

NQF 0052: Low Back Pain: Use of Imaging Studies

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 two sections may be distributed as stand-alone references.

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

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

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

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

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NQF 0052: Low Back Pain: Use of Imaging Studies

The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Menu measure
Related to other measures?	<ul style="list-style-type: none"> 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 Encounter code¹ Active diagnosis of low back pain¹ (first occurrence during measurement period)
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> Active diagnosis of low back pain or cancer or trauma or IV drug abuse or neurologic impairment² Date of previous active diagnosis of low back pain³
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Spinal imaging study⁴

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>

¹ This data element(s) must be documented during the measurement period

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

³ This data element(s) must be documented no more than 180 days before the first active diagnosis of low back pain during the measurement period

⁴ This data element(s) must be documented no more than 28 days following the first active diagnosis of low back pain during the measurement period.

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> Ensures only patients who are 19 to 50 years of age during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Date of birth 	
2. Record date and type of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. For this measure, an outpatient (including orthopedics and chiropractics) encounter is required within the measurement period. 	<ul style="list-style-type: none"> Date of visit Code for outpatient (including orthopedics and chiropractics) encounter⁵ 	
3. Record first active diagnosis of low back pain during measurement period.	<ul style="list-style-type: none"> Ensures only patients with a diagnosis of low back pain during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Document date of first occurrence of low back pain active diagnosis 	
4. Check patient record or assess patient for active diagnosis of cancer, trauma, IV drug use or neurologic impairment.	<ul style="list-style-type: none"> Ensures patients with active diagnosis of any of the conditions listed are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Document active diagnosis of cancer, trauma, IV drug use or neurologic impairment, if any. 	
5. Check patient record for documentation of previous active diagnosis of low back pain.	<ul style="list-style-type: none"> Ensures patients whose prior active diagnosis of low back pain no more than 180 days before this diagnosis of low back pain are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Document date of previous active diagnosis of low back pain, if any (particularly those less than or equal to 180 days before this diagnosis). 	
6. Check patient record for documentation of spinal imaging study.	<ul style="list-style-type: none"> Ensures only patients <i>without</i> a spinal imaging study during the 28 days following the active diagnosis of low back pain are counted in the numerator. 	<ul style="list-style-type: none"> Document spinal imaging study performed, if any⁶. 	

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

⁶ See Technical Supplement for numerator inclusion details (spinal imaging study): [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 constitutes an acute 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; first 30-74 minutes

What constitutes an ED 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 constitutes an non-acute inpatient encounter? (CPT Codes)

- Initial nursing facility 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 nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history; an examination; and medical decision making.
- Nursing facility discharge day management.
- Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a history; an examination; and medical decision making.
- Domiciliary or rest 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.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires at least 2 of these 3 key components: a history; an examination; and medical decision making.

What constitutes outpatient (including orthopedics and chiropractics) encounter? (CPT Codes)

- Osteopathic manipulative treatment (OMT)
- Chiropractic manipulative treatment (CMT); spinal

NUMERATOR INCLUSION CRITERIA

What constitutes an imaging study-spinal? (CPT codes)

- Radiologic examination, chest; single view, frontal
- Radiologic examination, spine, single view, specify level
- Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies
- Radiologic examination, spine, lumbosacral; 2 or 3 views
- Radiologic examination, spine, lumbosacral; minimum 4 views
- Radiologic examination, spine, lumbosacral; complete, including bending views
- Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views
- Computed tomography, lumbar spine; without contrast material

What constitutes an imaging study-spinal? (CPT codes)

- Computed tomography, lumbar spine; with contrast material
- Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
(For intrathecal injection procedure, see 61055, 62284)
(To report 3D rendering, see 76376, 76377)
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material followed by contrast material(s) and further sequences; cervical
- Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material followed by contrast material(s) and further sequences; lumbar
- 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

What constitutes an imaging study-spinal? (SNOMED-CT codes)

- Diagnostic radiography of sacrococcygeal joint (procedure)
- Radiographic procedure on spine AND/OR pelvis (procedure)
- Computerized axial tomography of thoracic spine with contrast (procedure)
- Instability views spine (procedure)
- Symphysis pubis X-ray (procedure)
- Sacroiliac joint arthrogram (procedure)
- Vertebral arteriogram (procedure)
- Diagnostic radiography of pelvis, stereo views (procedure)
- Water soluble contrast myelogram (procedure)
- Radiologic examination of cervical spine, anteroposterior and lateral (procedure)
- X-ray of lumbosacral spine (procedure)
- Scoliosis survey X-ray (procedure)
- Spinal contrast procedure (procedure)
- Scoliosis myelogram (procedure)
- Air myelogram (procedure)
- Epidurogram (procedure)
- Facet joint arthrogram (procedure)
- Apophyseal joint arthrogram (procedure)
- Spinal arteriogram (procedure)
- Ultrasound scan of spine (procedure)
- Computed tomography of spine (procedure)
- Computed tomography of lumbar spine (procedure)

What constitutes an imaging study-spinal? (SNOMED-CT codes)

