

# **AAAAI Allergy, Asthma & Immunology Quality Clinical Data Registry in collaboration with CECity**

## **Measure Specifications**

Hosting Measures Owned and Developed by:

**American Medical Association-convened Physician Consortium for Performance Improvement®**

**Health Care Incentives Improvement Institute, Inc.  
Bridges to Excellence®**

**The Joint Task Force on Quality Performance Measures Workgroup  
Approved by the American Academy of Allergy, Asthma & Immunology (AAAAI),  
American College of Allergy, Asthma & Immunology (ACAAI)  
and the Joint Council of Allergy, Asthma and Immunology**

**MN Community Measurement**

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MN Community Measurement Measures (MNCM):

Permission granted by MN Community Measurement for denominator modification from patients aged 5 - 50 years to patients aged 5 years and older.

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Measures developed by the Joint Task Force on Quality Performance Measures Workgroup have been approved by the American Academy of Allergy, Asthma & Immunology (AAAAI), American College of Allergy, Asthma & Immunology (ACAAI) and the Joint Council of Allergy, Asthma and Immunology. The AAAAI is responsible for the development of the specifications of the measures as included in this document in the QCDR.

## Table of Contents

Section	Page
<b>American Medical Association-convened Physician Consortium for Performance Improvement Owned Physician Quality Reporting System Asthma Measures</b>	<b>4</b>
Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting	5
Measure #64 (NQF 0001): Asthma: Assessment of Asthma Control - Ambulatory Care Setting	7
Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting	9
Measure #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting	11
<b>Joint Task Force on Quality Performance Measures Workgroup Measures</b>	<b>14</b>
Allergy Immunotherapy Treatment: Allergen Specific Immunoglobulin E (IgE) Sensitivity Assessed and Documented Prior to Treatment	15
Documentation of Clinical Response to Allergy Immunotherapy within One Year	16
Documented Rationale to Support Long-Term Aeroallergen Immunotherapy beyond Five years, as Indicated	18
Achievement of Projected Effective Dose of Standardized Allergens for Patient Treated With Allergy Immunotherapy for at Least One Year	19
Assessment of Asthma Symptoms Prior to Administration of Allergy Immunotherapy Injection(s)	21
Documentation of the Consent Process for Subcutaneous Allergy Immunotherapy in the Medical Record	23
<b>Bridges to Excellence Asthma Care Recognition Program Clinician Assessment Measures</b>	<b>25</b>
Asthma Assessment and Classification	26
Lung Function/Spirometry Evaluation	27
Influenza Immunization	28
Patient Self-Management Plan	30
Body Mass Index	31
<b>MN Community Measurement Owned Asthma Measure</b>	<b>33</b>
Optimal Asthma Care: Control Component	34

**American Medical Association-convened Physician Consortium for Performance Improvement® Owned Physician Quality Reporting System (PQRS)  
Asthma Measures**

AMA-PCPI developed PQRS measures are used with modification to the upper age limits from 5-64 years to 5 years and older in the Allergy, Asthma and Immunotherapy Qualified Clinical Data Registry (QCDR) with permission from the measure owner

**Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting**

**DESCRIPTION:**

Percentage of patients aged 5 year and older with a diagnosis of persistent asthma who were prescribed long-term control medication

**INSTRUCTIONS:**

This measure is to be reported a minimum of **once per reporting period** for **all** patients with a diagnosis of persistent asthma 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 will be calculated with 3 performance rates:**

- 1) Patients prescribed inhaled corticosteroids (ICS) as their long-term control medication
- 2) Patients prescribed other alternative long-term control medications (non-ICS)
- 3) Total patients prescribed long-term control medication

**Data Source:**

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.

**DENOMINATOR:**

All patients aged 5 years and older with a diagnosis of persistent asthma

**Denominator Instructions:** Documentation of persistent asthma must be present. One method of identifying persistent asthma is at least daily use of short-acting bronchodilators

**Denominator Criteria (Eligible Cases):**

Patients aged 5 years and older on date of encounter

**AND**

**Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]:** 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

**Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]:** J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

**AND**

**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

**AND**

Persistent Asthma (mild, moderate or severe) **(1038F)**

**NUMERATOR:**

Patients who were prescribed long-term control medication

**Definitions:**

**Long-Term Control Medication Includes:**

Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)

**OR**

Patients prescribed alternative long-term control medications (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines).

**Prescribed** – May include prescription given to the patient for inhaled corticosteroid OR an acceptable alternative long-term control medication at one or more visits in the 12-month period OR patient already taking inhaled corticosteroid OR an acceptable alternative long-term control medication as documented in current medication list.

**Numerator Options:**

Inhaled corticosteroids prescribed **(4140F)**

**OR**

Alternative long-term control medication prescribed **(4144F)**

**OR**

Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (eg, patient declined, other patient reason) **(4140 with 2P)**

**OR**

Inhaled corticosteroids or alternative long-term control medication **not** prescribed, reason not otherwise specified **(4140F with 8P)**

**RATIONALE:**

The following statement is quoted verbatim from the NHLBI/NAEPP guideline (NHLBI, 2007):  
“The broad action of ICS on the inflammatory process may account for their efficacy as preventive therapy. Their clinical effects include reduction in severity of symptoms; improvement in asthma control and quality of life; improvement in PEF and spirometry; diminished airway hyper-responsiveness; prevention of exacerbations; reduction in systemic corticosteroid courses; emergency department (ED) care; hospitalizations, and deaths due to asthma; and possibly the attenuation of loss of lung function in adults.” (Rafferty P 1985; Haahtela T 1991; Jeffery PK 1992; Van Essen-Zandvliet EE 1992; Barnes NC 1993; Fabbri L 1993; Gustafsson P 1993; Kamada AK 1996; Suissa S 2000; Pauwels RA 2003; Barnes PJ October 1992)

