

NQF 0018: Controlling High Blood Pressure

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.

TABLE OF CONTENTS

NQF 0018: Controlling High Blood Pressure	4
Technical Supplement.....	TS-1
Denominator Inclusion Criteria	TS-2
exclusion or exception Criteria	TS-4
Numerator Inclusion Criteria.....	TS-7
Types of codes required from your EHR for calculating this clinical quality measure.....	TS-8

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The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

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 measure: <ul style="list-style-type: none"> Hypertension: Blood Pressure Management (NQF 0013) Ischemic Vascular Disease (IVD): Blood Pressure Management (NQF 0073) Diabetes: Blood Pressure Management (NQF 0061)
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Encounter code¹ Active diagnosis of Hypertension²
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Diastolic blood pressure value Systolic blood pressure value
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> Active diagnosis or procedures indicative of ESRD Active diagnosis of pregnancy

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

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> Ensures only patients who are 18 to 75 years of age during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Date of birth 	
2. Record the type and date of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. 	<ul style="list-style-type: none"> Date of visit Encounter code³ 	

¹This data element(s) must occur at least once during the measurement period.

² This data element(s) must be no more than 6 months after the start of the measurement period

³ See Technical Supplement for denominator inclusion criteria (encounter): 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 for active diagnosis of hypertension	<ul style="list-style-type: none"> Ensures only patients with an active hypertension diagnosis are included in the denominator. 	<ul style="list-style-type: none"> Diagnosis code for hypertension⁴ Date of hypertension diagnosis 	
4. Check patient record or assess for active diagnosis of pregnancy	<ul style="list-style-type: none"> Ensures patients with an active diagnosis of pregnancy during the measurement period are identified as exclusion or exceptions. 	<ul style="list-style-type: none"> Diagnosis of pregnancy Date of diagnosis or pregnancy 	
5. Check patient record or assess for active diagnosis of ESRD	<ul style="list-style-type: none"> Ensures patients with an active diagnosis of ESRD or procedure indicative of ESRD during the measurement period are identified as exceptions or exclusions 	<ul style="list-style-type: none"> Procedure indicative of ESRD Date of active diagnosis of ESRD⁵ or procedure indicative of ESRD⁶ 	
6. Check patient record or take patient's diastolic and systolic blood pressure	<ul style="list-style-type: none"> Ensures only patients with most recent diastolic BP < 90 mmHg and most recent systolic BP < 140 are counted in the numerator. 	<ul style="list-style-type: none"> Minimum systolic blood pressure⁷ Minimum diastolic blood pressure⁸ 	

⁴ See Technical Supplement for denominator inclusion criteria (hypertension diagnosis): [pp. TS-2](#)

⁵ See Technical Supplement for exception/exclusion (ESRD diagnosis): [pp. TS-4](#)

⁶ See Technical Supplement for exception/exclusion criteria (ESRD procedure): [pp. TS-5](#)

⁷ See Technical Supplement for numerator inclusion criteria (systolic blood pressure): [pp. TS-7](#)

⁸ See Technical Supplement for numerator inclusion criteria (diastolic blood pressure): [pp. TS-7](#)

Technical Supplement

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

DENOMINATOR INCLUSION CRITERIA

What counts as an encounter? (CPT codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an evaluation and medical decision making.
- 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 evaluation and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history, an evaluation and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation 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 evaluation 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; 18-39 years
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual
- Preventive medicine counseling and/or risk factor reduction intervention(s) providers to individuals in a group setting
- Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
- Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

What counts as a diagnosis of hypertension? (SNOMED CT codes)

- Benign hypertension (disorder)
- Hypertensive heart AND renal disease complicating AND/OR reason for care during puerperium (disorder)
- Benign essential hypertension (disorder)
- Hypertensive heart AND renal disease complicating AND/OR reason for care during childbirth (disorder)

What counts as a diagnosis of hypertension? (SNOMED CT codes)

