

NQF 0033: Chlamydia Screening for Women

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, 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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The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Also report for women 15-19 years of age, and 20-24 years of age)

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Menu set 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"> Age Gender Outpatient encounter code Documentation that patient is sexually active
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> Pregnancy test Retinoid medication active, ordered, or dispensed¹ X-ray study performed¹
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Documentation of chlamydia screening

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 and gender	<ul style="list-style-type: none"> Ensures only patients who are 15-24 years of age during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Date of birth Gender is female 	
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 code² 	
3. Check patient record or assess patient for indication of sexual activity	<ul style="list-style-type: none"> Ensures patients who are sexually active are captured in the denominator 	<ul style="list-style-type: none"> Document any applicable procedures indicative of sexual activity³ 	

¹ This data element(s) must be ≤7 days after a pregnancy test

² See Technical Supplement for denominator inclusion criteria (encounter): pp. TS-2

³ See Technical Supplement for denominator inclusion criteria (sexual activity): pp. TS-2

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
4. Check patient record or ask patient if a pregnancy test has been performed	<ul style="list-style-type: none"> Ensures all patients who have had a pregnancy test are captured as exclusions or exceptions 	<ul style="list-style-type: none"> Document date test performed or pregnancy test⁴ result if applicable 	
5. Check patient record or ask patient if they received retinoid medication or an x-ray within 7 days of the pregnancy test, if applicable	<ul style="list-style-type: none"> Ensures all patients who had retinoid medication or an x-ray are captured as exclusions or exceptions 	<ul style="list-style-type: none"> Document retinoid medication⁵, if applicable Document x-ray test⁶, if applicable 	
6. Check patient record for chlamydia test, or perform one if appropriate	<ul style="list-style-type: none"> Ensures all patients who are screened for chlamydia are captured in the numerator 	<ul style="list-style-type: none"> Document date of chlamydia test⁷ 	

⁴ See Technical Supplement for exclusion/exception criteria (pregnancy test): [pp. TS-8](#)

⁵ See Technical Supplement for exclusion/exception criteria (retinoid medication): [pp. TS-8](#)

⁶ See Technical Supplement for exclusion/exception criteria (x-ray test): [pp. TS-8](#)

⁷ See Technical Supplement for numerator inclusion criteria (chlamydia screening): [pp. TS-18](#)

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.
- 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 or periodic 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 or established patient
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual
- Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by treating physician or other than the treating physician that includes: completion of a medical history, performance of an examination, formulation of a diagnosis, assessment of capabilities and stability, calculation of impairment, development of future medical treatment plan, and completion of necessary documentation/certificates and report.

What counts as an encounter? (ICD-9 codes)

- Encounter for assisted reproductive fertility procedure cycle
- Encounter for antenatal screening of mother
- Encounter for routine screening or malformation using ultrasonics
- Encounter for fetal amniotic survey
- Encounter for screening of risk of pre-term labor
- Pregnancy examination or test
- Pregnancy examination or test, pregnancy unconfirmed
- Pregnancy examination or test, negative result
- Pregnancy examination or result, positive result

What indicates sexual activity? (CPT codes)

- Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)
- Syphilis test, non-treponemal antibody; quantitative
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection

What indicates sexual activity? (CPT codes)

- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification
- Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification
- Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
- Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
- Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis
- Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
- Urine pregnancy test, by visual color comparison methods
- Gonadotropin, chorionic (hCG); quantitative
- Gonadotropin, chorionic (hCG); qualitative
- Insertion, implantable contraceptive capsules
- Removal, implantable contraceptive capsules
- Removal with reinsertion, implantable contraceptive capsules
- Incision and drainage of vaginal hematoma; obstetrical/postpartum
- Diaphragm or cervical cap fitting with instructions
- Insertion of intrauterine device (IUD)
- Removal of intrauterine device (IUD)
- Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
- Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
- Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
- Follicle puncture for oocyte retrieval, any method
- Embryo transfer, intrauterine
- Gamete, zygote, or embryo intrafallopian transfer, any method
- Amniocentesis; diagnostic
- Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
- Cordocentesis (intrauterine), any method
- Chorionic villus sampling, any method
- Fetal contraction stress test
- Fetal non-stress test
- Fetal scalp blood sampling
- Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; supervision and interpretation
- Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; interpretation only
- Transabdominal amnioinfusion, including ultrasound guidance
- Fetal umbilical cord occlusion, including ultrasound guidance