**CLINICAL RECOMMENDATION STATEMENTS:**

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The Expert Panel recommends that long-term control medications be taken daily on a long-term basis to achieve and maintain control of persistent asthma. The most effective long-term control medications are those that attenuate the underlying inflammation characteristic of asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most potent and clinically effective long-term control medication for asthma. (Evidence A) (NHLBI, 2007)

The Expert Panel concludes that ICS is the most effective long-term therapy available for patients who have persistent asthma, and, in general, ICS is well tolerated and safe at the recommended dosages. (Evidence A) (NHLBI, 2007)

## Measure #64 (NQF 0001): Asthma: Assessment of Asthma Control – Ambulatory Care Setting

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with a diagnosis of asthma who were evaluated at least once during the measurement period for asthma control (comprising asthma impairment and asthma risk)

### **INSTRUCTIONS:**

This measure is to be reported a minimum of **once per reporting period** for patients with asthma 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.

### **Data Source:**

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.

There are no allowable performance exclusions for this measure.

### **DENOMINATOR:**

All patients aged 5 years and older with a diagnosis of asthma

#### **Denominator Criteria (Eligible Cases):**

Patients aged 5 years and older on date of encounter

#### **AND**

**Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]:** 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

**Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]:** J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

#### **AND**

**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### **NUMERATOR:**

Patients who were evaluated at least once during the measurement period for asthma control

**Numerator Instructions:** Completion of a validated questionnaire will also meet the numerator requirement for this component of the measure. Validated questionnaires for asthma assessment include, but are not limited to, the Asthma Therapy Assessment Questionnaire [ATAQ], the Asthma Control Questionnaire [ACQ], or the Asthma Control Test [ACT].

The specifications of this numerator enable documentation for the impairment and risk components separately to facilitate quality improvement. Evaluation of asthma impairment and asthma risk must occur during the same medical encounter.

### **Definition:**

**Evaluation of Asthma Control** - Documentation of an evaluation of asthma impairment which must include: daytime symptoms AND nighttime awakenings AND interference with normal activity AND short-acting beta2-agonist use for symptom control AND documentation of asthma risk which must include the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months.

#### **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

Asthma impairment assessed (CPT II 2015F)

**AND**

Asthma risk assessed (**CPT II 2016F**)

**OR**

Asthma impairment **not** assessed, reason not otherwise specified (**2015F with 8P**)

**OR**

Asthma risk **not** assessed, reason not otherwise specified (**2016F with 8P**)

**RATIONALE:**

The goal of asthma therapy is to achieve asthma control. The level of asthma control serves as a basis for treatment modification (ie, whether or not a patient needs a step up or step down in therapy). Patients with poorly controlled asthma can experience significant asthma burden (Fuhlbrigge AL, 2002), decreased quality of life (Schatz M, 2005), and increased health utilization. (Vollmer WM, 2002; Schatz M, 2005) A large international study found that guideline-defined asthma control can be achieved. In their trial, 30% of the patients achieved total control (defined as absence of asthma symptoms) and 60% achieve well-controlled asthma (defined as low-level of symptoms or rescue medication use. (Bateman ED, 2004) A follow-up to this study found that this control can be maintained, which can lead to a decrease in the use of unscheduled health care visits. (Bateman ED, 2008)

**CLINICAL RECOMMENDATION STATEMENTS:**

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that asthma control be defined as follows: (Evidence A) (NHLBI, 2007)

- Reduce Impairment
- Prevent chronic and troublesome symptoms (eg, coughing or breathlessness in the daytime, night, or after exertion)
- Require infrequent use ( $\leq 2$  days a week) of SABA for quick relief of symptoms
- Maintain (near) "normal" pulmonary function
- Maintain normal activity levels (including exercise and other physical activity and attendance at work or school)
- Meet patients' and families' expectations of satisfaction with asthma care
- Reduce risk
- Prevent recurrent exacerbations of asthma and minimize the need for ED visits or hospitalizations
- Prevent progressive loss of lung function; for children, prevent reduced lung growth
- Provide optimal pharmacotherapy with minimal or no adverse effects



## Measure #231: Asthma: Tobacco Use: Screening – Ambulatory Care Setting

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with a diagnosis of asthma (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period

### **INSTRUCTIONS:**

This measure is to be reported a minimum of **once per reporting period** for patients with asthma seen during the measurement period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma. For the purpose of this measure, the primary caregiver can respond on behalf of the patient if the patient is unable to provide a response (eg, pediatric patient).

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.

There are no allowable performance exclusions for this measure.

### **DENOMINATOR:**

All patients aged 5 years and older with a diagnosis of asthma during the one-year measurement period

#### **Denominator Criteria (Eligible Cases):**

Patients aged 5 years and older on date of encounter

#### **AND**

**Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]:** 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

**Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]:** J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

#### **AND**

**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### **NUMERATOR:**

Patients (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once

**Numerator Instructions:** Information regarding tobacco exposure for patients under 18 obtained from a parent or guardian is valid for reporting the numerator. In order to meet the measure, there must be a note in the medical record documenting that the patient was queried about both smoking status AND exposure to environmental smoke in the home environment.

**NUMERATOR NOTE:** For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including smokeless tobacco users eg, chew, snuff).

#### **Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Tobacco Use Assessed, Including Exposure to Second hand Smoke**

**CPT II 1031F:** Smoking status and exposure to second hand smoke in the home assessed

OR

**Tobacco Use, Including Exposure to Second hand Smoke not Assessed, Reason Not Otherwise Specified**

Append a reporting modifier (**8P**) to CPT Category II code **1031F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**1031F with 8P:** Smoking status and exposure to second hand smoke in the home **not** assessed, reason not otherwise specified

**RATIONALE:**

Patients with asthma who smoke or are exposed to second hand smoke are at greater risk for experiencing increased frequency in asthma symptoms, a decrease in lung function, and an increased use of health services. (Sippel JM, 1999; Eisner MD, 2007) By identifying patients who are tobacco users or who are exposed to second hand smoke, intervention can be offered, resulting in the possibility of decreasing the adverse effects.

