

NQF 0086: Primary Open Angle Glaucoma (POAG) Optic Nerve Evaluation

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.

NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR). The first two sections may be distributed as stand-alone references.

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and exclusions or exceptions.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and exceptions or exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, ICD, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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NQF 0086: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.

| Quick Facts | |
|---|--|
| Type of measure: core, alternate core, or menu? | <ul style="list-style-type: none"> Menu measure |
| Related to other measures? | <ul style="list-style-type: none"> Not related to other Stage 1 MU clinical quality measures |
| Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure) | <ul style="list-style-type: none"> Age Encounter codes¹ Active diagnosis of primary open angle glaucoma (POAG)² |
| Data required to identify the <u>exceptions</u> or <u>exclusions</u> | <ul style="list-style-type: none"> Procedure not done: medical reason |
| Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred) | <ul style="list-style-type: none"> Optic head nerve evaluation³ |

Note: This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, please visit: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

| Key Clinical Activities | | Planning Your EHR Documentation | |
|---|--|---|----------------------------|
| To-Do List | Why Needed? | Data Elements Needed | Responsible Person or Role |
| 1. Confirm the patient's date of birth | <ul style="list-style-type: none"> Ensures only patients who are at least 18 years of age during the measurement period are included in the denominator. | <ul style="list-style-type: none"> Date of birth | |

¹ This data element(s) must be documented during the measurement period

² This data element(s) must be documented before or during the encounter

³ This data element(s) must be documented during the encounter

| Key Clinical Activities | | Planning Your EHR Documentation | |
|---|--|--|----------------------------|
| To-Do List | Why Needed? | Data Elements Needed | Responsible Person or Role |
| 2. Record the dates and types of visits | <ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. For this measure, at least two domiciliary, nursing facility, office and outpatient consult, or ophthalmological services encounters are required during the measurement period. | <ul style="list-style-type: none"> Dates of visits Codes for domiciliary, nursing facility, office and outpatient consult, or ophthalmological services encounters⁴ | |
| 3. Check patient record or assess patient for active diagnosis of primary open angle glaucoma (POAG). | <ul style="list-style-type: none"> Ensures only patients with an active diagnosis of POAG are included in the denominator. | <ul style="list-style-type: none"> Document diagnosis of primary open angle glaucoma (POAG), if any | |
| 4. Check patient record or assess patient for medical reason not to perform optic head nerve evaluation. | <ul style="list-style-type: none"> Ensures patients with a documented medical reason for procedure not done are identified as exclusions or exceptions. | <ul style="list-style-type: none"> Record medical reason for not performing optic head nerve evaluation, if any⁵ | |
| 5. Check patient record for optic nerve evaluation, or if appropriate, perform procedure. | <ul style="list-style-type: none"> Ensures only patients with documentation of optic nerve evaluation are counted in the numerator. | <ul style="list-style-type: none"> Document optic nerve evaluation procedure, if any⁶ | |

⁴ See Technical Supplement for denominator inclusion details (encounter types): [pp. TS-2](#)

⁵ See Technical Supplement for exclusion or exception details (medical reason procedure not done): [pp. TS-2](#)

⁶ See Technical Supplement for numerator inclusion details (optic nerve head evaluation): [pp. TS-3](#)

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure denominator and numerator.

DENOMINATOR INCLUSION CRITERIA

What constitutes a nursing facility encounter? (CPT codes)

- Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.

What constitutes a domiciliary encounter? (CPT codes)

- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A history; an examination; and medical decision making.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires at least 2 of these 3 key components: A history; an examination; and medical decision making.

What constitutes an office and outpatient consult encounter? (CPT codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A history; an evaluation; and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A history; an evaluation; and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: A history; an evaluation; and medical decision making.

What constitutes an ophthalmological services encounter? (CPT codes)

- Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; new patient
- Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; established patient

EXCLUSION OR EXCEPTION CRITERIA

What constitutes a medical reason for not performing an optic head nerve evaluation? (HL7 codes)

- The therapy has been found to not have the desired therapeutic benefit on the patient.
- The underlying condition has been resolved or has evolved such that a different treatment is no longer needed.
- A new therapy will be commenced when current supply exhausted.
- Testing has shown that the patient already has immunity to the agent targeted by the immunization.
- The patient currently has a medical condition for which the vaccine is contraindicated or for which precaution is warranted.
- The prescribed product has specific clinical release or other therapeutic characteristics not shared by other substitutable medications.
- The patient has an intolerance to the medication.
- Patient has had a prior allergic intolerance response to alternate product or one of its components.
- The specific manufactured drug is part of a clinical trial.
- Contraindication identified

NUMERATOR INCLUSION CRITERIA

What constitutes an optic head nerve evaluation? (SNOMED-CT codes)

- Exploration of optic nerve (II) (procedure)
- Ophthalmic examination and evaluation (procedure)

TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

| NQF0086 | CPT | CPT Modifier | CVX | Grouping | HCPSC | HL7 | ICD-9* | ICD-10 | LOINC | RxNorm | SNOMED* |
|--------------------------|-----|--------------|-----|----------|-------|-----|--------|--------|-------|--------|---------|
| Numerator ¹ | | | | | | | | | | | × |
| Denominator ² | × | | | × | | | × | × | | | × |
| Exceptions or exclusions | | | | | | × | | | | | |

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerator in this CQM, a SNOMED code is required.
- ² To identify the denominator in this CQM, a CPT code and one of the following code types is required: GROUPING, ICD-9, ICD-10, SNOMED.
- ³ To identify exclusions or exceptions in this CQM, an HL7 code is required.

| Abbreviation | Long Name | Definition/Description |
|--------------|---|--|
| CPT | Current Procedural Terminology | The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC) |
| CVX | Codes for Vaccine Administered | This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK) |
| HCPSC | Healthcare Common Procedure Coding System | Level I of the HCPSC is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPSC is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS) |
| HL7 | Health Level Seven | HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE) |

| Abbreviation | Long Name | Definition/Description |
|--------------|---|---|
| ICD-9 | International Statistical Classification of Diseases and Related Health Problems, 9th revision | The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC) |
| ICD-10 | International Statistical Classification of Diseases and Related Health Problems, 10th revision | The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC) |
| LOINC | Logical Observation Identifiers Names and Codes | A universal code system for identifying laboratory and clinical observations. (Source: LOINC) |
| RxNorm | RxNorm | RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH) |
| SNOMED-CT | Systematic Nomenclature of Medicine - Clinical Terms | SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH) |

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