What indicates sexual activity? (CPT codes)

- Fetal fluid drainage (e.g., vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
- Fetal shunt placement, including ultrasound guidance
- Hysterectomy, abdominal (e.g., for hydatidiform mole, abortion)
- Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
- Surgical treatment of ectopic pregnancy; tubal or ovarian, without salpingectomy and/or oophorectomy
- Surgical treatment of ectopic pregnancy; abdominal pregnancy
- Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy
- Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy with partial resection of uterus
- Surgical treatment of ectopic pregnancy; cervical, with evacuation
- Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
- Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oophorectomy
- Curettage, postpartum
- Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)
- Episiotomy or vaginal repair, by other than attending physician
- Cerclage of cervix, during pregnancy; vaginal
- Cerclage of cervix, during pregnancy; abdominal
- Hysterorrhaphy of ruptured uterus
- 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
- External cephalic version, with or without tocolysis
- Delivery of placenta (separate procedure)
- Antepartum care only; 4-6 visits
- Antepartum care only; 7 or more visits
- Postpartum care only (separate procedure)
- Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- Cesarean delivery only;
- Cesarean delivery only; including postpartum care
- Subtotal or total hysterectomy after cesarean delivery
- 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
- Treatment of incomplete abortion, any trimester, completed surgically
- Treatment of missed abortion, completed surgically; first trimester
- Treatment of missed abortion, completed surgically; second trimester

What indicates sexual activity? (CPT codes)

- Treatment of septic abortion, completed surgically
- Induced abortion, by dilation and curettage
- Induced abortion, by dilation and evacuation
- Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
- Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
- Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterectomy (failed intra-amniotic injection)
- Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
- Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
- Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterectomy (failed medical evacuation)
- Multifetal pregnancy reduction(s) (MPR)
- Uterine evacuation and curettage for hydatidiform mole
- Removal of cerclage suture under anesthesia (other than local)
- Unlisted fetal invasive procedure, including ultrasound guidance, when performed
- Unlisted laparoscopy procedure, maternity care and delivery
- Unlisted procedure, maternity care and delivery
- Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation)
- Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach, single or first gestation
- Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach, single or first gestation
- Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
- Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
- Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
- Ultrasound, pregnant uterus, real time with image documentation, transvaginal
- Fetal biophysical profile; with non-stress testing
- Fetal biophysical profile; without non-stress testing
- Doppler velocimetry, fetal; umbilical artery
- Doppler velocimetry, fetal; middle cerebral artery
- Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
- Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up assessment
- Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
- Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study

What indicates sexual activity? (CPT codes)

- Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation
- Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation
- Ultrasonic guidance for amniocentesis, imaging supervision and interpretation
- Obstetric panel
- Urine pregnancy test, by visual color comparison methods
- Alpha-fetoprotein (AFP); serum
- Alpha-fetoprotein (AFP); amniotic fluid
- Amniotic fluid scan (spectrophotometric)
- Fetal fibronectin, cervicovaginal secretions, semi-quantitative
- Lactogen, human placental (HPL) human chorionic somatomammotropin
- Fetal lung maturity assessment; lecithin sphingomyelin (L/S) ratio
- Fetal lung maturity assessment; foam stability test
- Fetal lung maturity assessment; fluorescence polarization
- Fetal lung maturity assessment; lamellar body density
- Pregnancy-associated plasma protein-A (PAPP-A)
- Gonadotropin, chorionic (hCG); quantitative
- Gonadotropin, chorionic (hCG); qualitative
(For urine pregnancy test by visual color comparison, use 81025)
- Gonadotropin, chorionic (hCG); free beta chain
- Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
- Syphilis test, non-treponemal antibody; quantitative
- Antibody; Chlamydia
- Antibody; Chlamydia, IgM
- Culture, chlamydia, any source
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
- Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multi-step method; adenovirus enteric types 40/41
- Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
- Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification
- Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, quantification
- Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
- Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
- Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis
- Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis
- Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
- Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician

