**Measure #33 (NQF 0241): Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge – National Quality Strategy Domain: Effective Clinical Care**

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
REGISTRY ONLY

**DESCRIPTION:**
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

**INSTRUCTIONS:**
This measure is to be reported for patients under active treatment for ischemic stroke or TIA with documented atrial fibrillation at discharge from a hospital during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting will submit this measure.

**Measure Reporting via Registry:**
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**
All patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation

**Definitions:**
First Detected – Only one diagnosed episode.
Persistent Atrial Fibrillation – Recurrent episodes that last more than 7 days.
Paroxysmal Atrial Fibrillation – Recurrent episodes that self terminate in less than 7 days.
Permanent Atrial Fibrillation – An ongoing long term episode.

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter

**AND**
Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]: G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

**AND**
Diagnosis for atrial fibrillation (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 427.31
Diagnosis for atrial fibrillation (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I48.0, I48.1, I48.2

**AND**
Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239

**NUMERATOR:**
Patients who were prescribed an anticoagulant at discharge

**Definitions:**
Anticoagulants – warfarin, low molecular weight heparin, dabigatran, rivaroxaban*

*The above list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA’s web site page entitled “Drug Safety Communications” for up-to-date drug recall and alert information when prescribing medications.

Prescribed – May include prescription given to the patient for anticoagulant therapy at discharge OR anticoagulant to be continued after discharge as documented in the discharge medication list.

**NUMERATOR NOTE:** In order to meet the measure, anticoagulant therapy is to be prescribed at the time of discharge. If a physician other than the discharging physician (eg, consulting physician) is reporting on this measure, it should be clear from the documentation that the prescription is being ordered for the patient at the time of discharge, and included in the “medications prescribed at discharge”.

**Numerator Options:**

**Performance Met:**
Anticoagulant therapy prescribed at discharge (4075F)

**Medical Performance Exclusion:**
Anticoagulant therapy not prescribed at discharge for medical reason (eg, patient expired during inpatient stay, other medical reason(s)) (4075F with 1P)

**Patient Performance Exclusion:**
Anticoagulant therapy not prescribed at discharge for patient reason (eg, patient left against medical advice, other patient reason(s)) (4075F with 2P)

**Performance Not Met:**
Anticoagulant therapy not prescribed at discharge, reason not otherwise specified (4075F with 8P)

**RATIONALE:**
In patients with nonvalvular AF, prior stroke or TIA is the strongest independent predictor of stroke, significantly associated with stroke in all 6 studies in which it was evaluated with incremental relative risk between 1.9 and 3.7 (averaging approximately 3.0). The pathogenic constructs of stroke in AF are incomplete, but available data indicate that all patients with prior stroke or TIA are at high risk of recurrent thromboembolism and require anticoagulation unless there are firm contraindications in a given patient. Patients with atrial fibrillation (permanent, persistent, or paroxysmal) and stroke should be prescribed an anticoagulant to prevent recurrent strokes.

**CLINICAL RECOMMENDATION STATEMENTS:**
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications. (Class I, Level of Evidence A) (ACC/AHA/ESC, 2006)

The selection of the antithrombotic agent should be based upon the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient. (Class I, Level of Evidence A) (ACC/AHA/ESC, 2006)