Quality ID #392 (CBE 2474): Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Outcome – High Priority

- *INVERSE MEASURE: LOWER SCORE – BETTER*

DESCRIPTION:
Rate of cardiac tamponade and/or pericardiocentesis following atrial fibrillation ablation. This measure is submitted as four rates stratified by age and gender:

- Submission Age Criteria 1: Females 18-64 years of age
- Submission Age Criteria 2: Males 18-64 years of age
- Submission Age Criteria 3: Females 65 years of age and older
- Submission Age Criteria 4: Males 65 years of age and older

INSTRUCTIONS:
Reporting Frequency:
This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria.

Intent and Clinician Applicability:
This measure is intended to reflect the quality of services provided for patients who underwent atrial fibrillation ablation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains four strata defined by four submission criteria.
This measure produces five performance rates.

There are four Submission Criteria for this measures:

1) Females 18-64 years of age

AND

2) Males 18-64 years of age

AND

3) Females 65 years of age and older

AND

4) Males 65 years of age and older

This measure will be calculated with 5 performance rates:

1) Females 18-64 years of age
2) Males 18-64 years of age
3) Females 65 years of age and older
4) Males 65 years of age and older
5) Overall percentage of patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days

MIPS eligible clinicians should continue to submit the measure as specified, with no additional steps needed to account for

multiple performance rates. For accountability reporting in the CMS MIPS program, the rate for Submission Criteria 5 is used for performance.

Implementation Considerations:
For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code (QDC) will be used if the measure is submitted more than once.

This is an inverse measure which means a lower calculated performance rate for this measure indicates better clinical care or control. The "Performance Not Met" numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Include only patients that have had atrial fibrillation ablation performed by November 30, 2026 for evaluation of cardiac tamponade and/or pericardiocentesis occurring within 30 days within the performance period. This will allow the evaluation of cardiac tamponade and/or pericardiocentesis complications within the performance period. A minimum of 30 cases is recommended by the measure owner to ensure a volume of data that accurately reflects provider performance; however, this minimum number is not required for purposes of QPP submission.

Telehealth:
NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 18 years and older with atrial fibrillation ablation performed during the reporting period.

Denominator Criteria (Eligible Cases):
SUBMISSION CRITERIA 1: Females 18-64 years old
OR
SUBMISSION CRITERIA 2: Males 18-64 years old
OR
SUBMISSION CRITERIA 3: Females 65 years of age and older
OR
SUBMISSION CRITERIA 4: Males 65 years of age and older
AND
Diagnosis code for atrial fibrillation during the reporting period (ICD-10-CM): I48.0, I48.11, I48.19, I48.20, I48.21, I48.91
AND
Procedure code for atrial fibrillation ablation during the reporting period (ICD-10-PCS): 02583ZZ, 02584ZZ

AND/OR
Ablation procedures that have been performed by November 30 of current performance period (CPT): 93656

NUMERATOR:
The number of patients from the denominator with cardiac tamponade and/or pericardiocentesis occurring within 30 days following atrial fibrillation ablation.

Numerator Instructions:
INVERSE MEASURE – see Implementation Considerations

Numerator Options:

Performance Not Met:	Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days (G9409)

OR

Performance Met:	Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days (G9408)

RATIONALE:
Cardiac tamponade is one of the most serious complications of atrial fibrillation ablation that can lead to substantial morbidity due to a significant drop in the cardiac output and blood pressure leading to hypo-perfusion of important organs such as the brain, heart, and kidneys. In many cases, cardiac tamponade has to be treated surgically, and it invariably prolongs hospital stay. If not treated promptly, cardiac tamponade can lead to death. The risk of this dreaded complication has been reported to range from 2 to 6%; however, these rates were observed in tertiary referral centers where the procedure was performed by experienced and skillful operators. Given that the occurrence of cardiac tamponade is largely dependent on the operator's level of experience and, therefore, is in most cases preventable, higher rates are expected to occur when less experienced operators perform the procedure. These issues prove the need to measure performance in this area.

