

NQF 0002: Appropriate Testing for Children with Pharyngitis

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

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NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR). The first two sections may be distributed as stand-alone references.

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and exclusions or exceptions.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and exceptions or exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, ICD, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Menu measure
Related to other measures?	<ul style="list-style-type: none"> Not related to other Stage 1 MU clinical quality measures
Data required to identify the denominator (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Encounter code¹ Diagnosis of pharyngitis² Prescription of pharyngitis antibiotics³
Data required to identify the exceptions or exclusions	<ul style="list-style-type: none"> Prescription of pharyngitis antibiotics⁴
Data required to identify the numerator (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Group A streptococcus test⁵

Note: This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, please visit: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> Ensures only patients who are at least 2 years old and no more than 18 years old are included in the denominator 	<ul style="list-style-type: none"> Date of birth 	
2. Record date and type of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. 	<ul style="list-style-type: none"> Date of visit Code for an ambulatory encounter, including pediatrics⁶ 	
3. Check patient record for active diagnosis of pharyngitis	<ul style="list-style-type: none"> Ensures only patients with an active diagnosis of pharyngitis are included in the denominator. 	<ul style="list-style-type: none"> Active diagnosis of pharyngitis⁷ 	

¹ This data element(s) must be documented during the measurement period

² This data element(s) must be documented during the encounter

³ This data element(s) must be documented on or no more than 3 days after the encounter

⁴ This data element(s) must be documented no more than 30 days before and no later than the encounter

⁵ This data element(s) must be documented no more than 3 days after prescription of pharyngitis antibiotics identified as part of the denominator.

⁶ See Technical Supplement for denominator inclusion details (encounter types): [pp. TS-2](#)

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
4. Check patient record for prescription of pharyngitis antibiotics or, if appropriate, prescribe antibiotics for pharyngitis	<ul style="list-style-type: none"> Ensures only patients who were prescribed antibiotics for pharyngitis are included in the denominator 	<ul style="list-style-type: none"> Pharyngitis antibiotics (medication active, order, dispensed) 	
5. Check patient record for previous prescription of pharyngitis antibiotics	<ul style="list-style-type: none"> Ensures patients with documentation of pharyngitis antibiotics prescribed before encounter are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Pharyngitis antibiotics (medication active, order, dispensed) 	
6. Check patient record for documentation of group A streptococcus laboratory test performed	<ul style="list-style-type: none"> Ensures only patients with documentation of a group A streptococcus test are counted in the numerator. 	<ul style="list-style-type: none"> Streptococcus laboratory test⁸ 	

⁷ See Technical Supplement for denominator inclusion details (diagnosis of pharyngitis): [pp. TS-3](#)

⁸ See Technical Supplement for numerator inclusion criteria (streptococcus A test): [pp. TS-5](#)

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure numerator and denominator.

DENOMINATOR INCLUSION CRITERIA

What constitutes an ED encounter? (CPT Codes)

- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a history; an examination; and medical decision making.

What constitutes an outpatient encounter? (CPT Codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A history; An evaluation; medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A history; An examination; medical decision making.
- Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status.")
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A history; A examination; and Medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: A history; An examination; and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: A history; An examination; and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: A history; An examination; and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; and Medical decision making.
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)
- Preventive medicine counseling and/or risk factor reduction intervention(s) providers to individuals in a group setting (separate procedure)
- Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

What constitutes an outpatient encounter? (ICD-9 Codes)

- | | |
|--|-------|
| • General medical examination: Routine general medical examination at a health care facility | V70.0 |
| • General medical examination: Other medical examination for administrative purposes | V70.3 |

What constitutes an outpatient encounter? (ICD-9 Codes)

• General medical examination: Health examination of defined subpopulations	V70.5
• General medical examination: Health examination in population surveys	V70.6
• General medical examination: Examination of potential donor of organ or tissue	V70.
• General medical examination: Unspecified general medical examination	V70.9

What constitutes a diagnosis of pharyngitis? (SNOMED-CT Codes)

- Peritonsillar cell (disorder)
- Suppurative tonsillitis (disorder)
- Cellulitis of parapharyngeal space (disorder)
- Pharyngeal bursitis (disorder)
- Pneumococcal tonsillitis (disorder)
- Peritonsillar cell (disorder)
- Suppurative tonsillitis (disorder)
- Cellulitis of parapharyngeal space (disorder)
- Pharyngeal bursitis (disorder)
- Pneumococcal tonsillitis (disorder)
- Staphylococcal tonsillitis (disorder)
- Exudative pharyngitis (disorder)
- Cellulitis of nasopharynx (disorder)
- Chronic pharyngitis (disorder)
- Ulcerative tonsillitis (disorder)
- Viral pharyngitis (disorder)
- O/E - granular pharyngitis (disorder)
- Acute tonsillitis (disorder)
- Herpangina (disorder)
- Viral pharyngoconjunctivitis (disorder)
- Vincent's angina (disorder)
- Acute gangrenous pharyngitis (disorder)
- Acute phlegmonous pharyngitis (disorder)
- Acute ulcerative pharyngitis (disorder)
- Acute bacterial pharyngitis (disorder)
- Acute pneumococcal pharyngitis (disorder)
- Acute staphylococcal pharyngitis (disorder)
- Acute viral pharyngitis (disorder)
- Allergic pharyngitis (disorder)
- Acute erythematous tonsillitis (disorder)
- Acute follicular tonsillitis (disorder)
- Acute ulcerative tonsillitis (disorder)
- Acute catarrhal tonsillitis (disorder)
- Acute gangrenous tonsillitis (disorder)
- Acute bacterial tonsillitis (disorder)

