

# NQF 0034: Colorectal Cancer Screening

## 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.

## TABLE OF CONTENTS

NQF 0034: Colorectal Cancer Screening .....	4
Technical Supplement.....	TS-1
Denominator Inclusion Criteria .....	TS-2
Exclusion or Exception Criteria.....	TS-2
Numerator Inclusion Criteria.....	TS-4
Types of codes required from your EHR for calculating this clinical quality measure .....	TS-7

## NQF 0034: Colorectal Cancer Screening

The percentage of men 50-75 years of age who had appropriate screening for colorectal cancer.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> <li>Menu set measure</li> </ul>
Related to other measures?	<ul style="list-style-type: none"> <li>Not related to other Stage 1 MU clinical quality measures</li> </ul>
Data required to identify the <b>denominator</b> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> <li>Age</li> <li>Outpatient encounter code<sup>1</sup></li> </ul>
Data required to identify the <b>exceptions or exclusions</b>	<ul style="list-style-type: none"> <li>Procedure code for total colectomy<sup>2</sup></li> <li>Diagnosis of colorectal cancer</li> </ul>
Data required to identify the <b>numerator</b> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> <li>Documentation of colonoscopy<sup>3</sup>, sigmoidoscopy<sup>4</sup>, or fecal occult blood testing<sup>5</sup></li> </ul>

**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. <b>Confirm the patient's date of birth</b>	<ul style="list-style-type: none"> <li>Ensures only patients who are 50-75 years of age during the measurement period are included in the <b>denominator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Date of birth</li> </ul>	
2. <b>Record the type and date of visit</b>	<ul style="list-style-type: none"> <li>Ensures only appropriate visits are captured in the <b>denominator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Date of visit</li> <li>Encounter code<sup>6</sup></li> </ul>	
3. <b>Check patient record for a total colectomy or diagnosis of colorectal cancer (active, inactive, or resolved)</b>	<ul style="list-style-type: none"> <li>Ensures patients who have had a total colectomy or colorectal cancer are captured as <b>exceptions or exclusions</b>.</li> </ul>	<ul style="list-style-type: none"> <li>Total colectomy code<sup>7</sup> if applicable</li> <li>Colorectal cancer<sup>8</sup> diagnosis code, if applicable</li> </ul>	

<sup>1</sup> This data element(s) must be documented  $\leq 2$  years before or simultaneous to the measurement end date

<sup>2</sup> This data element(s) must be documented before or simultaneously to the measurement period

<sup>3</sup> This data element(s) must be documented  $\leq 10$  years before or simultaneous to the measurement end date

<sup>4</sup> This data element(s) must be documented  $\leq 5$  years before or simultaneous to the measurement end date

<sup>5</sup> This data element(s) must be documented before or simultaneous to the measurement end date

<sup>6</sup> See Technical Supplement for denominator inclusion criteria (encounter): pp. TS-2

<sup>7</sup> See Technical Supplement for exception of exclusion criteria (colectomy): pp. TS-4

<sup>8</sup> See Technical Supplement for exception of exclusion criteria (colorectal cancer): pp. TS-2

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
4. <b>Check patient record for a colonoscopy, flexible sigmoidoscopy, or fecal occult blood test. Schedule as screening test is appropriate</b>	<ul style="list-style-type: none"> <li>• Ensure all patients who have had a screening test are captured in the <b>numerator</b>.</li> </ul>	<ul style="list-style-type: none"> <li>• Date of colonoscopy<sup>9</sup>, sigmoidoscopy<sup>10</sup>, or fecal blood test<sup>11</sup></li> <li>• Applicable code for colonoscopy, sigmoidoscopy, or fecal blood test</li> </ul>	

<sup>9</sup> See Technical Supplement for numerator inclusion criteria (colonoscopy): [pp. TS-4](#)

<sup>10</sup> See Technical Supplement for numerator inclusion criteria (flexible sigmoidoscopy): [pp. TS-5](#)

<sup>11</sup> See Technical Supplement for numerator inclusion criteria (fecal occult blood test): [pp. TS-6](#)

## 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)

- Routine general medical examination at a health care facility
- Other medical examination for administrative purposes
- Health examination of defined subpopulations
- Health examination in population surveys
- Other specified general medical examinations
- Unspecified general medical examination

## EXCLUSION OR EXCEPTION CRITERIA

### What counts as a colorectal cancer? (SNOMED CT codes)

- Overlapping malignant neoplasm of colon (disorder)
- Neoplasm of colon (disorder)
- Malignant neoplasm, overlapping lesion of colon (disorder)
- Malignant neoplasm of other specified sites of colon (disorder)
- Carcinoma of colon (disorder)
- Carcinoma of the rectosigmoid junction (disorder)
- Carcinoma of sigmoid colon (disorder)
- Metastasis to colon of unknown primary (disorder)

