

NQF 0036: Use of Appropriate Medications for Asthma

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

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The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR).

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and denominator exclusion.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and denominator exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

TABLE OF CONTENTS

NQF 0036: Use of Appropriate Medications for Asthma	4
Technical Supplement	TS-1
Denominator Inclusion Criteria	TS-2
Exclusion or Exception Criteria.....	TS-6
Numerator Inclusion Criteria.....	TS-9
Types of codes required from your EHR for calculating this clinical quality measure	TS-9

NQF 0036: Use of Appropriate Medications for Asthma

Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total.)

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"> Information entered for this clinical quality measure also can be used for calculations in the following measure: <ul style="list-style-type: none"> NQF 0001 Asthma Assessment NQF 0047 Asthma Pharmacologic Therapy
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Encounter codes¹ Active diagnosis of asthma⁵ Prescription of medications related to asthma⁵
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measured occurred)	<ul style="list-style-type: none"> Prescription of medications related to asthma²
Data required to identify the <u>denominator exceptions or exclusions</u>	<ul style="list-style-type: none"> Active diagnosis of COPD Active diagnosis of Cystic Fibrosis Active diagnosis of Emphysema Active diagnosis of Acute Respiratory Failure

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

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> Ensures only patients who 5 to 50 years of age during the measurement period are captured in the denominator. 	<ul style="list-style-type: none"> Date of birth 	
2. Record date(s) and type(s) of asthma medications prescribed, ordered, or active	<ul style="list-style-type: none"> Ensures patients who were dispensed, ordered, or remained active on asthma medication are captured in the numerator. 	<ul style="list-style-type: none"> Date of medication dispensation Type of asthma medication³ 	

¹ This data element(s) must be documented at ≤1 year before or simultaneously to the measurement period

² This data element(s) must be documented within the measurement period.

³ See Technical Supplement for denominator inclusion details (asthma medication): pp. TS-4

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
3. Check patient record for active diagnosis of asthma	<ul style="list-style-type: none"> Ensures only patients with active asthma are captured in the denominator. 	<ul style="list-style-type: none"> Document active diagnosis of asthma⁴, if any 	
4. Check patient record for an emergency department or acute inpatient encounter.	<ul style="list-style-type: none"> Ensure patients who had an ED or acute inpatient encounter are captured in the denominator 	<ul style="list-style-type: none"> Date of encounter Type of encounter⁵ 	
5. Check patient record for 4 or more outpatient encounters and 2 or more instances of asthma medication being dispensed, ordered, or active	<ul style="list-style-type: none"> Ensure patients who had four or more outpatient encounters, and more than two instances of asthma medication being ordered, dispensed or active, are captured denominator.⁶ 	<ul style="list-style-type: none"> Date of encounters Type of encounters⁵ Date of medication dispensation, order, or activity Type(s) of asthma medication being dispensed, ordered, or active.³ 	
6. Check patient record for 4 or more instances of being dispensed, ordered, or actively on asthma medication.	<ul style="list-style-type: none"> Ensures patients with four or more instances of asthma medication being ordered, dispensed or active are captured denominator.⁶ 	<ul style="list-style-type: none"> Date of medication dispensation, order, or activity Type(s) of asthma medication being dispensed, ordered, or active.³ 	
7. Check record to see if active COPD is present	<ul style="list-style-type: none"> Ensures patients who have COPD are captured as exclusions or exceptions. 	<ul style="list-style-type: none"> Document diagnosis of COPD.⁷ 	
8. Check record to see if active cystic fibrosis is present	<ul style="list-style-type: none"> Ensures patients who have cystic fibrosis are captured as exclusions or exceptions. 	<ul style="list-style-type: none"> Document diagnosis of cystic fibrosis.⁸ 	
9. Check record to see if active emphysema is present	<ul style="list-style-type: none"> Ensures patients who have emphysema are captured as exclusions or exceptions. 	<ul style="list-style-type: none"> Document diagnosis of emphysema.⁹ 	

⁴ See Technical Supplement for denominator inclusion details (asthma diagnosis): [pp. TS-3](#)

⁵ See Technical Supplement for denominator inclusion details (encounters): [pp. TS-2](#)

⁶ Note patients who meet these criteria may not need an active diagnosis of asthma to be included in the denominator. See Technical Supplement for more details: [pp. TS-11](#)

⁷ See Technical Supplement for exclusion/exception details (COPD diagnosis): [pp. TS-6](#)

