

NQF 0014: Prenatal Care: Anti-D Immune Globulin

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 0014: Prenatal Care: Anti-D Immune Globulin

Percentage of D(Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.

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"> Some of the information entered for this clinical quality measure also can be used for calculations in the following measures: <ul style="list-style-type: none"> Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) (NQF 0012)
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Diagnosis active or procedure performed: Delivery live births¹ Encounter code² Diagnosis active: D(Rh) negative³ Diagnosis active: primigravida or multigravida¹ Laboratory test result: Rh status mother value = negative⁴ Laboratory test result Rh status baby value=negative⁴
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> Medication not done: patient reason, medical reason, or system reason Anti-D immune globulin declined
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 Medication administered: anti-D immune globulin

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 date and type of visit	<ul style="list-style-type: none"> Ensures the appropriate encounter types are included in the denominator. 	<ul style="list-style-type: none"> Encounter code for prenatal visit⁵ 	

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

² This data element(s) must be documented after the estimated date of conception

³ This data element(s) must be documented before or during the measurement period

⁴ This data element(s) must be documented before or simultaneous to delivery live births (procedure or diagnosis)

⁵ 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
2. Check patient record or assess patient for active diagnosis of or procedure performed: delivery live births	<ul style="list-style-type: none"> Ensures only patients with live birth delivery during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Diagnosis code or procedure code for delivery live birth⁶ 	
3. Check patient record or assess patient for D(Rh) negative active diagnosis.	<ul style="list-style-type: none"> Ensures only patients with an active diagnosis of D(Rh) negative are included in the denominator. 	<ul style="list-style-type: none"> Diagnosis code for D(Rh) negative 	
4. Check patient record or assess patient for either active diagnosis of primigravida or active diagnosis of multigravida	<ul style="list-style-type: none"> Ensures only patients with active diagnosis of either primigravida or multigravida are included in the denominator. 	<ul style="list-style-type: none"> Diagnosis code for primigravida, or Diagnosis code for multigravida 	
5. If patient has an active diagnosis of primigravida, check patient record for laboratory test result of Rh Status mother: negative If patient has an active diagnosis of multigravida, check patient record for laboratory test result of Rh status mother: negative and laboratory test result of Rh status baby: negative	<ul style="list-style-type: none"> Ensures patients with an active diagnosis of primigravida and Rh status mother: negative OR An active diagnosis of multigravida and Rh status mother: negative and Rh status baby: negative are included in the denominator. 	<ul style="list-style-type: none"> Laboratory test result: Rh status mother: negative Laboratory test result: Rh status baby: negative (if multigravida) 	

⁶ See Technical Supplement for denominator inclusion details (delivery live birth): [pp. TS-2](#)

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
6. Check patient record or assess patient for patient, medical, or system reason for medication not done or indicate if medication was declined.	<ul style="list-style-type: none"> Ensures patients who are at least 26 weeks of gestation or no more than 30 weeks gestation (and less than 10 months before delivery live birth) who have a patient, medical, or system reason for medication not done or who declined the medication are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Estimated date of conception Delivery live birth (procedure or diagnosis) Patient, medical, or system reason⁷ medication not done, or Documentation of medication declined⁷ 	
7. Check patient record for medication administered: anti-D immune globulin. Or, if appropriate, prescribe anti-D immune globulin.	<ul style="list-style-type: none"> Ensures only patients who have been prescribed anti-D immune globulin between 26-30 weeks gestation are counted in the numerator. 	<ul style="list-style-type: none"> Medication administered: anti-D immune globulin Estimated date of conception⁸ Procedure performed: delivery live births 	

⁷ See Technical Supplement for exclusion or exception details (patient, medical or system reason): [pp. TS-9](#)

⁸ See Technical Supplement for exclusion or exception details (estimated date of conception): [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)

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

- Spontaneous breech delivery (procedure)
- 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)

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

- Mauriceau Smellie Veit maneuver (procedure)
- 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)
- Duhrssen'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)

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

- Ultrasound scan for fetal anomaly (procedure)
- 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)

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

- Delivery by Kielland rotation (procedure)
- 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 refusal of Anti-D immune globulin? (SNOMED-CT codes)

- Antenatal Anti-D prophylaxis refused (finding)

What constitutes a medical reason for patient exclusion? (HL7 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? (HL7 codes)

- The Patient requested the action
- Moved at the request of the patient.

