

NQF 0043: Pneumonia Vaccination Status for Older Adults

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 0043: Pneumonia Vaccination Status for Older Adults.....	4
Technical Supplement.....	TS-1
Denominator Inclusion Criteria.....	TS-2
Numerator Inclusion Criteria	TS-2
Types of codes required from your EHR for calculating this clinical quality measure	TS-3

NQF 0043: Pneumonia Vaccination Status for Older Adults

The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

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 denominator (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Encounter codes¹
Data required to identify the exceptions or exclusions	<ul style="list-style-type: none"> NA
Data required to identify the numerator (cases in which the process or outcome being measured occurred)	<ul style="list-style-type: none"> Pneumococcal vaccine (procedure or medication)¹

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 at least 65 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 visit	<ul style="list-style-type: none"> Ensures appropriate patient visits are captured in the denominator. 	<ul style="list-style-type: none"> Date of visit Encounter Code² 	
3. Check patient record for pneumococcal vaccination, if needed and appropriate, administer one	<ul style="list-style-type: none"> Ensures all patients who are vaccinated are captured in the numerator. 	<ul style="list-style-type: none"> Document pneumococcal vaccine³ 	

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

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

³ See the Technical Supplement for numerator inclusion details (pneumococcal vaccination): [pp. TS-2](#)

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 outpatient encounter? (CPT Codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient, 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 detailed or comprehensive history a history, an evaluation, and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an evaluation, and medical decision making.
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient.
- 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
- Preventive medicine counseling and/or risk factor reduction intervention(s) providers to individuals in a group setting
- Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
- Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

NUMERATOR INCLUSION CRITERIA

What counts as a pneumococcal vaccination? (CPT codes)

- Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
- Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
- Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

What counts as pneumococcal vaccination? (CVX codes)

- pneumococcal conjugate

What counts as pneumococcal vaccination? (CVX codes)

- pneumococcal conjugate 13 valent
- Polyvalent pneumococcal vaccine

What counts as pneumococcal vaccination? (RxNorm codes)

- pneumococcal capsular polysaccharide type
- pneumococcal capsular polysaccharide type 10A vaccine
- pneumococcal capsular polysaccharide type 11A vaccine
- pneumococcal capsular polysaccharide type 12F vaccine
- pneumococcal capsular polysaccharide type 14 vaccine
- pneumococcal capsular polysaccharide type 15B vaccine
- pneumococcal capsular polysaccharide type 17F vaccine
- pneumococcal capsular polysaccharide type 18C vaccine
- pneumococcal capsular polysaccharide type 19A vaccine
- pneumococcal capsular polysaccharide type 2 vaccine
- pneumococcal capsular polysaccharide type 20 vaccine
- pneumococcal capsular polysaccharide type 22F vaccine
- pneumococcal capsular polysaccharide type 23F vaccine
- pneumococcal capsular polysaccharide type 3 vaccine
- pneumococcal capsular polysaccharide type 33F vaccine
- pneumococcal capsular polysaccharide type 4 vaccine
- pneumococcal capsular polysaccharide type 5 vaccine
- pneumococcal capsular polysaccharide type 6B vaccine
- pneumococcal capsular polysaccharide type 7F vaccine
- pneumococcal capsular polysaccharide type 8 vaccine
- pneumococcal capsular polysaccharide type 9N vaccine
- pneumococcal capsular polysaccharide type 9V vaccine
- pneumococcal capsular polysaccharide type 1 vaccine

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

NQF0043	CPT	CPT Modifier	CVX	Grouping	HCPSC	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	×		×							×	
Denominator ²	×					×					
Exceptions or exclusions											

- (Codes with an asterisk (*) are required from certified EHRs)
- ¹ To identify the numerator in this CQM, the following standard codes are required: one "procedure" code from CPT or CVX, OR one "medication" code from RxNorm
- ² To identify the denominator in this CQM, the following standard codes are required: an "encounter" code from CPT, AND an "individual characteristic" code from HL7.

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)
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.