CLINICAL RECOMMENDATION STATEMENTS:
In recognition that there is an absence of applicable physician-level performance measures for the profession of cardiac electrophysiology, the Heart Rhythm Society (the international professional society focused on the care of patients with heart rhythm disorders) convened a Performance Measures Development Task Force to consider and develop potential physician-level measures cardiac electrophysiologists. The task force consisted of thought leaders in atrial fibrillation ablation, cardiovascular health policy, performance measures development, clinical outcomes, and population science.

The process for consideration of the evidence included review of multi-stakeholder professional society clinical expert consensus statements on the topic, such as the 2012 Heart Rhythm Society/European Heart Rhythm Association/European Cardiac Arrhythmia Society Expert Consensus Statement on Catheter and Surgical Ablation of Atrial Fibrillation (Calkins et al, 2012), and the relevant literature both referenced within this document and in the knowledge of the members of the task force (Cappato et al, 2005; Hsu et al, 2005; Andrade et al, 2011; Bunch et al, 2005; Cappato et al, 2009; Cappato et al, 2010; Cappato et al, 2011; Fisher et al, 2000; Hsu et al, 2003; Latchamsetty et al, 2011; O'Neill et al, 2008; Tsang et al, 2002).

The expert consensus statement does not provide a specific recommendation related to this proposed outcome measure, but rather summarizes that in high-volume and high-quality programs, the incidence of complications in general should be comparable to the low rates of complications observed in published studies, including the world- wide survey of atrial fibrillation ablation (Cappato et al, 2005; Cappato et al, 2009; Cappato et al, 2010; Cappato et al, 2011). Collectively, the incidence of this complication has in general ranged from between 1.2 and 2.4% across the literature evaluated (Cappato et al, 2005; Hsu et al, 2005; Calkins et al, 2012; Andrade et al, 2011; Bunch et al, 2005; Cappato et al, 2009; Cappato et al, 2010; Cappato et al, 2011; Fisher et al, 2000; Hsu et al, 2003; Latchamsetty et al, 2011; O'Neill et al, 2008; Tsang et al, 2002).

REFERENCES:

Calkins H, Kuck KH, Cappato R, Brugada J, Camm AJ, Chen SA, Crijns HJ, Damiano RJ Jr, Davies DW, DiMarco J, Edgerton J, Ellenbogen K, Ezekowitz MD, Haines DE, Haissaguerre M, Hindricks G, Iesaka Y, Jackman W, Jalife J, Jais P, Kalman J, Keane D, Kim YH, Kirchhof P, Klein G, Kottkamp H, Kumagai K, Lindsay BD, Mansour M, Marchlinski FE, McCarthy PM, Mont JL, Morady F, Nademanee K, Nakagawa H, Natale A, Nattel S, Packer DL, Pappone C, Prystowsky E, Raviele A, Reddy V, Ruskin JN, Shemin RJ, Tsao HM, Wilber D. 2012 HRS/EHRA/ECAS Expert Consensus Statement on Catheter and Surgical Ablation of Atrial Fibrillation: recommendations for patient selection, procedural techniques, patient management and follow-up, definitions, endpoints, and research trial design. Europace. 2012 Apr;14(4):528-606. doi: 10.1093/europace/eus027. Epub 2012 Mar 1. PMID: 22389422.

Cappato R, Calkins H, Chen SA, Davies W, Iesaka Y, Kalman J, Kim YH, Klein G, Packer D, Skanes A. Worldwide survey on the methods, efficacy, and safety of catheter ablation for human atrial fibrillation. Circulation. 2005 Mar 8;111(9):1100-5. doi: 10.1161/01.CIR.0000157153.30978.67. Epub 2005 Feb 21. PMID: 15723973.

