Asthma Medication Management

MEASURE DESCRIPTION:

Asthma Medication Management indicates whether a patient with persistent asthma, aged 5 to 64 years, was prescribed an inhaled corticosteroid or an acceptable alternative of preferred asthma therapy medication. This excludes patients with a diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, or acute respiratory failure.

This measure is based on the HEDIS measure *Use of Appropriate Medications for People with Asthma* (ASM).

PROPRIETARY STATUS:
This measure is owned by NCQA [NQF-Endorsed™].

CRITERIA REVISION:
- This measure is based on the HEDIS® 2013 Technical Specifications for Physician Measurement criteria.
- The NDC drug codes are from the NCQA files released November 2012.

CRITERIA REVIEW DATE: 03/29/2013

MEASURE TYPE: Quality - process of care

MEASURE PACKAGE: Advantage Nationally Endorsed

MINIMUM DATA REQUIREMENTS (months): 24

MEASURE DETAILS:

DENOMINATOR:

Identifies the unique count of patients, age 5 to 64 years at the end of the measurement year, with persistent asthma. Patients are identified as having persistent asthma if they meet at least one of the 5 criteria below during both the measurement year and the year prior to the measurement year (criteria need not be the same across both years).

It excludes patients with a diagnosis of emphysema, COPD, cystic fibrosis, or acute respiratory failure, anytime prior to or during the measurement period (based on claims included in the database).

At least one emergency department (ED) visit with a principal diagnosis of asthma (during the measurement year or the year prior)	(CPT Procedure Code = 99281-99285 Or Revenue Code UB = 045*, 0981) And ICD-9 Diagnosis Code Principal = 493.0*, 493.1*, 493.8*, 493.9*
OR	
At least one acute inpatient discharge with a principal diagnosis of asthma (during the measurement year or the year prior)	(CPT Procedure Code = 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291 Or Revenue Code UB = 010*, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144,

	0149, 0150-0154, 0159, 016*, 020*, 021*, 072*, 0987) And ICD-9 Diagnosis Code Principal = 493.0*, 493.1*, 493.8*, 493.9*
OR	
At least 4 outpatient asthma visits *and* at least 2 asthma medication dispensing events (during the measurement year or the year prior)	(CPT Procedure Code = 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429 Or Revenue Code = 051*, 0520-0523, 0526-0529, 0570-0599, 0982, 0983) And ICD-9 Diagnosis Code = 493.0*, 493.1*, 493.8*, 493.9* And At least 2 asthma medication dispensing events for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, methylxanthines, or inhaled beta-2 agonists. NDC Codes as defined by NCQA (www.ncqa.org) An event is defined as Days Supply/30, rounded down. If days supply <=30, it is counted as one event. Multiple prescriptions on the same day are counted as separate events. Inhaler medications are counted as one dispensing event regardless of the number of days supply. However, multiple prescriptions for the same inhaler on the same date of service are counted as only one event.
OR	
At least 4 asthma medication dispensing events where a leukotriene modifier *was not* the sole medication dispensed. (i.e., an asthma medication was dispensed on 4 occasions) (during the measurement year or the year prior)	At least 4 asthma medication dispensing events for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, methylxanthines, or inhaled beta-2 agonists, and not all events were equal to leukotriene modifiers. NDC Codes as defined by NCQA (www.ncqa.org) An event is defined as Days Supply/30, rounded down. If days supply <=30, it is counted as one event. Multiple prescriptions on the same day are counted as separate events. Inhaler medications are counted as one dispensing event regardless of the number of days supply. However, multiple prescriptions for the

	same inhaler on the same date of service are counted as only one event.
OR	
At least 4 asthma medication dispensing events where a leukotriene modifier *was* the sole medication dispensed, and there was a diagnosis of asthma in any setting in the same year Note: The diagnosis criterion and drug criterion must be met in the same year.	ICD-9 Diagnosis Code = 493.0*, 493.1*, 493.8*, 493.9* And At least 4 asthma medication dispensing events where all events are leukotriene modifiers. NDC Codes defined by NCQA (www.ncqa.org) An event is defined as Days Supply/30, rounded down. If days supply <=30, it is counted as one event. Multiple prescriptions on the same day are counted as separate events.
AND	
Age in years (as of the end of the measurement year)	Age in Years = 5-64

EXCLUSIONS:

Excludes from the eligible population all patients diagnosed with emphysema, COPD, cystic fibrosis, or acute respiratory failure anytime prior to or during the measurement year (based on claims included in the database).

History of emphysema, COPD, cystic fibrosis, or acute respiratory failure (anytime prior to or during the measurement year)	ICD-9 Diagnosis Code = 277.0*, 491.2*, 492*, 493.2*, 496, 506.4, 518.1, 518.2, 518.81

NUMERATOR:

Identifies patients with persistent asthma, aged 5 to 64 years, who were prescribed an inhaled corticosteroid or an acceptable alternative of preferred asthma therapy medication.

At least one prescription for preferred asthma drugs (during the measurement year)	NDC Codes as defined by NCQA (www.ncqa.org)

CONTINUOUS ENROLLMENT:

Continuously enrolled with medical coverage during the measurement year and the year prior to the measurement year, which equates to 24 out of 24 months. Continuously enrolled with drug coverage during the measurement year.

MEASURE BACKGROUND:

Asthma is characterized by episodic and reversible airway obstruction. It is the most common chronic disease of childhood and is a frequent cause of hospitalizations. It may develop at any age, but onset is usually during childhood. Asthma may be exacerbated by respiratory infections, environmental allergens, exercise, temperature, humidity, environmental irritants such as perfume, smoke, and some drugs (aspirin, NSAIDs, beta-blockers, sulfites in foods). Most asthma treatment should be done in

the office/outpatient setting. Patients and families should be instructed in adjusting medications if PEFR (Peak Expiratory Flow Rate) changes or symptoms worsen. Severe exacerbations not controlled at home may require ER treatment and/or admission. A stable asthma patient should be evaluated every 1 to 6 months, with evaluation that includes spirometry, or PEFR if spirometry is not available.

The goals of chronic asthma management are to reduce symptoms and maintain normal lung function, including the ability to exercise, and to reduce the risk of recurrent exacerbations and the need for ER or inpatient care, avoiding adverse effects of treatment. Adequate asthma control is considered the onset of daytime symptoms that require the need for a short-acting beta-agonist (SABA) less than twice a week (excluding the preventative use of a SABA, such as prior to exercise). Night-time symptoms should not occur more than twice a month. The need for oral glucocorticoids or urgent care visits should not occur more than once a year.

A step-wise approach is used for asthma treatment, with medications and doses adjusted as necessary to control symptoms. Symptoms of intermittent asthma may be controlled with the use of a quick-acting inhaled beta-agonist as needed, including prior to a symptom trigger, such as exercise. Patients with mild persistent asthma are generally treated with inhaled corticosteroids to decrease symptoms, decrease the need for SABA treatment, and prevent or decrease the risk of severe exacerbations. Leukotriene receptor antagonists are an alternative treatment, but not preferred. Theophyllines and cromoglycates may also be used. Patients with moderate persistent asthma may add a long-acting beta-agonist (LABA) or increase the dose of an inhaled corticosteroid. Alternative treatments include adding a leukotriene modifier (leukotriene receptor antagonist or lipoxygenase inhibitor) or theophylline to inhaled corticosteroids. If symptoms remain uncontrolled, the inhaled steroid dose may be increased (and LABA added) or oral steroids added. The anti-IgE therapy omalizumab is used as adjunctive therapy for patients older than 12 years of age, who have sensitivity to relevant allergens and have severe persistent asthma.
