

ASTHMA MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN ASTHMA MEASURES GROUP:

- #53. Asthma: Pharmacologic Therapy
- #64. Asthma: Asthma Assessment
- #231. Asthma: Tobacco Use: Screening - Ambulatory Care Setting
- #232. Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Asthma Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8645: I intend to report the Asthma Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the Asthma Measures Group are patients aged 5 through 50 years with a specific diagnosis of Asthma accompanied by a specific patient encounter:

The following diagnosis codes indicating Asthma: 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.82, 493.90, 493.92

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report quality-data codes on **all** measures within the Asthma Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Asthma Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G code G8646: All quality actions for the applicable measures in the Asthma Measures Group have been performed for this patient

- To report satisfactorily for the Asthma Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8546 (and G8550 if reported) as well as all other line items containing QDCs. N365 indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #53: Asthma: Pharmacologic Therapy

DESCRIPTION:

Percentage of patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

NUMERATOR:

Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta₂-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

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

Definition:

Prescribed – May include prescription given to the patient for long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta₂-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines) at one or more visits in the 12-month period or patient already taking long-term control medication or an acceptable alternative treatment as documented in current medication list.

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The “correct combination” of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed

(Two CPT II codes [4015F & 1038F] are required on the claim form to submit this numerator option)

CPT II 4015F: Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed

AND

CPT II 1038F: Persistent asthma (mild, moderate or severe)

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed for Patient Reasons

(Two CPT II codes [4015F-2P & 1038F] are required on the claim form to submit this numerator option)

Append a modifier (**2P**) to CPT Category II code **4015F** to report documented circumstances that appropriately exclude patients from the denominator.

4015F with 2P: Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta2-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

AND

CPT II 1038F: Persistent asthma (mild, moderate or severe)

OR

If patient is not eligible for this measure because patient does not have persistent asthma, report:

(One CPT II code [1039F] is required on the claim form to submit this numerator option)

CPT II 1039F: Intermittent asthma

OR

Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed, Reason not Specified

(Two CPT II codes [4015F-8P & 1038F] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **4015F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4015F with 8P: Persistent asthma, preferred long term control medication or acceptable alternative treatment not prescribed, reason not otherwise specified

AND

CPT II 1038F: Persistent asthma (mild, moderate or severe)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #64: Asthma: Asthma Assessment

DESCRIPTION:

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

NUMERATOR:

Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Numerator Instructions: To be counted in calculation of this measure, symptom frequency must be numerically quantified. Measure may also be met by clinician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tool may include the Quality Metric Asthma Control Test™, National Asthma Education & Prevention Program (NAEPP) Asthma Symptoms, and Peak Flow Diary.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Asthma Symptom Frequency Evaluated

CPT II 1005F: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

OR

Asthma Symptom Frequency not Evaluated, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1005F with 8P: *Asthma symptoms not evaluated, reason not otherwise specified*

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting

DESCRIPTION:

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

NUMERATOR:

Patients who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

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

NUMERATOR NOTE: For the purpose of this measure, “tobacco user” refers to tobacco smokers and “tobacco non-user” refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tobacco Use Assessed, Including Exposure to Secondhand Smoke

Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

G8686: Currently a Tobacco Smoker OR Current Exposure to Secondhand Smoke

OR

Current Tobacco Non-User AND No Exposure to Secondhand Smoke

G8687: Currently a Tobacco Non-User AND No Exposure to Secondhand Smoke

OR

Tobacco Use not Assessed, Reason Not Specified

G8689: Tobacco Use not assessed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

DESCRIPTION:

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment) who received tobacco cessation intervention within 12 months

NUMERATOR:

Patients who received tobacco use cessation intervention

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

Definitions:

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patients who Received Tobacco Use Cessation Intervention

CPT II 4000F: Tobacco Use Cessation Intervention, Counseling

OR

CPT II 4001F: Tobacco Use Cessation Intervention, Pharmacologic Therapy

AND

Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

OR

If patient is not eligible for this measure because patient is a non tobacco user AND Has No Exposure to Secondhand Smoke, report:

G8691: Current Tobacco Non-User AND No Exposure to Secondhand Smoke

OR

Tobacco Use not Assessed, Reason Not Specified

G8693: Tobacco Use not assessed, reason not specified

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Tobacco Use Cessation Intervention not Performed, Reason Not Specified

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

4000F with 8P: Tobacco Use Cessation Intervention, Counseling, not performed, reason not otherwise specified

OR

4001F with 8P: Tobacco Use Cessation Intervention, Pharmacologic Therapy, not performed, reason not otherwise specified

AND

Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.