Cappato R, Calkins H, Chen SA, Davies W, Iesaka Y, Kalman J, Kim YH, Klein G, Natale A, Packer D, Ricci C, Skanes A, Ranucci M. Delayed cardiac tamponade after radiofrequency catheter ablation of atrial fibrillation: a worldwide report. J Am Coll Cardiol. 2011 Dec 13;58(25):2696-7. doi: 10.1016/j.jacc.2011.09.028. PMID: 22152959.

2026 Clinical Quality Measure Flow for Quality ID #392 (CBE 2474): Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation

Multiple Performance Rates

INVERSE MEASURE: LOWER SCORE – BETTER

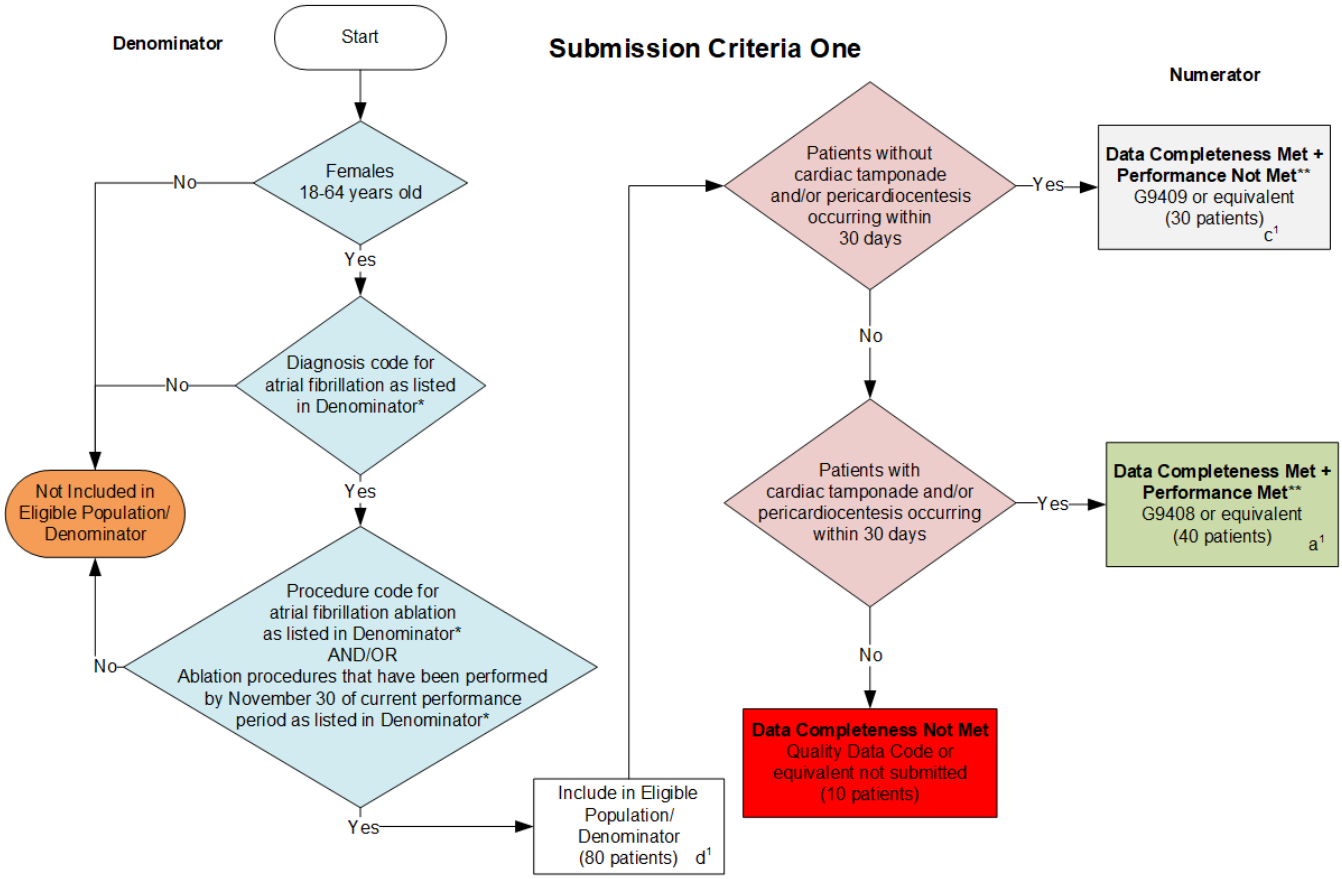
Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