- Computed tomography of sacral spine (procedure)
- Computed tomography myelogram (procedure)
- Computed tomography myelogram of lumbar region (procedure)
- Computed tomography discogram of lumbar region (procedure)
- Magnetic resonance imaging of spine (procedure)
- Magnetic resonance imaging of lumbar spine (procedure)
- Diagnostic radiography of coccyx (procedure)
- Diagnostic radiography of lumbar spine, combined AP and lateral (procedure)
- Odontoid peg X-ray (procedure)
- Myelography of entire spinal canal (procedure)
- Arthrogram of spinal joint (procedure)
- Specific spinal X-ray (procedure)
- Diagnostic radiography of thoracolumbar spine, supine and erect for scoliosis (procedure)
- Myelogram (procedure)
- Magnetic resonance imaging of lumbar spine with contrast (procedure)
- Imaging of spine (procedure)
- Fluoroscopic cervical myelogram (procedure)
- Radionuclide study of sacroiliac joints (procedure)
- Fluoroscopy of spine (procedure)
- Computed tomography of sacroiliac joints (procedure)
- Fluoroscopic lumbar myelogram (procedure)
- Ultrasound doppler scan of vertebral arteries (procedure)
- Fluoroscopic angiography of vertebral artery (procedure)
- Fluoroscopic angioplasty of vertebral artery (procedure)
- Fluoroscopic angiography of spinal artery (procedure)
- Fluoroscopic arthrography of facet joint (procedure)
- Fluoroscopy of lumbar spine (procedure)
- Fluoroscopic thoracic myelogram (procedure)
- Fluoroscopic discography (procedure)
- X-ray of lumbar spine and sacroiliac joints (procedure)
- Magnetic resonance imaging of sacroiliac joints (procedure)
- Fluoroscopic myelogram (procedure)
- Dual energy X-ray photon absorptiometry scan of lumbar spine (procedure)
- Ultrasound scan of sacral spine (procedure)
- Computed tomography of whole spine with contrast (procedure)
- Injection of lumbar zygapophyseal joint using computed tomography guidance (procedure)
- Injection of lumbar spinal nerve root using computed tomography guidance (procedure)
- Fluoroscopic arthrography of sacroiliac joint with contrast (procedure)
- Lumbar epidural injection using computed tomography guidance (procedure)

What constitutes an imaging study-spinal? (SNOMED-CT codes)

- Computed tomography of whole spine (procedure)
- Fluoroscopic arthrography of zygapophyseal joint with contrast (procedure)
- Injection of sacral spinal nerve root using computed tomography guidance (procedure)
- Fluoroscopic arthrography of zygapophyseal joint of cervical spine with contrast (procedure)
- Fluoroscopic arthrography of zygapophyseal joint of lumbar spine with contrast (procedure)
- Fluoroscopic arthrography of zygapophyseal joint of thoracic spine with contrast (procedure)
- Injection of sacroiliac joint using computed tomography guidance (procedure)
- Computed tomography of spine for radiotherapy planning (procedure)
- Sacral epidural injection using computed tomography guidance (procedure)
- Injection of thoracic spinal nerve root using computed tomography guidance (procedure)
- Computed tomography of coccyx (procedure)
- Computed tomography of sacral spine with contrast (procedure)
- Computed tomography of sacral spine with contrast (procedure)
- Magnetic resonance imaging myelography of lumbar spine (procedure)
- Radionuclide two-phase bone imaging of lumbar spine (procedure)
- Kyphoplasty of fracture of lumbar spine using fluoroscopic guidance (procedure)
- Percutaneous sacral vertebroplasty using fluoroscopic guidance (procedure)
- Magnetic resonance imaging of lumbar spine and pelvis (procedure)
- Kyphoplasty of fracture of cervical spine using fluoroscopic guidance (procedure)
- Injection of sacroiliac joint using fluoroscopic guidance (procedure)
- Destruction of intervertebral disc by injection using fluoroscopic guidance (procedure)
- Vertebroplasty of lumbar spine using computed tomography guidance (procedure)
- Fluoroscopy of spine for assessment of spinal movement (procedure)
- Fluoroscopic intravenous digital subtraction angiography of vascular structure of spine (procedure)
- Injection of nerve root of sacral spine using fluoroscopic guidance (procedure)
- Percutaneous lumbar vertebroplasty using fluoroscopic guidance (procedure)
- X-ray of cervical spine using mobile image intensifier (procedure)
- Epidural injection using fluoroscopic guidance (procedure)
- Kyphoplasty of fracture of lumbar spine using computed tomography guidance (procedure)
- Percutaneous laser decompression of intervertebral disc using fluoroscopic guidance (procedure)
- Percutaneous intradiscal electrothermal annuloplasty using fluoroscopic guidance (procedure)
- Fluoroscopy of whole spine (procedure)
- Fluoroscopic discography of lumbar spine (procedure)
- Single photon emission computed tomography of bone of head and neck (procedure)
- X-ray of lumbar spine using mobile image intensifier (procedure)
- X-ray of lumbar spine and pelvis (procedure)
- Marking of skin of spine using magnetic resonance imaging guidance (procedure)
- Vertebroplasty using fluoroscopic guidance (procedure)
- Magnetic resonance imaging of spine with contrast (procedure)

