AAAAl Allergy, Asthma & Immunology
Quality Clinical Data Registry in collaboration with CECity

2015 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 and 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

June 2015
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Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its measures for all potential applications. The Consortium encourages the testing and evaluation of its measures.

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MN Community Measurement Measures (MN CMM):

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

Joint Task Force on Quality Performance Measures (JTF QPM):

Measures developed by the Joint Task Force on Quality and 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.
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About the AAAAI QCDR

Background
In 2014, the Centers for Medicare and Medicaid Services established the qualified clinical data registry (QCDR) as a new individual eligible professional reporting mechanism for the Physician Quality Reporting System (PQRS). According to CMS, a QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The AAAAI Allergy Asthma and Immunology Quality Clinical Data Registry was developed in collaboration with CECity, a leading provider of cloud-based registry platforms, in 2014 and has been updated to include additional measures for the 2015 reporting year.

In order to be considered as a QCDR, the American Academy of Allergy Asthma and Immunology (AAAAI) submitted a self-nomination to CMS and successfully completed the qualification process.

Requirements
As finalized in the 2015 Medicare Physician Fee Schedule (MPFS), successful reporting through a QCDR in 2015 for the purposes of avoiding the 2017 payment adjustment of 2% requires the following:

- Report on at least nine (9) measures covering at least three (3) of the National Quality Strategy (NQS) domains
- Of these measures, report at least two (2) outcomes measures
- Report each measure for 50% of the eligible professional’s patients that apply to the measure across all payers (ie: not limited to Medicare patients)

Please refer to page 4 for a listing of each measure by its NQS domain and page 5 for a breakdown of process and outcome measures. The six NQS domains include:

- Communication and Care Coordination
- Community Population Health
- Effective Clinical Care
- Efficiency and Cost Reduction
- Patient Safety
- Person and Caregiver-Centered Experience and Outcomes

Measures
A qualified clinical data registry differs from a qualified registry in reporting requirements and is the only PQRS reporting method that hosts non-PQRS measures approved by CMS for the purposes of PQRS reporting. Non-PQRS measures are measures that are not contained in the PQRS measures set released by CMS for the applicable reporting period. These can be “homegrown” measures developed by entities such as the Joint Task Force on Quality and Performance Measurement (a joint task force of the AAAAI and the American College of Allergy Asthma and Immunology) or PQRS measures that have substantive differences in the manner reported by the QCDR.

PQRS measure #398: Optimal Asthma Control is used in the AAAAI QCDR without the upper age limit of 50 with the permission of the measure steward, Minnesota Community Measurement, and is therefore considered a non-PQRS measure. Other non-PQRS measures in the AAAAI QCDR include measures from the Bridges to Excellence® Asthma Care Recognition Program, owned and developed by Health Care Incentives Improvement Institute, Inc and former PQRS measure #64: Asthma: Assessment of Asthma Control. The measure is used without the upper age limit of 64 with permission of the measure steward, the American Medical Association-convened Physician’s Consortium on Practice Improvement. Additionally, the AAAAI QCDR hosts 9 PQRS measures.

Registration
In order to register for the AAAAI QCDR, go to www.medconcert.com/AAAAIQIR.
Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting – National Quality Strategy Domain: Effective Clinical Care

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 5 years 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 alternative long-term control medications (non-ICS)
3) Total patients prescribed long-term control medication

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

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

DENOMINATOR:
All patients aged 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 a minimum, daily use of short-acting bronchodilators

Denominator Criteria (Eligible Cases):
Patients aged ≥ 5 years on date of encounter
AND
Diagnosis for asthma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 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 10/01/2015-12/31/2015]: 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

Definition:
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) 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:

Performance Met: Inhaled corticosteroids prescribed (4140F)

OR

Performance Met: Alternative long-term control medication prescribed (4144F)

OR

Patient Performance Exclusion: Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (e.g., patient declined, other patient reason) (4140F with 2P)

OR

Performance Not Met: 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 Essesn-Zandvliet EE 1992; Barnes NC 1993; Fabbrì 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 Type: Process

The AMA-convened Physician Consortium for Performance Improvement owned and developed measure, Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting, specifications are copied verbatim from the 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.
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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of asthma seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with asthma based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
Patients aged 5 years and older with asthma

Denominator Criteria (Eligible Cases):
Patients aged ≥ 5 years
AND
Diagnosis for asthma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, 493.92
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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, 99354, 99355
AND
At least two visits for asthma over the last two years with at least one visit for any reason in the last 12 months
AND NOT
Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 277.00, 277.01, 277.02, 277.03, 277.09, 491.20, 491.21, 491.22, 492.0, 492.8, 493.20, 493.21, 493.22, 496, 506.4, 518.1, 518.2, 518.81
Diagnosis for chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure (ICD-10-CM) [for use 10/1/2015-12/31/2015]: E84.0, E84.11, E84.19, E84.8, E84.9, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J68.4, J96.00, J96.01, J96.02, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J98.2, J98.3
AND NOT
Death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period

NUMERATOR:
Asthma well-controlled (use the most recent asthma control result available) using any of the following tools below:

- Asthma Control Test™ (ACT) score of 20 or above - ages 12 and older
- Childhood Asthma Control Test (C-ACT) score of 20 or above - ages 11 and younger
- Asthma Control Questionnaire (ACQ) score of 0.75 or lower - ages 17 and older
- Asthma Therapy Assessment Questionnaire (ATAQ) score of 0 – Pediatric (ages 5 – 17) or Adult (ages 18 and older)

**Numerator Options:**

**Performance Met:** Asthma well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score and results documented (G9432)

OR

**Other Performance Exclusion:** Death, permanent nursing home resident or receiving hospice or palliative care any time during the measurement period (G9433)

OR

**Performance Not Met:** Asthma not well-controlled based on the ACT, C-ACT, ACQ, or ATAQ score, OR specified asthma control tool not used, reason not given (G9434)

**RATIONALE:**
Roughly 7% of adults and children in Minnesota are currently living with asthma. 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.

**CLINICAL RECOMMENDATION STATEMENTS:**
From the National Quality Forum’s 2013 report, Patient Reported Outcomes (PROs) in Performance Measurement:

Patient and family engagement is increasingly acknowledged as a key component of a comprehensive strategy, (along with performance improvement and accountability), to achieve a high quality, affordable health system. Emerging evidence affirms that patients who are engaged in their care tend to experience better outcomes and choose less costly but effective interventions.

Historically, with the exception of collecting feedback on satisfaction or experience with care, patients remain an untapped resource in assessing the quality of healthcare and of long-term support services. Patients are a valuable and, arguably, the authoritative source of information on outcomes beyond experience with care. These include health-related quality of life, functional status, symptom and symptom burden, and health behaviors.

