

NQF 0027: Smoking and Tobacco Use Cessation, Medical Assistance:

**a. Advising Smokers and Tobacco Users to Quit;
b. Discussing Smoking and Tobacco Use Cessation Medications; c. Discussing Smoking and Tobacco Use Cessation Strategies**

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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Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

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"> Preventive Care and Screening Measure Pair (NQF 0028)
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
Data required to identify the <u>exceptions</u> or <u>exclusions</u>	<ul style="list-style-type: none"> None
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Patient characteristic: tobacco user² Tobacco use cessation counseling²

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

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

¹ This data element(s) must be documented no more than 2 years before the measurement end date and no later than the measurement end date.

² This data element(s) must be documented no more than 1 year before the measurement end date and no later than the measurement end date.

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
2. 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, one outpatient encounter is required. 	<ul style="list-style-type: none"> Date of visit Code for outpatient encounter³ 	
3. Ascertain whether the patient was a tobacco user last year or is one this year.	<ul style="list-style-type: none"> Ensures only patients identified as tobacco users are counted in numerator 1 and numerator 2 	<ul style="list-style-type: none"> Document tobacco use as appropriate⁴ 	
4. If patient is a tobacco user, provide smoking cessation counseling	<ul style="list-style-type: none"> Ensures only patients with documentation of tobacco cessation counseling are counted in numerator 2 	<ul style="list-style-type: none"> Document tobacco cessation counseling⁵ 	

³ See Technical Supplement for denominator inclusion details (encounter types): [pp. TS-2](#)

⁴ See Technical Supplement for numerator 1 inclusion details (patient characteristic: tobacco user): [pp. TS-2](#)

⁵ See Technical Supplement for numerator 2 inclusion criteria (tobacco cessation counseling): [pp. TS-3](#)

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 an outpatient encounter? (CPT codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history; an evaluation; and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history; an examination, and medical decision making.
- Observation care discharge day management
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history; an examination; and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history; an examination; and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history; an examination; and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history; an examination; and medical decision making
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient,
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient.
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure).
- Preventive medicine counseling and/or risk factor reduction intervention(s) providers to individuals in a group setting (separate procedure).
- Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by physician or someone 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.

What constitutes an outpatient encounter? (CPT codes)

- | | |
|--|-------|
| • General medical examination: routine general medical examination at a health care facility ; Health checkup | V70.0 |
| • General medical examination: other medical examination for administrative purposes | V70.3 |
| • General medical examination: health examination of defined subpopulations | V70.5 |
| • General medical examination: health examination in population surveys | V70.6 |
| • General medical examination: other specified general medical examinations; examination of potential donor of organ or tissue | V70.8 |
| • General medical examination: unspecified general medical examination | V70.9 |

NUMERATOR 1 INCLUSION CRITERIA

What constitutes a tobacco user? (SNOMED-CT codes)

- Light cigarette smoker (1-9 cigs/day) (finding)
- Moderate cigarette smoker (10-19 cigs/day) (finding)
- Heavy cigarette smoker (20-39 cigs/day) (finding)

What constitutes a tobacco user? (SNOMED-CT codes)

- Very heavy cigarette smoker (40+ cigs/day) (finding)
- Rolls own cigarettes (finding)
- Snuff user (finding)
- User of moist powdered tobacco (finding)
- Chews plug tobacco (finding)
- Chews twist tobacco (finding)
- Chews loose leaf tobacco (finding)
- Chews fine cut tobacco (finding)
- Chews products containing tobacco (finding)
- Occasional cigarette smoker (finding)
- Light cigarette smoker (finding)
- Moderate cigarette smoker (finding)
- Heavy cigarette smoker (finding)
- Very heavy cigarette smoker (finding)
- Chain smoker (finding)
- Occasional cigarette smoker (less than one cigarette/day) (finding)
- Chews tobacco (finding)

NUMERATOR 2 INCLUSION CRITERIA

What constitutes smoking cessation counseling? (SNOMED-CT codes)

- Pregnancy smoking education (procedure)
- Smoking cessation education (procedure)
- Smoking effects education (procedure)
- Referral to stop-smoking clinic (procedure)
- Smoking cessation assistance (regime/therapy)
- Referral to smoking cessation advisor (procedure)
- Pregnancy smoking education (procedure)

What constitutes smoking cessation counseling? (CPT codes)

- Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

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

NQF0027	CPT	CPT Modifier	CVX	Grouping	HCPSCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x										x
Denominator ²	x			x		x	x				
Exceptions or exclusions											

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerators, the following standard codes are required: a "physical exam" SNOMED code, AND an "encounter" CPT code and a "communication" SNOMED code if applicable.
- ² To identify the denominator in this CQM, the following standard codes are required: an "individual characteristic" code from HL7, AND an "encounter" code from CPT, ICD-9 or GROUPING.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)

Abbreviation	Long Name	Definition/Description
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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