

NQF 0387: Oncology Breast Cancer:

Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer

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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Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.

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"> Age¹ Gender³ Encounter codes² Active diagnosis of breast cancer or inactive diagnosis of breast cancer history³ Procedure result of breast cancer Stage IC-IIIC3 Procedure result of breast cancer ER or PR positive³
Data required to identify the <u>exceptions</u> or <u>exclusions</u>	<ul style="list-style-type: none"> Active diagnosis of metastatic sites common to breast cancer³, or Medication intolerance, adverse event, or allergy regarding tamoxifen or aromatase inhibitor therapy², or Medication active for gonadotropin-releasing hormone analogue medication³, or Procedure performed: bilateral oophorectomy, radiation therapy, or chemotherapy³, or Medical, patient, or system reason for not prescribing medication
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Medication order or active: tamoxifen or aromatase inhibitor therapy²

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>

¹ This data element(s) must be documented before the beginning of the measurement period

² This data element(s) must be documented during the measurement period

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

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 18 years and over at the start of the measurement period are included in the denominator 	<ul style="list-style-type: none"> Date of birth 	
2. Confirm the patient's gender	<ul style="list-style-type: none"> Ensures only female patients are included in the denominator 	<ul style="list-style-type: none"> Patient gender 	
3. Record the date and type of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. For this measure, two or more encounters are required within the measurement period. 	<ul style="list-style-type: none"> Date of visit Code for an office visit encounter⁴ 	
4. Check patient record or assess patient for active diagnosis of breast cancer or an inactive diagnosis of breast cancer history	<ul style="list-style-type: none"> Ensures only patients with an active diagnosis of breast cancer or an inactive diagnosis of breast cancer history are included in the denominator. 	<ul style="list-style-type: none"> Diagnosis code breast cancer or breast cancer history⁵ 	
5. Check patient record for procedure result indicating Stage IC-IIIIC and ER or PR positive breast cancer	<ul style="list-style-type: none"> Ensures only patients with ER or PR positive stage IC-IIIIC breast cancer are included in the denominator. 	<ul style="list-style-type: none"> Procedure result: breast cancer stage IC-IIIIC, Procedure result: breast cancer ER or PR positive 	

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

⁵ See Technical Supplement for denominator inclusion details (breast cancer history): [pp. TS-2](#)

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
6. Check patient record or assess patient for possible reasons not to prescribe tamoxifen or aromatase inhibitor therapy	<ul style="list-style-type: none"> Ensures patients with documentation of at least one reason for not taking tamoxifen or aromatase inhibitor therapy are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Medication intolerance, adverse event, or allergy to tamoxifen or aromatase inhibitor therapy, or Procedure performed: bilateral oophorectomy, radiation therapy, or chemotherapy, or Active diagnosis of metastatic sites common to breast cancer, or Patient, medical, or system reason medication not done 	
7. Check patient record for medication order or active: tamoxifen or aromatase inhibitor therapy. Or, if appropriate, order tamoxifen or aromatase inhibitor therapy.	<ul style="list-style-type: none"> Ensures only patients with documentation of tamoxifen or aromatase inhibitor therapy active or ordered are counted in the numerator 	<ul style="list-style-type: none"> Medication order or active: tamoxifen or aromatase inhibitor therapy⁶ 	

⁶ See Technical Supplement for numerator inclusion details (tamoxifen or aromatase inhibitor therapy): [pp. TS-2](#)

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 an office 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 examination; and medical decision making.

What constitutes a diagnosis of breast cancer history? (ICD-10)

- Personal history of malignant neoplasm of breast

What constitutes a diagnosis of breast cancer history? (ICD-9)

- Breast: history of conditions classifiable to malignant neoplasm of female breast or malignant neoplasm of male breast

What constitutes a diagnosis of breast cancer history? (ICD-9)

- History of malignant neoplasm of breast (situation)

NUMERATOR INCLUSION CRITERIA

What constitutes tamoxifen or aromatase inhibitor therapy? (RxNorm codes)

- Anastrozole
- Letrozole
- Tamoxifen
- Exemestane

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

NQF0387	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹										x	
Denominator ²	x			x		x	x	x			x
Exceptions or exclusions ³	x			x		x	x	x		x	x

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerator in this CQM, an RxNorm code is required
- ² To identify the denominator in this CQM, 2 HL7 codes, 2 CPT codes, and a GROUPING, ICD-9, ICD-10 or SNOMED code are required.
- ³ To identify exclusions or exceptions in this CQM, an RxNorm, CPT, GROUPING, SNOMED, ICD-9, ICD-10 or an HL7 code are 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)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS 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)
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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