**CLINICAL RECOMMENDATION STATEMENTS:**

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI, 2007)

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI, 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (Fiore, Jaen et al., 2008)

## Measure #233: Asthma: Tobacco Use: Intervention – Ambulatory Care Setting

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with a diagnosis of asthma who were identified as tobacco users (or their primary caregiver) who received tobacco cessation intervention at least once during the one-year measurement period

### **INSTRUCTIONS:**

This measure is to be reported a minimum of **once per reporting period** for patients with asthma seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma. For the purpose of this measure, the primary caregiver can respond on behalf of the patient if the patient is unable to provide a response (eg, pediatric patient).

### **Data Source:**

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.

### **DENOMINATOR:**

All patients aged 5 years and older with a diagnosis of asthma identified as tobacco users during the measurement period

#### **Definition:**

**Tobacco users** – Include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.

#### **Denominator Criteria (Eligible Cases):**

Patients aged 5 years and older on date of encounter

#### **AND**

**Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]:** 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

**Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]:** J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

#### **AND**

**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### **NUMERATOR:**

Patients (or their primary caregiver) who received tobacco use cessation intervention

**Numerator Instructions:** Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator compliant even if the primary caregiver is not the source of second hand smoke in the home.

#### **Definitions:**

**Tobacco Users** – Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.

**Tobacco Use Cessation Intervention** – May include brief counseling (3 minutes or less) and/or pharmacotherapy.

**Numerator Note:** For the purpose of this measure, “tobacco user” refers to tobacco smokers and “tobacco non-user” refers to non-smokers (including smokeless tobacco users (eg, chew, snuff)).

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Patients (or their Primary Caregiver) who Received Tobacco Use Cessation Intervention**  
(Two CPT II codes [400xF & 1032F] are required on the claim form to submit this numerator option)

**CPT II 4000F:** Tobacco use cessation intervention, counseling

**OR**

**CPT II 4001F:** Tobacco use cessation intervention, pharmacologic therapy

**AND**

**Current Tobacco Smoker OR Current Exposure to Second Hand Smoke**

**CPT II 1032F:** Current tobacco smoker OR currently exposed to second hand smoke

**OR**

**If patient is not eligible for this measure because patient (or primary caregiver) is a non-tobacco user AND has no exposure to second hand smoke, report:**

(One CPT II code [1033F] is required on the claim form to submit this numerator option)

**CPT II 1033F:** Current tobacco non-smoker AND not currently exposed to second hand smoke

**OR**

**Tobacco Use, not Assessed, Reason Not Given**

(One quality-data code [G8751] is required on the claim form to submit this numerator option)

**G8751:** Smoking status and exposure to second hand smoke in the home **not** assessed, reason not given

**OR**

**Tobacco Use Cessation Intervention not Performed, Reason Not Otherwise Specified**

Append a reporting modifier (**8P**) to CPT Category II code **4000F OR 4001F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

(Two CPT II codes [400xF-8P & 1032F] are required on the claim form to submit this numerator option)

**4000F with 8P:** Tobacco use cessation intervention, counseling, **not** performed, reason not otherwise specified

**OR**

**4001F with 8P:** Tobacco use cessation intervention, pharmacologic therapy, **not** performed, reason not otherwise specified

**AND**

**Current Tobacco Smoker OR Currently Exposed to Second Hand Smoke**

**CPT II 1032F:** Current tobacco smoker OR currently exposed to second hand smoke

**RATIONALE:**

There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in both the primary care setting and hospital settings are successful in helping tobacco users quit. (Fiore MC, 2008) Patients who are able to stop smoking or their exposure to second hand smoke may experience an increase in quality of life, a decrease in asthma symptoms, and may not use health resources as often. (NHLBI, 2007)

**CLINICAL RECOMMENDATION STATEMENTS:**

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI, 2007)

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI, 2007)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (Fiore, Jaen et al., 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (Fiore MC, 2008)

The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when the medication use is contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = B) (Fiore MC, 2008)

**The Joint Task Force on Quality Performance Measures Workgroup**

**Approved by the American Academy of Allergy, Asthma & Immunology (AAAAI),  
American College of Allergy, Asthma & Immunology (ACAAI)  
and the Joint Council of Allergy, Asthma and Immunology**

**Allergy Immunotherapy Treatment: Allergen Specific Immunoglobulin E (IgE) Sensitivity Assessed and Documented Prior to Treatment**

**DESCRIPTION:**

Percentage of patients aged 5 years and older who were assessed for IgE sensitivity to allergens prior to initiating allergy immunotherapy AND results documented in the medical record.

**NQS Domain:** Patient Safety

**DENOMINATOR:**

All patients aged 5 years and older who initiated allergy immunotherapy

**Denominator Criteria (Eligible cases):**

Patients aged 5 years and older on the date of the encounter. Reported encounter is for the initial allergy immunotherapy treatment.

**AND**

**Allergy Immunotherapy (CPT):** 95115, 95117, 95125, 95144, 95120, 95165

**OR**

**Venom (stinging) Immunotherapy (CPT):** 95130, 95131, 95132, 95133, 95134, 95145, 95146, 95147, 95148, 95149, 95170, 95180

**Denominator Exclusions:**

None

**NUMERATOR:**

Patients who have **documentation** of IgE sensitivity to allergens in the medical record

**Numerator Instructions:**

This measure requires documentation of IgE sensitivity to allergens in the medical record. Written documentation of assessment within the medical record OR documentation of serum specific IgE laboratory testing (CPT 82785, 86003) OR skin prick testing (CPT 95004, 95017 95018) OR intradermal testing (CPT 95024, 95027, 95028) will meet the numerator requirement for this component of the measure.