#### What counts as a colorectal cancer? (SNOMED CT codes)

- Adenocarcinoma of sigmoid colon (disorder)
- Carcinoma of ascending colon (disorder)
- Carcinoma of transverse colon (disorder)
- Carcinoma of hepatic flexure (disorder)
- Carcinoma of splenic flexure (disorder)
- Local recurrence of malignant tumor of colon (disorder)
- Hereditary nonpolyposis colon cancer (disorder)
- Malignant tumor of colon (disorder)
- Malignant tumor of hepatic flexure (disorder)
- Malignant tumor of transverse colon (disorder)
- Malignant tumor of descending colon (disorder)
- Malignant tumor of sigmoid colon (disorder)
- Malignant tumor of ascending colon (disorder)
- Malignant tumor of splenic flexure (disorder)
- Malignant tumor of rectosigmoid junction (disorder)
- Malignant tumor of large intestine (disorder)
- Adenocarcinoma of rectosigmoid junction (disorder)
- History of polyp of colon (situation)
- History of adenomatous polyp of colon (situation)
- History of malignant neoplasm of colon (situation)
- Primary malignant neoplasm of ascending colon (disorder)
- Primary malignant neoplasm of colon (disorder)
- Primary malignant neoplasm of descending colon (disorder)
- Primary malignant neoplasm of hepatic flexure of colon (disorder)
- Primary malignant neoplasm of sigmoid colon (disorder)
- Primary malignant neoplasm of splenic flexure of colon (disorder)
- Primary malignant neoplasm of transverse colon (disorder)
- Secondary malignant neoplasm of ascending colon (disorder)
- Secondary malignant neoplasm of colon (disorder)
- Secondary malignant neoplasm of descending colon (disorder)
- Secondary malignant neoplasm of hepatic flexure of colon (disorder)
- Secondary malignant neoplasm of rectosigmoid junction (disorder)
- Secondary malignant neoplasm of sigmoid colon (disorder)
- Secondary malignant neoplasm of splenic flexure of colon (disorder)
- Secondary malignant neoplasm of transverse colon (disorder)
- Secondary malignant neoplasm of colon (disorder)

#### What counts as a colorectal cancer? (ICD-9 codes)

- Malignant neoplasm of colon
- Malignant neoplasm of hepatic flexure
- Malignant neoplasm of transverse colon
- Malignant neoplasm of descending colon
- Malignant neoplasm of cecum
- Malignant neoplasm of splenic flexure
- Malignant neoplasm of other specified sites of large intestine
- Malignant neoplasm of colon, unspecified
- Malignant neoplasm of rectum, rectosigmoid junction
- Malignant neoplasm of rectum



#### What counts as a colorectal cancer? (ICD-9 codes)

- Malignant neoplasm of large intestine and rectum
- Personal history of malignant neoplasm, large intestine

#### What counts as a total colectomy? (CPT codes)

- Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
- Colectomy, total, abdominal, without proctectomy; with continent ileostomy
- Colectomy, total, abdominal, with proctectomy; with ileostomy
- Colectomy, total, abdominal, with proctectomy; with continent ileostomy
- Colectomy, total, abdominal with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed
- Colectomy, total, abdominal with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
- Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy
- Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed
- Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy

#### What counts as a total colectomy? (SNOMED CT codes)

- Restorative proctocolectomy (procedure)
- Colectomy (procedure)
- Total colectomy (procedure)
- Panproctocolectomy, anastomosis of ileum to anus and creation of pouch however further qualified (procedure)
- Total colectomy and ileostomy (procedure)
- Total colectomy, ileostomy and rectal mucous fistula (procedure)
- Total colectomy, ileostomy and closure of rectal stump (procedure)
- History of colectomy (procedure)
- Total abdominal colectomy with rectal mucosectomy and ileoanal anastomosis (procedure)

## NUMERATOR INCLUSION CRITERIA

#### What counts as a colonoscopy? (CPT codes)

- Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- Colonoscopy through stoma; with biopsy, single or multiple
- Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- Colonoscopy through stoma; with removal of foreign body
- Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
- Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

#### What counts as a colonoscopy? (CPT codes)

- Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures
- Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s) any substance
- Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination
- Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
- Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
- Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
- Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple

#### What counts as a colonoscopy? (HCPCS codes)

- Colorectal cancer screening; colonoscopy on individual at high risk
- Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

#### What counts as a colonoscopy? (ICD-10 codes)

- Encounter for screening for malignant neoplasm of colon

#### What counts as a colonoscopy? (SNOMED CT codes)

- Total colectomy, ileostomy and creation of rectal fistula however further qualified (procedure)
- Total abdominal colectomy with ileostomy (procedure)

#### What counts as a flexible sigmoidoscopy? (CPT codes)

- Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
- Sigmoidoscopy, flexible; with biopsy, single or multiple
- Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
- Sigmoidoscopy, flexible; with decompression of volvulus, any method
- Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures
- Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
- Sigmoidoscopy, flexible; with endoscopic ultrasound examination
- Sigmoidoscopy, flexible; with removal of foreign body
- Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
- Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
- Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)