What indicates sexual activity? (CPT codes)

- Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
- Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreeing under physician supervision
- Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
- Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreeing under physician supervision
- Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreeing under physician supervision
- Cytopathology, slides, cervical or vaginal; with manual screening and rescreeing under physician supervision
- Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreeing using cell selection and review under physician supervision
- Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)
- Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
- Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreeing under physician supervision
- Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreeing under physician supervision
- Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreeing using cell selection and review under physician supervision
- Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
- Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreeing or review, under physician supervision
- Tissue culture for neoplastic disorders; amniotic fluid or chorionic villus cells
- Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
- Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding

What indicates sexual activity? (SNOMED CT codes)

- Condom use education (procedure)
- Contraception education (procedure)
- Diaphragm use education (procedure)
- Contraceptive use education (procedure)
- Intrauterine contraceptive device fitted (finding)
- Intrauterine contraceptive device re-fitted (finding)
- Contraceptive IUD checked - no problems (finding)
- Contraceptive IUD checked - problems (finding)
- Contraceptive IUD - defaulted from check (finding)
- Contraceptive IUD fitting awaited (finding)
- Contraceptive IUD removal awaited (finding)
- Contraceptive IUD change due (finding)
- Contraceptive IUD check due (finding)
- Contraceptive IUD expelled (finding)
- Contraceptive IUD failure - pregnant (finding)
- Contraceptive IUD partially expelled (finding)
- Contraceptive IUD threads lost (finding)
- Contraceptive IUD check (finding)

What indicates sexual activity? (SNOMED CT codes)

- Sexually active (finding)
- Sexually transmitted infectious disease (disorder)

EXCLUSION OR EXCEPTION CRITERIA

What counts as a pregnancy test? (CPT codes)

- Urine pregnancy test, by visual color comparison methods
- Gonadotropin, chorionic (hCG); quantitative
- Gonadotropin, chorionic (hCG); qualitative

What counts as retinoid medication? (RxNorm codes)

- Isotretinoin

What counts as an x-ray? (CPT codes)

- Myelography, posterior fossa, radiological supervision and interpretation
- Cisternography, positive contrast, radiological supervision and interpretation
- Radiologic examination, eye, for detection of foreign body
- Radiologic examination, mandible; partial, less than 4 views
- Radiologic examination, mandible; complete, minimum of 4 views
- Radiologic examination, mastoids; less than 3 views per side
- Radiologic examination, mastoids; complete, minimum of 3 views per side
- Radiologic examination, internal auditory meati, complete
- Radiologic examination, facial bones; less than 3 views
- Radiologic examination, facial bones; complete, minimum of 3 views
- Radiologic examination, nasal bones, complete, minimum of 3 views
- Dacryocystography, nasolacrimal duct, radiological supervision and interpretation
- Radiologic examination; optic foramina
- Radiologic examination; orbits, complete, minimum of 4 views
- Radiologic examination, sinuses, paranasal, less than 3 views
- Radiologic examination, sinuses, paranasal, complete, minimum of 3 views
- Radiologic examination, sella turcica
- Radiologic examination, skull; less than 4 views
- Radiologic examination, skull; complete, minimum of 4 views
- Radiologic examination, teeth; single view
- Radiologic examination, teeth; partial examination, less than full mouth
- Radiologic examination, teeth; complete, full mouth
- Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
- Radiologic examination, temporomandibular joint, open and closed mouth; bilateral
- Temporomandibular joint arthrography, radiological supervision and interpretation
- Magnetic resonance (e.g., proton) imaging, temporomandibular joint(s)
- Cephalogram, orthodontic
- Orthopantomogram
- Radiologic examination; neck, soft tissue
- Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique

What counts as an x-ray? (CPT codes)

- Complex dynamic pharyngeal and speech evaluation by cine or video recording
- Laryngography, contrast, radiological supervision and interpretation
- Radiologic examination, salivary gland for calculus
- Sialography, radiological supervision and interpretation
- Computed tomography, head or brain; without contrast material
- Computed tomography, head or brain; with contrast material(s)
- Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
- Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
- Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
- Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
- Computed tomography, maxillofacial area; without contrast material
- Computed tomography, maxillofacial area; with contrast material(s)
- Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
- Computed tomography, soft tissue neck; without contrast material
- Computed tomography, soft tissue neck; with contrast material(s)
- Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
- Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; without contrast material(s)
(For head or neck magnetic resonance angiography studies, see 70544-70546, 70547-70549)
- Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences
(Report 70540-70543 once per imaging session)
- Magnetic resonance angiography, head; without contrast material(s)
- Magnetic resonance angiography, head; with contrast material(s)
- Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance angiography, neck; without contrast material(s)
- Magnetic resonance angiography, neck; with contrast material(s)
- Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material
- Magnetic resonance (e.g., proton) imaging, brain (including brain stem); with contrast material
- Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
- Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration
- Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing
- Magnetic resonance (e.g., proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (e.g., to assess for residual tumor or residual vascular malformation); without contrast material
- Magnetic resonance (e.g., proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (e.g., to assess for residual tumor or residual vascular malformation); with contrast material(s)

What counts as an x-ray? (CPT codes)

- Magnetic resonance (e.g., proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (e.g., to assess for residual tumor or residual vascular malformation); without contrast material(s), followed by contrast material(s) and further sequences
- Radiologic examination, chest; single view, frontal
- Radiologic examination, chest; stereo, frontal
- Radiologic examination, chest, 2 views, frontal and lateral;
- Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure
- Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections
- Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy
- Radiologic examination, chest, complete, minimum of 4 views
- Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy
- Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)
- Bronchography, unilateral, radiological supervision and interpretation
- Bronchography, bilateral, radiological supervision and interpretation
- Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation
- Radiologic examination, ribs, unilateral; 2 views
- Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views
- Radiological examination, ribs, bilateral; 3 views
- Radiological examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views
- Radiologic examination; sternum, minimum of 2 views
- Radiologic examination; sternoclavicular joint or joints, minimum of 3 views
- Computed tomography, thorax; without contrast material
- Computed tomography, thorax; with contrast material(s)
- Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections
- Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)
- Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, chest (e.g., for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
- Radiologic examination, spine, entire, survey study, anteroposterior and lateral
- Radiologic examination, spine, single view, specify level
- Radiologic examination, spine, cervical; 2 or 3 views
- Radiologic examination, spine, cervical; minimum of 4 views
- Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
- Radiologic examination, spine, thoracolumbar, standing (scoliosis)
- Radiologic examination, spine; thoracic, 2 views
- Radiologic examination, spine; thoracic, 3 views
- Radiologic examination, spine; thoracic, minimum of 4 views
- Radiologic examination, spine; thoracolumbar, 2 views
- Radiologic examination, spine; scoliosis study, including supine and erect studies
- Radiologic examination, spine, lumbosacral; 2 or 3 views

What counts as an x-ray? (CPT codes)

