

NQF 0012: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)

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 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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NQF 0012: Prenatal Care: Screening for Human Immunodeficiency Virus

Percentage of patients regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit.

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 <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Prenatal visit encounter code¹ Active diagnosis of delivery live births or Delivery live births procedure²
Data required to identify the <u>exceptions</u> or <u>exclusions</u>	<ul style="list-style-type: none"> Active or inactive diagnosis of HIV³ Medical or patient reason laboratory test not done
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Estimated date of conception⁴ HIV Screening⁵

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. Record the date and type of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. For this measure, at least one prenatal encounter is required during the measurement period. 	<ul style="list-style-type: none"> Date of visit Code for a prenatal encounter⁶ 	
2. Check patient record for delivery live births diagnosis or procedure	<ul style="list-style-type: none"> Ensures only patients with a live birth during the measurement period are counted in the denominator. 	<ul style="list-style-type: none"> Diagnosis code for active diagnosis of delivery live births⁶, or Procedure code for delivery live births⁶ 	

¹ This data element(s) must be documented after the estimated date of conception

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

³ This data element(s) must be documented before or simultaneous to the prenatal encounter.

⁴ This data element(s) must be documented no more than 10 months before and no later than diagnosis active or procedure performed: delivery live births

⁵ This data element(s) must be documented no more than 30 days after and not before the first or second prenatal visit

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
3. Check patient record or assess patient for active or inactive diagnosis of HIV	<ul style="list-style-type: none"> Ensures patients with an active or inactive diagnosis of HIV are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Active diagnosis of HIV⁷, or Inactive diagnosis of HIV⁷ 	
4. Check patient record or assess patient for medical or patient reason HIV Screening not done.	<ul style="list-style-type: none"> Ensures patients with a documented reason for not having HIV screening performed are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Medical reason for laboratory test not done⁸, or Patient reason for laboratory test not done⁸. 	
5. Check patient record or assess patient for estimated date of conception	<ul style="list-style-type: none"> Ensures only patients with an estimated date of conception no more than 10 months before the delivery live birth are counted in the numerator 	<ul style="list-style-type: none"> Estimated date of conception 	
6. Check patient record for HIV screening or, if appropriate, order HIV screening test	<ul style="list-style-type: none"> Ensures patients with an HIV screening test no more than 30 days following either their first or second encounter are included in the numerator. 	<ul style="list-style-type: none"> Laboratory test performed: HIV screening⁹ 	

⁷ See Technical Supplement for exclusion or exception criteria (diagnosis of HIV): [pp. TS-9](#)

⁸ See Technical Supplement for exclusion or exception criteria (medical or patient reason for exclusion): [pp. TS-10](#)

⁹ See Technical Supplement for numerator inclusion criteria (HIV screening): [pp. TS-11](#)

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 denominator and numerator.

DENOMINATOR INCLUSION CRITERIA

What constitutes a prenatal encounter? (CPT codes)

- Prenatal initial visit (regimen/therapy)
- Prenatal visit (regimen/therapy)

What constitutes a prenatal encounter? (ICD-9 codes)

- | | |
|--|-------|
| • Normal Pregnancy: supervision of normal first pregnancy | V22.0 |
| • Normal Pregnancy: supervision of other normal first pregnancy | V22.1 |
| • Normal Pregnancy: prenatal state, incidental. Pregnant state NOS | V22.2 |

What constitutes a prenatal encounter? (ICD-10 codes)

- | | |
|--|-------|
| • Encounter for supervision of normal pregnancy | Z34 |
| • Encounter for supervision of normal first pregnancy | Z34.0 |
| • Encounter for supervision of other normal pregnancy | Z34.8 |
| • Encounter for supervision of normal pregnancy, unspecified | Z34.9 |

