

NQF 0056: Diabetes: Foot Exam

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 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 0056: Diabetes: Foot Exam

The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

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"> Some of the information entered for this clinical quality measure also can be used for calculations in the following measures: <ul style="list-style-type: none"> Diabetes: Eye Exam (NQF 0055) Diabetes: Blood Pressure Management (NQF 0061) Diabetes: Urine Screening (NQF 0062) Diabetes: LDL Management and Control (NQF 0064) Diabetes: HA1c Poor Control (NQF 0059) Diabetes: HA1c Control (NQF 0575)
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 diabetes or medications indicative of diabetes²
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> Active diagnosis of polycystic ovaries²; or Active diagnosis of gestational diabetes and medications indicative of diabetes²; or Active diagnosis of steroid induced diabetes and medications indicative of diabetes²
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Code for foot exam¹

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.

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 18 to 75 years of age during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Date of birth 	
2. Record the date(s) and type(s) of visit(s)	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. For this measure, at least one acute inpatient encounter or at least two non-acute inpatient, outpatient, or ophthalmology encounters must take place during the measurement period. 	<ul style="list-style-type: none"> Date(s) of visit(s) Code(s) for an inpatient, emergency department, outpatient, or ophthalmological encounter(s)³ 	
3. Check patient record or assess patient for active diagnosis of diabetes	<ul style="list-style-type: none"> Ensures only patients with an active diagnosis of diabetes are captured in the denominator. 	<ul style="list-style-type: none"> Active diagnosis of diabetes; Medications indicative of diabetes 	
4. Check patient record or assess for active diagnosis of polycystic ovaries, gestational diabetes, or steroid induced diabetes	<ul style="list-style-type: none"> Ensures patients with an active diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes are identified as exclusions or exceptions. 	<ul style="list-style-type: none"> Active diagnosis of polycystic ovaries, gestational diabetes, or steroid induced diabetes (if applicable) 	
5. Check patient record for or perform foot exam (visual inspection, sensory exam with mono-filament, or pulse exam)	<ul style="list-style-type: none"> Ensures only patients who have documentation of foot exam during the measurement period are counted in the numerator. 	<ul style="list-style-type: none"> Documentation of foot exam⁴ 	

³ See Technical Supplement for denominator inclusion details (encounter types): [pp. TS-2](#)

⁴ See Technical Supplement for numerator inclusion criteria details (foot exam): [pp. TS-4](#)

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 denominator and numerator.

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 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. with.
- 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,

What constitutes an outpatient encounter? (CPT codes)

- 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).
- 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 (eg, health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by physician or someone 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.

What constitutes an outpatient encounter? (ICD-9 CM codes)

- | | |
|--|-------|
| • General medical examination: routine general medical examination at a health care facility ; Health checkup | V70.0 |
| • General medical examination: other medical examination for administrative purposes | V70.3 |
| • General medical examination: health examination of defined subpopulations | V70.5 |
| • General medical examination: health examination in population surveys | V70.6 |
| • General medical examination: other specified general medical examinations; examination of potential donor of organ or tissue | V70.8 |
| • General medical examination: unspecified general medical examination | V70.9 |

What constitutes an ophthalmology encounter? (CPT codes)

- Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
- Undefined
- Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
- Undefined
- Undefined
- Undefined
- Undefined
- Undefined
- Undefined
- Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
- Undefined
- Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

NUMERATOR INCLUSION CRITERIA

What constitutes a foot exam? (SNOMED-CT codes)

- Diabetic foot examination (regime/therapy)
- Diabetic foot examination (regime/therapy)
- Sensory testing (procedure)
- Sensory and motor testing
- Pedal pulse taking (procedure)

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

NQF0056	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹											x
Denominator ²	x			x		x	x	x		x	x
Exceptions or exclusions ³				x			x	x		x	x

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

Abbreviation	Long Name	Definition/Description
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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