- Radiologic examination, spine, lumbosacral; minimum of 4 views
- Radiologic examination, spine, lumbosacral; complete, including bending views
- Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views
- Computed tomography, cervical spine; without contrast material
- Computed tomography, cervical spine; with contrast material
- Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
- Computed tomography, thoracic spine; without contrast material
- Computed tomography, thoracic spine; with contrast material
- Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
- Computed tomography, lumbar spine; without contrast material
- Computed tomography, lumbar spine; with contrast material(s)
- Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, thoracic; without contrast material
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
- Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
- Magnetic resonance angiography, spinal canal, and contents, with or without contrast material(s)
- Radiologic examination, pelvis; 1 or 2 views
- Radiologic examination, pelvis; complete, minimum of 3 views
- Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Computed tomography, pelvis; without contrast material
- Computed tomography, pelvis; with contrast material(s)
- Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
- Magnetic resonance (e.g., proton) imaging, pelvis; without contrast material(s)
- Magnetic resonance (e.g., proton) imaging, pelvis; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance angiography, pelvis, with or without contrast material(s)
- Radiologic examination, sacroiliac joints; less than 3 views
- Radiologic examination, sacroiliac joints; 3 or more views
- Radiologic examination, sacrum and coccyx, minimum of 2 views
- Myelography, cervical, radiological supervision and interpretation
- Myelography, thoracic, radiological supervision and interpretation
- Myelography, lumbosacral, radiological supervision and interpretation
- Myelography, 2 or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation

What counts as an x-ray? (CPT codes)

- Epidurography, radiological supervision and interpretation
- Discography, cervical or thoracic, radiological supervision and interpretation
- Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance
- Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance
- Discography, lumbar, radiological supervision and interpretation
- Radiological examination; clavicle, complete
- Radiological examination; scapula, complete
- Radiologic examination, shoulder; 1 view
- Radiologic examination, shoulder; complete, minimum of 2 views
- Radiologic examination, shoulder, arthrography, radiological supervision and interpretation
- Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction
- Radiologic examination; humerus, minimum of 2 views
- Radiologic examination, elbow; 2 views
- Radiologic examination, elbow; complete, minimum of 3 views
- Radiologic examination, elbow, arthrography, radiological supervision and interpretation
- Radiologic examination; forearm, 2 views
- Radiologic examination; upper extremity, infant, minimum of 2 views
- Radiologic examination, wrist; 2 views
- Radiologic examination, wrist; complete, minimum of 3 views
- Radiologic examination, wrist, arthrography, radiological supervision and interpretation
- Radiologic examination, hand; 2 views
- Radiologic examination, hand; minimum of 3 views
- Radiologic examination, finger(s), minimum of 2 views
- Computed tomography, upper extremity; without contrast material
- Computed tomography, upper extremity; with contrast material(s)
- Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections
- Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; without contrast material(s)
- Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s)
- Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance angiography, upper extremity, with or without contrast material(s)
- Radiologic examination, hip, unilateral; 1 view
- Radiologic examination, hip, unilateral; complete, minimum of 2 views
- Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis
- Radiologic examination, hip, arthrography, radiological supervision and interpretation
- Radiologic examination, hip, during operative procedure
- Radiologic examination, pelvis and hips, infant or child, minimum of 2 views

What counts as an x-ray? (CPT codes)

- Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation
- Radiologic examination, femur, 2 views
- Radiologic examination, knee; 1 or 2 views
- Radiologic examination, knee; 3 views
- Radiologic examination, knee; complete, 4 or more views
- Radiologic examination, knee; both knees, standing, anteroposterior
- Radiologic examination, knee, arthrography, radiological supervision and interpretation
- Radiologic examination; tibia and fibula, 2 views
- Radiologic examination; lower extremity, infant, minimum of 2 views
- Radiologic examination, ankle; 2 views
- Radiologic examination, ankle; complete, minimum of 2 views
- Radiologic examination, ankle, arthrography, radiological supervision and interpretation
- Radiologic examination, foot; 2 views
- Radiologic examination, foot; complete, minimum of 3 views
- Radiologic examination; calcaneus, minimum of 2 views
- Radiologic examination; toe(s), minimum of 2 views
- Computed tomography, lower extremity; without contrast material
- Computed tomography, lower extremity; with contrast material(s)
- Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections
- Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image post processing
- Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; without contrast material(s)
- Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
- Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences
- Magnetic resonance angiography, lower extremity, with or without contrast material(s)
- Radiologic examination, abdomen; single anteroposterior view
- Radiologic examination, abdomen; anteroposterior and additional oblique and cone views
- Radiologic examination, abdomen; complete, including decubitus and/or erect views
- Radiologic examination, abdomen; complete, acute abdomen series, including supine, erect, and/or decubitus views, single view chest
- Computed tomography, abdomen; without contrast material
- Computed tomography, abdomen; with contrast material
- Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
- Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material(s)
- Magnetic resonance (e.g., proton) imaging, abdomen; with contrast material(s)
- Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences
- Magnetic resonance angiography, abdomen, with or without contrast material(s)