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Good neonatal condition at birth (finding)
- Well male newborn (finding)
- Well female newborn (finding)
- Well premature newborn (finding)
- Normal delivery but ante- or post-natal conditions present (finding)
- Twin pregnancy - delivered (finding)
- Triplet pregnancy - delivered (finding)
- Quadruplet pregnancy - delivered (finding)
- Multiple delivery, all spontaneous (finding)
- Multiple delivery, all by forceps and vacuum extractor (finding)
- Multiple delivery, all by cesarean section (finding)
- Other multiple pregnancy - delivered (finding)
- Grand multiparity - delivered (finding)
- Elderly primigravida - delivered (finding)
- Forceps delivery unspecified (finding)
- Forceps delivery - delivered (finding)
- Delivery by combination of forceps and vacuum extractor (finding)
- Delivered by mid-cavity forceps with rotation (finding)
- Vacuum extractor delivery - delivered (finding)
- Breech extraction unspecified (finding)
- Breech extraction - delivered (finding)
- Deliveries by cesarean (finding)
- Cesarean delivery unspecified (finding)
- Cesarean delivery - delivered (finding)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Cesarean section - pregnancy at term (finding)
- Delivery by elective cesarean section (finding)
- Delivery by emergency cesarean section (finding)
- Delivery by cesarean hysterectomy (finding)
- Cesarean section following previous cesarean section (finding)
- Deliveries by destructive operation (finding)
- Labor established (finding)
- Premature birth of multiple newborns (finding)
- Term birth of newborn male (finding)
- Term birth of newborn male (finding)
- Term pregnancy delivered (finding)
- Vaginal delivery following previous cesarean section (finding)
- Premature bith of newborn quintuplets (finding)
- Finding of speed of delivery (finding)
- Caul membrane over baby's head at delivery (finding)
- Labor not established (finding)
- Uterine observation in labor (finding)
- Maternal effort during second stage of labor (finding)
- Desire to push in labor (finding)
- Maternal condition during labor (finding)
- Deliveries by vacuum extractor (finding)
- Delivered by low forceps delivery (finding)
- Delivered by mid-cavity forceps delivery (finding)
- Deliveries by breech extraction (finding)
- Deliveries by spontaneous breech delivery (finding)
- Delivery problem for fetus (finding)
- Grand multip in labor (finding)
- Elderly primiparous with labor (finding)
- Abnormal delivery (finding)
- Brow delivery (finding)
- Face delivery (finding)
- Rapid rate of delivery (finding)
- Normal rate of delivery (finding)
- Slow rate of delivery (finding)
- Twin birth (finding)
- Livebirth (finding)
- Triplet birth (finding)
- Premature delivery (finding)
- Normal delivery - occipitoanterior (finding)
- Abnormal head presentation delivery (finding)
- Born after precipitate delivery (finding)
- Born after induced labor (finding)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Finding of first stage of labor (finding)
- Finding of second stage of labor (finding)
- Second stage of labor established (finding)
- Second stage of labor not established (finding)
- Second stage of labor problem (finding)
- Normal second stage of labor (finding)
- Finding of delivery push in labor (finding)
- Pushing effectively in labor (finding)
- Not pushing well in labor (finding)
- Urge to push in labor (finding)
- Reluctant to push in labor (finding)
- Pushing voluntarily in labor (finding)
- Pushing involuntarily in labor (finding)
- Finding of third stage of labor (finding)
- Normal length of third stage of labor (finding)
- Prolonged third stage of labor (finding)
- Rapid expulsion of placenta (finding)
- Delayed expulsion of placenta (finding)
- Normal rate of expulsion of placenta (finding)
- Finding of pattern of labor (finding)
- Finding of blood loss in labor (finding)
- Finding of measures of labor (finding)
- Device-assisted finding of labor (finding)
- Mother delivered (finding)
- Mother not delivered (finding)
- Finding of pattern of delivery (finding)
- Vaginal delivery (finding)
- Delivery problem (finding)
- Operculum passed (finding)
- Finding of uterine contractions (finding)
- Finding of contraction state of uterus (finding)
- Cervix dilated (finding)
- Rim of cervix palpable (finding)