⁸ See Technical Supplement for exclusion/exception details (cystic fibrosis diagnosis): [pp. TS-7](#)

⁹ See Technical Supplement for exclusion/exception details (emphysema diagnosis): [pp. TS-7](#)

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
10. Check record to see if active acute respiratory failure is present	<ul style="list-style-type: none"> Ensures patients who have acute respiratory failure are captured as exclusions or exceptions. 	<ul style="list-style-type: none"> Document diagnosis of acute respiratory failure.¹⁰ 	

¹⁰ See Technical Supplement for exclusion/exception details (acute respiratory failure diagnosis): [pp. TS-8](#)

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 a an inpatient encounter? (CPT Codes)

- Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 components: a history, an examination, and medical decision making.
- Hospital discharge day management
- Inpatient consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Critical care, evaluation and management of the critically ill or critically injured patient

What counts as an emergency department encounter? (CPT Codes)

- Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.

What counts as a an outpatient encounter? (CPT Codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, 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 examination, and medical decision making.
- Observation care discharge day management
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an examination, and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an examination, and medical decision making.
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient
- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient;
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)

What counts as a an outpatient encounter? (CPT Codes)

- Preventive medicine counseling and/or risk factor reduction intervention(s) providers to individuals in a group setting (separate procedure)
- Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by other than the treating physician or treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

What counts as a diagnosis of asthma? (ICD-9 Codes)

- | | |
|---|--------|
| • Extrinsic asthma, unspecified | 493.00 |
| • Extrinsic asthma with status asthmaticus | 493.01 |
| • Extrinsic asthma with acute exacerbation | 493.02 |
| • Intrinsic asthma, unspecified | 493.10 |
| • Intrinsic asthma with status asthmaticus | 493.11 |
| • Intrinsic asthma with acute exacerbation | 493.12 |
| • Chronic obstructive asthma, unspecified | 493.20 |
| • Chronic obstructive asthma, with acute exacerbation | 493.22 |
| • Other forms of asthma | 493.81 |
| • Cough variant asthma | 493.82 |
| • Asthma, unspecified | 493.90 |
| • Unspecified asthma with status asthmaticus | 493.91 |
| • Unspecified asthma with acute exacerbation | 493.92 |

What counts as a diagnosis of asthma? (SNOMED-CT Codes)

- Acute asthma (disorder)
- Acute exacerbation of chronic asthmatic bronchitis (disorder)
- Allergic asthma (disorder)
- Allergic-infective asthma (disorder)
- Aspirin-induced asthma (disorder)
- Asthma (disorder)
- Asthma attack (disorder)
- Asthma unspecified (disorder)
- Asthma with status asthmaticus (disorder)
- Asthma without status asthmaticus (disorder)
- Asthmatic bronchitis (disorder)
- Brittle asthma (disorder)
- Byssinosis (disorder)
- Byssinosis grade 3 (disorder)
- Chemical-induced asthma (disorder)
- Childhood asthma (disorder)

What counts as a diagnosis of asthma? (SNOMED-CT Codes)

- Chronic asthmatic bronchitis (disorder)
- Cough variant asthma (disorder)
- Drug-induced asthma (disorder)
- Exacerbation of asthma (disorder)
- Exacerbation of intermittent asthma (disorder)
- Exacerbation of persistent asthma (disorder)
- Exercise-induced asthma (disorder)
- Extrinsic asthma with asthma attack (disorder)
- Extrinsic asthma with status asthmaticus (disorder)
- Extrinsic asthma without status asthmaticus (disorder)
- Flax-dressers' disease (disorder)
- Hay asthma (disorder)
- Hay fever with asthma (disorder)
- IgE-mediated allergic asthma (disorder)
- Intermittent asthma (disorder)
- Intrinsic Asthma (disorder)
- Intrinsic asthma with asthma attack (disorder)
- Intrinsic asthma with status asthmaticus (disorder)
- Intrinsic asthma without status asthmaticus (disorder)
- Late onset asthma (disorder)
- Mild asthma (disorder)
- Mild intermittent asthma (disorder)
- Mild persistent asthma (disorder)
- Millers' asthma (disorder) (disorder)
- Mixed asthma (disorder)
- Moderate asthma (disorder)
- Moderate persistent asthma (disorder)
- Non-IgE mediated allergic asthma (disorder)
- Occasional asthma (disorder)
- Pneumopathy due to inhalation of other dust (disorder)
- Severe asthma (disorder)
- Severe persistent asthma (disorder)
- Substance induced asthma (disorder)
- Sulfite-induced asthma (disorder)
- Weavers' cough (disorder)
- Wood asthma (disorder)