What constitutes an imaging study-spinal? (SNOMED-CT codes)

- Kyphoplasty of fracture of spine using fluoroscopic guidance (procedure)
- Laser decompression of spinal disc using computed tomography guidance (procedure)
- Vertebroplasty of sacral spine using computed tomography guidance (procedure)
- X-ray of sacrum using mobile image intensifier (procedure)
- Magnetic resonance imaging of sacral spine (procedure)
- Epidural injection of lumbar spine using fluoroscopic guidance (procedure)
- Magnetic resonance imaging of coccyx (procedure)
- Magnetic resonance imaging myelography of thoracic spine with contrast (procedure)
- Ultrasonography of coccyx (procedure)
- Magnetic resonance imaging arthrography of facet joint (procedure)
- Ultrasonography of lumbar spine (procedure)
- Single photon emission computed tomography of bone of lumbar spine (procedure)
- Injection of facet joint using fluoroscopic guidance (procedure)
- Ultrasonography of sacroiliac joint (procedure)
- Radionuclide bone imaging of lumbar spine (procedure)
- Injection of cervical zygapophyseal joint using computed tomography guidance (procedure)
- Kyphoplasty of fracture of thoracic spine using computed tomography guidance (procedure)
- Epidural injection of sacral spine using fluoroscopic guidance (procedure)
- Vertebroplasty of thoracic spine using computed tomography guidance (procedure)
- Magnetic resonance imaging of lumbar and sacral spine with contrast (procedure)
- Magnetic resonance imaging of lumbar and sacral spine (procedure)
- Fluoroscopy of sacrum (procedure)
- Injection of nerve root of lumbar spine using fluoroscopic guidance (procedure)
- Lumbar puncture using fluoroscopic guidance (procedure)
- Percutaneous transluminal balloon test occlusion of vertebral artery using fluoroscopic guidance (procedure)
- Percutaneous transluminal angioplasty of vertebral artery using fluoroscopic guidance (procedure)
- Percutaneous embolization of spinal neoplasm using fluoroscopic guidance (procedure)
- percutaneous balloon test occlusion of anterior cerebral artery (procedure)
- Injection into facet joint of lumbar spine using fluoroscopic guidance (procedure)
- Percutaneous intradiscal annuloplasty using fluoroscopic guidance (procedure)
- Percutaneous embolization of arteriovenous fistula of spinal dura using fluoroscopic guidance (procedure)
- Percutaneous embolization of spinal arteriovenous malformation using fluoroscopic guidance (procedure)
- Fluoroscopic angiography of vertebral artery by direct puncture (procedure)
- Fluoroscopic imaging of spinal vein with contrast (procedure)
- Percutaneous embolization of neoplasm of cervical vertebra using fluoroscopic guidance (procedure)
- Radiologic examination of lumbosacral spine, anteroposterior and lateral (procedure)
- Diagnostic radiography of sacral spine, combined AP and lateral (procedure)
- Lumbar discography (procedure)
- Radiologic examination of lumbosacral spine, complete, with bending views (procedure)

What constitutes an imaging study-spinal? (SNOMED-CT codes)

- Angiography of cervical vertebral arteries, bilateral (procedure)
- Diagnostic radiography of sacrum (procedure)
- Radiography of pelvic soft tissue (procedure)
- Diagnostic radiography of spine with flexion and extension studies (procedure)
- Diagnostic radiography of sacroiliac joints (procedure)
- Myelogram of posterior fossa (procedure)
- Radiologic examination of complete spine, anteroposterior and lateral (procedure)
- Spinal angiography, selective (procedure)
- Computerized axial tomography of cervical spine with contrast (procedure)
- Discogram (procedure)
- Angiography of cervical vertebral and intracranial arteries (procedure)
- Radiologic examination of thoracolumbar spine, anteroposterior and lateral (procedure)
- Echography of spinal canal and contents (procedure)
- Radiography of spine (procedure)
- Radiography of sacrococcygeal spine (procedure)
- Radiologic examination of lumbosacral spine, complete, with oblique views (procedure)
- Lumbosacral myelography (procedure)
- Radiography of pelvic bones (procedure)
- Computerized axial tomography of lumbar spine with contrast (procedure)
- Diagnostic radiography of lumbar spine (procedure)
- Diagnostic radiography of spine, survey study (procedure)

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

NQF0052	CPT	CPT Modifier	CVX	Grouping	HCPSCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x			x			x	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: no "diagnostic study performed" code from CPT or SNOMED.
- ² To identify the denominator in this CQM, the following standard codes are required: an "individual characteristic" code from HL7, (2) an "encounter" code from CPT, ICD-9, or Grouping and a "diagnosis/condition/problem" code from ICD-9, ICD-10, SNOMED, or GROUPING.
- ³ To identify the exclusions in this CQM, the following standard codes are required if the person is not already in the denominator: a "diagnosis/condition/problem" code from ICD-9, ICD-10, 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)
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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