**Data Source:**

CPT codes, electronic medical record data and patient demographics

**MEASURE TYPE:** Process

**CLINICAL RECOMMENDATIONS, TREATMENT GOALS:**

Summary Statement 7: Allergen immunotherapy should be considered for patients who have demonstrable evidence of specific IgE antibodies to clinically relevant allergens. The decision to begin allergen immunotherapy might depend on a number of factors, including but not limited to patient's preference, acceptability, adherence, medication requirements, response to avoidance measures, and the adverse effects of medications.<sup>1</sup>

<sup>1</sup>Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, Nelson M, Weber R, Bernstein DI, Blessing-Moore J, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph C, Schuller DE, Spector SL, Tilles S, Wallace D. J *Allergen immunotherapy: a practice parameter third update*. Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.

## Documentation of Clinical Response to Allergy Immunotherapy within One Year

### **DESCRIPTION:**

Percentage of patients aged 5 years and older who were evaluated for clinical improvement and efficacy within one year after initiating allergy immunotherapy AND assessment documented in the medical record.

### **NQS DOMAIN:**

Communication and Care Coordination

### **DENOMINATOR:**

All patients aged 5 years and older who initiated allergy immunotherapy within the past year

#### **Denominator Criteria (Eligible cases):**

Patients aged 5 years and older on the date of the encounter

**AND**

**Allergy Immunotherapy (CPT):** 95115, 95117, 95125, 95144, 95120, 95165

**OR**

**Venom (stinging) Immunotherapy (CPT):** 95130, 95131, 95132, 95133, 95134, 95145, 95146, 95147, 95148, 95149, 95170, 95180

**AND**

**Follow-up visit code (CPT):** 99212, 99213, 99214, 99215, 95115, 95117, 95125, 95144, 95120, 95165, 95130, 95131, 95132, 95133, 95134, 95145, 95146, 95147, 95148, 95149, 95170, 95180

#### **Denominator Exclusions:**

Patients who discontinued allergy immunotherapy regimen

### **NUMERATOR:**

Patients who initiated allergy immunotherapy within the past year who have documentation in the medical record of being evaluated for clinical improvement and efficacy within the first year of treatment

#### **Numerator Instructions:**

In order to meet the measure, there must be documentation of evaluation for clinical improvement and efficacy in the medical record.

**Did you assess that the patient is showing clinical improvement and efficacy within one year after initiating allergy immunotherapy treatment?**

Yes

No

### **Data Source:**

CPT codes, electronic medical record data and patient demographics

**MEASURE TYPE:** Process

### **CLINICAL RECOMMENDATIONS, TREATMENT GOALS:**

Summary Statement 23: Patients should be evaluated at least every 6 to 12 months while they receive immunotherapy in order to assess efficacy, implement and reinforce its safe administration, monitor adverse reactions, assess the patient's compliance with treatment, determine whether immunotherapy can be discontinued and to determine whether adjustments in the immunotherapy to dosing schedule or allergen content are necessary.<sup>1</sup>



<sup>1</sup>Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, Nelson M, Weber R, Bernstein DI, Blessing-Moore J, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph C, Schuller DE, Spector SL, Tilles S, Wallace D. *J Allergen immunotherapy: a practice parameter third update*. Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.

**Documented Rationale to Support Long-Term Aeroallergen Immunotherapy beyond Five years, as Indicated**

**DESCRIPTION:**

Percentage of patients aged 5 years and older who were assessed for clinical rationale prior to continuation of aeroallergen immunotherapy beyond 5 years AND rationale documented in the medical record.

**NQS DOMAIN:**

Efficiency and Cost Reduction

**DENOMINATOR:**

All patients aged 5 years and older receiving aeroallergen immunotherapy for more than five years

**Denominator Criteria (Eligible cases):**

Patients aged 5 years and older on the date of the encounter

**AND**

**Allergy Immunotherapy:** 95115, 95117, 95125, 95144, 95120, 95165

**AND**

**Follow-up visit code (CPT):** 99212, 99213, 99214, 99215, 95115, 95117, 95125, 95144, 95120, 95165, 95130, 95131, 95132, 95133, 95134, 95145, 95146, 95147, 95148, 95149, 95170, 95180

**Exclusions:**

None

**NUMERATOR:**

All patients who have received aeroallergen immunotherapy beyond five years with a statement in the medical record to document the reason for continuation of allergy immunotherapy

**Numerator Instructions:**

Documentation of rationale for continuation of treatment such as explanation of treatment goals will meet the numerator requirement for this component of the measure

**Is rationale for continuation of allergy immunotherapy beyond 5 years documented?**

Yes

No

**Data Source:**

CPT codes, electronic medical record data and patient demographics

**MEASURE TYPE:** Process

**CLINICAL RECOMMENDATION STATEMENTS:**

Duration of treatment: Summary Statement 24: The patient's response to immunotherapy should be evaluated on a regular basis. A decision about continuation of effective immunotherapy should generally be made after the initial period of 3 to 5 years of treatment. Some patients might experience sustained clinical remission of their allergic disease after discontinuing immunotherapy, but others might relapse. The severity of disease, benefits sustained from treatment, and convenience of treatment are all factors that should be considered in determining whether to continue or stop immunotherapy for any individual patient.<sup>1</sup>

<sup>1</sup>Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, Nelson M, Weber R, Bernstein DI, Blessing-Moore J, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph C, Schuller DE, Spector SL, Tilles S, Wallace D. J *Allergen immunotherapy: a practice parameter third update*. Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.