- Premature birth of newborn triplets (finding)
- Finding of birth outcome (finding)
- Delivered by cesarean section - pregnancy at term (finding)
- Delivered by cesarean delivery following previous cesarean delivery (finding)
- Spontaneous vertex delivery (finding)
- Normal labor (finding)
- Finding of outcome of delivery (finding)
- Finding of progess of second stage of labor (finding)
- Finding related to ability to push in labor (finding)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Finding of speed of delivery of placenta (finding)
- Arrested labor (finding)
- Live birth surviving more than one year (finding)
- Spontaneous placental expulsion, Schultz mechanism (finding)
- Second stage of labor (finding)
- Multiple birth (finding)
- Labor problem (finding)
- Immature cervix (finding)
- Delivery normal (finding)
- Premature birth of newborn male (finding)
- Premature pregnancy delivered (finding)
- Term birth of newborn twins (finding)
- Term birth of newborn sextuplets (finding)
- Missed labor (finding)
- Prodromal stage labor (finding)
- Premature birth of newborn female (finding)
- Premature labor (finding)
- First stage of labor (finding)
- Inversion of uterine contraction (finding)
- Term birth of newborn quadruplets (finding)
- Term birth of newborn triplets (finding)
- Term birth of newborn quintuplets (finding)
- Trial labor (finding)
- Term birth of newborn female (finding)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Delivery of transverse presentation (procedure)
- Braxton Hicks obstetrical version with extraction (procedure)
- High forceps delivery with episiotomy (procedure)
- Placental localization (procedure)
- US scan - fetal cephalometry (procedure)
- US scan - fetal maturity (procedure)
- Ultrasound scan for fetal presentation (procedure)
- Dating/booking US scan (procedure)
- Ultrasound scan for fetal viability (procedure)
- Ultrasound obstetric diagnostic scan NOS (procedure)
- Antenatal ultrasound scan 4-8 weeks (procedure)
- Antenatal ultrasound scan at 9-16 weeks (procedure)
- Antenatal ultrasound scan at 17-22 weeks (procedure)
- Breech extraction delivery with version (procedure)
- Other specified breech extraction delivery (procedure)
- Spontaneous breech delivery (procedure)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Assisted breech delivery (procedure)
- Forceps cephalic delivery (Code 177161009) (procedure)
- High forceps cephalic delivery with rotation (procedure)
- Midforceps cephalic delivery with rotation (procedure)
- Barton forceps cephalic delivery with rotation (procedure)
- DeLee forceps cephalic delivery with rotation (procedure)
- Piper forceps delivery (procedure)
- Other specified forceps cephalic delivery (procedure)
- High vacuum delivery (procedure)
- Low vacuum delivery (procedure)
- Vacuum delivery before full dilation of cervix (procedure)
- Trial of vacuum delivery (procedure)
- Other specified vacuum delivery (procedure)
- Cephalic vaginal delivery with abnormal presentation of head at delivery without instrument (procedure)
- Manipulative cephalic vaginal delivery with abnormal presentation of head at delivery without instrument (procedure)
- Non-manipulative cephalic vaginal delivery with abnormal presentation of head at delivery without instrument (procedure)
- Normal delivery procedure (procedure)
- Water birth delivery (procedure)
- Other methods of delivery (procedure)
- Manual removal of products of conception from delivered uterus (procedure)
- Manual removal of placenta from delivered uterus (procedure)
- Other specified manual removal of products of conception from delivered uterus (procedure)
- Normal delivery of placenta (procedure)
- Low forceps delivery with episiotomy (procedure)
- Forceps delivery failed (procedure)
- Vibration of cervix (procedure)
- Surgical treatment of missed abortion of first trimester (procedure)
- Low forceps delivery (procedure)
- Partial breech delivery with forceps to aftercoming head (procedure)
- Fetal biophysical profile (procedure)
- Vaginal delivery, medical personnel present (procedure)
- Delivery by Ritgen maneuver (procedure)
- Delivery procedure (procedure)
- Instrumental delivery (procedure)
- Nonrotational forceps delivery (procedure)
- Outlet forceps delivery (procedure)
- Forceps application to aftercoming head (procedure)
- Groin traction at breech delivery (procedure)