What constitutes a patient reason for patient exclusion? (HL7 codes)

- 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

What constitutes a system reason for patient exclusion? (HL7 codes)

- Client was registered in error.
- When a client has no contact with the health system for an extended period, coverage is suspended. Client will be reinstated to original start date upon proof of identification, residency etc. Example: Coverage may be suspended during a strike situation, when employer benefits for employees are not covered (i.e. not in effect).
- The covered party (patient) specified with the Invoice is not correct.
- The policy specified with the Invoice is not correct. For example, it may belong to another Adjudicator or Covered Party.
- The billing information, specified in the Invoice Elements, is not correct. This could include incorrect costing for items included in the Invoice.
- The provider specified with the Invoice is not correct.
- In the case of 'substitution', indicates that the substitution occurred because the ordered item was not in stock. In the case of 'no substitution', indicates that a cheaper equivalent was not substituted because it was not in stock.
- Indicates that the decision to substitute or to not substitute was driven by a jurisdictional regulatory requirement mandating or prohibiting substitution.
- Indicates that the decision to substitute or to not substitute was driven by a desire to maintain consistency with a pre-existing therapy. I.e. The performer provided the same item/service as had been previously provided rather than providing exactly what was ordered, or rather than substituting with a lower-cost equivalent.
- Indicates that the decision to substitute or to not substitute was driven by a policy expressed within the formulary.
- Code assigned to indicate the rationale for not performing an evaluation investigation on a device for which a defect has been reported.
- Examples include: device received in a condition that made analysis impossible, device evaluation anticipated but not yet begun, device not made by company.
- Identifies the reason or rationale for why a person is eligible for benefits under an insurance policy or program. Examples: A person is a claimant under an automobile insurance policy are client deceased & adopted client has been given a new policy identifier. A new employee is eligible for health insurance as an employment benefit. A person meets a government program eligibility criteria for financial, age or health status.
- The reason a referral was made. Examples: Specialized Medical Assistance, Other Care Requirements.
- The medication is no longer being manufactured or is otherwise no longer available.
- The manufacturer or other agency has requested that stocks of a medication be removed from circulation.
- The product does not have (or no longer has) coverage under the patients insurance policy.
- Patient must see prescriber prior to further fills.
- Patient no longer or has never been under this prescribers care.
- Original prescriber is no longer available to prescribe and no other prescriber has taken responsibility for the patient.
- Request for further authorization must be done through patient's family physician.
- Patient has already been given a new (renewal) prescription.

What constitutes a system reason for patient exclusion? (HL7 codes)

- Therapy has been changed and new prescription issued
- This medication is on hold.
- The patient should have medication remaining.
- There was no supply of the product on hand to perform the service.
- The information was recorded incorrectly or was recorded in the wrong record.
- The decision on which the recorded information was based was changed before the decision had an effect.
- Example: Aborted prescription before patient left office, released prescription before suspend took effect.
- Identifies the reason or rationale for coverage of a service or product based on coverage exclusions related to the risk of adverse selection by covered parties.
- Identifies the reason or rationale for coverage of a service or product based on financial participation responsibilities of the covered party.
- Identifies the reason or rationale for limitations on the coverage of a service or product based on coverage contract provisions. Example: The maximum cost per unit; or the maximum number of units per period, which is typically the policy or program effective time.
- Identifies the reason or rationale for coverage of a service or product based on characteristics of the provider, e.g., contractual relationship to payor, such as in or out-of-network; relationship of the covered party to the provider. Example: In closed managed care plan, a covered party is assigned a primary care provider who provides primary care services and authorizes referrals and ancillary and non-primary care services.
- Identifies the reason or rationale for coverage of a service or product based on clinical efficacy criteria or practices prescribed by the payor.
- Patient does not meet required protocol
- Patient not eligible for drug
- Provider is not authorized to prescribe or dispense
- The user does not have permission
- The target facility does not recognize the dispensing facility
- This product is not available or manufactured
- There is no match
- There is no match for the product in the master file repository
- There is no permission
- The agent does not have permission

NUMERATOR INCLUSION CRITERIA

What constitutes an estimated date of conception? (SNOMED-CT codes)

- Estimated date of conception (observable entity)

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

NQF0014	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹				x			x	x		x	x
Denominator ²	x			x			x	x	x		x
Exceptions or exclusions	x			x		x					x

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