Patient Reported Outcome Measures (PROMs) are standardized instruments that capture patients’ self-assessment of their health and can provide timely information on patient health status, function and symptoms over time that can be used to improve patient-centered care and inform clinical decision-making.
The Asthma Control TestTM (ACT) is a validated self-administered survey utilizing 5 questions to assess asthma control on a scale from 0 (poor control) to 5 (total control) in individuals 12 years and older. © 2002 by QualityMetric Incorporated. Asthma Control Test is a trademark of QualityMetric Incorporated.

The Childhood Asthma Control Test (C-ACT) is a caregiver-assisted, child-completed tool that can be used with or without lung function assessment to assess pediatric asthma control at home or in clinical practice for children ages 4-11 years. It consists of 7 questions of which 4 are child-reported and 3 are caregiver-reported questions. ©2011 The GlaxoSmithKline Group of Companies.

The Asthma Control Questionnaire (ACQ) is a validated, self-administered survey available in various formats from the developer, Elizabeth F. Juniper, MCSP, MSc. http://www.qoltech.co.uk/acq.html

The Asthma Therapy Assessment Questionnaire (ATAQ) is available in a version for adults (18 and over) and a version for children and adolescents (5 – 17). © 2011 Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.

The Minnesota Community Measurement owned and developed Optimal Asthma Care measure is used in the Allergy, Asthma and Immunotherapy Quality Clinical Data Registry with permission granted by Minnesota Community Measurement for denominator modification from patients aged 5 - 50 years to patients aged 5 years and older.

This measure is equivalent to PQRS measure #398 with the exception of the modification to the upper age limit and is copied from the 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

Measure Type: Outcome
Asthma: Assessment of Asthma Control – Ambulatory Care Setting – National Quality Strategy
Domain: Effective Clinical Care

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

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

AND
Diagnosis for asthma (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 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 10/01/2015-12/31/2015]: 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, 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:

**Performance Met:** Asthma impairment assessed (CPT II 2015F)

**AND**

**Performance Met:** Asthma risk assessed (CPT II 2016F)

**OR**

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

**OR**

**Performance Not Met:** 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 (i.e., 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 (e.g., coughing or breathlessness in the daytime, night, or after exertion)
- Require infrequent use (≤ 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

The Expert Panel recommends that ongoing monitoring of asthma control be performed to determine whether all the goals of therapy are met—that is reducing both impairment and risk. (Evidence B) (NHLBI, 2007)

The Expert Panel recommends that the frequency of visits to a clinician for a review of asthma control is a matter of clinical judgment; in general, patients who have intermittent or mild persistent asthma that has been under control for at least 3 months should be seen by a physician about every 6 months, and patients who have uncontrolled and/or severe persistent asthma and those who need additional supervision to help them follow their treatment plan need to be seen more often. (NHLBI, 2007)

The Expert Panel recommends that symptoms and clinical signs of asthma should be assessed at each health care visit through physical examination and appropriate questions. (EPR-2, 1997) (NHLBI/NAEPP, 2007)
The AMA-convened Physician Consortium for Performance Improvement owned and developed Asthma: Assessment of Asthma Control – Ambulatory Care Setting measure is used with modification to the age range of 5-64 years to 5 years and older with permission from the measure owner.

This measure is equivalent to former PQRS measure #64 with the exception of the modification to the upper age limit.

**Measure Type:** Process
Asthma Control: Minimal Important Difference Improvement – National Quality Strategy  
Domain: Person and Caregiver-Centered Experience and Outcomes

**DESCRIPTION:**
Percentage of patients aged 12 years and older whose asthma is not well-controlled as indicated by the Asthma Control Test, Asthma Control Questionnaire, or Asthma Therapy Assessment Questionnaire and who demonstrated a minimal important difference improvement upon a subsequent office visit during the 12-month reporting period.

**INSTRUCTIONS:**
This outcomes measure is to be reported a **minimum of once per reporting period** for all patients with a diagnosis of asthma who demonstrate a score ≤ 19 on the Asthma Control Test (ACT), ≥ 1.5 on the Asthma Control Questionnaire (ACQ) or ≥1 on the Asthma Therapy Assessment Questionnaire (ATAQ) and who had at least one follow-up ACT, ACQ, or ATAQ within the 12-month reporting period. In order to meet this measure, the patient must demonstrate a minimal importance difference (MID) improvement between their asthma control score from the initial visit and a subsequent score taken during the 12-month reporting period using the same patient-completed questionnaire. An increase in score by greater than or equal to 3 points on the ACT, decrease in score by greater than or equal to .5 points on the ACQ or a decrease in score by greater than or equal to 1 point on the ATAQ will indicate a minimal importance difference improvement and a higher measure performance. 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 coding.

**Data Source:**
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure’s denominator. Medical record data and the listed numerator options are used to report the numerator of the measure.

**DENOMINATOR:**
All patients aged 12 years or older whose asthma is not well-controlled and who had at least one follow-up ACT, ACQ, or ATAQ within the 12-month reporting period.

**Definition:**
For the purposes of this measure, asthma that is not well-controlled will be defined by a score of ≤ 19 on the ACT, ≥ 1.5 on the ACQ or ≥1 on the ATAQ.

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 12 years on date of encounter  
**AND**
**Diagnosis for asthma (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 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 10/01/2015-12/31/2015]:** 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**
At least two patient encounters during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215  
**AND**
Asthma was not well-controlled based on score of ≤ 19 on the ACT or ≥ 1.5 on the ACQ or ≥1 on the ATAQ at one visit  
**AND**
At least one subsequent patient encounter during the reporting period with completion of the same asthma assessment patient-completed questionnaire (ACT, ACQ or ATAQ)  
**AND NOT**
**Diagnosis for COPD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496  
**Diagnosis for COPD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
NUMERATOR:
Patients who demonstrate a minimal important difference (MID) improvement using one of the following three asthma assessment patient-completed questionnaires:

- Change in the Asthma Control Test (ACT) by ≥ 3 points
- Change in Asthma Control Questionnaire (ACQ) by ≥ 0.5 points
- Change in Asthma Therapy Assessment Questionnaire (ATAQ) by ≥ 1 point

**Numerator Options:**

- **Performance Met:** MID improvement demonstrated, increase in score by ≥ 3 points on the ACT
- OR
- **Performance Met:** MID improvement demonstrated, decrease in score by ≥ 0.5 points on the ACQ
- OR
- **Performance Met:** MID improvement demonstrated, decrease in score by ≥ 1 point on the ATAQ
- OR
- **Medical Performance Exclusion:** Medical reason(s) for patient not demonstrating MID improvement (eg, respiratory infection within 4 weeks of follow-up visit)
- OR
- **Patient Performance Exclusion:** Patient reasons for not demonstrating MID improvement (eg, patients with poor adherence to controller therapy as determined by self-report or pharmacy records (per cent of days covered < 50 %))
- OR
- **Performance Not Met:** MID improvement NOT demonstrated, reason not otherwise specified

RATIONALE:
Current asthma guidelines recommend assessing an asthma patient’s level of control and emphasize that the goal of asthma therapy is to achieve control. Several validated asthma questionnaires can be used to assess control. In order to assess clinical improvement or worsening of asthma control in an individual or population overtime, the minimal important difference (MID) [also referred to as the minimal clinically important difference or MCID] can be used. The MID is defined as the smallest difference in score on the instrument that represents a clinically significant change (Schatz 2009).