ACCOUNTABILITY REPORTING IN THE CMS MIPS PROGRAM: SAMPLE CALCULATIONS

Overall Data Completeness (All Submission Criteria) =
Performance Met ($a^1+a^2+a^3+a^4$=160 patients) + Performance Not Met ($c^1+c^2+c^3+c^4$=120 patients) = 280 patients = **87.50%**
Eligible Population / Denominator ($d^1+d^2+d^3+d^4$=320 patients) = 320 patients

Overall Performance Rate (Performance Rate 5) =
Performance Met ($a^1+a^2+a^3+a^4$= 160 patients) = 160 patients = **57.14%**
Data Completeness Numerator (280 patients) = 280 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process



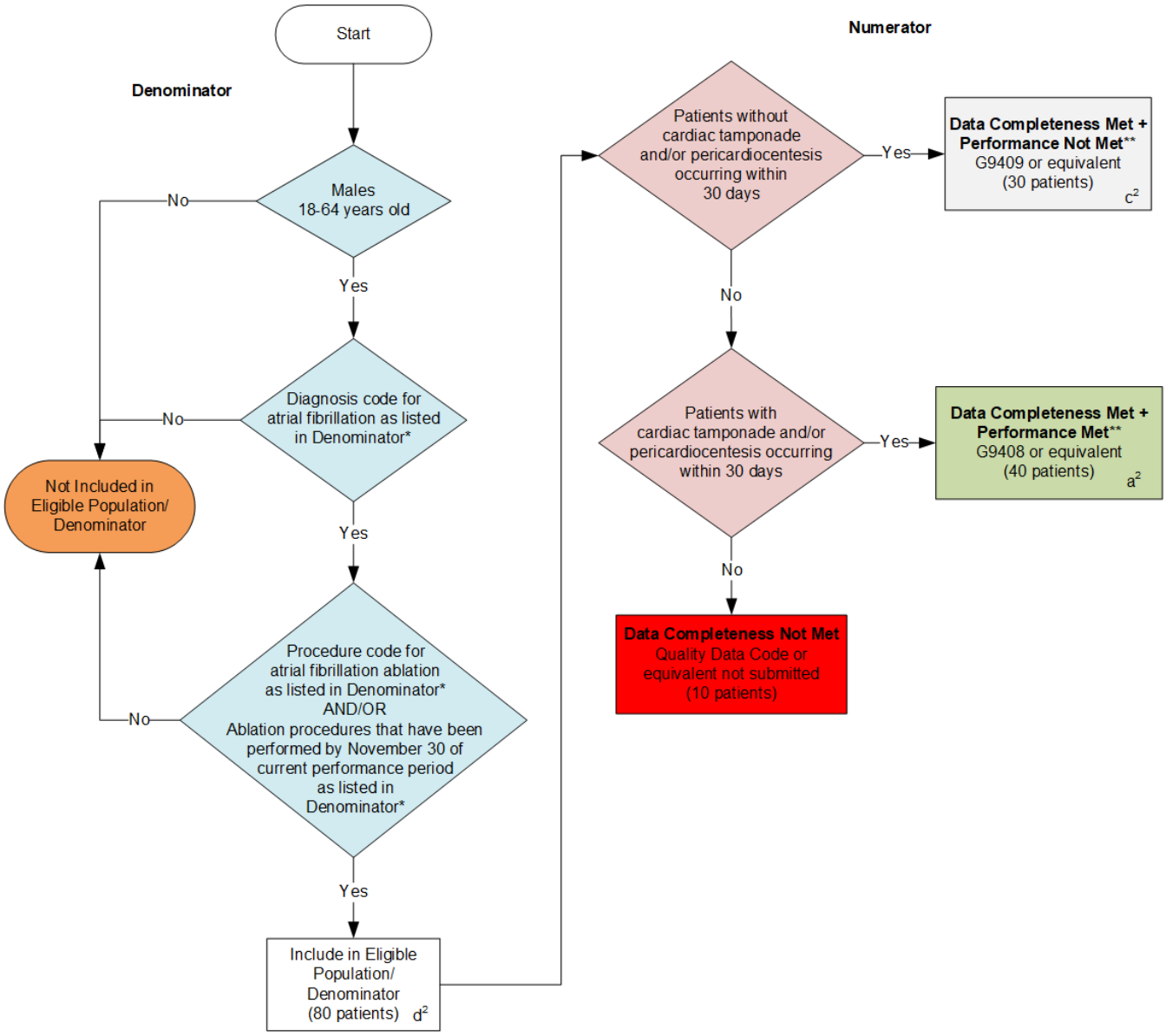
SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=
Performance Met (a^1=40 patients) + Performance Not Met (c^1=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d^1=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a^2=40 patients) + Performance Not Met (c^2=30 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d^2=80 patients) = 80 patients

