>CPT Diagnosis codes: 92980-92982, 92984, 92995, 92996, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536</p> <p><i>And</i></p> <p>CPT codes for patient visit:                      99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397,</p>	None	

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CAD: Smoking Cessation Intervention	AMA PCPI/ ACC/AHA*	<p>Patients identified as cigarette smokers who received smoking cessation intervention</p> <p>Cessation intervention may include smoking cessation counseling (eg, advise to quit, referral for counseling) and/or pharmacologic therapy</p>	<p>99401-99404 <i>And</i> Patient's age is <math>\geq</math> 18 years</p> <p>All patients with CAD <math>\geq</math> 18 years of age identified as cigarette smokers</p> <p>Patient Selection: ICD-9-CM codes for CAD: 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0- 411.89, 413.0-413.9, V45.81, V45.82; <i>Or</i> CPT Diagnosis codes: 92980- 92982, 92984, 92995, 92996, 33140, 33510-33514, 33516- 33519, 33521-33523, 33533- 33536 <i>And</i> CPT codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>And</i> Additional individual medical record review must be completed to identify the patient as a cigarette smoker</p> <p>Patient's age is <math>\geq</math> 18 years</p> <p>All patients with heart failure <math>\geq</math> 18 years of age</p>	None	EHRs, Retrospective paper medical records, Prospective flow sheet
Heart Failure (HF): Left Ventricular	AMA PCPI/ ACC/AHA*	Patients with quantitative or qualitative results of LVF assessment recorded.		None	EHRs, Retrospective paper

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Function (LVF) Assessment		CPT procedure codes for LVF assessment testing: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93543, 93555 And Medical record must include documentation of quantitative or qualitative results of LVF assessment	Patient Selection: ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-28.33, 428.40-428.43, 428.9 And Patient's age is $\geq$ 18 years		medical records, Prospective flow sheet
HF: Weight Measurement	AMA PCPI/ ACC/AHA*	Patient visits with weight measurement recorded.	All visits for patients with HF $\geq$ 18 years of age Patient Selection: ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-28.33, 428.40-428.43, 428.9 And Patient's age is $\geq$ 18 years	Patient visits in which practitioner was unable to weigh patient	EHRS, Retrospective paper medical records, Prospective flow sheet
HF: Assessment of Clinical <u>Symptoms</u> of Volume Overload (Excess)	AMA PCPI/ ACC/AHA*	Patient visits with assessment of clinical symptoms of volume overload (excess) or documentation of standardized scale or completion of assessment tool.*  Medical record must include: Assessment for the absence or presence of symptoms of volume overload – Dyspnea or orthopnea Or Documentation that a standardized	All patient visits for patients aged $\geq$ 18 years with HF  Patient Selection: ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9 And CPT codes for patient visit:	None	EHRS, Retrospective paper medical records, Prospective flow sheet

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HF: Assessment of Activity Level	AMA PCPI/ ACC/AHA*	scale or assessment tool was used  *Standardized scale or assessment tools may include the New York Heart Association Functional Classification of Congestive Heart Failure (level of activity only); Kansas City Cardiomyopathy Questionnaire; Minnesota Living with Heart Failure™ Questionnaire; or Chronic Heart Failure Questionnaire (Guyatt).	99201-99205, 99212-99215, 99241-99245, 99354, 99355, 99385-99387, 99395-99397, 99401-99404  And Patient's age is ≥ 18 years	None	EHRS, Retrospective paper medical records, Prospective flow sheet
		Patient visits with assessment of current level of activity OR documentation of standardized scale or completion of assessment tool*  Medical record must include: Documentation of the current level of activity Or Documentation that a standardized scale or assessment tool was used  *Standardized scale or assessment tools may include the New York Heart Association Functional Classification of Congestive Heart Failure (level of activity only); Kansas City Cardiomyopathy Questionnaire; Minnesota Living with Heart Failure™ Questionnaire; or Chronic Heart Failure Questionnaire (Guyatt).	All patient visits for patients aged ≥18 years with HF  Patient Selection: ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9 And CPT codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 And Patient age is ≥ 18 years		