- Renal sclerosis with hypertension (disorder)
- Toxemia of pregnancy (disorder)
- Eclampsia (disorder)
- Arteriolar nephritis (disorder)
- Hypertension induced by oral contraceptive pill (disorder)
- Essential hypertension complicating AND/OR reason for care during childbirth (disorder)
- Benign hypertensive renal disease (disorder)
- Hypertensive renal disease with renal failure (disorder)
- Hypertensive heart and renal disease with (congestive) heart failure (disorder)
- Secondary benign hypertension (disorder)
- Secondary benign hypertension NOS (disorder)
- Hypertension secondary to endocrine disorder (disorder)
- Hypertension secondary to drug (disorder)
- High-renin essential hypertension (disorder)
- Hypertension complicating pregnancy, childbirth and the puerperium (disorder)
- Hypertension complicating pregnancy, childbirth and the puerperium (disorder)
- Benign essential hypertension complicating pregnancy, childbirth and the puerperium unspecified (disorder)
- Benign essential hypertension complicating pregnancy, childbirth and the puerperium - delivered (disorder)
- Benign essential hypertension complicating pregnancy, childbirth and the puerperium - delivered with postnatal complication (disorder)
- Benign essential hypertension complicating pregnancy, childbirth and the puerperium - not delivered (disorder)
- Benign essential hypertension complicating pregnancy, childbirth and the puerperium with postnatal complication (disorder)
- Transient hypertension of pregnancy - delivered (disorder)
- Transient hypertension of pregnancy - delivered with postnatal complication (disorder)
- Transient hypertension of pregnancy - not delivered (disorder)
- Transient hypertension of pregnancy with postnatal complication (disorder)
- Severe pre-eclampsia - delivered (disorder)
- Severe pre-eclampsia - delivered with postnatal complication (disorder)
- Severe pre-eclampsia - not delivered (disorder)
- Severe pre-eclampsia with postnatal complication (disorder)
- Hypertensive heart AND renal disease complicating AND/OR reason for care during pregnancy (disorder)
- Paroxysmal hypertension (disorder)
- Benign essential hypertension complicating AND/OR reason for care during pregnancy (disorder)
- Transient hypertension of pregnancy (disorder)
- Impending eclampsia (disorder)
- Eclampsia in labor (disorder)
- Malignant hypertension complicating AND/OR reason for care during puerperium (disorder)
- Chronic hypertension complicating AND/OR reason for care during puerperium (disorder)
- Hypertension secondary to renal disease complicating AND/OR reason for care during childbirth (disorder)
- Mild or unspecified pre-eclampsia (disorder)
- Labile hypertension (disorder)
- Maternal hypertension (disorder)

What counts as a diagnosis of hypertension? (SNOMED CT codes)

- Eclampsia in puerperium (disorder)
- Hypertension without albuminuria AND without edema in the obstetric context (disorder)
- Gestational hypertension (disorder)
- Secondary hypertension (disorder)
- Labile essential hypertension (disorder)
- Hypertensive disorder (disorder)
- Hypertension with albuminuria (disorder)
- Pre-eclampsia (disorder)
- Hypertension associated with transplantation (disorder)
- Hypertension secondary to kidney transplant (disorder)
- Exertional hypertension (disorder)
- Systolic essential hypertension (disorder)
- Diastolic hypertension (disorder)
- Pregnancy-induced hypertension (disorder)
- Transient hypertension (disorder)
- Systolic hypertension (disorder)
- Essential hypertension (disorder)
- Sustained diastolic hypertension (disorder)
- Endocrine hypertension (disorder)
- Hypertensive episode (disorder)
- Benign essential hypertension in obstetric context (disorder)
- Labile diastolic hypertension (disorder)
- Malignant hypertension (disorder)
- Benign essential hypertension complicating AND/OR reason for care during childbirth (disorder)
- Essential hypertension in obstetric context (disorder)
- Hypertensive renal disease in obstetric context (disorder)
- Malignant essential hypertension (disorder)
- Chronic hypertension complicating AND/OR reason for care during childbirth (disorder)
- Rebound hypertension (disorder)
- Pre-existing hypertension in obstetric context (disorder)
- Chronic hypertension in obstetric context (disorder)
- Malignant secondary hypertension (disorder)
- Essential hypertension complicating AND/OR reason for care during puerperium (disorder)

EXCLUSION OR EXCEPTION CRITERIA

What counts as a diagnosis of ESRD? (SNOMED CT codes)

- Hypertensive heart and renal disease with renal failure (disorder)
- Hypertensive heart and renal disease with both (congestive) heart failure and renal failure (disorder)
- End stage renal failure untreated by renal replacement therapy (disorder)
- End stage renal failure on dialysis (disorder)
- End stage renal failure with renal transplant (disorder)

What counts as a diagnosis of ESRD? (ICD-9 codes)

• Venous catheterization for renal dialysis	38.95
• Arteriovenostomy for renal dialysis	39.27
• Revision of arteriovenous shunt for renal dialysis	39.42
• Removal of arteriovenous shunt for renal dialysis	39.43
• Repair of arteriovenous fistula	39.53
• Insertion of vessel-to-vessel cannula	39.93
• Replacement of vessel-to-vessel cannula	39.94
• Hemodialysis	39.95
• Peritoneal dialysis	54.98
• Transplant of kidney	55.6
• Renal autotransplantation	55.61
• Other kidney transplantation	55.69
• Chronic kidney disease, stage v	585.5
• End stage renal disease	585.6
• Kidney replaced by transplant	V42.0
• Postsurgical renal dialysis status	V45.1
• Renal dialysis status	V45.11
• Noncompliance with renal dialysis	V45.12
• Encounter for dialysis and dialysis catheter care	V56
• Aftercare involving extracorporeal dialysis	V56.0
• Fitting and adjustment of extracorporeal dialysis catheter	V56.1
• Fitting and adjustment of peritoneal dialysis catheter	V56.2
• Encounter for adequacy testing for dialysis	V56.3
• Encounter for adequacy testing for hemodialysis	V56.31
• Encounter for adequacy testing for peritoneal dialysis	V56.32
• Aftercare involving other dialysis	V56.8

What counts as a diagnosis of ESRD? (ICD-10 codes)