- Lovset's maneuver (procedure)
- Delivery of the after coming head (procedure)
- Burns Marshall maneuver (procedure)
- Mauriceau Smellie Veit maneuver (procedure)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Operation to facilitate delivery (procedure)
- Right mediolateral episiotomy (procedure)
- Placental delivery procedure (procedure)
- Complete breech delivery (procedure)
- Ultrasonography for antepartum monitoring of fetus (procedure)
- Ultrasound scan for fetal growth (procedure)
- Ultrasound scan for amniotic fluid volume (procedure)
- Delivery by Scanzoni maneuver (procedure)
- Mid forceps delivery with episiotomy (procedure)
- Delivery by vacuum extraction with episiotomy (procedure)
- Midforceps delivery without rotation (procedure)
- Ultrasound scan - obstetric (procedure)
- Fetal anatomy study (procedure)
- Neville-Barnes forceps delivery (procedure)
- Simpson's forceps delivery (procedure)
- Wigand-Martin maneuver (procedure)
- Breech/instrumental delivery operations (procedure)
- Dilation/incision of cervix - delivery aid (procedure)
- Supervision - normal delivery (procedure)
- Routine episiotomy and repair (procedure)
- Prague maneuver (procedure)
- Delivery by double application of forceps (procedure)
- Breech extraction with internal podalic version (procedure)
- Forceps delivery (procedure)
- Controlled cord traction of placenta (procedure)
- Barton's forceps delivery (procedure)
- Breech presentation, no version (procedure)
- Antenatal ultrasound scan at 22-40 weeks (procedure)
- Dilatation of cervix for delivery (procedure)
- Echography, scan B-mode for fetal growth rate (procedure)
- Internal and combined version with extraction (procedure)
- Partial breech extraction (procedure)
- Partial breech delivery (procedure)
- Delivery of vertex presentation (procedure)
- Frank breech delivery (procedure)
- Dührssen's incisions of cervix to assist delivery (procedure)
- Obstetric procedure (procedure)
- Pubiotomy to assist delivery (procedure)
- Delivery by Malstrom's extraction with episiotomy (procedure)
- Wright's obstetrical version with extraction (procedure)
- Kristeller maneuver (procedure)
- Ultrasound scan for fetal anomaly (procedure)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- Ultrasound scan for fetal nuchal translucency (procedure)
- Delivery of placenta by maternal effort (procedure)
- Nuchal ultrasound sca (procedure)
- Total breech extraction (procedure)
- Breech extraction (procedure)
- US obstetric doppler (procedure)
- Antenatal ultrasound scan for possible abnormality (procedure)
- Obstetric uterine artery Doppler (procedure)
- Fetal biometry using ultrasound (procedure)
- Obstetric umbilical artery Doppler (procedure)
- Transvaginal nuchal ultrasonography (procedure)
- Transvaginal obstetric ultrasonography (procedure)
- Transvaginal obstetric doppler ultrasonography (procedure)
- Chorionic villus sampling using obstetric ultrasound guidance (procedure)
- Potter's obstetrical version with extraction (procedure)
- Vaginal delivery with forceps including postpartum care (procedure)
- Van Hoorn maneuver (procedure)
- Spontaneous unassisted delivery, medical personnel present (procedure)
- Surgical treatment of missed abortion of second trimester (procedure)
- Total breech delivery with forceps to aftercoming head (procedure)
- Diagnostic ultrasound of gravid uterus (procedure)
- Manually assisted spontaneous delivery (procedure)
- Delivery of placenta following delivery of infant outside of hospital (procedure)
- Bracht maneuver (procedure)
- Removal of fetal structures (procedure)
- Delivery by vacuum extraction (procedure)
- Mid forceps delivery (procedure)
- Surgical treatment of spontaneous abortion of any trimester (procedure)
- Episiotomy (procedure)
- Delivery by midwife (procedure)
- Extraction of fetus (procedure)
- Cleidotomy (procedure)
- Trial forceps delivery (procedure)
- Surgical treatment of missed abortion of third trimester (procedure)
- Forceps delivery with rotation of fetal head (procedure)
- Footling breech delivery (procedure)
- Pinard maneuver (procedure)
- Ultrasonography of uterus (procedure)
- Delivery, medical personnel present (procedure)
- Episiotomy (procedure)
- Echography, scan B-mode for placental localization (procedure)
- Delivery by Kielland rotation (procedure)