#### What counts as a flexible sigmoidoscopy? (HCPC codes)

- Colorectal cancer screening; flexible sigmoidoscopy

#### What counts as a flexible sigmoidoscopy? (ICD-9 codes)

- Flexible sigmoidoscopy, Endoscopy of descending colon; Excludes rigid proctosigmoidoscopy

#### What counts as a flexible sigmoidoscopy? (SNOMED CT codes)

- Diagnostic endoscopic examination of lower bowel and sampling for bacterial overgrowth using fiberoptic sigmoidoscope (procedure)
- Diagnostic endoscopic examination of sigmoid colon using rigid sigmoidoscope (procedure)
- Flexible fiberoptic sigmoidoscopy (procedure)
- Flexible fiberoptic sigmoidoscopy for removal of foreign body (procedure)
- Flexible fiberoptic sigmoidoscopy with biopsy (procedure)
- Intraoperative sigmoidoscopy (procedure)
- Other specified diagnostic endoscopic examination of sigmoid colon using rigid sigmoidoscope (procedure)
- Rigid sigmoidoscopy (procedure)
- Sigmoidoscopy through artificial stoma (procedure)
- Sigmoidoscopy with biopsy (procedure)
- Sigmoidoscopy with biopsy (procedure)

#### What counts as fecal occult blood testing? (CPT codes)

- Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
- Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations

#### What counts as fecal occult blood testing? (HCPC codes)

- Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous

#### What counts as fecal occult blood testing? (ICD-9 codes)

- Colon; Excludes rectum

#### What counts as fecal occult blood testing? (LOINC codes)

- Hemoglobin.gastrointestinal [Presence] in Stool --4th specimen
- Hemoglobin.gastrointestinal [Presence] in Stool --5th specimen
- Hemoglobin.gastrointestinal [Presence] in Stool --1st specimen
- Hemoglobin.gastrointestinal [Presence] in Stool --2nd specimen
- Hemoglobin.gastrointestinal [Presence] in Stool --3rd specimen
- Hemoglobin.gastrointestinal [Presence] in Stool
- Hemoglobin.gastrointestinal [Mass/mass] in Stool
- Hemoglobin.gastrointestinal [Presence] in Stool --6th specimen
- Hemoglobin.gastrointestinal [Presence] in Stool --7th specimen
- Hemoglobin.gastrointestinal [Presence] in Stool --8th specimen
- Hemoglobin.gastrointestinal [Presence] in Stool by Immunologic method

#### What counts as fecal occult blood testing? (SNOMED-CT codes)

- Guaiac test for occult blood in feces specimen (procedure)
- Measurement of occult blood in body fluid specimen (procedure)
- Measurement of occult blood in single stool specimen (procedure)
- Measurement of occult blood in stool specimen using immunoassay (procedure)
- Measurement of occult blood in three separate stool specimens (procedure)
- Measurement of occult blood in two separate stool specimens (procedure)
- Occult blood screening (procedure)
- Qualitative measurement of occult blood in gastric fluid specimen (procedure)
- Ward guaiac test (procedure)

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

NQF0034	CPT	CPT Modifier	CVX	Grouping	HCPSC	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator <sup>1</sup>	×			×	×		×	×	×		×
Denominator <sup>2</sup>	×			×		×	×				
Exceptions or exclusions <sup>3</sup>	×			×	×		×	×			×

- (Codes with an asterisk (\*) are required from certified EHRs)
- <sup>1</sup> To identify the numerator in this CQM, the following standard codes are required: (1) a "procedure" code for colonoscopy from CPT, HCPSC, ICD-9-CM, ICD-10-CM, SNOMED, or GROUPING; OR (2) a "procedure" code for a flexible sigmoidoscopy from CPT, HCPSC, ICD-9-CM, SNOMED, or GROUPING; OR (3) a "procedure" or "laboratory test" for FOBT from CPT, HCPSC, ICD-9-CM, LOINC, SNOMED.
- <sup>2</sup> To identify the denominator in this CQM, the following standard codes are required: (1) an "individual characteristic" code from HL7, AND (2) an outpatient "encounter" code from CPT, ICD-9-CM.
- <sup>3</sup> To identify the exclusions or exceptions in this CQM, the following standard codes are required: (1) a "procedure" code for total colectomy from CPT, ICD-9-CM, SNOMED, or GROUPING; OR (2) a "diagnosis" or "diagnostic study" for colorectal cancer from HCPSC, ICD-9-CM, ICD-10-CM, SNOMED 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)

Abbreviation	Long Name	Definition/Description
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)
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)

**THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.**

© 2010 American Medical Association and /or National Committee for Quality Assurance. All Rights Reserved.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measure specifications is copyright 2004- 2010 American Medical Association. LOINC® copyright 2004 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2010 International Health Terminology Standards Development Organisation. All Rights Reserved.