Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

*This measure is to be reported for all patients aged 18 years and older with myelodysplastic syndrome (MDS) — a minimum of **once** per reporting period. It is anticipated that clinicians who provide services for patients with the diagnosis of myelodysplastic syndromes will submit this measure.*

Measure description

Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy[1] with documentation of iron stores[2] prior to initiating erythropoietin therapy

What will you need to report for each patient with MDS for this measure?

If you select this measure for reporting, you will report:

- Whether or not the patient is receiving erythropoietin therapy[1]

If the patient is receiving erythropoietin therapy[1], you will then need to report:

- Whether or not you documented iron stores[2] prior to initiating therapy (regardless of when the documentation of iron stores occurred)

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to document iron stores prior to initiating erythropoietin therapy, due to:

- System reasons (eg, resources to perform the services not available, other reason attributable to health care delivery system)

In these cases, you will need to indicate that the system reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).

[1]For the purposes of this measure, erythropoietin therapy includes the following medications: epoetin and darbepoetin.

[2]Documentation of iron stores includes either: Bone marrow examination including iron stain OR serum iron measurement by ferritin or serum iron and TIBC.

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