What constitutes a diagnosis of delivery live births? (SNOMED-CT codes)

- High forceps delivery (procedure)
- Delivery by Malstrom's extraction (procedure)
- Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- Vaginal delivery only (with or without episiotomy and/or forceps);
- Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
- Antepartum care only; 4-6 visits
- Antepartum care only; 7 visits
- Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- Cesarean delivery only
- Cesarean delivery only; including postpartum care
- Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);
- Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
- Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
- Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;
- Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

EXCLUSION OR EXCEPTION CRITERIA

What constitutes a diagnosis of HIV? (SNOMED-CT codes)

- Acute HIV infection (disorder)
- Human immunodeficiency virus infection constitutional disease (disorder)
- Human immunodeficiency virus with neurological disease (disorder)
- Human immunodeficiency virus infection with secondary clinical infectious disease (disorder)
- Human immunodeficiency virus with secondary cancers (disorder)
- Human immunodeficiency virus (HIV) disease resulting in mycobacterial infection (disorder)
- Human immunodeficiency virus (HIV) disease resulting in cytomegaloviral disease (disorder)
- Human immunodeficiency virus (HIV) disease resulting in candidiasis (disorder)
- Human immunodeficiency virus (HIV) disease resulting in multiple infections (disorder)
- Human immunodeficiency virus (HIV) disease resulting in Burkitt's lymphoma (disorder)
- Human immunodeficiency virus (HIV) disease resulting in multiple malignant neoplasms (disorder)
- Human immunodeficiency virus (HIV) disease resulting in lymphoid interstitial pneumonitis (disorder)
- Human immunodeficiency virus leukoencephalopathy (disorder)
- Human immunodeficiency virus myelitis (disorder)
- Neuropathy due to human immunodeficiency virus (disorder)
- Human immunodeficiency virus - associated periodontitis (disorder)
- Human immunodeficiency virus enteropathy (disorder)
- Acquired immune deficiency syndrome-related nephropathy (disorder)
- Human immunodeficiency virus myopathy (disorder)

What constitutes a diagnosis of HIV? (SNOMED-CT codes)

- Acquired immune deficiency syndrome-related complex (disorder)
- Congenital acquired immune deficiency syndrome (disorder)
- Congenital human immunodeficiency virus positive status syndrome (disorder)
- Human immunodeficiency virus HIV-related gut disease - cause unknown (disorder)
- Human immunodeficiency virus (HIV) infection with aseptic meningitis (disorder)
- Acquired immunodeficiency syndrome (AIDS) with dermatomycosis (disorder)
- Human immunodeficiency virus encephalopathy (disorder)
- Human immunodeficiency virus encephalitis (disorder)
- Human immunodeficiency virus (HIV) serconversion exanthem (disorder)
- Human immunodeficiency virus (HIV) seropositivity (disorder)
- Human immunodeficiency virus I infection (disorder)
- Immune recovery uveitis (disorder)
- Human immunodeficiency virus (HIV) infection with infectious mononucleosis-like syndrome (disorder)
- Congenital human immunodeficiency virus infection (disorder)
- Human immunodeficiency virus (HIV) infection with infection by another virus (disorder)
- Acquired immunodeficiency syndrome (AIDS)-like syndrome (disorder)
- Acquired immunodeficiency syndrome (AIDS) (disorder)
- Acquired immunodeficiency syndrome (AIDS) with Salmonella infection (disorder)
- Human immunodeficiency virus II infection (disorder)
- Human immunodeficiency virus infection (disorder)
- Human immunodeficiency virus (HIV) infection with acute lymphadenitis (disorder)
- Acquired immunodeficiency syndrome (AIDS) virus infection associated with pregnancy (disorder)
- Asymptomatic human immunodeficiency virus infection (disorder)
- Asymptomatic human immunodeficiency virus infection in pregnancy (disorder)
- Persistent generalized lymphadenopathy (disorder)

What constitutes a medical reason for patient exclusion? (SNOMED-CT codes)