What counts as asthma medication? (RXNorm codes)

- Dyphylline / guaifenesin
- Guaifenesin / theophylline
- Potassium iodide / theophylline

What counts as asthma medication? (RXNorm codes)

- Ephedrine / guaifenesin / theophylline
- Guaifenesin / pseudoephedrine / theophylline
- Omalizumab
- Beclomethasone
- Budesonide
- Flunisolide
- Triamcinolone
- Codeine phosphate / guaifenesin / phenylephrine
- Triamcinolone
- Tramadol hydrochloride
- Budesonide / formoterol
- Mometasone furoate
- Triamcinolone acetonide
- Fluticasone furoate
- Fluticasone propionate
- Fluticasone propionate / salmeterol
- Montelukast
- Zileuton
- Zafirlukast
- Formoterol
- Salmeterol
- Albuterol / cromolyn
- Cromolyn sodium
- Cromolyn sodium / xylometazoline
- Theophylline
- Aminophylline
- Dyphylline
- Mersalyl / theophylline
- Potassium iodide / theophylline
- Aminophylline / ephedrine / phenobarbital
- Aminophylline / guaifenesin / phenobarbital
- Aminophylline / potassium iodide
- Aminophylline / phenobarbital
- Ephedrine / theophylline
- Noscapine / theophylline
- Aminophylline / ephedrine
- Aminophylline / guaifenesin
- Albuterol / ipratropium
- Albuterol
- Pirbuterol
- Levalbuterol
- Methylprednisolone

What counts as asthma medication? (RXNorm codes)

- Furosemide
- Albuterol / ipratropium bromide

EXCLUSION OR EXCEPTION CRITERIA

What counts as COPD? (SNO-MED CT codes)

- Bronchiolitis Obliterans Organizing Pneumonia
- End stage chronic obstructive airways disease
- Chronic Obstructive Airway Disease
- Obstructive emphysema
- Acute exacerbation of chronic obstructive airways disease
- Chronic bullous emphysema
- Zonal bullous emphysema
- Acute vesicular emphysema
- Chronic obstructive pulmonary disease with acute lower respiratory infection
- Chronic emphysema due to chemical fumes
- Toxic bronchiolitis obliterans
- Subacute obliterative bronchiolitis
- Drug-induced bronchiolitis obliterans
- Pulmonary emphysema in alpha-1 PI deficiency
- Toxic emphysema
- Scar emphysema
- Seasonal cryptogenic organizing pneumonia with biochemical cholestasis
- Bronchiolitis obliterans with usual interstitial pneumonitis
- Vanishing lung
- Atrophic (senile) emphysema
- Acute infective exacerbation of chronic obstructive airways disease
- Cystic-bullous disease of the lung
- Mild chronic obstructive pulmonary disease
- Moderate chronic obstructive pulmonary disease
- Severe chronic obstructive pulmonary disease
- Bronchiolitis Obliterans
- Paraseptal emphysema
- Chronic obliterative bronchiolitis due to inhalation of chemical fumes AND/OR vapors
- Compensatory emphysema
- Subacute obliterative bronchiolitis due to inhalation of chemical fumes AND/OR vapors
- Bronchiolitis Obliterans
- Congenital emphysema
- Chronic obliterative bronchiolitis
- Panacinar Emphysema
- Emphysematous bleb of lung
- Hemolytic anemia with emphysema AND cutis laxa

What counts as COPD? (SNO-MED CT codes)

- Chronic diffuse emphysema due to inhalation of chemical fumes AND/OR vapors
- Congenital emphysema
- Centriacinar Emphysema
- Bronchial atresia with segmental pulmonary emphysema
- Interstitial emphysema of lung
- Ruptured emphysematous bleb of lung
- Pulmonary Emphysema

What counts as COPD? (ICD-10 codes)

- | | |
|---|-------|
| • Other chronic obstructive pulmonary disease | J44 |
| • Compensatory emphysema | J98.4 |

What counts as COPD? (ICD-9 codes)