What counts as an x-ray? (CPT codes)

- Peritoneogram (e.g., after injection of air or contrast), radiological supervision and interpretation
- Radiologic examination; pharynx and/or cervical esophagus
- Radiologic examination; esophagus
- Swallowing function, with cineradiography/videoradiography
- Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation
- Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB
- Radiologic examination, gastrointestinal tract, upper; with or without delayed films, with KUB
- Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial films
- Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB
- Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with KUB
- Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through
- Radiologic examination, small intestine, includes multiple serial films;
- Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube
- Duodenography, hypotonic
- Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB
- Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon
- Therapeutic enema, contrast or air, for reduction of intussusception or other intraluminal obstruction (e.g., meconium ileus)
- Cholecystography, oral contrast;
- Cholecystography, oral contrast; additional or repeat examination or multiple day examination
- Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation
- Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation
- Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation
- Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation
- Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation
- Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation
- Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation
- Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation
- Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation
- Percutaneous placement of enteroclysis tube, radiological supervision and interpretation
- Intraluminal dilation of strictures and/or obstructions (e.g., esophagus), radiological supervision and interpretation
- Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation
- Urography (pyelography, intravenous, with or without KUB, with or without tomography)
- Urography, infusion, drip technique and/or bolus technique;
- Urography, infusion, drip technique and/or bolus technique; with nephrotomography
- Urography, retrograde, with or without KUB
- Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation
- Cystography, minimum of 3 views, radiological supervision and interpretation
- Vasography, vesiculography, or epididymography, radiological supervision and interpretation
- Corpora cavernosography, radiological supervision and interpretation

What counts as an x-ray? (CPT codes)

- Urethrocystography, retrograde, radiological supervision and interpretation
- Urethrocystography, voiding, radiological supervision and interpretation
- Radiologic examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation
- Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation
- Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation
- Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation
- Pelvimetry, with or without placental localization
- Hysterosalpingography, radiological supervision and interpretation
- Transcervical catheterization of fallopian tube, radiological supervision and interpretation
- Perineogram (e.g., vaginogram, for sex determination or extent of anomalies)
- Cardiac magnetic resonance imaging for morphology and function without contrast material;
- Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging
- Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;
- Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
- Aortography, thoracic, without serialography, radiological supervision and interpretation
- Aortography, thoracic, by serialography, radiological supervision and interpretation
- Aortography, abdominal, by serialography, radiological supervision and interpretation
- Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation
- Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation
- Angiography, brachial, retrograde, radiological supervision and interpretation
- Angiography, external carotid, unilateral, selective, radiological supervision and interpretation
- Angiography, external carotid, bilateral, selective, radiological supervision and interpretation
- Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation
- Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation
- Angiography, carotid, cervical, unilateral, radiological supervision and interpretation
- Angiography, carotid, cervical, bilateral, radiological supervision and interpretation
- Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation
- Angiography, spinal, selective, radiological supervision and interpretation
- Angiography, extremity, unilateral, radiological supervision and interpretation
- Angiography, extremity, bilateral, radiological supervision and interpretation
- Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation
- Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation
- Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation
- Angiography, adrenal, unilateral, selective, radiological supervision and interpretation
- Angiography, adrenal, bilateral, selective, radiological supervision and interpretation
- Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation
- Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation
- Angiography, pulmonary, bilateral selective, radiological supervision and interpretation