Lack of asthma control impairs quality of life and is a risk factor for subsequent exacerbations. When control is not achieved, escalation of therapy is warranted to attain and maintain control.


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

Once treatment is started, the results of the measures of impairment and risk are used to monitor asthma control rather than severity. Monitoring the level of asthma control is used to adjust medication as needed.
Four instruments have established cutoff values for uncontrolled versus controlled asthma: ACQ score of 1.5 or greater, ACT score of 19 or less, ATAQ score of 1 or greater, and Childhood Asthma Control Test score of 19 or less (US study).

Two asthma control composite score instruments (ACQ and ACT) have been designated as core measures for the NIH-initiated clinical research in adults because of (1) the importance of asthma control as a goal of therapy; (2) extensive validation data for these instruments, using the widest range of criterion and construct measures and including demonstration of responsiveness to therapy and an MCID; and (3) low patient burden and risk.


The Asthma Control: Minimal Important Difference Improvement measure was developed by the American Academy of Allergy Asthma and Immunology (AAAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

Measure Type: Outcome
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.

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

Measure Type: Process

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: 94010, 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.

Health Care Incentives Improvement Institute, Inc. owned and developed Bridges to Excellence® Asthma Care Recognition Program Clinician Assessment Measure, Lung Function/Spirometry Evaluation, is used with modification to the upper age limit; from 5 through 75 years to 5 years and older in the Allergy, Asthma and Immunotherapy Qualified Clinical Data Registry (QCDR) with permission from the measure owner.

Measure Type: Process
**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

**RATIONAL:**
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.

Health Care Incentives Improvement Institute, Inc. owned and developed Bridges to Excellence® Asthma Care Recognition Program Clinician Assessment Measure, Lung Function/Spirometry Evaluation, is used with modification to the upper age limits; from 5 through 75 years to 5 years and older in the Allergy, Asthma and Immunotherapy Qualified Clinical Data Registry (QCDR) with permission from the measure owner.

**Measure Type:** Process
DESCRIPTION:
Percentage of patients aged 5 years and older who were assessed for IgE sensitivity to allergens prior to initiating allergen immunotherapy AND results documented in the medical record.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients who initiated allergen immunotherapy during the reporting period. This measure is intended to reflect the quality of services provided for patients undergoing allergen immunotherapy. There is a wide consensus that shows confirming the results of IgE sensitivity testing is a necessary step in evaluating and appropriately selecting patients to begin allergen immunotherapy. There is no diagnosis associated with this measure. A patient will be considered denominator eligible if they had an office visit for their initial allergen immunotherapy treatment during the reporting period AND professional services for allergen immunotherapy were billed during the reporting period. Professional services for allergen immunotherapy CPT coding is used to identify patient on allergen immunotherapy but do not have to be billed on the same date as the patient encounter during which IgE sensitivity to allergens was reviewed and documented in the medical record. 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.

Measure Reporting via Qualified Clinical Data Registry:
CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure’s denominator. Medical record data and the listed numerator options are used to report the numerator of the measure.

DENOMINATOR:
Patients aged 5 years and older who initiated allergen immunotherapy during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 5 years on the date of the encounter
AND
Professional Services for Allergen Immunotherapy (CPT): 95165, 95115, 95117, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 95144, 95145, 95146, 95147, 95148, 95149, 95170
AND
Patient Encounter during the Reporting Period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Patient’s initial allergen immunotherapy treatment takes place during the reporting period

NUMERATOR:
Patients who were assessed and had documentation of IgE sensitivity to allergens in the allergen immunotherapy prescription prior to initiating allergen immunotherapy

Numerator Instructions: This measure requires documentation of IgE sensitivity to allergens in the medical record. 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) OR written documentation in the medical record will meet the numerator requirement for this component of the measure. Review of test results from a referring physician’s office will meet the numerator requirement if results are documented in the medical record.
**Numerator Options:**

**Performance Met:**

IgE sensitivity to allergens in the allergen immunotherapy prescription was assessed and documented in the medical record prior to initiating allergen immunotherapy.

**OR**

**Performance Not Met:**

IgE sensitivity to allergens in the allergen immunotherapy prescription was not assessed and/or documented in the medical record prior to initiating allergen immunotherapy.

**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.¹


The Allergen Immunotherapy Treatment: Allergen Specific Immunoglobulin E (IgE) Sensitivity Assessed and Documented Prior to Treatment measure was developed by the Joint Task Force on Quality and Performance Measures, a joint task force of the American Academy of Allergy Asthma and Immunology (AAAAI) and American College of Allergy Asthma and Immunology (ACAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

**Measure Type:** Process
DESCRIPTION:
Percentage of patients aged 5 years and older who were evaluated for clinical improvement and efficacy within one year after initiating allergen immunotherapy AND assessment documented in the medical record.

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for patients receiving allergen immunotherapy who initiated allergen immunotherapy one year prior to the date of encounter. On the date of service, the patient should be evaluated for clinical improvement and efficacy. Further, assessment results should be documented in the medical record or there should be written documentation that the patient was evaluated for clinical improvement and efficacy at least once within 12 months of being placed on allergen immunotherapy. There is no diagnosis associated with this measure. This measure is intended to reflect the quality of services provided for patients undergoing allergen immunotherapy. 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.

Measure Reporting via Qualified Clinical Data Registry:
CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure’s denominator. Medical record data and the listed numerator options are used to report the numerator of the measure.