- The therapy has been found to not have the desired therapeutic benefit on the patient.
- The underlying condition has been resolved or has evolved such that a different treatment is no longer needed.
- A new therapy will be commenced when current supply exhausted.
- Testing has shown that the patient already has immunity to the agent targeted by the immunization.
- The patient currently has a medical condition for which the vaccine is contraindicated or for which precaution is warranted.
- The prescribed product has specific clinical release or other therapeutic characteristics not shared by other substitutable medications.
- The patient has an intolerance to the medication.
- Patient has had a prior allergic intolerance response to alternate product or one of its components.
- The specific manufactured drug is part of a clinical trial.
- Contraindication identified

What constitutes a patient reason for patient exclusion? (SNOMED-CT codes)

- The Patient requested the action

What constitutes a patient reason for patient exclusion? (SNOMED-CT codes)

- Moved at the request of the patient.
- Client deceased.
- The patient is not (or is no longer) able to use the medication in a manner prescribed. Example: Can't swallow.
- The patient refused to take the product.
- The patient or their guardian objects to receiving the vaccine on religious grounds.
- The patient or their guardian objects to receiving the vaccine because of concerns over its safety.
- The intended vaccine has expired or is otherwise believed to no longer be effective. Example: Due to temperature exposure.
- Patient has compliance issues with medication such as differing appearance, flavor, size, shape or consistency.
- Patient changed their mind regarding obtaining medication

NUMERATOR INCLUSION CRITERIA

What constitutes an HIV screening laboratory test? (SNOMED-CT codes)

- Human immunodeficiency virus (HIV) 1 antigen assay (procedure)
- Human immunodeficiency virus (HIV) 1 p24 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p24 antigen assay (procedure)
- Human immunodeficiency virus (HIV) 1 p58 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 antibody band pattern determination (procedure)
- Human immunodeficiency virus HIV-1 gp105 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 gp120 AND gp160 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 gp120 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 gp160 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 gp34 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 gp41 AND gp43 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 gp41 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 p15 AND p18 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p15 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p17 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p19 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p23 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p26 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p28 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p31 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p32 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p41 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p51 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p53 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p55 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p64 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p65 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p66 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 1 p68 antibody assay (procedure)

What constitutes an HIV screening laboratory test? (SNOMED-CT codes)

- Human immunodeficiency virus (HIV) 2 gp105 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 gp120 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 gp125 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 gp15 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 gp34 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 gp36 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 gp80 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p26 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p31 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p41 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p53 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p55 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p56 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p58 antibody assay (procedure)
- Human immunodeficiency virus (HIV) 2 p68 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 passive hemagglutination assay (procedure)
- Human immunodeficiency virus HIV-2 antibody assay (procedure)
- Human immunodeficiency virus HIV-1 antibody assay (procedure)
- Human immunodeficiency virus (HIV) antigen test (procedure)
- Antenatal screening for human immunodeficiency virus (procedure)
- Polymerase chain reaction test for HIV 1 (procedure)
- Rapid HIV-1 antibody test (procedure)
- Human immunodeficiency virus HIV-1 radioimmunoprecipitation assay (procedure)
- Human immunodeficiency virus HIV-1 antibody confirmatory test (procedure)
- Human immunodeficiency virus HIV-2 confirmatory assay (procedure)
- Human immunodeficiency virus-1 (HIV-1) enzyme linked immunosorbent assay (ELISA) (procedure)
- Human immunodeficiency virus-1 (HIV) indirect immunofluorescence assay (procedure)
- Human immunodeficiency virus-1 (HIV-1) rapid latex agglutination assay (procedure)
- Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1
- Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-2
- Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
- Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification

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

NQF0012	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x			x					x		x
Denominator ²	x			x			x	x			x
Exceptions or exclusions ³				x		x	x	x			x

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerator in this CQM, 2 SNOMED codes or a SNOMED and a CPT, LOINC, or GROUPING code are required
- ² To identify the denominator in this CQM, a GROUPING, ICD-10, ICD-9, SNOMED or a CPT, GROUPING, or SNOMED code is required in addition to a GROUPING, ICD-10, ICD-9, or SNOMED code.
- ³ To identify the exclusions or exceptions, an ICD-9, ICD-10 or SNOMED or an HL7 code is required.

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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