- Chronic kidney disease, stage 5
- End stage renal disease
- Encounter for care involving renal dialysis
- Preparatory care for renal dialysis
- Encounter for fitting and adjustment of extracorporeal dialysis catheter

What counts as an ESRD procedure? (ICD-10 codes)

- Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
- Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention
- Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein

What counts as an ESRD procedure? (ICD-10 codes)

- Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type)
- Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure
- Arteriovenous anastomosis, open; by upper arm cephalic vein transposition
- Arteriovenous anastomosis, open; by upper arm basilic vein transposition
- Arteriovenous anastomosis, open; by forearm vein transposition
- Arteriovenous anastomosis open; direct, any site (e.g., Cimino type) (separate procedure)
- Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)
- Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
- Donor nephrectomy (including cold preservation); open, from living donor
- Recipient nephrectomy (separate procedure)
- Renal allotransplantation, implantation of graft; without recipient nephrectomy
- Renal allotransplantation, implantation of graft; with recipient nephrectomy
- Removal of transplanted renal allograft
- Renal autotransplantation, reimplantation of kidney
- Hemodialysis procedure with single physician evaluation
- Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
- Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method
- Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation
- Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), requiring repeated physician evaluations, with or without substantial revision of dialysis prescription
- End-stage renal disease (ESRD) related services monthly, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- End-stage renal disease (ESRD) related services for home dialysis per full month, to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- End-stage renal disease (ESRD) related services for home dialysis per full month
- End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day
- Dialysis training, patient, including helper where applicable, any mode, completed course
- Dialysis training, patient, including helper where applicable, any mode, course not completed,
- Hemoperfusion (e.g., with activated charcoal or resin)
- Unlisted dialysis procedure, inpatient or outpatient
- Home visit for hemodialysis

What counts as an ESRD procedure? (HCPC codes)

- Unscheduled or emergency dialysis treatment for an esrd patient in a hospital outpatient department that is not certified as an esrd facility
- End stage renal disease (esrd) related services for home dialysis patients per full month; for patients twenty years of age and older
- End stage renal disease (esrd) related services less than full month, per day; for patients between twelve and nineteen years of age
- End stage renal disease (esrd) related services less than full month, per day; for patients twenty years of age and over

What counts as an ESRD procedure? (HCPC codes)

- Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial
- Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous
- Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

NUMERATOR INCLUSION CRITERIA

What counts as a diastolic blood pressure documentation? (SNOMED CT codes)

- Systolic blood pressure (observable entity)
- Minimum systolic blood pressure (observable entity)
- Maximum systolic blood pressure (observable entity)
- Average systolic blood pressure (observable entity)
- Minimum day interval systolic blood pressure (observable entity)
- Minimum night interval systolic blood pressure (observable entity)
- Maximum night interval systolic blood pressure (observable entity)
- Maximum day interval systolic blood pressure (observable entity)
- Average night interval systolic blood pressure (observable entity)
- Average day interval systolic blood pressure (observable entity)
- Systolic arterial pressure (observable entity)

What counts as a systolic blood pressure documentation? (SNOMED CT codes)

- Normal systolic arterial pressure (finding)
- On examination - Systolic BP reading (finding)
- Non-invasive systolic arterial pressure (observable entity)
- Invasive systolic arterial pressure (observable entity)
- Systolic blood pressure (observable entity)
- Minimum systolic blood pressure (observable entity)
- Maximum systolic blood pressure (observable entity)
- Average systolic blood pressure (observable entity)
- Minimum day interval systolic blood pressure (observable entity)
- Minimum night interval systolic blood pressure (observable entity)
- Maximum night interval systolic blood pressure (observable entity)
- Maximum day interval systolic blood pressure (observable entity)
- Average night interval systolic blood pressure (observable entity)
- Average day interval systolic blood pressure (observable entity)
- Minimum 24 hour systolic blood pressure (observable entity)
- Maximum 24 hour systolic blood pressure (observable entity)
- Average 24 hour systolic blood pressure (observable entity)
- 24 hour systolic blood pressure (observable entity)
- Target systolic blood pressure (observable entity)
- Systolic blood pressure on admission (observable entity)

What counts as a systolic blood pressure documentation? (SNOMED CT codes)

- Standing systolic blood pressure (observable entity)
- Sitting systolic blood pressure (observable entity)
- Lying systolic blood pressure (observable entity)
- Systolic arterial pressure (observable entity)
- Decreased systolic arterial pressure (finding)

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

NQF0018	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹											x
Denominator ²	x			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, the following standard codes are required: one “systolic blood pressure” code from SNOMED, and a “systolic blood pressure” code from SNOMED
- ² To identify the denominator in this CQM, the following standard codes are required: an “individual characteristic” code from HL7, a “hypertension” diagnosis code from ICD-9, ICD-10, or SNOMED, and an “outpatient encounter” code from CPT.
- ³ To identify the exclusions or exceptions in this CQM, the following standard codes are required: an “ESRD procedure” code from CPT or HCPCS, “pregnancy” diagnosis code from ICD-9, ICD-10, or SNOMED, or an “ESRD” diagnosis code from ICD-9, ICD-10, 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)

Abbreviation	Long Name	Definition/Description
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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