What counts as an x-ray? (CPT codes)

- Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation
- Angiography, internal mammary, radiological supervision and interpretation
- Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)
- Lymphangiography, extremity only, unilateral, radiological supervision and interpretation
- Lymphangiography, extremity only, bilateral, radiological supervision and interpretation
- Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation
- Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation
- Shuntogram for investigation of previously placed indwelling nonvascular shunt (e.g., LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation
- Splenoportography, radiological supervision and interpretation
- Venography, extremity, unilateral, radiological supervision and interpretation
- Venography, extremity, bilateral, radiological supervision and interpretation
- Venography, caval, inferior, with serialography, radiological supervision and interpretation
- Venography, caval, superior, with serialography, radiological supervision and interpretation
- Venography, renal, unilateral, selective, radiological supervision and interpretation
- Venography, renal, bilateral, selective, radiological supervision and interpretation
- Venography, adrenal, unilateral, selective, radiological supervision and interpretation
- Venography, adrenal, bilateral, selective, radiological supervision and interpretation
- Venography, venous sinus (e.g., petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation
- Venography, superior sagittal sinus, radiological supervision and interpretation
- Venography, epidural, radiological supervision and interpretation
- Venography, orbital, radiological supervision and interpretation
- Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation
- Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation
- Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation
- Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation
- Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
- Transcatheter therapy, embolization, any method, radiological supervision and interpretation
- Transcatheter therapy, infusion, any method (e.g., thrombolysis other than coronary), radiological supervision and interpretation
- Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion
- Exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation
- Mechanical removal of pericatheter obstructive material (e.g., fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation
- Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation
- Percutaneous placement of IVC filter, radiological supervision and interpretation
- Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel
- Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)
- Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation
- Placement of proximal or distal extension prosthesis for endovascular repair of intrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation

What counts as an x-ray? (CPT codes)

- Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, radiological supervision and interpretation
- Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation
- Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation
- Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation
- Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation
- Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel
- Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation
- Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation
- Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)
- Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation
- Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation
- Transcatheter biopsy, radiological supervision and interpretation
- Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation
- Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation
- Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation
- Change of percutaneous tube or drainage catheter with contrast monitoring (e.g., genitourinary system, abscess), radiological supervision and interpretation
- Radiological guidance (i.e., fluoroscopy, ultrasound, or computed tomography, for percutaneous drainage (e.g., abscess, specimen collection), with placement of catheter, radiological supervision and interpretation
- Transluminal atherectomy, peripheral artery, radiological supervision and interpretation
- Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation
- Transluminal atherectomy, renal, radiological supervision and interpretation
- Transluminal atherectomy, visceral, radiological supervision and interpretation
- Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation
- Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)
- Fluoroscopy, physician time more than 1 hour, assisting a nonradiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)
- Radiologic examination from nose to rectum for foreign body, single view, child
- Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation
- Radiological examination, surgical specimen
- Radiologic examination, single plan body section (e.g., tomography), other than with urography
- Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than with urography; unilateral
- Radiologic examination, complex motion (i.e., hypercycloidal) body section (e.g., mastoid polytomography), other than with urography; bilateral
- Cineradiography/videoradiography, except where specifically included

What counts as an x-ray? (CPT codes)

- Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)
- Consultation on X-ray examination made elsewhere, written report
- Xeroradiography
- 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation
- 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation
- Computed tomography, limited or localized follow-up study
- Magnetic resonance spectroscopy
- Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)
- Unlisted computed tomography procedure (e.g., diagnostic, interventional)
- Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
- Unlisted diagnostic radiographic procedure

What counts as an x-ray? (SNOMED CT codes)

