Measure #6: Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with coronary artery disease seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is 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 who were prescribed oral antiplatelet therapy

Definition: "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Numerator Instructions: Oral antiplatelet therapy consists of aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox

Numerator Coding:
Oral Antiplatelet Therapy Prescribed
CPT II 4011F: Oral antiplatelet therapy prescribed (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)
OR

Oral Antiplatelet Therapy not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P, or 3P) to Category II code 4011F to report documented circumstances that appropriately exclude patients from the denominator.

- 1P: Documentation of medical reason(s) for not prescribing oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)
- 2P: Documentation of patient reason(s) for not prescribing oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)
- 3P: Documentation of system reason(s) for not prescribing oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)

OR

Oral Antiplatelet Therapy not Prescribed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4011F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Oral antiplatelet therapy (eg, aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox) was not prescribed, reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease

Denominator Coding:
An ICD-9 diagnosis code for coronary artery disease and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

RATIONALE:
Oral antiplatelet therapy, preferably aspirin unless contraindicated, is recommended for all patients with coronary artery disease. By limiting the ability of clots to form in the arteries, antiplatelet agents have proven benefits in reducing the risk of non-fatal myocardial infarction, non-fatal stroke and death.

CLINICAL RECOMMENDATION STATEMENTS:
Chronic Stable Angina: Class I – Aspirin 75-325 mg daily should be used routinely in all patients with acute and chronic ischemic heart disease with or without manifest symptoms in the absence of contraindications. Class IIa – Clopidogrel is recommended when aspirin is absolutely contraindicated. Class III – Dipyridamole. Because even the usual oral doses of dipyridamole can

enhance exercise-induced myocardial ischemia in patients with stable angina, it should not be used as an antiplatelet agent. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Aspirin 75 to 325 mg/dl in the absence of contraindications. Class I – Clopidogrel 75 qd for patients with a contraindication to ASA. (ACC/AHA)

Acute Myocardial Infarction (AMI): Class I – A dose of aspirin, 160 to 325 mg, should be given on day one of AMI and continued indefinitely on a daily basis thereafter. Trials suggest long-term use of aspirin in the postinfarction patient in a dose as low as 75 mg per day can be effective, with the likelihood that side effects can be reduced. Class IIb – Other antiplatelet agents such as dipyridamole, ticlopidine or clopidogrel may be substituted if true aspirin allergy is present or if the patient is unresponsive to aspirin. (ACC/AHA)

Coronary Artery Bypass Graft Surgery: Aspirin is the drug of choice for prophylaxis against early saphenous graft thrombotic closure and should be considered a standard of care for the first postoperative year. In general, patients are continued on aspirin indefinitely, given its benefit in the secondary prevention of AMI. Ticlopidine is efficacious but offers no advantage over aspirin except as an alternative in the truly aspirin-allergic patient. Clopidogrel offers the potential of fewer side effects compared with ticlopidine as an alternative to aspirin for platelet inhibition. Indobufen appears to be as effective as aspirin for saphenous graft patency over the first postoperative year but with fewer gastrointestinal side effects. Current evidence suggests that dipyridamole adds nothing to the aspirin effect for saphenous graft patency. (ACC/AHA)