Performance Rate=

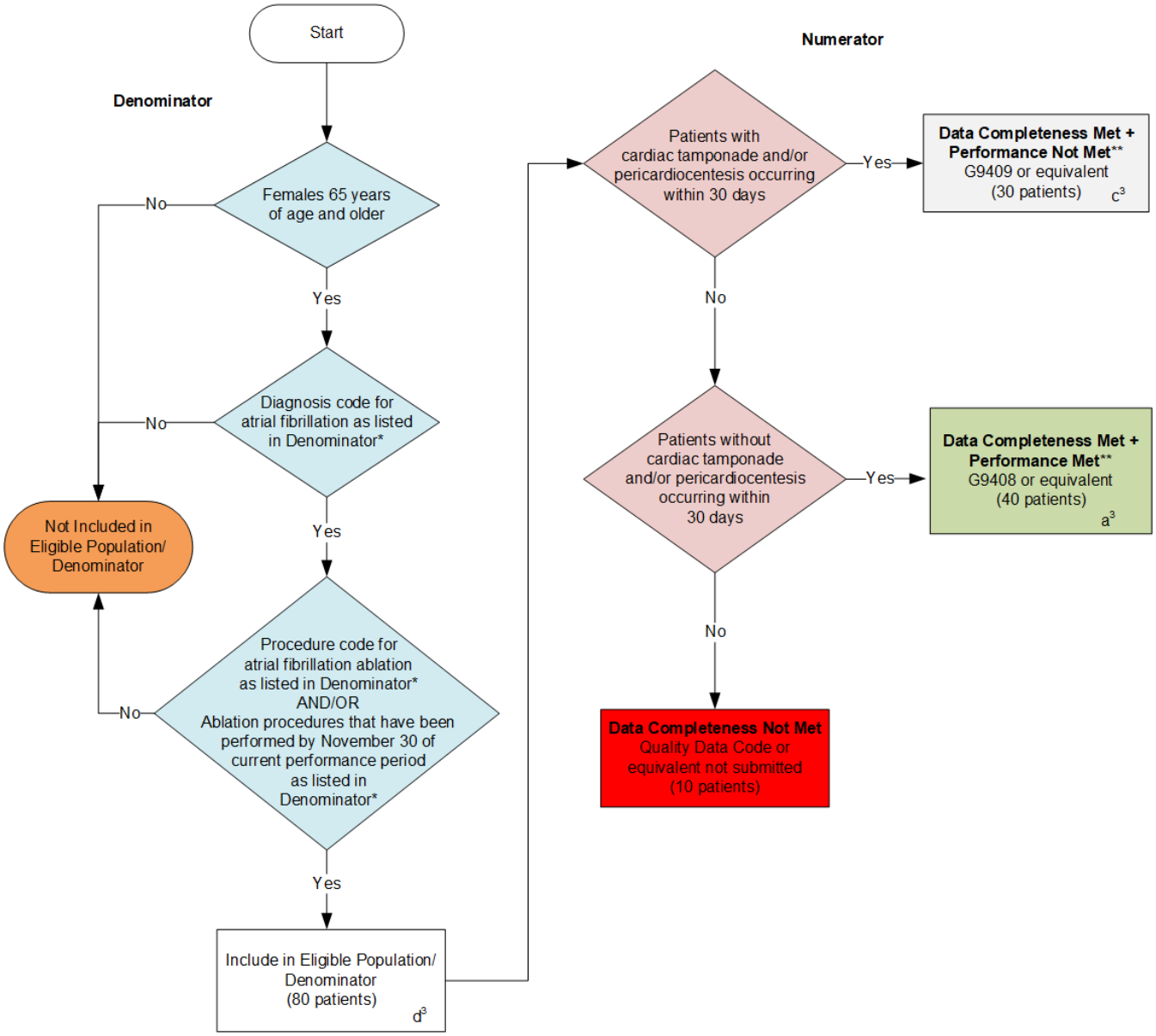
Performance Met (a^2=40 patients) = 40 patients = **57.14%**

Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

v10

Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

Performance Met (a^3=40 patients) + Performance Not Met (c^3=30 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d^3=80 patients) = 80 patients

Performance Rate=

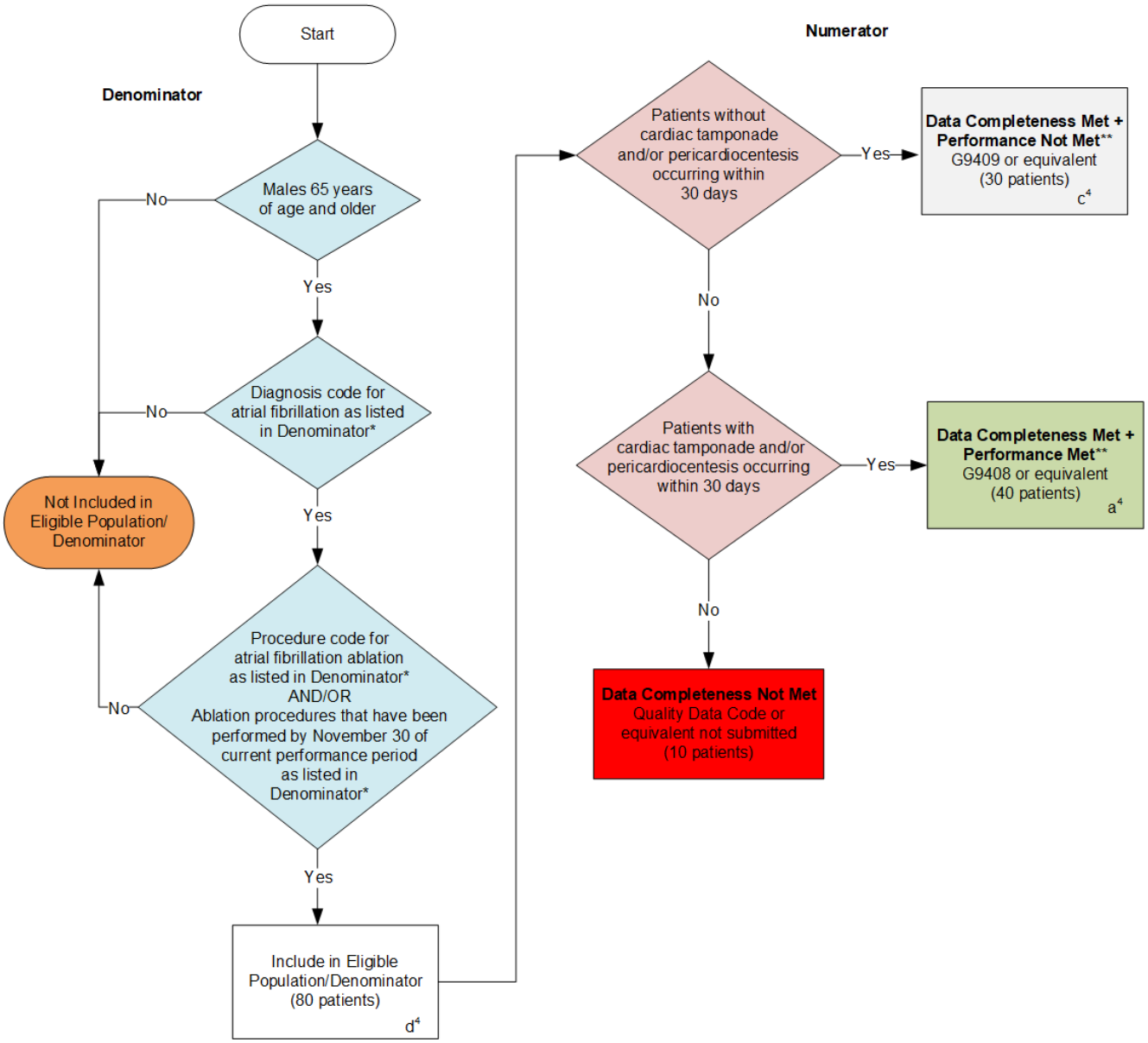
Performance Met (a^3=40 patients) = 40 patients = **57.14%**

Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

v10

Submission Criteria Four



SAMPLE CALCULATIONS: SUBMISSION CRITERIA FOUR

Data Completeness=

Performance Met (a^4=40 patients) + Performance Not Met (c^4=30 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d^4=80 patients) = 80 patients

Performance Rate=

Performance Met (a^4=40 patients) = 40 patients = **57.14%**

Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.
NOTE: Submission Frequency: Patient-Process

v10

2026 Clinical Quality Measure Flow Narrative for Quality ID #392 (CBE #2474): Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation

Multiple Performance Rates

INVERSE MEASURE: LOWER SCORE – BETTER

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

Accountability Reporting in the CMS MIPS Program: Sample Calculations:

Overall Data Completeness (All Submission Criteria) equals Performance Met (a^1 plus a^2 plus a^3 plus a^4 equals 160 patients) plus Performance Not Met (c^1 plus c^2 plus c^3 plus c^4 equals 120 patients) divided by Eligible Population/Denominator (d^1 plus d^2 plus d^3 plus d^4 equals 320 patients). All equals 280 patients divided by 320 patients. All equals 87.50 percent.

Overall Performance Rate (Performance Rate 5) equals Performance Met (a^1 plus a^2 plus a^3 plus a^4 equals 160 patients) divided by Data Completeness Numerator equals 280 patients. All equals 160 patients divided by 280 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

Submission Criteria One:

1. Start with Denominator
2. Check *Females 18 to 64 years old*:
    a. If *Females 18 to 64 years old* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Females 18 to 64 years old* equals Yes, proceed to check *Diagnosis code for atrial fibrillation as listed in Denominator**.
3. Check *Diagnosis code for atrial fibrillation as listed in Denominator**:
    a. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals Yes, proceed to check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**.
4. Check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**:
    a. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation*

*procedures that have been performed by November 30 of current performance period as listed in Denominator** equals Yes, check *Telehealth Modifier as listed in denominator*.

5. Denominator Population

    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d_1 equals 80 patients in the Sample Calculation.

6. Start Numerator

7. Check *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days*:

    a. If *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c_1 equals 30 patients in the Sample Calculation.

    b. If *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals No, proceed to check *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*.

