Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with Coronary Artery Disease and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)

*This measure is to be reported for all patients aged 18 years and older with coronary artery disease — a minimum of **once** per reporting period.*

Measure description

Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who also have diabetes mellitus and/or left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy

What will you need to report for each patient with coronary artery disease for this measure?

There are two different reporting criteria for this measure. You should only report on one criteria per patient.

Reporting Criteria 1 — For patient with coronary artery disease

If the patient has coronary artery disease (without diabetes) and you select this measure for reporting, you will report:

- If the patient has LVSD, you will then need to report:
  - Whether or not you prescribed ACE inhibitor or ARB therapy

OR

Reporting Criteria 2 — For patient with coronary artery disease and diabetes

If the patient has coronary artery disease AND diabetes mellitus (as determined through line item ICD-9 diagnoses) and you select this measure for reporting, you will report:

- Whether or not you prescribed ACE inhibitor or ARB therapy

If patient has coronary artery disease AND diabetes AND LVSD, use reporting criteria 2.

Note: Left ventricular systolic dysfunction is defined as left ventricular ejection fraction (LVEF) less than 40% or moderately or severely depressed left ventricular systolic function

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

There may be times when it is not appropriate to prescribe ACE inhibitor or ARB therapy, due to:

- Documented reasons (eg, patient was not an eligible candidate for ACE inhibitor or ARB therapy)

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