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HF: Beta Blocker Therapy	AMA PCPI/ ACC/AHA *	Patients who were prescribed beta blocker therapy (drug list is available)	<p>All HF patients <math>\geq</math> 18 years of age with LVEF &lt; 40% or with moderately or severely depressed left ventricular systolic function</p> <p>Patient Selection:                      ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-28.33, 428.40-428.43, 428.9</p> <p><i>And</i>                      CPT procedure codes for LVF assessment testing: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93543</p> <p><i>And</i>                      Additional individual medical record review must be completed to identify patients who had documentation of an ejection fraction &lt; 40% (use most recent value) or moderately or severely depressed left ventricular systolic function</p> <p><i>And</i>                      Patient's age is <math>\geq</math> 18 years</p>	<ul style="list-style-type: none"> <li>Documentation of bradycardia &lt; 50 bpm (without beta-blocker therapy) on two consecutive readings, history of Class IV (congestive) heart failure, history of second- or third-degree atrioventricular (AV) block without permanent pacemaker ICD-9-CM exclusion codes: 493.xx, 458.xx, 426.0 without V45.01, 426.12 without V45.01, 426.13 without V45.01, 427.81, 427.89</li> <li>Or</li> <li>Other medical reason(s) documented by the practitioner for not prescribing beta blocker therapy;</li> <li>Or</li> <li>Patient reason(s) (e.g., economic, social, religious)</li> </ul>	EHRS, Retrospective paper medical records, Prospective flow sheet
HF: ACE Inhibitor/ARB Therapy	AMA PCPI/ ACC/AHA *	Patients who were prescribed ACE Inhibitor or ARB therapy (drug list is available)	<p>All HF patients <math>\geq</math> 18 years of age with LVEF &lt; 40% or with moderately or severely</p>	<ul style="list-style-type: none"> <li>Allergy or intolerance to ACE inhibitor or ARB;</li> <li>Or</li> </ul>	EHRS, Retrospective paper

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HEART DISEASE MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
			<p>depressed left ventricular systolic function</p> <p>Patient Selection:                      ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-28.33, 428.40-428.43, 428.9</p> <p><i>And</i></p> <p>CPT procedure codes for LVF assessment testing: 78414, 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350, 93543</p> <p><i>And</i></p> <p>Additional individual medical record review must be completed to identify for those patients who were tested had documentation of an ejection fraction &lt; 40% (use most recent value) or moderately or severely depressed left ventricular systolic function</p> <p><i>And</i></p> <p>Patient's age is <math>\geq</math> 18 years</p>	<ul style="list-style-type: none"> <li>ACE inhibitor contraindications including angioedema, anuric renal failure, moderate or severe aortic stenosis or pregnancy ICD-9-CM exclusion codes: 440.1, V56.0, V56.8, 39.95, 54.98, 788.5, 586, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 584.x, 585, 395.0, 395.2, 396.0, 396.2, 396.8, 425.1, 747.22, V22.0-V23.9, 277.6;</li> </ul> <p><i>Or</i></p> <ul style="list-style-type: none"> <li>Other medical reason(s) documented by the practitioner for not prescribing ACE inhibitor or ARB therapy;</li> <li>Patient reason(s) (eg, economic, social, religious)</li> </ul>	medical records, Prospective flow sheet
HF: Warfarin Therapy for Patients with Atrial Fibrillation	AMA PCPI/ ACC/AHA*	Patients who were prescribed warfarin therapy (drug list is available)	All HF patients $\geq$ 18 years of age with paroxysmal or chronic atrial fibrillation	<ul style="list-style-type: none"> <li>Allergy/intolerance 995.0 and E934.2, 995.1 and E934.2, 995.2 and E934.2; <i>Or</i></li> </ul>	EHRS, Retrospective paper medical

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HEART DISEASE MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
			<p>Patient Selection:                      ICD-9-CM codes for HF: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-28.33, 428.40-428.43, 428.9                      And                      ICD-9-CM code for Atrial Fibrillation: 427.31                      And                      Patient's age is <math>\geq</math> 18 years</p>	<ul style="list-style-type: none"> <li>Risk of bleeding or bleeding disorder                              ICD-9-CM exclusion codes: 203.00-208.91, 280.0, 280.9, 285.1, 286.0-286.9, 287.3-287.5, 430, 431, 432.0, 432.1, 432.9, 437.3, 459, 530.7, 531.00-531.01, 531.20-531.21, 531.40-531.41, 531.60-531.61, 532.00-532.01, 532.20-532.21, 532.40-532.41, 532.60-532.61, 533.00-533.01, 533.20-533.21, 533.40-533.41, 533.60-533.61, 534.00-534.01, 534.20-534.21, 534.40-534.41, 534.60-534.61, 569.3, 570, 571.2, 571.5, 578.0, 578.1, 578.9, 599.7, 786.3;                              Or</li> <li>Other medical reason(s) documented by the practitioner for not prescribing warfarin therapy;                              Or</li> <li>Patient reason(s) (e.g., economic, social, religious)</li> </ul>	<p>records,                      Prospective flow sheet</p>

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HYPERTENSION	MEASURE	IP OWNER	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Plan of Care	CMS/ AMA PCPI/ ACC/AHA*	Patient visits with a documented plan of care for hypertension  Examples of plan of care include follow up visit scheduled, addition or change to antihypertensive pharmacologic therapy, or addition or change to non pharmacological therapy such as weight loss, exercise, decrease sodium or alcohol intake.	All visits for patients with HTN $\geq$ 18 years of age with either systolic blood pressure $\geq$ 140 mm Hg or diastolic blood pressure $\geq$ 90 mm Hg  Patient Selection: ICD-9-CM codes for Hypertension: 401.0, 401.1, 401.9, 402.xx, 403.xx, 404.xx <i>And</i> CPT codes for patient visit: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>And</i> Additional individual medical record review must be completed to identify patient visits with a systolic blood pressure $\geq$ 140 mm Hg or a diastolic blood pressure $\geq$ 90 mm Hg <i>And</i> Patient's age is $\geq$ 18 years	None	EHRS, Retrospective paper medical records, Prospective flow sheet	