DENOMINATOR:
All patients aged 5 years and older who initiated allergen immunotherapy within one year prior to the date of encounter

**Denominator Criteria (Eligible cases):**
Patients aged 5 years and older on the date of the encounter.

**AND**
Professional Services for Allergen Immunotherapy (CPT): 95165, 95115, 95117, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 95144, 95145, 95146, 95147, 95148, 95149, 95170

**AND**
Patient Encounter during the Reporting Period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

**AND**
Patients who initiated allergen immunotherapy within one year prior to the date of encounter

**AND NOT**
Patients who discontinued allergen immunotherapy regimen

NUMERATOR:
Patients who were evaluated for clinical improvement and efficacy at least once within the first year of treatment with assessment documented in the medical record

**Numerator Options:**

**Performance Met:**
The patient was assessed for clinical improvement and efficacy at least once within 12 months of initiating allergen immunotherapy treatment and assessment was documented in medical record

**OR**

**Performance Not Met:**
The patient **was not** assessed for clinical improvement and efficacy at least once within 12 months of initiating allergen immunotherapy treatment and/or assessment was **not** documented in medical record
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.¹

Documented Rationale to Support Long-Term Aeroallergen Immunotherapy Beyond Five Years, as Indicated – National Quality Strategy Domain: Efficiency and Cost Reduction

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.

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients who have been on aeroallergen immunotherapy for more than 5 years seen during the reporting period. After a patient has received immunotherapy for 5 years, a risk-benefit assessment should be performed that favors continued inhalant immunotherapy with rationale for continuation of therapy documented within the medical record. This should also take place every subsequent year thereafter. There is no diagnosis associated with this measure. This measure is intended to reflect the quality of services provided for patients undergoing aeroallergen immunotherapy. 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.

Measure Reporting via Registry:
CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure’s denominator. Medical record data and the listed numerator options are used to report the numerator of the measure.

DENOMINATOR:
All patients aged 5 years and older receiving aeroallergen immunotherapy beyond 5 years

Denominator Criteria (Eligible cases):
Patients aged 5 years and older on the date of the encounter.
AND
Professional Services for Allergen Immunotherapy (CPT): 95165, 95115, 95117, 95120, 95125, 95144
AND
Patient Encounter during the Reporting Period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Patients receiving aeroallergen immunotherapy beyond 5 years

NUMERATOR:
Patients who were assessed for clinical rationale prior to continuation of aeroallergen immunotherapy with documentation of rationale for continuation of treatment in the medical record

Numerator Options:
Performance Met: Rationale for continuation of allergen immunotherapy beyond 5 years was documented within the past 12 months
OR
Performance Not Met: Rationale for continuation of allergen immunotherapy beyond 5 years was not documented within the past 12 months

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.¹


The Documented Rationale to Support Long-Term Aeroallergen Immunotherapy Beyond Five Years, as Indicated measure was developed by the Joint Task Force on Quality and Performance Measures, a joint task force of the American Academy of Allergy Asthma and Immunology (AAAAI) and American College of Allergy Asthma and Immunology (ACAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

Measure Type: Process
Achievement of Projected Effective Dose of Standardized Allergens for Patient Treated With Allergen Immunotherapy for at Least One Year – National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Proportion of patients receiving subcutaneous allergen 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.

**INSTRUCTIONS:**
This outcomes measure is to be reported **once per reporting period** when a patient seen during the reporting period receiving subcutaneous allergen immunotherapy for at least one standardized extract achieves the projected effective dose after one year of treatment. This measure is intended to reflect the quality of services provided for patients undergoing allergen immunotherapy. 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.

**Measure Reporting via Registry:**
CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure’s denominator. Medical record data and the listed numerator options are used to report the numerator of the measure.

**DENOMINATOR:**
All patients aged 5 years and older who received subcutaneous allergen 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**
  - Professional Services for Allergen Immunotherapy (CPT): 95115, 95117, 95120, 95125, 95144, 95165
  - **AND**
  - Patient Encounter during the Reporting Period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
  - **AND**
  - Patients receiving subcutaneous allergen immunotherapy containing at least one standardized extract (cat, dust mite, grass, bermuda, or short ragweed) for 1 year

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

**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.

**Numerator Instructions:**
The following doses can be used to determine if the patient 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


**Numerator Options:**

**Performance Met:** Projected effective dose of all applicable standardized extracts was achieved

**OR**

**Medical Performance Exclusion:** Documentation of medical reasons for not achieving the projected effective dose such as local or systemic reactions, interruptions in therapy due to co-morbid conditions (e.g., pregnancy) or patient intolerance to the projected effective dose

**Patient Performance Exclusion:** Documentation of patient reason(s) for not achieving the projected effective dose such as interruptions in therapy due to noncompliance

**Other Performance Exclusion:** Patients who are receiving allergen immunotherapy prescribed and prepared by eligible professional by an outside entity (providing supervision only)

**OR**

**Performance Not Met:** Projected effective dose of all applicable standardized extracts was not achieved, reason not otherwise specified

**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.¹

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 (e.g., 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.¹


The Achievement of Projected Effective Dose of Standardized Allergens for Patient Treated With Allergen Immunotherapy for at Least One Year measure was developed by the Joint Task Force on Quality and Performance Measures, a joint task force of the American Academy of Allergy Asthma and Immunology (AAAAI) and American College of Allergy Asthma and Immunology (ACAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

**Measure Type:** Outcome
Assessment of Asthma Symptoms Prior to Administration of Allergen Immunotherapy Injection(s) – National Quality Strategy Domain: Patient Safety

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

INSTRUCTIONS:
This measure is to be reported once per reporting period for all patients with a diagnosis of asthma seen for allergen immunotherapy injections during the reporting period. Prior to administration of allergen immunotherapy injections, an assessment of asthma symptoms should be performed. This measure is intended to reflect the quality of services provided for patients undergoing allergen immunotherapy. 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.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. Medical record data and 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 AND who are receiving subcutaneous allergen immunotherapy

Denominator Criteria (Eligible Cases):
Patients aged 5 years and older on the date of the encounter
AND
Diagnosis of Asthma (ICD-9-CM): 493.00, 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 of Asthma (ICD-10-CM): 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
Professional Services for Allergen Immunotherapy (CPT): 95165, 95115, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 95144, 95145, 95146, 95147, 95148, 95149, 95170 AND
Patient Encounter during the Reporting Period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients with documentation of an asthma symptom assessment prior to administration of allergen immunotherapy injection(s)

Numerator Instructions:
The patient must be evaluated for the presence of asthma symptoms prior to administration of allergen immunotherapy injection(s). This assessment should be documented in the medical record in order to meet the numerator requirement for this measure. Prior to subcutaneous allergen immunotherapy injection(s), 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

**Numerator Options:**

**Performance Met:**
Documentation of an asthma symptom assessment prior to administration of allergen immunotherapy injection(s)

**OR**

**Performance Not Met:**
No documentation of an asthma symptom assessment prior to administration of allergen immunotherapy injection(s)

**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. Before the administration of the allergy injection, the patient should be evaluated for the presence of asthma symptoms.