- | | |
|--|--------|
| • Obstructive chronic bronchitis | 491.2 |
| • Obstructive chronic bronchitis without exacerbation | 491.20 |
| • Obstructive chronic bronchitis with exacerbation | 491.21 |
| • Obstructive chronic bronchitis with acute bronchitis | 491.22 |
| • Emphysematous bleb | 492.0 |
| • Chronic obstructive asthma | 493.2 |
| • Chronic obstructive asthma unspecified | 493.20 |
| • Chronic obstructive asthma with status asthmaticus | 493.21 |
| • Chronic obstructive asthma with acute exacerbation | 493.22 |
| • Chronic airway obstruction not elsewhere classified | 496 |
| • Chronic respiratory conditions due to fumes and vapors | 506.4 |

What counts as cystic fibrosis? (ICD-9 codes)

- | | |
|--|--------|
| • Cystic Fibrosis | 277.0 |
| • Cystic fibrosis without mention of meconium ileus | 277.00 |
| • Cystic fibrosis with mention of meconium ileus | 277.01 |
| • Cystic fibrosis with pulmonary manifestation | 277.02 |
| • Cystic fibrosis with gastrointestinal manifestations | 277.03 |
| • Cystic fibrosis with other manifestations | 277.09 |

What counts as cystic fibrosis? (ICD-10 codes)

- | | |
|---|-----|
| • Disorders of plasma=protein metabolism not elsewhere classified | E88 |
|---|-----|

What counts as cystic fibrosis? (SNO-MED CT codes)

- Cystic Fibrosis
- Cystic fibrosis with intestinal manifestations
- Fibrocystic Disease of Pancreas
- Cystic fibrosis without meconium ileus

What counts as cystic fibrosis? (SNO-MED CT codes)

- Cystic fibrosis with meconium ileus
- Pulmonary Cystic Fibrosis

What counts as emphysema? (ICD-9 codes)

- | | |
|--------------------------|-------|
| • Emphysema | 492 |
| • Emyphesemous bleb | 492.0 |
| • Other emphysema | 492.8 |
| • Interstitial emphysema | 518.1 |
| • Compensatory emphysema | 518.2 |

What counts as emphysema? (ICD-10 codes)

- | | |
|---|-------|
| • Other chronic obstructive pulmonary disease | J44 |
| • Respiratory conditions due to inhalation of chemicals, gases, fumes, and vapors | J68 |
| • Interstitial emphysema | J98.2 |

What counts as emphysema? (SNOMED CT codes)

- Giant bullous emphysema
- Obstructive emphysema
- Chronic bullous emphysema
- Segmental bullous emphysema
- Zonal bullous emphysema
- Acute vesicular emphysema
- Chronic emphysema due to chemical fumes
- Pulmonary emphysema in alpha-1 PI deficiency
- Toxic emphysema
- Scar emphysema
- Vanishing Lung
- Bullous emphysema with collapse
- Atrophic (senile) emphysema
- Cystic-bullous disease of the lung
- Paraseptal emphysema
- Compensatory emphysema
- Congenital emphysema
- Panacinar Emphysema
- Emphysematous bleb of lung
- Hemolytic anemia with emphysema AND cutis laxa
- Chronic diffuse emphysema due to inhalation of chemical fumes AND/OR vapors
- Centriacinar Emphysema
- Bronchial atresia with segmental pulmonary emphysema
- Interstitial emphysema of lung
- Ruptured emphysematous bleb of lung
- Pulmonary Emphysema

What counts as acute respiratory failure? (ICD-9 codes)

- Acute respiratory failure 518.81

What counts as acute respiratory failure? (ICD-10 codes)

- Acute respiratory failure J96.0

What counts as acute respiratory failure? (SNO-MED CT codes)

- Acute respiratory failure requiring reintubation
- Acute respiratory failure
- Acute-on-chronic respiratory failure

NUMERATOR INCLUSION CRITERIA

- Refer to asthma medication denomination inclusions on pp. TS-4

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

NQF0036	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹				x						x	
Denominator ²				x		x				x	
Exceptions or exclusions ³				x			x	x			x

- (Codes with an asterisk (*) are required from certified EHRs)
- ¹ To identify the numerator in this CQM, the following standard codes are required: one "asthma medication" code from RxNorm.
- ² To identify the denominator in this CQM, the following standard codes are required: an "asthma diagnosis" code from ICD-9, ICD-10 or SNOMED, AND either an "inpatient encounter" or "ED encounter" code from CPT, or an "outpatient encounter" code from CPT and an "asthma medication": code from RxNorm AND an "individual characteristic" code from HL7.
- ³ To identify the exceptions or exclusions in this CQM, the following standard codes are required: a "COPD", "emphysema", "cystic fibrosis", or "acute respiratory failure" code from ICD-9, ICD-10, or SNOMED.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)

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)

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