**Achievement of Projected Effective Dose of Standardized Allergens for Patient Treated With Allergy Immunotherapy for at Least One Year**

**DESCRIPTION:**

Proportion of patients receiving subcutaneous allergy immunotherapy that contains at least one standardized extract (mite, ragweed, grass, and/or cat)) who achieved the projected effective dose for all included standardized allergen extract(s) after at least one year of treatment.

**NQS DOMAIN:**

Effective Clinical Care

**DENOMINATOR:**

All patients aged 5 years and older who received subcutaneous allergy immunotherapy for at least one year containing at least one standardized antigen

**Denominator Criteria (Eligible cases):**

Patients aged 5 years and older on the date of the encounter

**AND**

**Allergy Immunotherapy:** 95115, 95117, 95125, 95144, 95120, 95165

**Denominator Exclusions:**

- Patients experiencing local or systemic reactions preventing achievement of the projected effective dose
- Patients with interruptions in therapy due to co-morbid conditions (e.g. pregnancy)
- Patients whose noncompliance makes it impossible to achieve the projected effective dose within the specified year
- Patients who are receiving allergy immunotherapy prescribed and prepared by eligible professional by an outside entity (providing supervision only)

**NUMERATOR:**

Patients who achieved the projected effective dose for all standardized extracts included in the prescription

**Numerator Instructions:**

Patients receiving subcutaneous allergy immunotherapy for at least one year who achieved the projected effective dose for all standardized extracts included in the prescription:

- Cat 1000 BAU per injection
- Dust mite (Dp,Df) 500 AU per injection (or 7mcg Der p 1)
- Grass (100,000 BAU/ml) 1000 BAU per injection
- Bermuda (10,000 BAU/ml) 300 BAU
- Short ragweed 1000 AU or 6mcg Amb a 1

**Has the patient reached the following projected effective dose of all standardized extracts?**

Cat	1000 BAU per injection	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dust mite (Dp,Df)	500 AU per injection (or 7mcg Der p 1)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Grass (100,000 BAU/ml)	1000 BAU per injection	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bermuda (10,000 BAU/ml)	300 BAU	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Short ragweed	1000 AU or 6mcg Amb a 1	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Numerator Options:**

Did not meet all standardized dose(s) due to patient reasons: Local or systemic reactions; interruptions in therapy or non-compliance

**Data Source:**

CPT codes, electronic medical record data and patient demographics

**MEASURE TYPE:** Outcome

**Definitions:**

**Projected Effective Dose:** The allergen dose projected to provide therapeutic efficacy. Not all patients will tolerate the projected effective dose, and some patients experience therapeutic efficacy at lower doses.

**CLINICAL RECOMMENDATION STATEMENTS:**

Summary Statement 80: The efficacy of immunotherapy depends on achieving an optimal therapeutic dose of each of the constituents in the allergen immunotherapy extract.<sup>1</sup>

Summary Statement 81: The maintenance concentrate should be formulated to deliver a dose considered to be therapeutically effective for each of its constituent components. The maintenance concentrate vial is the highest concentration allergy immunotherapy vial (eg, 1:1 vol/vol vial). The projected effective dose is called the maintenance goal. Some subjects unable to tolerate the projected effective dose will experience clinical benefits at a lower dose. The maintenance dose is the dose that provides therapeutic efficacy without significant adverse local or systemic reactions and might not always reach the initially calculated projected effective dose. This reinforces that allergy immunotherapy must be individualized.<sup>1</sup>

<sup>1</sup>Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, Nelson M, Weber R, Bernstein DI, Blessing-Moore J, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph C, Schuller DE, Spector SL, Tilles S, Wallace D. *J Allergen immunotherapy: a practice parameter third update*. Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.

## Assessment of Asthma Symptoms Prior to Administration of Allergy Immunotherapy Injection(s)

**DESCRIPTION:**

Percentage of patients aged 5 years and older who are receiving subcutaneous allergy immunotherapy with a documented assessment of asthma symptoms prior to administration of allergy immunotherapy injections.

**NQS DOMAIN:**

Patient Safety

**DENOMINATOR:**

All patients aged 5 years and older with a diagnosis of asthma AND who are receiving subcutaneous allergy immunotherapy

**Denominator Criteria (Eligible cases):**

Patients aged 5 years and older on the date of the encounter

**AND**

**Diagnosis of Asthma (ICD-9-CM):** 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

**Diagnosis of Asthma (ICD-10-CM):** J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J44.0, J44.1, J45.40, J45.41, J45.42, J45.50, J45.51, J45.42, J45.991, J45.909, J45.998, J45.901, J45.902

**AND**

**Allergy Immunotherapy:** 95115, 95117, 95125, 95144, 95120, 95165

**OR**

**Venom (stinging) Immunotherapy:** 95130, 95131, 95132, 95133, 95134, 95145, 95146, 95147, 95148, 95149, 95170, 95180

**OR**

Intention of this patient visit was to receive allergy immunotherapy

**Denominator Exclusions:** None

**NUMERATOR:**

Patients with documentation of an asthma symptom assessment prior to each injection-type visit.

**Numerator Options:**

**Were asthma symptoms assessed prior to allergy immunotherapy administration?**

Yes  No

**Numerator Instructions:**

Documentation of assessment of asthma symptoms will meet the numerator requirement for this component of the measure. Documentation of asthma assessment/risk must occur during the injection visit.

Prior to subcutaneous allergy immunotherapy injections;

Assess/inquire about one of the following:

- Increased daytime symptoms
- Increased nighttime awakenings
- Interference with normal activity
- Increased short acting beta agonist use for symptom control
- Increased number of asthma exacerbations
- Evaluation of peak flow meter results

- Evaluation of spirometry results

**Data Source:**

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, electronic medical record data and patient demographics

**MEASURE TYPE:** Process

**CLINICAL RECOMMENDATION STATEMENTS:**

An assessment of the patient's current health status should be made before administration of the allergy immunotherapy injection to determine whether there were any health changes that might require modifying or withholding that patient's immunotherapy treatment.<sup>1</sup> Before the administration of the allergy injection, the patient should be evaluated for the presence of asthma symptoms.<sup>1</sup>

<sup>1</sup>Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, Nelson M, Weber R, Bernstein DI, Blessing-Moore J, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph C, Schuller DE, Spector SL, Tilles S, Wallace D. *J Allergen immunotherapy: a practice parameter third update*. Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.

