

# **NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement**

## **Clinical Quality Measure Quick Reference Guide and Technical Supplement**

### **Provided By:**

The National Learning Consortium (NLC)

### **Developed By:**

Health Information Technology Research Center (HITRC)

*The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.*

## 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 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 denominator exclusion.

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 denominator 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, 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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## NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> <li>Menu set measure</li> </ul>
Related to other measures?	<ul style="list-style-type: none"> <li>Not related to other stage 1 MU clinical quality measures</li> </ul>
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> <li>Age</li> <li>CPT encounter code<sup>1</sup></li> <li>Alcohol or drug dependence diagnosis code<sup>1, 2</sup></li> <li>Rehabilitation or detoxification procedure code<sup>1</sup></li> </ul>
Data required to identify the <u>numerator 1</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> <li>CPT encounter code<sup>3,4</sup></li> <li>Rehabilitation or detoxification procedure code</li> <li>Alcohol or drug dependence diagnosis code</li> </ul>
Data required to identify the <u>numerator 2</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> <li>CPT encounter codes<sup>5</sup></li> <li>Alcohol or drug dependence diagnosis codes</li> </ul>
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> <li>None</li> </ul>

**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>

<sup>1</sup> This data element must be between 45 days before or simultaneous to and 1 year before or simultaneous to the end of the measurement period.

<sup>2</sup> The diagnosis must be more 60 days after the initial diagnosis.

<sup>3</sup> This data element must be between 45 days before or simultaneous to and 1 year before or simultaneous to end of the measurement period if there is a corresponding rehab or detox procedure.

<sup>4</sup> This data element must be ≤ 14 days after the first AOD diagnosis if there is no corresponding rehab or detox procedure.

<sup>5</sup> This data element must be ≤ 30 days after first AOD treatment.

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. <b>Confirm the patient's date of birth</b>	<ul style="list-style-type: none"> <li>Ensures only patients who are 12 years and over at the start of the measurement period are included in the denominator.</li> </ul>	<ul style="list-style-type: none"> <li>Date of birth</li> </ul>	
2. <b>Check patient record for emergency department, inpatient (acute or non-acute, or outpatient behavioral health, encounter with first diagnosis of AOD.</b>	<ul style="list-style-type: none"> <li>Ensures patients with a first time AOD diagnosis are captured for the <b>denominator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Date of encounter</li> <li>Encounter code<sup>6</sup></li> <li>AOD diagnosis<sup>7</sup></li> </ul>	
3. <b>Check patient record for an inpatient encounter (acute or non-acute) with an AOD detoxification or rehabilitation procedure.</b>	<ul style="list-style-type: none"> <li>Ensures patients being treated for AOD are captured for the <b>denominator</b></li> </ul>	<ul style="list-style-type: none"> <li>Date of inpatient encounter</li> <li>Inpatient encounter code<sup>6</sup></li> <li>Detoxification or rehabilitation procedure code<sup>8</sup></li> </ul>	
4. <b>Check patient record for a detoxification intervention</b>	<ul style="list-style-type: none"> <li>Ensures patients being treated for AOD are captured in the <b>denominator</b></li> </ul>	<ul style="list-style-type: none"> <li>Date of detoxification intervention</li> <li>Detoxification intervention procedure code<sup>8</sup></li> </ul>	
5. <b>Confirm date of first diagnosis of AOD</b>	<ul style="list-style-type: none"> <li>Ensure patients who have been diagnosed for more than 60 days are captured for the <b>denominator</b></li> </ul>	<ul style="list-style-type: none"> <li>Date of first AOD diagnosis</li> </ul>	
6. <b>Check patient record for an inpatient encounter (acute or non-acute) with AOD detoxification or rehabilitation procedure performed</b>	<ul style="list-style-type: none"> <li>Ensures patients who receive their first AOD treatment during an inpatient encounter are captured in the <b>numerator</b></li> </ul>	<ul style="list-style-type: none"> <li>Date of inpatient encounter</li> <li>Inpatient encounter code<sup>6</sup></li> <li>Detoxification or rehabilitation procedure code<sup>8</sup></li> </ul>	

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

<sup>7</sup> See Technical Supplement for denominator inclusion details (AOD diagnosis): [pp. TS-4](#)

<sup>8</sup> See Technical Supplement for denominator inclusion details (detox and rehab procedures): [pp. TS- 8](#)