What constitutes a diagnosis of pharyngitis? (SNOMED-CT Codes)

- Acute pneumococcal tonsillitis (disorder)
- Acute staphylococcal tonsillitis (disorder)
- Acute viral tonsillitis (disorder)
- Recurrent acute tonsillitis (disorder)
- Tracheopharyngitis (disorder)
- Pharyngitis keratosa (disorder)
- Pharyngitis sicca (disorder)
- Chronic follicular pharyngitis (disorder)
- Chronic adenotonsillitis (disorder)
- Caseous tonsillitis (disorder)
- Lingular tonsillitis (disorder)
- Influenza with pharyngitis (disorder)
- Pharyngeal diverticulitis (disorder)
- Cellulitis of pharynx (disorder)
- Acute herpes simplex pharyngitis (disorder)
- Acute herpes zoster pharyngitis (disorder)
- Glandular fever pharyngitis (disorder)
- Meningococcal pharyngitis (disorder)
- Chlamydial pharyngitis (disorder)
- Acute pharyngeal candidiasis (disorder)
- Chronic ulcerative pharyngitis (disorder)
- Chronic pharyngeal candidiasis (disorder)
- Vincent's tonsillitis (disorder)
- Chronic adenoiditis (disorder)
- Nasopharyngeal sarcoidosis (disorder)
- Chronic granular pharyngitis (disorder)
- Fusobacterial necrotizing tonsillitis (disorder)
- Lymphonodular coxsackie pharyngitis (disorder)
- Gangosa of yaws (disorder)
- Follicular tonsillitis (disorder)
- Uvulitis (disorder)
- Acute lingual tonsillitis (disorder)
- Infective pharyngitis (disorder)
- Respiratory syncytial virus pharyngitis (disorder)
- Acute pharyngitis (disorder)
- Ulcerative pharyngitis (disorder)
- Fusospirochetal pharyngitis (disorder)
- Pharyngitis (disorder)
- Enteroviral lymphonodular pharyngitis (disorder)
- Tonsillitis due to Gram negative bacteria (disorder)
- Streptococcal tonsillitis (disorder)
- Streptococcal sore throat (disorder)

What constitutes a diagnosis of pharyngitis? (SNOMED-CT Codes)

- Chronic nasopharyngitis (disorder)
- Viral tonsillitis (disorder)
- Nasopharyngitis (disorder)
- Acute laryngopharyngitis (disorder)
- Suppurative pharyngitis (disorder)
- Parainfluenza virus rhinopharyngitis (disorder)
- Phlegmonous pharyngitis (disorder)
- Atrophic pharyngitis (disorder)
- Gangrenous tonsillitis (disorder)
- Adenoiditis (disorder)
- Gangrenous pharyngitis (disorder)
- Pneumococcal pharyngitis (disorder)
- Adenoviral pharyngitis (disorder)
- Parainfluenza virus pharyngitis (disorder)
- Staphylococcal pharyngitis (disorder)
- Hypertrophic pharyngitis (disorder)
- Tonsillitis (disorder)
- Chronic tonsillitis (disorder)
- Mycoplasmal pharyngitis (disorder)

NUMERATOR INCLUSION CRITERIA

What constitutes a group A streptococcus test? (SNOMED-CT codes)

- Streptococcus pyogenes antigen assay (procedure)
- Streptococcus pyogenes culture (procedure)
- Measurement of Streptococcus pyogenes enzyme antibody (procedure)
- Streptococcus pyogenes rRNA assay (procedure)
- Microbial identification kit, rapid strep method (procedure)

What constitutes a group A streptococcus test? (CPT codes)

- Culture, bacterial; any other source except urine, blood, or stool, aerobic, with isolation and presumptive identification of isolates
- Culture, bacterial; quantitative, aerobic with isolation and presumptive identification of isolates, any source except urine, blood or stool
- Culture, presumptive, pathogenic organisms, screening only
- Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multi-step method; Streptococcus, group A
- Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus, group A, quantification
- Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A

TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

NQF0002	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	×			×			×		×	×	×
Denominator ²	×			×		×	×			×	×
Exceptions or exclusions ³											

- (Codes with an asterisk (*) are required from certified EHRs)
- ¹ To identify the numerator in this CQM, the following standard codes are required: (1) RxNorm medication code; (2) either a CPT or ICD-9 “encounter” code; and (3) a CPT, LOINC, or SNOMED-CT “laboratory test performed” code.
- ² To identify the denominator in this CQM, the following standard codes are required: (1) RxNorm medication code; (2) either a CPT or ICD-9 “encounter” code; (3) an ICD-9, ICD-10 or SNOMED-CT code “diagnosis code”; and (4) an HL7 code
- ³ To identify the exclusions in this CQM, the following standard codes are required: (1) (1) RxNorm medication code; and (2) either a CPT or ICD-9 “encounter” code.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)

Abbreviation	Long Name	Definition/Description
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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