**Documentation of the Consent Process for Subcutaneous Allergy Immunotherapy in the Medical Record**

**DESCRIPTION:**

Percentage of patients aged 5 years and older initiating subcutaneous allergy immunotherapy injections documented to have received education (or parents, legal guardian received education) about possible adverse reactions

**NQS DOMAIN:**

Person and Caregiver-Centered Experience and Outcomes

**DENOMINATOR:**

All patients aged 5 years and older receiving subcutaneous allergy immunotherapy

**Denominator Criteria (Eligible cases):**

Patients aged 5 years and older on the date of the encounter. Reported encounter is for the initial allergy immunotherapy treatment.

**AND**

**Allergy Immunotherapy:** 95115, 95117, 95125, 95144, 95120, 95165

**OR**

**Venom (stinging) Immunotherapy:** 95130, 95131, 95132, 95133, 95134, 95145, 95146, 95147, 95148, 95149, 95170, 95180

**Denominator Exclusions:**

None

**NUMERATOR:**

Patients with documentation in the medical record of discussion and education about the potential risk of adverse reactions (examples can be found [here](#)).

**Numerator Instructions:**

Patients with documentation in the medical record of education about the potential risk of local allergic reactions following injections, including redness, pruritus, and swelling at the injection site which occur after leaving the clinic.

Patients with documentation in the medical record of education about the potential risk of systemic allergic reactions following injections, including life threatening anaphylaxis and severe delayed reactions which occur after leaving the clinic.

Informed consent should include a discussion of the potential immunotherapy induced adverse reactions during an office visit and this discussion should be documented in the medical record. If the patient is less than 18 years old, a parent or legal guardian must receive informed consent as described above.

**Was the patient (or their primary caregiver) educated on risks and benefits of allergy immunotherapy prior to initiating immunotherapy treatment?**

Yes

No

**Data Source:**

CPT codes, electronic medical record data and patient demographics

**MEASURE TYPE:** Process

**CLINICAL RECOMMENDATION STATEMENTS:**

Informed consent should include a discussion of the potential immunotherapy-induced adverse reactions, and this discussion should be documented in the patient's medical record.<sup>1</sup>

<sup>1</sup>Cox L, Nelson H, Lockey R, Calabria C, Chacko T, Finegold I, Nelson M, Weber R, Bernstein DI, Blessing-Moore J, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph C, Schuller DE, Spector SL, Tilles S, Wallace D. J *Allergen immunotherapy: a practice parameter third update*. Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.



**Health Care Incentives Improvement Institute, Inc. Owned  
Bridges to Excellence® Asthma Care Recognition Program Clinician  
Assessment Measures**

Health Care Incentives Improvement Institute, Inc. owned and developed Bridges to Excellence® Asthma Care Recognition Program Clinician Assessment Measures are used with modification to the upper age limits; from 5 through 75 years, 13 through 75 years of age, and 18 through 75 years of age to 5 years and older, 13 years and older and 18 years and older, in the Allergy, Asthma and Immunotherapy Qualified Clinical Data Registry (QCDR) with permission from the measure owner

## Asthma Assessment and Classification

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with asthma and documentation of an asthma assessment and classification

### **FREQUENCY:**

Most recent documentation over the last 12 months from last day of the reporting period

### **Data source:**

Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with asthma for the denominator, and medical record data for the assessment and classification information for the numerator.

### **DENOMINATOR:**

Patients aged 5 years and older with a documented diagnosis of asthma

### **NUMERATOR:**

Patients aged 5 years and older with a diagnosis of asthma and documentation of an asthma assessment and classification

#### **Medical Record Collection:**

The patient is numerator compliant if he or she has at a minimum, a note indicating the date and frequency (numeric) of daytime and nocturnal asthma symptoms. The measure may also be met by clinician documentation or patient completion of a validated asthma assessment tool/survey/questionnaire. In either case the document completion date must fall within the reporting period. Numerator compliant asthma assessment tools include but are not limited to the following:

1. Quality Metric Asthma Control Test
2. NAEPP Asthma Symptoms and Peak Flow Diary

The following is not acceptable documentation for asthma assessment or classification:

1. Patient self---reporting

### **RATIONALE:**

The National Asthma Education and Prevention Program Expert Panel Report 3 (NAEPP-EPR-3) guidelines recommend monitoring signs and symptoms (daytime; nocturnal awakening) of asthma to determine whether goals of asthma therapy (i.e. reduction of impairment and risk) are being met. It is anticipated that clinicians who provide services for the primary management of asthma will submit this measure.

## Lung Function/Spirometry Evaluation

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with asthma and documentation of a spirometry evaluation

### **FREQUENCY:**

Most recent documentation over the last 12 months from last day of the reporting period

### **Data Source:**

Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with asthma for the denominator, and claims/encounter data or medical record data for spirometry information for the numerator.