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
7. Check patient record for an inpatient (acute or non-acute) or outpatient behavioral health encounter > 14 days after first diagnosis of AOD.	<ul style="list-style-type: none"> <li>Ensures patient who are initiating treatment are captured in the <b>numerator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Date of encounter</li> <li>Date of first AOD diagnosis</li> <li>AOD diagnosis code</li> </ul>	
8. Check patient record for 2 or more inpatient (acute or non-acute), or outpatient behavioral health encounters < 30 days after first AOD diagnosis	<ul style="list-style-type: none"> <li>Ensures all patients engaged in treatment are captured in the <b>numerator</b></li> </ul>	<ul style="list-style-type: none"> <li>Date of encounters</li> <li>Encounter codes</li> </ul>	

## Technical Supplement

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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 counts as an inpatient encounter? (CPT codes)

- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making
- Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 components: a history, an examination, and medical decision making.
- Hospital discharge day management; 30 minutes or less
- Hospital discharge day management; more than 30 minutes
- Inpatient consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Critical care, evaluation and management of the critically ill or critically injured patient;
- Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.
- Nursing facility discharge day management
- Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a history, an examination, and medical decision making.
- Domiciliary or rest 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.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.

### What counts as an emergency department 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 counts as an outpatient behavioral health encounter? (CPT codes)

- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services
- Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)
- Physician education services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with.
- 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, and medical decision making.



### What counts as an outpatient behavioral health encounter? (CPT codes)

- Observation care discharge day management
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an 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
- 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)
- Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)
- Home visit for individual, family, or marriage counseling
- Psychiatric diagnostic interview examination\*
- Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication\*
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting\*
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, with medical evaluation and management services\*
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting.\*
- psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms Individual of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, with medical evaluation and management services\*
- Psychoanalysis\*
- Family psychotherapy (conjoint psychotherapy)(with patient present)\*
- Multiple-family group psychotherapy\*
- Group psychotherapy (other than of a multiple-family group)\*
- Interactive group psychotherapy\*
- Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy\*
- Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supporting psychotherapy)\*
- Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supporting psychotherapy)\*

### What counts as an outpatient behavioral health encounter? (CPT codes)

- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.\*
- Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making\*
- Hospital discharge day management\*

\*These visits may be at a school, Indian Health Service freestanding facility, Tribal 638 freestanding facility, office, home, assisted living facility, group home, mobile unit, urgent care facility, outpatient hospital, custodial care facility, independent clinic, federally qualified health center, psychiatric facility, community mental health center, non-residential substance abuse treatment facility, public health clinic, or rural health clinic.

### What counts as an AOD diagnosis? (ICD-9 codes)

• Alcohol induced mental disorders	291
• Alcohol withdrawal delirium	291.0
• Alcohol induced persisting amnesic disorder	291.1
• Alcohol induced persisting dementia	291.2
• Alcohol induced psychotic disorder with hallucinations	291.3
• Idiosyncratic alcohol intoxication	291.4
• Alcohol induced psychotic disorder with delusions	291.5
• Other specified alcohol induced mental disorders	291.8
• Alcohol withdrawal	291.81
• Alcohol induced sleep disorders	291.82
• Other alcohol induced mental disorders	291.89
• Unspecified alcohol induced mental disorders	291.9
• Drug induced mental disorders	292
• Drug withdrawal	292.0
• Drug induced psychotic disorders	292.1
• Drug induced psychotic disorder with delusions	292.11
• Drug induced psychotic disorder with hallucinations	292.12
• Pathological drug intoxication	292.2
• Other specified drug induced mental disorders	292.8
• Drug induced delirium	292.81
• Drug induced persisting dementia	292.82
• Drug induced persisting amnesic disorder	292.83
• Drug induced mood disorder	292.84
• Drug induced sleep disorder	292.85
• Other drug induced mental disorder	292.89
• Unspecified drug induced mental disorder	292.9
• Alcohol dependence syndrome	303.
• Acute alcoholic intoxication unspecified	303..00
• Acute alcoholic intoxication continuous	303..01
• Acute alcoholic intoxication episodic	303..02
• Other and unspecified alcohol dependence	303.90
• Other and unspecified alcohol dependence, continuous	303.91