The Assessment of Asthma Symptoms Prior to Administration of Allergen Immunotherapy Injection(s) measure was developed by the Joint Task Force on Quality and Performance Measures, a joint task force of the American Academy of Allergy Asthma and Immunology (AAAAI) and American College of Allergy Asthma and Immunology (ACAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

**Measure Type:** Process
**DESCRIPTION:**
Percentage of patients aged 5 years and older initiating subcutaneous allergen immunotherapy injections documented to have received education (or their primary caregiver) about possible adverse reactions.

**INSTRUCTIONS:**
This measure is to be reported **once per reporting period** for each patient that is initiating allergen immunotherapy injections during the reporting period. The patient or their legal guardian/primary caregiver should be educated about the possible adverse reactions with immunotherapy injections including life threatening anaphylaxis, immediate reactions and severe delayed reactions which could occur after leaving the clinic. Informed consent should be obtained. This measure is intended to reflect the quality of services provided for patients undergoing allergen immunotherapy. 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.

**Measure Reporting via Registry:**
CPT codes, patient demographics and medical record data are used to identify patients who are included in the measure’s denominator. Medical record data and 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 who initiated subcutaneous allergen immunotherapy during the reporting period

- **Denominator Criteria (Eligible cases):**
  - Patients aged 5 years and older on the date of the encounter
  - **AND**
  - **Professional Services for Allergen Immunotherapy (CPT):** 95165, 95115, 95117, 95120, 95125, 95130, 95131, 95132, 95133, 95134, 95144, 95145, 95146, 95147, 95148, 95149, 95170
  - **AND**
  - **Patient Encounter during the Reporting Period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
  - **AND**
  - Patients who initiated allergen immunotherapy during the reporting period

**NUMERATOR:**
Patients with documentation in the medical record of discussion and education about the potential risk of adverse reactions of subcutaneous allergen immunotherapy

- **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. Reported encounter should be for the initial allergen immunotherapy treatment or at a prior office visit.

  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.

**Numerator Options:**

**Performance Met:** The patient (or their primary caregiver) received education about the risks and benefits of allergen immunotherapy prior to initiating allergen immunotherapy treatment.

**OR**

**Performance Not Met:** The patient (or their primary caregiver) **did not** received education about the risks and benefits of allergen immunotherapy prior to initiating allergen immunotherapy treatment.

**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.¹


The Documentation of the Consent Process for Subcutaneous Allergen Immunotherapy in the Medical Record measure was developed by the Joint Task Force on Quality and Performance Measures, a joint task force of the American Academy of Allergy Asthma and Immunology (AAAAI) and American College of Allergy Asthma and Immunology (ACAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

**Measure Type:** Process
**Penicillin Allergy: Appropriate Removal or Confirmation – National Quality Strategy Domain: Communication and Care Coordination**

**DESCRIPTION:**
Percentage of patients, regardless of age, with a primary diagnosis of penicillin or ampicillin/amoxicillin allergy, who underwent elective skin testing or antibiotic challenge that resulted in the removal of the penicillin or ampicillin/amoxicillin allergy label from the medical record if negative or confirmation of the penicillin or ampicillin/amoxicillin allergy label if positive.

**INSTRUCTIONS:**
This outcomes measure is to be reported **once per reporting period** for all patients with a penicillin or ampicillin/amoxicillin allergy label in the medical record who are seen during the reporting period. Patients with a history of penicillin allergy without preceding skin testing, in vitro testing or antibiotic challenge will qualify for the measure denominator. For the purposes of this measure, a “penicillin allergy” will only include natural penicillins or aminopenicillins, ampicillin and amoxicillin. A discussion regarding the risks and benefits of elective skin testing or penicillin challenge should take place with the patient or their caregiver/guardian. If the patient has previously declined skin testing or antibiotic challenge, they can be exempt from the measure numerator. In order to meet the numerator of this measure, skin testing or antibiotic challenge results should be reviewed and documented in the medical record. Further, the penicillin allergy label should be removed if results are negative or confirmed if positive. 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 coding.

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

**DENOMINATOR:**
All patients, regardless of age, with a diagnosis of primary penicillin or ampicillin/amoxicillin allergy seen during the reporting period

**Definition:**
**Penicillin Allergy** – For the purposes of this measure, a “penicillin allergy” will only include a history of allergy to natural penicillins (penicillin G and penicillin V) OR aminopenicillins (ampicillin and amoxicillin).

**Denominator Criteria (Eligible Cases):**
All patients regardless of age
AND
Diagnosis for personal history of allergy to penicillin (ICD-9-CM) [for use 1/1/2015-9/30/2015]: V14.0
Adverse effect of penicillins (ICD-10-CM) [for use 10/01/2015-12/31/2015]: T36.0X5A, T36.0X5D, T36.0X5S
Allergy status to penicillin (ICD-10-CM) [for use 10/01/2015-12/31/2015]: Z88.0
AND
Patient encounter during the reporting period: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
AND NOT
Diagnosis for Steven-Johnson Syndrome (ICD-9) [for use 1/1/2015-9/30/2015]: 695.13
Diagnosis for Steven-Johnson Syndrome (ICD-10) [for use 10/01/2015-12/31/2015]: L51.1
Diagnosis for Serum-Sickness (ICD-9) [for use 1/1/2015-9/30/2015]: 999.51, 999.52, 999.5
Diagnosis for Serum-Sickness (ICD-10) [for use 10/01/2015-12/31/2015]: T80.61XA, T80.61XD, T80.61XS
NUMERATOR:
Patients who underwent elective skin testing or penicillin challenge AND who had the penicillin or ampicillin/amoxicillin allergy label removed from the medical record if results were negative or confirmed in the medical record if results were positive.

**NUMERATOR NOTE:** A positive result consists of either a positive skin test or positive challenge after a negative skin test.

**Numerator Options**

*Performance Met:*
Patient underwent elective skin testing or penicillin challenge AND had the penicillin or ampicillin/amoxicillin allergy label removed from the medical record if results were negative or confirmed in the medical record if results were positive

*Medical Performance Exclusion:*
Medical reason(s) for not documenting and reviewing (eg, previous positive penicillin skin test, patients with severe anaphylaxis to penicillin within the past 5 years, patients with penicillin reaction histories consistent with severe non-IgE-mediated reactions, significant comorbid disease and patients unable to discontinue medications with antihistaminic effects or beta-blockers)

*Patient Performance Exclusion:*
Patient reason(s) for not documenting and reviewing results (eg, patients who decline or are non-adherent with skin testing/challenge recommendations)

*Performance Not Met:*
Patient did **NOT** undergo elective skin testing/penicillin challenge and did not have the penicillin or ampicillin/amoxicillin allergy label removed or confirmed on the medical record, reason not otherwise specified

**RATIONALE:**
Most patients with a diagnosis of penicillin allergy are not allergic to penicillin. The avoidance of penicillin and related beta-lactam antibiotics may result in use of antibiotics that are less effective, more costly or more toxic. Additionally, rapid penicillin desensitization may be pursued unnecessarily, which also results in higher costs.