### **DENOMINATOR:**

Patients aged 5 years and older with a documented diagnosis of asthma

### **NUMERATOR:**

Patients aged 5 years and older with a diagnosis of asthma and documentation of a spirometry evaluation, unless a physical inability exists. Two methods are provided to identify patients documented spirometry evaluation and/or physical inability:

#### **Electronic Collection:**

The patient is numerator compliant if he or she has documentation of spirometry evaluation during the reporting period, as evidenced through claims data. Below is a list of codes to identify spirometry evaluation. CPT-I codes: 9410, 94014, 94015, 94016, 94060, 94070, 94620

#### **Medical Record Collection:**

The patient is numerator compliant if he or she has documentation in the medical record of spirometry results OR a physical inability to perform spirometry. This includes those patients with asthma who had one of the following:

1. Documentation indicating the date and spirometry results (FEV1 and FEV1/FVC) during the reporting period.
2. Documentation of spirometry evaluation and results from another treating clinician during the reporting period.
3. Documentation of a physical inability to perform spirometry. The following is not acceptable documentation for spirometry evaluation and results:
  1. Patient self-reporting

### **RATIONALE:**

The National Asthma Education and Prevention Program Expert Panel Report 3 (NAEPP- EPR-3) guidelines recommend monitoring pulmonary function (spirometry; peak flow monitoring) to determine whether goals of asthma therapy are being met. It is anticipated that clinicians who provide services for the primary management of asthma will submit this measure.

## Influenza Immunization

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with asthma who received the influenza vaccination, in the absence of contraindications

### **FREQUENCY:**

Most recent documentation over the last 12 months from last day of the reporting period

### **Data source:**

Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with asthma for the denominator, and claims/encounter data or medical record data for influenza vaccination information for the numerator.

### **DENOMINATOR:**

Patients aged 5 years and older with a documented diagnosis of asthma

### **NUMERATOR:**

Patients aged 5 years and older with a diagnosis of asthma and documentation of having received the influenza vaccine, in the absence of contraindications. Two methods are provided to identify patients documented influenza vaccine:

#### **Electronic Collection:**

The patient is numerator compliant if he or she has documented evidence of having received the influenza vaccine or contraindication to the influenza vaccine, as identified by claims data. This includes those patients with asthma who had one of the following:

1. Influenza vaccine administered during the reporting period
2. Evidence of contraindication or previous adverse reaction to the influenza vaccine

#### Influenza Vaccine:

The following codes may be used to identify the administration of the influenza vaccine:

**ICD-9 codes:** V04.81

**CPT-I codes:** 90656, 90658, 90660

#### Evidence of Contraindication or Previous Adverse Reaction:

The following codes may be used to identify contraindications to the administration of the influenza vaccine:

#### **ICD-9 Codes:**

Egg allergy: 693.1, V15.03, 995.68

Adverse reaction to the influenza vaccine: 995.0 with E949.6, 995.1 with E949.6, and 995.2 with E949.6

#### **Medical Record Collection:**

The patient is numerator compliant if he or she has documentation in the medical record of having received the influenza vaccine **OR** previous adverse reaction or contraindication to the influenza vaccine.

This includes those patients with asthma who had one of the following:

1. Documentation indicating the date on which the influenza vaccine was administered to the patient during the reporting period.

2. Documentation of administration of the influenza vaccine by another treating clinician during the reporting period.

3. Documentation of diagnosis or medical treatment for one of the following indicating a contraindication to the administration of the influenza vaccine.

- Egg allergy
- Adverse reaction to the influenza vaccine

The following is not acceptable documentation for influenza vaccine:

1. Patient self-reporting

**RATIONALE:**

The National Asthma Education and Prevention Program Expert Panel Report 3 (NAEPP-EPR-3) guidelines recommend monitoring annual influenza vaccination for individuals with persistent asthma. The CDC advisory committee on Immunization Practices recommends vaccination for persons who have asthma because they are considered to be at risk for complications from influenza. It is anticipated that clinicians who provide services for the primary management of asthma will submit this measure.

## Patient Self-Management and Action Plan

### **DESCRIPTION:**

Percentage of patients aged 5 years and older with asthma and documentation of an asthma self-management plan

### **FREQUENCY:**

Most recent documentation over the last 12 months from last day of the reporting period.

### **Data source:**

Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter or medical record data for identification of patients with asthma for the denominator, and medical record data for patient self-management plan information for the numerator.

### **DENOMINATOR:**

Patients aged 5 years and older with a documented diagnosis of asthma

### **NUMERATOR:**

Patients aged 5 years and older with a diagnosis of asthma and documentation of an asthma self-management plan. The patient self-management plan is recommended to include the following:

1. Written instructions specifying under which conditions the patient should contact his or her treating clinician or go to the emergency room.
2. Instructions on when to change medications in response to a change in patient symptoms.

### **Medical Record Collection:**

The patient is numerator compliant if he or she has:

1. A dated copy of an asthma management plan on record during the reporting period.
- AND**
2. A dated note documenting having given the patient written asthma instructions during the reporting period.

**OR**

Documentation of the patient having received written asthma instructions from another treating clinician during the reporting period. The following is not acceptable documentation for self-management plan:

1. Patient self-reporting

### **RATIONALE:**

The National Asthma Education and Prevention Program Expert Panel Report 3 (NAEPP-EPR-3) guidelines for the management of patients with asthma recommend that the patient or patient caregiver receive a written asthma management plan, which includes specific written instructions under which conditions the patient should contact his or her treating clinician or go to the emergency room. They also stress the importance of integrating asthma self-management education into all aspects of asthma care. It is anticipated that clinicians who provide services for the primary management of asthma will submit this measure.

## Body Mass Index

### **DESCRIPTION:**

Percentage of patients' aged 18 years and older with asthma for whom a documented body mass index (BMI) is calculated

### **FREQUENCY:**

Most recent test result over the last 12 months from last day of the reporting period.

**Not Eligible/Not Appropriate for BMI Measurement-** Patients can be considered not eligible in the following situations:

1. If the patient has a terminal illness – life expectancy less than 6 months
2. If the patient is pregnant

### **Datas source:**

Electronic data (visit, lab, encounter data, or claims) and/or medical record data (paper-based or EHR). This measure requires the use of claims/encounter, pharmacy or medical record data for identification of patients with asthma for the denominator, and claims/encounter and medical record data for BMI information for the numerator.