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<b>PRENATAL</b>					
<b>MEASURE</b>	<b>IP OWNER</b>	<b>NUMERATOR</b>	<b>DENOMINATOR</b>	<b>EXCLUSIONS</b>	<b>DATA SOURCE</b>
Anti-D Immune Globulin	AMA PCPI*	Patients receiving anti-D immune globulin at 26-30 weeks gestation Rho(D) immune globulin: CPT codes: 90384, 90385, 90386	All patients who are D (Rh) negative and unsensitized who gave birth during a 12-month period, seen for continuing prenatal care  Patient Selection: ICD codes for pregnancy: V22.0-V23.9  Or Delivery of a stillborn after 28 weeks	None	EHRs, Retrospective paper medical records, Prospective flow sheet
Screening for Human Immunodeficiency Virus (HIV)	AMA PCPI*	Patients who are screened for HIV infection during the first or second prenatal care visit HIV Screening: CPT codes: HIV-1 87390, 87534-87539 HIV-2 87391 LOINC codes: 14092-1, 24012-7, 29893-5, 31201-7, 5221-7, 5222-5, 7917-8, 7918-6	All patients who gave birth during a 12-month period, seen for continuing prenatal care  Patient Selection: ICD codes for pregnancy: V22.0-V23.9  Or Delivery of a stillborn after 28 weeks	<ul style="list-style-type: none"> <li>• Patient with known HIV infection</li> <li>Or</li> <li>• Documentation of patient reason(s) for not screening for HIV (eg, economic, social, religious)</li> </ul>	EHRs, Retrospective paper medical records, Prospective flow sheet

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<b>PREVENTION, IMMUNIZATION AND SCREENING</b>					
<b>MEASURE</b>	<b>IP OWNER</b>	<b>NUMERATOR</b>	<b>DENOMINATOR</b>	<b>EXCLUSIONS</b>	<b>DATA SOURCE</b>
Tobacco Use	AMA PCPI*	Patients who were queried about tobacco use one or more times	All patients $\geq$ 18 years of age at the beginning of the two-year measurement period  Patient Selection: CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404 <i>And</i> Patient's age is $\geq$ 18 years	None	EHRs, Retrospective paper medical records, Prospective flow sheet
Tobacco Cessation	AMA PCPI*	Patients identified as tobacco users who received cessation intervention  Cessation intervention may include smoking cessation counseling (eg, advise to quit, referral for counseling) and/or pharmacologic therapy	All patients $\geq$ 18 years of age identified as tobacco users at the beginning of the two-year measurement period  Patient Selection: [CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99385-99387, 99395-99397, 99401-99404] <i>And</i> [ICD-9-CM codes for tobacco user: 305.1 <i>Or</i> Individual medical record review must be completed to identify those patients who are tobacco users] <i>And</i> Patient's age is $\geq$ 18 years	None	EHRs, Retrospective paper medical records, Prospective flow sheet

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<b>PREVENTION, IMMUNIZATION AND SCREENING</b>					
<b>MEASURE</b>	<b>IP OWNER</b>	<b>NUMERATOR</b>	<b>DENOMINATOR</b>		
<b>EXCLUSIONS</b>			<b>DATA SOURCE</b>		
Influenza Vaccination	AMA PCPI*	<p>Patients who received influenza vaccination from September through February of the year prior to the measurement period</p> <p>ICD-9-CM codes for need vaccine: V04.8, and V04.81</p> <p>Or</p> <p>CPT procedure codes for adult influenza vaccine: 90656, 90658, 90659, 90660</p> <p>Or</p> <p>HCDCS code: G0008</p> <p>Or</p> <p>Medical record includes documentation of patient report of having received the vaccination</p>	<p>All patients ≥ 50 years of age at the beginning of the one-year measurement period</p> <p>Patient Selection:                      CPT codes for patient visits: 99201-99205, 99212-99215, 99241-99245, 99354-99355, 99386-99387, 99396-99397, 99401-99404, 90471-90474                      And                      Patient's age is ≥ 50 years at the beginning of the one-year measurement period</p>	<ul style="list-style-type: none"> <li>Egg allergy ICD-9-CM exclusion codes: V15.03, 995.68</li> <li>Or</li> <li>Adverse reaction to influenza vaccine ICD-9-CM exclusion codes: 693.1, 995.0 and E949.6, 995.1 and E949.6, 995.2 and E949.6</li> <li>Or</li> <li>Other medical reason(s) documented by the practitioner for not receiving an influenza vaccination</li> <li>Or</li> <li>Patient reason(s) (eg, economic, social, religious)</li> </ul>	<p>EHRs, Retrospective paper medical records, Prospective flow sheet</p>