In regards to exclusions, testing for penicillin requires the ability to test without concomitant use of a medicine with antihistaminic effects. Severe non-IgE-mediated penicillin reactions cannot be diagnosed via penicillin skin testing. Patients with significant comorbid diseases may be at higher risk of reaction due to skin testing and challenge. Also, should the patient be on a beta-blocker and unable to withhold before challenge this could be exclusion.

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

Summary Statement 54: The most useful test for detecting IgE-mediated drug reactions caused by penicillin and many large-molecular-weight biologicals is immediate hypersensitivity skin testing. (B)

Summary Statement 71: Approximately 10% of patients report a history of penicillin allergy, but after complete evaluation, up to 90% of these individuals are able to tolerate penicillins. (B)
Summary Statement 72: Treatment of patients assumed to be penicillin allergic with alternate broad-spectrum antibiotics may compromise optimal medical care by leading to multiple drug-resistant organisms, higher costs, and increased toxic effects. (C)

Summary Statement 73: Evaluation of patients with penicillin allergy by skin testing leads to reduction in the use of broad-spectrum antibiotics and may decrease costs. (B)

Joint Task Force on Practice Parameters; American Academy of Allergy, Asthma and Immunology; American College of Allergy, Asthma and Immunology; Joint Council of Allergy, Asthma and Immunology: Drug allergy: an updated practice parameter. Ann Allergy Asthma Immunol 2010, 105:259–273.

The Penicillin Allergy: Appropriate Removal or Confirmation measure was developed by the American Academy of Allergy Asthma and Immunology (AAAAI). The measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The CPT® contained in the measure specification is copyright 2004-2014 American Medical Association.

Measure Type: Outcome

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms

INSTRUCTIONS:
This measure is to be reported once for each occurrence for patients with acute sinusitis 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.

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

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both: Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination. Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination. Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99216, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99224, 99225, 99226, 99227, 99228, 99229, 99230, 99231, 99232, 99233, 99234, 99235, 99236, 99237, 99238, 99239, 99240, 99241, 99242, 99243, 99244, 99245, 99246, 99247, 99248, 99249, 99250

NUMERATOR:
Patients prescribed any antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms

Numerator Instructions: The desired performance goal is not an antibiotic prescribing rate of zero. This measure is an overall rate of all patients receiving an antibiotic.
A lower calculated performance rate for this measure indicates better clinical care or control.

**Numerator Options:**

**Performance Met:**
Antibiotic regimen prescribed within 7 days of diagnosis or within 10 days after onset of symptoms (G9286)

**OR**

**Performance Not Met:**
Antibiotic regimen not prescribed within 7 days of diagnosis or within 10 days after onset of symptoms (G9287)

**RATIONALE:**
Antibiotic treatment for sinusitis is indicated for some patients, but overtreatment of acute sinusitis with antibiotics is common and often not indicated. Further, treatment with antibiotics may increase patient harm and can lead to antibiotic resistance.

A Cochrane systematic review was undertaken to quantify the effectiveness of antibiotic therapy for patients diagnosed with acute sinusitis and treated in ambulatory settings. The authors concluded that antibiotics have a small benefit for improving clinical outcomes in patients with uncomplicated acute sinusitis and symptoms lasting more than seven days in a primary care setting. However, 80% of patients treated with a placebo also improved within two weeks.

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

AAO-HNS Sinusitis Guideline (2007)

Observation without use of antibiotics is an option for selected adults with uncomplicated ABRS who have mild illness (mild pain and temperature < 38.3°C or 101°F) and assurance of follow-up.

Option based on double-blind randomized controlled trials with heterogeneity in diagnostic criteria and illness severity, and a relative balance of benefit and risk.

Antibiotics are not recommended for treating viral rhinosinusitis (VRS) because they are ineffective and do not relieve symptoms directly.


**Measure Type:** Process

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with acute bacterial sinusitis 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.

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

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute bacterial sinusitis

Definitions:
Acute Bacterial Rhinosinusitis (ABRS):
Acute rhinosinusitis that is caused by, or is presumed to be caused by, bacterial infection. A clinician should diagnose ABRS when: (a) symptoms or signs of acute rhinosinusitis are present 10 days or more beyond the onset of upper respiratory symptoms, or (b) symptoms or signs of acute rhinosinusitis worsen within 10 days after an initial improvement (double worsening).

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Sinusitis caused by, or presumed to be caused by, bacterial infection: G9364

NUMERATOR:
Patients who were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis
Numerator Options:

**Performance Met:** Amoxicillin, with or without clavulanate, prescribed as a first line antibiotic at the time of diagnosis (G9315)

**OR**

**Other Performance Exclusion:** Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis for documented reason (e.g., cystic fibrosis, immotile cilia disorders, ciliary dyskinesia, immune deficiency, prior history of sinus surgery within the past 12 months, and anatomic abnormalities, such as deviated nasal septum, resistant organisms, allergy to medication, recurrent sinusitis, chronic sinusitis, or other reasons) (G9313)

**OR**

**Performance Not Met:** Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis, reason not given (G9314)

**RATIONALE:**
The use of broad-spectrum antibiotics as first line treatment have contributed to the rising incidence of drug-resistant strains of bacteria and to increased costs.

Once antibiotics therapy is initiated due to severity and/or duration of symptoms, the goal is to choose a first-line antibiotic treatment that is efficacious, cost-effective and that results in minimal side effects. The justification for amoxicillin as first-line therapy for most patients with ABRS relates to its favorable adverse effect profile, efficacy, low cost, and narrow microbiologic spectrum.

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

*AAO-HNS Sinusitis Guideline (2007)*

If a decision is made to treat ABRS with an antibiotic agent, the clinician should prescribe amoxicillin as first-line therapy for most adults.

Recommendation based on randomized controlled trials with heterogeneity and noninferiority design with a preponderance of benefit over harm.

*IDSA Clinical Practice Guideline for Acute Bacterial Rhinosinusitis in Children and Adults (2012)*

Amoxicillin-clavulanate rather than amoxicillin alone is recommended as empiric antimicrobial therapy for ABRS in adults (weak, low).

Evidence for at least 1 critical outcome from observational studies, from RCTs with serious flaws or indirect evidence.

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**Measure Type:** Process
Measure #333: Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older, with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis

INSTRUCTIONS:
This measure is to be reported once for each occurrence for patients with acute sinusitis 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.