### What counts as an AOD diagnosis? (ICD-9 codes)

• Other and unspecified alcohol dependence, episodic	303.92
• Opioid type dependence, unspecified	304.00
• Opioid type dependence, continuous	304.01
• Opioid type dependence, episodic	304.02
• Sedative, hypnotic, or anxiolytic dependence, unspecified	304.10
• Sedative, hypnotic, or anxiolytic dependence, continuous	304.11
• Sedative, hypnotic, or anxiolytic dependence, episodic	304.12
• Cocaine dependence, unspecified	304.20
• Cocaine dependence, continuous	304.21
• Cocaine dependence, episodic	304.22
• Cannabis dependence, unspecified	304.30
• Cannabis dependence, continuous	304.31
• Cannabis dependence, episodic	304.32
• Amphetamine and other psychostimulant dependence, unspecified	304.40
• Amphetamine and other psychostimulant dependence, continuous	304.41
• Amphetamine and other psychostimulant dependence, episodic	304.42
• Hallucinogen dependence, unspecified	304.50
• Hallucinogen dependence, continuous	304.51
• Hallucinogen dependence, episodic	304.52
• Other specified drug dependence, unspecified	304.60
• Other specified drug dependence, continuous	304.61
• Other specified drug dependence, episodic	304.62
• Combinations of opioid type drug dependence, unspecified	304.70
• Combinations of opioid type drug dependence, continuous	304.71
• Combinations of opioid type drug dependence, episodic	304.72
• Combinations of drug dependence excluding opioid type, unspecified	304.80
• Combinations of drug dependence excluding opioid type, continuous	304.81
• Combinations of drug dependence excluding opioid type, episodic	304.82
• Unspecified drug dependence, unspecified	304.90
• Unspecified drug dependence, continuous	304.91
• Unspecified drug dependence, episodic	304.92
• Alcohol abuse, unspecified	305.00
• Alcohol abuse, continuous	305.01
• Alcohol abuse, episodic	305.02
• Cannabis abuse, unspecified	305.20
• Cannabis abuse, continuous	305.21
• Cannabis abuse, episodic	305.22
• Hallucinogen abuse, unspecified	305.30
• Hallucinogen abuse, continuous	305.31
• Hallucinogen abuse, episodic	305.32
• Sedative, hypnotic, or anxiolytic abuse, unspecified	305.40
• Sedative, hypnotic, or anxiolytic abuse, continuous	305.41

#### What counts as an AOD diagnosis? (ICD-9 codes)

• Sedative, hypnotic, or anxiolytic abuse, episodic	305.42
• Opioid abuse, unspecified	305.50
• Opioid abuse, continuous	305.51
• Opioid abuse, episodic	305.52
• Cocaine abuse, unspecified	305..60
• Cocaine abuse, continuous	305.61
• Cocaine abuse, episodic	305.62
• Amphetamine or related acting sympathomimetic abuse, unspecified	305.70
• Amphetamine or related acting sympathomimetic abuse, continuous	305.71
• Amphetamine or related acting sympathomimetic abuse, episodic	305.72
• Antidepressant type abuse, unspecified	305.80
• Antidepressant type abuse, continuous	305.81
• Antidepressant type abuse, episodic	305.82
• Other, mixed, or unspecified drug abuse, unspecified	305.90
• Other, mixed, or unspecified drug abuse, continuous	305.91
• Other, mixed, or unspecified drug abuse, episodic	305.92
• Alcoholic gastritis	535.3
• Alcoholic gastritis without mention of hemorrhage	535.30
• Alcoholic gastritis with hemorrhage	535.31
• Acute alcoholic hepatitis	571.1

#### What counts as an AOD diagnosis? (SNOMED CT codes)

- Continuous chronic alcoholism (disorder)
- Episodic chronic alcoholism (disorder)
- Drug dependence (disorder)
- Continuous opioid dependence (disorder)
- Episodic opioid dependence (disorder)
- Hypnotic or anxiolytic dependence, continuous (disorder)
- Hypnotic or anxiolytic dependence, episodic (disorder)
- Cocaine type drug dependence (disorder)
- Cocaine dependence, continuous (disorder)
- Cocaine dependence, episodic (disorder)
- Cannabis dependence, continuous (disorder)
- Cannabis dependence, episodic (disorder)
- Cannabis dependence in remission (disorder)
- Hallucinogen dependence, continuous (disorder)
- Hallucinogen dependence, episodic (disorder)
- Glue sniffing dependence (disorder)
- Glue sniffing dependence, continuous (disorder)
- Glue sniffing dependence, episodic (disorder)
- Combined opioid with other drug dependence (disorder)