### **DENOMINATOR:**

Patients aged 18 years and older with a documented diagnosis of asthma

Exclusions:

1. If the patient has a terminal illness – life expectancy less than 6 months
2. If the patient is pregnant

### **NUMERATOR:**

Patients aged 18 years and older years with a diagnosis of asthma and a documented BMI calculated.

#### **Electronic Collection:**

The patient is numerator compliant if he or she has a calculation of their BMI documented during the reporting period, as identified by claims data. The following codes may be used to identify a documented BMI:

**CPT II Code:** 3008F

**HCPCS Codes:** G8417-G8420

**ICD-9: V-Codes:** V85.0 BMI less than 19, adult; V85.1 BMI between 19-24, adult; V85.2 BMI between 25-29, adult; V85.3 BMI between 30-39, adult; V85.4 BMI between 40 and over, adult.

#### **Medical Record Collection:**

The patient is numerator compliant if he or she has had their BMI calculated and documented.

This includes those patients with asthma who had one of the following:

1. Documentation of the result of a BMI calculation during the reporting period

2. Documentation in the medical record must include BMI result and exam date.

**Calculated BMI** – Requires that both the height and weight are actually measured by an

The following are not acceptable documentation for documented BMI calculation:

1. Patient self-reporting

### **RATIONALE:**

The USPSTF (2009) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. The clinical guideline for obesity recommends assessment of BMI at each encounter (National Heart, Lung and Blood Institute).



**MN Community Measurement Owned Optimal Asthma Care:  
Control Component Measure**

The MN Community Measurement Optimal Asthma Care: Control Component owned and developed measure is used in the Allergy, Asthma and Immunotherapy Qualified Clinical Data Registry (QCDR).

Permission granted by MN Community Measurement for denominator modification from patients aged 5 - 50 years to patients aged 5 years and older.

## Optimal Asthma Care: Control Component

### DESCRIPTION:

Patients aged 5 years and older (pediatrics ages 5-17) whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.

**Methodology** Population identification is accomplished via a query of a practice management system or Electronic Medical Record (EMR) to identify the population of eligible patients (denominator). Data elements are either extracted from an EMR system or abstracted through medical record review.

### Measurement Period

Measurement period will be a fixed twelve month period: mm/dd/yyyy to mm/dd/yyyy.

### DENOMINATOR:

Established patient who meets each of the following criteria is included in the population:

- Patient was at least 5 years of age at the start of the measurement period (date of birth was on or between mm/dd/yyyy and mm/dd/yyyy).
- Patient was seen by an eligible provider in an eligible specialty face-to-face at least two times during the last two years (mm/dd/yyyy to mm/dd/yyyy) with visits coded with an asthma ICD-9 code (in any position, not only primary). Use this date of service range when querying the practice management or EMR system to allow a count of the visits within this time frame.
- Patient was seen by an eligible provider in an eligible specialty face-to-face at least one time during the last twelve months (mm/dd/yyyy to mm/dd/yyyy) for any reason. This may or may not include one of the face-to-face asthma visits.
- Diagnosis of Asthma; ICD-9 diagnosis codes include: 493.00- 493.02; 493.10- 493.12; 493.81-493.82; 493.90-493.92.

Eligible specialties: Family Practice (Includes General Practice), Internal Medicine, Pediatrics, Allergy/Immunology, Pulmonology.

Eligible providers: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).

### Allowable exclusions

- Patient was a permanent nursing home resident during the measurement period.
- Patient was in hospice at any time during the measurement period.
- Patient died prior to the end of the measurement period.
- Documentation that diagnosis was coded in error.
- Patient was coded with any of the following diagnoses:
  - COPD (ICD-9 diagnosis codes 491.2, 491.20, 491.21, 491.22, 493.2, 493.20, 493.21, 493.22, 496, 506.4).
  - Emphysema (ICD-9 diagnosis codes 492, 492.20, 492.8, 506.4, 518.1, 518.2).
  - Cystic fibrosis (ICD-9 diagnosis codes 277.0, 277.01, 277.02, 277.03, 277.09).
  - Acute respiratory failure (ICD-9 diagnosis codes 518.81).

### NUMERATOR:

The number of asthma patients who met the following target:

- Asthma well-controlled (using the most recent and age-appropriate asthma control tool documented in the medical record):
  - Patient had an Asthma Control Test (ACT) score of 20 or above – for patients 12 years and older

OR

- Patient had a Childhood Asthma Control Test (C-ACT) score of 20 or above – for patients 11 years and younger
- OR
- Patient had an Asthma Control Questionnaire (ACQ) score of 0.75 or lower –for patients 17 years and older
- OR
- Patient had an Asthma Therapy Assessment Questionnaire (ATAQ) Pediatric score of 0 – for patients 5 – 17 years old
- OR
- Patient had an Asthma Therapy Assessment Questionnaire (ATAQ) Adult score of 0 – for patients 18 years and older

**RATIONALE\***

(\*Material written specifically for Minnesota as measure is used with permission of MN Community Measurement)

Asthma is a chronic disease associated with familial, infectious, allergenic, socioeconomic, psychosocial and environmental factors. It is not curable but is treatable. Despite improvements in diagnosis and management, and an increased understanding of the epidemiology, immunology, and biology of the disease, asthma prevalence has progressively increased over the past 15 years. In addition, variation in practice from recommended clinical guidelines is evident with only 33% of adult asthma patients in Minnesota reporting in 2005 to having an action plan and 75% reporting instruction on what to do when having an asthma attack. It is up to providers to assess patients, prescribe medications, educate about self-management, help patients identify and mitigate triggers so patients can prevent their exacerbations and demonstrate control.