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

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

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both:
- Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
- Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination
- Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99314, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99338, 99339, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis
Numerator Options:

Performance Met: CT scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis (G9349)

OR

Other Performance Exclusion: CT scan of the paranasal sinuses ordered at the time of diagnosis for documented reasons (eg, persons with sinusitis symptoms lasting at least 7 to 10 days, antibiotic resistance, immunocompromised, recurrent sinusitis, acute frontal sinusitis, acute sphenoid sinusitis, periorbital cellulitis, or other medical) (G9348)

OR

Performance Not Met: CT scan of the paranasal sinuses not ordered at the time of diagnosis or received within 28 days after date of diagnosis (G9350)

RATIONALE:
Most cases of uncomplicated acute and subacute sinusitis are diagnosed clinically and should not require any imaging procedure. Sinus CT scanning is of limited value in the routine evaluation of sinusitis due to the high prevalence of abnormal imaging findings. Forty percent of asymptomatic patients and 87 percent of patients with community-acquired colds have sinus abnormalities on sinus CT. Additionally, sinus CT imaging has a high sensitivity but a low specificity for demonstrating acute sinusitis. Furthermore, CT imaging is not recommended for the diagnosis of uncomplicated sinusitis because it is not cost-effective and exposes patients to unnecessary radiation.

Sinusitis cannot be diagnosed on the basis of imaging findings alone. Findings on CT scans should be interpreted in conjunction with clinical and endoscopic findings. Up to 40% of asymptomatic adults have abnormalities on sinus CT scans, as do more than 80% of those with minor upper respiratory tract infections.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines: AAO-HNS Sinusitis Guideline (2007)

Clinicians should not obtain radiographic imaging for patients who meet diagnostic criteria for acute rhinosinusitis, unless a complication or alternative diagnosis is suspected. Recommendation against based on diagnostic studies with minor limitations and a preponderance of benefit over harm.

Radiographic imaging of the paranasal sinuses is unnecessary for diagnosis in patients who already meet clinical diagnostic criteria (Table 5) for acute Rhinosinusitis Imaging modalities for the paranasal sinuses include plain film radiography, computed tomography (CT), and magnetic resonance (MR) imaging. The utility of ultrasound for diagnosis is inconclusive.

Imaging should only be considered for persons with rhinosinusitis symptoms lasting at least 7 to 10 days who have a history of recurrent symptoms or nonresponse to multiple courses of antibiotics in the past.

American College of Radiology ACR Appropriateness Criteria® For Sinonasal Disease (ACR, 2012)
Clinical Condition: Sinonasal Disease
Variant 1: Acute (<4 weeks) or subacute (4-12 weeks) uncomplicated rhinosinusitis.
Radiologic Procedure: CT paranasal sinuses without contrast
Rating: 5
Comments: Most episodes are managed without imaging, as this is primarily a clinical diagnosis. Imaging may be indicated if acute frontal sphenoid sinusitis is
suspected, or if there are atypical symptoms, or if the diagnosis is uncertain.
RRL*: 0.1-1 mSv
Radiologic Procedure: MRI head and paranasal sinuses without contrast
Rating: 4
Comments: May be useful as part of a general workup for headache.
RRL*: 0 mSv
Radiologic Procedure: MRI head and paranasal sinuses without and with contrast
Rating: 2
Comments: May be useful as part of a general workup for headache.
RRL*: 0.1-1 mSv
Radiologic Procedure: CT paranasal sinuses with contrast
Rating: 2
RRL*: 0.1-1 mSv
Radiologic Procedure: CT paranasal sinuses without and with contrast
Rating: 1
RRL*: 1-10 mSv
Radiologic Procedure: X-ray paranasal sinuses
Rating: 1
RRL*: <0.1 mSv
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate *Relative Radiation Level


Measure Type: Outcome
Measure #334: Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) – National Quality Strategy Domain: Efficiency and Cost Reduction

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:  
REGISTRY ONLY

DESCRIPTION:  
Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis

INSTRUCTIONS:  
This measure is to be reported at each visit for patients with chronic sinusitis 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.

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

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

DENOMINATOR:  
All patients aged 18 years and older with a diagnosis of chronic sinusitis

Definition:  
Chronic Sinusitis/Rhinosinusitis - is defined as twelve (12) weeks or longer of two or more of the following signs and symptoms: mucopurulent drainage (anterior, posterior, or both), nasal obstruction (congestion), facial pain-pressure-fullness, or decreased sense of smell AND inflammation is documented by one or more of the following findings: purulent (not clear) mucus or edema in the middle meatus or ethmoid region, polyps in nasal cavity or the middle meatus, and/or radiographic imaging showing inflammation of the paranasal sinuses.

Denominator Criteria (Eligible Cases):  
Patients aged ≥ 18 years on date of encounter
AND  
Diagnosis for chronic sinusitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 473.0, 473.1, 473.2, 473.3, 473.8, 473.9
Diagnosis for chronic sinusitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]: J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9
AND  
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:  
Patients who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. A lower percentage, with a definitional target approaching 0%, indicates appropriate use of CT in cases of chronic sinusitis (eg, not ordering more than one CT scan within 90 days after the date of diagnosis).
**Numerator Options:**

**Performance Met:** More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis, reason not given (G9352)

**OR**

**Other Performance Exclusion:** More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis for documented reasons (eg, patients with complications, second CT obtained prior to surgery, other medical reasons) (G9353)

**OR**

**Performance Not Met:** One CT scan or no CT scan of the paranasal sinuses ordered within 90 days after the date of diagnosis (G9354)

**RATIONALE:**
In contrast to acute or isolated cases of sinusitis, chronic or recurrent sinusitis may benefit from additional diagnostic evaluation (eg, CT scan, nasal endoscopy) and management to corroborate a diagnosis and/or investigate for underlying causes. When endoscopic sinus surgery is considered in patients with recurrent or chronic sinusitis, a CT of the paranasal sinuses should be obtained to provide the anatomic detail necessary to guide the surgery. Multiple CT scans, however, are not indicated for chronic sinusitis patients due to risk of radiation overexposure and the fact that sinusitis cannot be diagnosed on the basis of imaging findings alone.

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

AAO-HNS Sinusitis Guideline (2007)

**Diagnostic Testing**
The clinician should corroborate a diagnosis and/or investigate for underlying causes of chronic Rhinosinusitis and recurrent acute Rhinosinusitis.

Recommendation based on observational studies with a preponderance of benefit over harm.

**Radiographic Imaging**
The clinician should obtain computed tomography (CT) of the paranasal sinuses in diagnosing or evaluating a patient with chronic rhinosinusitis or recurrent acute Rhinosinusitis (AAO-HNS, 2007).