8. Check *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*:

    a. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a_1 equals 40 patients in the Sample Calculation.

    b. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals No, proceed to check *Data Completeness Not Met.*

9. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

<u>Sample Calculations: Submission Criteria One</u>

Data Completeness equals Performance Not Met (c_1 equals 30 patients) plus Performance Met (a_1 equals 40 patients) divided by Eligible Population/Denominator (d_1 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate** equals Performance Met (a_1 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator
2. Check *Males 18 to 64 years old*:
    a. If *Males 18 to 64 years old* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Males 18 to 64* years old equals Yes, proceed to check *Diagnosis code for atrial fibrillation as listed in Denominator**.
3. Check *Diagnosis code for atrial fibrillation as listed in Denominator**:
    a. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals Yes, proceed to check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**.
4. Check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**:
    a. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals Yes, check *Telehealth Modifier as listed in denominator*.
5. Denominator Population
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days:
    a. If Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days equals Yes, include in Data Completeness Met and Performance Not Met**.
        - Data Completeness Met and Performance Not Met** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c2 equals 30 patients in the Sample Calculation.

b. If Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days equals No, proceed to *check Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*.

8. Check *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*:

   a. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals Yes, include in *Data Completeness Met and Performance Met***.

      - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 40 patients in the Sample Calculation.

   b. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals No, proceed to check Data Completeness Not Met.

9. Check *Data Completeness Not Met*:

   - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Not Met (c_2 equals 30 patients) plus Performance Met (a_2 equals 40 patients) divided by Eligible Population/Denominator (d_2 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate** equals Performance Met (a_2 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.
**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Three:

1. Start with Denominator

2. Check *Females 65 years of age and older*:

   a. If *Females 65 years of age and older* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Females 65 years of age and older* equals Yes, proceed to check *Diagnosis code for atrial fibrillation as listed in Denominator**.

3. Check *Diagnosis code for atrial fibrillation as listed in Denominator**:

   a. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals Yes, proceed to

check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**.

4. Check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**:

    a. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals Yes, check *Telehealth Modifier as listed in denominator*.

5. Denominator Population

    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 patients in the Sample Calculation.

6. Start Numerator

7. Check Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days:

    a. If Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days equals Yes, include in Data Completeness Met and Performance Not Met**.

        - Data Completeness Met and Performance Not Met** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c2 equals 30 patients in the Sample Calculation.

    b. If Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days equals No, proceed to *check Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*.

8. Check *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*:

    a. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 40 patients in the Sample Calculation.

    b. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals No, proceed to check Data Completeness Not Met.

9. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Not Met (c_3 equals 30 patients) plus Performance Met (a_3 equals 40 patients) divided by Eligible Population/Denominator (d_3 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate** equals Performance Met (a_3 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Four:

1. Start with Denominator
2. Check *Males 65 years of age and older*:
    a. If *Males 65 years of age and older* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Males 65 years of age and older* equals Yes, proceed to check *Diagnosis code for atrial fibrillation as listed in Denominator**.
3. Check *Diagnosis code for atrial fibrillation as listed in Denominator**:
    a. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals No, do not include in

        Eligible Population/Denominator. Stop processing.
    b. If *Diagnosis code for atrial fibrillation as listed in Denominator** equals Yes, proceed to check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**.
4. Check *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator**:
    a. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Procedure code for atrial fibrillation ablation as listed in Denominator* AND/OR Ablation procedures that have been performed by November 30 of current performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator.*
5. Denominator Population
    - Denominator population is all Eligible Patients in the Denominator. Denominator is

represented as Denominator in the Sample Calculation listed at the end of this document. Letter d_4 equals 80 patients in the Sample Calculation.

6. Start Numerator

7. Check *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days*:

    a. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a_4 equals 40 patients in the Sample Calculation.

    b. If *Patients with cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals No, proceed to check *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days.*

8. Check *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days*:

    a. If *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c_4 equals 30 patients in the Sample Calculation.

    b. If *Patients without cardiac tamponade and/or pericardiocentesis occurring within 30 days* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations Submission Criteria Four

Data Completeness equals Performance Met (a_4 equals 40 patients) plus Performance Not Met (c_4 equals 30 patients) divided by Eligible Population/Denominator (d_4 equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate** equals Performance Met (a_4 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.