- Plain chest X-ray (procedure)
- X-ray of chest and abdomen (procedure)
- Plain x-ray of joint (procedure)
- X-ray of bone (procedure)
- Radiographic imaging of acetabulum (procedure)
- X-ray of hand and wrist for bone age (procedure)
- X-ray of carpometacarpal joint under stress (procedure)
- X-ray of zygoma (procedure)
- X-ray skeletal survey for multiple myeloma (procedure)
- X-ray of pelvis using mobile image intensifier (procedure)
- X-ray of cervical spine using mobile image intensifier (procedure)
- X-ray of upper limb using mobile image intensifier (procedure)
- X-ray of lumbar spine using mobile image intensifier (procedure)
- X-ray of lumbar spine and pelvis (procedure)
- X-ray of sacrum using mobile image intensifier (procedure)
- X-ray of thorax using mobile image intensifier (procedure)
- X-ray of thoracic spine using mobile image intensifier (procedure)
- X-ray of abdomen using mobile image intensifier (procedure)
- X-ray of hip using mobile image intensifier (procedure)
- X-ray of lower limb using mobile image intensifier (procedure)
- X-ray of hip using mobile image intensifier (procedure)
- X-ray of lower limb using mobile image intensifier (procedure)
- X-ray cystometrogram (procedure)
- X-ray of skull using mobile image intensifier (procedure)
- X-ray of teeth in oblique lateral view (procedure)
- X-ray of midfoot (procedure)

NUMERATOR INCLUSION CRITERIA

What counts as a chlamydia screening? (CPT codes)

- Chlamydia

What counts as a chlamydia screening? (CPT codes)

- Chlamydia, IgM
- Culture, chlamydia, any source
- Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
- Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multi-step method; adenovirus enteric types 40/41
- Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
- Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
- Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis

What counts as chlamydia screening? (SNOMED CT codes)

- Chlamydia antibody assay (procedure)
- Chlamydia IgM antibody assay (procedure)
- Chlamydia trachomatis G, F, AND K antibody assay (procedure)
- Antibody identification (procedure)
- Chlamydia pneumoniae antibody assay (procedure)
- Chlamydia pneumoniae antigen assay (procedure)
- Chlamydia psittaci antibody assay (procedure)
- Chlamydia species antigen assay (procedure)
- Chlamydia trachomatis antibody assay (procedure)
- Chlamydia trachomatis B antibody assay (procedure)
- Chlamydia trachomatis C antibody assay (procedure)
- Chlamydia psittaci antigen assay (procedure)
- Chlamydia trachomatis antigen assay (procedure)
- Chlamydia trachomatis culture (procedure)
- Chlamydia trachomatis rRNA assay (procedure)
- Chlamydia psittaci IgG level (procedure)
- Chlamydia psittaci IgM level (procedure)
- Chlamydia trachomatis IgM level (procedure)

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

NQF0033	CPT	CPT Modifier	CVX	Grouping	HPCPS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x			x					x		x
Denominator ²	x			x	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: (1) a "laboratory" code for Chlamydia screening from Grouping, CPT, LOINC, or SNOMED.

- ² To identify the denominator in this CQM, the following standard codes are required: : (1) an "individual characteristic" code from HL7, AND (2) an "encounter" code from Grouping, CPT, or ICD-9, AND (3) an "encounter" code for pregnancy from ICD-9, a "procedure" code from CPT, HCPCS, or ICD-9, a "laboratory" code from CPT, Grouping, or LOINC, a "device" code from SNOMED, a "communication" code from SNOMED, a "medication" code from RxNorm, or a "diagnosis" code from ICD-9, ICD-10, Grouping, or SNOMED
- ³ To identify the exclusions or exceptions in this CQM, the following standard codes are required: a "laboratory" code from CPT, or LOINC, a "medication" code from RxNorm, or a "diagnostic study" code from CPT or SNOMED.

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

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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