Recommendation based on diagnostic and observational studies and a preponderance of benefit over harm.

American College of Radiology ACR Appropriateness Criteria®: Sinonasal Disease (ACR, 2012):

Recurrent acute or chronic rhinosinusitis (possible surgical candidate)

Radiologic Procedure: CT paranasal sinuses without contrast

Rating: 9
Comments: Consider using as a surgical planning protocol.

RRL*: 0.1-1 mSv

Radiologic Procedure: CT paranasal sinuses with contrast

Rating: 4

RRL*: 0.1-1 mSv

Radiologic Procedure: CT paranasal sinuses without and with contrast

Rating: 3

RRL*: 1-10mSv
Radiologic Procedure: MRI head and paranasal sinuses without and with contrast
Rating: 3
RRL*: 0 mSv

Radiologic Procedure: MRI head and paranasal sinuses without contrast
Rating: 2
RRL*: 0 mSv

Radiologic Procedure: X-ray paranasal sinuses
Rating: 1
Comments: May be indicated for planning frontal sinus obliteration.
RRL*: <0.1 mSv

Radiologic Procedure: SPECT paranasal sinuses
Rating: 1
RRL*: 1-10 mSv
Rating Scale: 1,2,3 Usually not appropriate; 4,5,6 May be appropriate; 7,8,9 Usually appropriate

*Relative Radiation Level


Measure Type: Outcome
Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention – National Quality Strategy Domain: Community / Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P - medical reasons, 8P - reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.
Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use, Identified as a User and Received Intervention

Performance Met: CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

Performance Met: CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator

Medical Performance Exclusion: 4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed, Reason Not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: 4004F with 8P: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified

RATIONALE:

This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

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

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 use 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) (U.S. Department of Health and Human Services. Public Health Service, 2008)

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) (U.S. Department of Health and Human Services. Public Health Service, 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) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)
Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (ie, pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

The American Medical Association (AMA)-convened Physician Consortium for Performance Improvement ® (PCPI®) owned and developed Screening: Tobacco Use: Screening and Cessation Intervention measure specifications are copied verbatim from the 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

**Measure Type:** Process
Measure #402: Tobacco Use and Help with Quitting Among Adolescents – National Quality Strategy Domain: Community / Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY

DESCRIPTION:
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All patients aged 12-20 years with a visit during the measurement period.

Denominator Criteria (Eligible Cases):
Patients aged 12-20 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use Status – Any documentation of smoking or tobacco use status, including ‘never’ or ‘non-use’.
Tobacco User – Any documentation of active or current use of tobacco products, including smoking.

NUMERATOR NOTE: In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report G9460.

Numerator Options:
Performance Met:
Patient documented as tobacco user AND received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco...
use cessation program) if identified as a tobacco user (G9458)

OR

Performance Met:
Currently a tobacco non-user (G9459)

OR

Performance Not Met:
Tobacco assessment OR tobacco cessation intervention not performed, reason not otherwise specified (G9460)

RATIONALE:
This measure is intended to promote adolescent tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

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

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. (Strength of Recommendation = B) (U.S. Preventive Services Task Force, 2013)

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 use 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) (U.S. Department of Health and Human Services. Public Health Service, 2008)

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) (U.S. Department of Health and Human Services. Public Health Service, 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) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The National Committee for Quality Assurance (NCQA) owned and developed Tobacco Use and Help with Quitting Among Adolescents measure specifications are copied verbatim from the 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

Measure Type: Process
Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults – National Quality Strategy Domain: Community/Population Health

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients 65 years of age and older with a visit during the measurement period

DENOMINATOR NOTE: Pneumococcal vaccination is expected once ever for patients 65 years of age or older.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter

AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357, G0402

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pneumococcal Vaccination Administered or Previously Received

Performance Met:
CPT II 4040F: Pneumococcal vaccine administered or previously received
**OR**

**Pneumococcal Vaccination not Administered or Previously Received, Reason not Otherwise Specified**

Append a reporting modifier (8P) to CPT Category II code 4040F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

**Performance Not Met:** 4040F with 8P:

Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

**RATIONALE:**

Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003).

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011).

Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).

**CLINICAL RECOMMENDATION STATEMENTS:**

The Advisory Committee on Immunization Practices’ (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010).

The major updates for the 2010 update are: 1) the indications for which PPSV23 vaccination is recommended now include smoking and asthma, and 2) routine use of PPSV23 is no longer recommended for Alaska Natives or American Indians aged <65 years unless they have medical or other indications for PPV23.

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The National Committee for Quality Assurance owned and developed Pneumonia Vaccination Status for Older Adults measure specifications are copied verbatim from the **2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures**.

**Measure Type:** Process
Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbas, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration

INSTRUCTIONS:
This measure is to be reported each visit during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure’s denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

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

DENOMINATOR:
All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99210, 99212, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient’s current medications using all immediate resources available on the date of encounter. This list must include ALL known
prescriptions, over-the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosages, frequency and route of administration

**Definitions:**

**Current Medications** – Medications the patient is presently taking including all prescriptions, over-the-counter, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency and administered route.

**Route** – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

**Not Eligible** – A patient is not eligible if the following reason is documented:

- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

**NUMERATOR NOTE:** The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications

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

- **Current Medications Documented**
  - **Performance Met:** G8427: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications
  - OR
  - **Current Medications not Documented, Patient not Eligible**
  - **Other Performance Exclusion:** G8430: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional
  - OR
  - **Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given**
  - **Performance Not Met:** G8428: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given

**RATIONALE:**

In the American Medical Association’s (AMA) *Physician’s Role in Medication Reconciliation* (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs
in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs were $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million visit related ADEs (VADEs) in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices, The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient-days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

A Systematic Review on “Prevalence of Adverse Drug Events in Ambulatory Care” finds that “The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011)”.

The Agency for Healthcare Research and Quality’s (AHRQ) The National Healthcare Disparities Report (2011) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

**CLINICAL RECOMMENDATION STATEMENTS:**
The Joint Commission’s 2014 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section “Use Medicines Safely NPSG.03.06.01” includes the following: “Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor”.

The National Quality Forum’s 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA’s published report, The Physician’s Role in Medication Reconciliation, identified the best practice medication reconciliation team as one that is multidisciplinary and—in all settings of care—will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team’s variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

The American Medical Association and American Society of Hematology owned and developed measure, Documentation of Current Medications in the Medical Record, is copied verbatim from the 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

Measure Type: Process
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

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, 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 eligible professional or by their staff.

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).

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

Measure Type: Process
Influenza Immunization – National Quality Strategy Domain: Community/Population Health

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.

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

Measure Type: Process