#### What counts as an AOD diagnosis? (SNOMED CT codes)

- Combined opioid with other drug dependence, continuous (disorder)
- Combined opioid with other drug dependence, episodic (disorder)
- Combined opioid with other drug dependence in remission (disorder)
- Combined drug dependence, excluding opioids (disorder)
- Combined drug dependence, excluding opioid, continuous (disorder)
- Combined drug dependence, excluding opioid, episodic (disorder)
- Combined drug dependence, excluding opioid, in remission (disorder)
- Ecstasy type drug dependence (disorder)
- Drug dependence in the puerperium - baby delivered during previous episode of care (disorder)
- Amphetamine dependence (disorder)
- Lysergic acid diethylamide dependence (disorder)
- Mescaline dependence (disorder)
- Anxiolytic dependence (disorder)
- Barbiturate dependence (disorder)
- Benzodiazepine dependence (disorder)
- Diazepam dependence (disorder)
- Librium dependence (disorder)
- Heroin dependence (disorder)
- Methadone dependence (disorder)
- Morphine dependence (disorder)
- Opium dependence (disorder)
- Controlled drug dependence (disorder)
- Active drug dependence (disorder)
- Pregnancy and drug dependence (disorder)
- Psychoactive substance dependence (disorder)
- Drug dependence during pregnancy, childbirth and the puerperium (disorder)
- Hypnotic or anxiolytic dependence (disorder)
- Cannabis type drug dependence (disorder)
- Cocaine dependence (disorder)
- Hallucinogen dependence (disorder)
- Fentanyl dependence (disorder)
- Methamphetamine dependence (disorder)
- Sedative dependence (disorder)
- Combined drug dependence, continuous (disorder)
- Dependence on unknown drug (disorder)
- Stimulant Dependence (disorder)
- Inhalant dependence (disorder)
- Polysubstance dependence (disorder)
- Nicotine dependence (disorder)
- Phencyclidine (PCP) dependence (disorder)
- Alcohol dependence (disorder)
- Alcoholism (disorder)

#### What counts as an AOD diagnosis? (SNOMED CT codes)

- Opioid dependence (disorder)
- Cannabis dependence (disorder)
- Drug-related disorder (disorder)

#### What counts as a rehabilitation and detoxification intervention? (SNOMED CT codes)

- Alcohol rehabilitation and detoxification (regime/therapy)
- Combined alcohol and drug rehabilitation and detoxification (regime/therapy)
- Alcohol rehabilitation (regime/therapy)
- Rehabilitation therapy (regime/therapy)
- Drug rehabilitation and detoxification (regime/therapy)
- Combined alcohol and drug rehabilitation (regime/therapy)
- Drug rehabilitation (regime/therapy)

#### What counts as a detoxification intervention? (SNOMED CT codes)

- Detoxification Therapy (regime/therapy)

## NUMERATOR INCLUSION CRITERIA

Refer to “what counts as an inpatient encounter” on [pp. TS-2](#)

Refer to “what counts as an outpatient behavioral health encounter” on [pp. TS-2](#)

Refer to “what counts as a rehabilitation and detoxification intervention” on [pp. TS-8](#)

Refer to “what counts as a detoxification intervention” on [pp. TS-8](#)

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

NQF0004	CPT	CPT Modifier	CVX	Grouping	HCPSCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator <sup>1</sup>	x	x		x			x	x			x
Denominator <sup>2</sup>	x	x		x		x	x	x			x
Exceptions or exclusions											

- (Codes with an asterisk (\*) are required from certified EHRs)
- <sup>1</sup> To identify the numerator in this CQM, the following standard codes are required: one “encounter code” from CPT, one “alcohol or other drug dependence” code from ICD-9, ICD-10, or SNOMED, and one “alcohol drug rehab and detox intervention” or “detox intervention” code from ICD-9 or SNOMED.
- <sup>2</sup> To identify the denominator in this CQM, the following standard codes are required: an “individual characteristic” code from HL7, one or more “encounter” codes from CPT, one “alcohol or other drug dependence” code from ICD-9, ICD-10, or SNOMED, and one “alcohol drug rehab and detox intervention” or “detox intervention” code from ICD-9 or SNOMED.

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)
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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