

NQF 0062: Diabetes: Urine 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 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 0062: Diabetes: Urine Screening

The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy .

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: Foot Exam (NQF 0056) – Diabetes: Blood Pressure Management (NQF 0061) – 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"> Nephropathy–related procedures/tests¹ or Active diagnosis of nephropathy¹, or ACE inhibitors/ARBs¹

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 two 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 during the two years prior to the measurement end date 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 or assess for active diagnosis of nephropathy or evidence of a nephropathy-related procedure	<ul style="list-style-type: none"> Ensures only patients who have documentation of an active diagnosis of nephropathy or nephropathy-related procedures during the measurement period are counted in the numerator. 	<ul style="list-style-type: none"> Documentation of nephropathy screening, or nephropathy-related procedure^{4,5}; or Active diagnosis of nephropathy⁶; or ACE inhibitor/ARB therapy medication (active, order, dispensed) 	

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

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

⁵ See Technical Supplement for numerator inclusion criteria details (nephropathy-related procedures): [pp. TS-5](#)

⁶ See Technical Supplement for numerator inclusion criteria details (diagnosis of nephropathy): [pp. TS-9](#)

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 nephropathy screening? (CPT codes)

- Albumin; urine or other source, quantitative, each specimen
- Albumin; urine, microalbumin, quantitative
- Albumin; urine, microalbumin, semiquantitative (eg, reagent strip assay)
- Protein, total, except by refractometry; urine

What constitutes nephropathy screening? (LOINC codes)

- Microalbumin [Mass/volume] in Urine by Test strip
- Protein [Mass/volume] in 12 hour Urine
- Albumin/Creatinine [Mass ratio] in 24 hour Urine
- Protein/Creatinine [Mass ratio] in 24 hour Urine
- Albumin/Creatinine [Molar ratio] in Urine
- Microalbumin [Mass/time] in 24 hour Urine
- Microalbumin [Mass/volume] in Urine
- Microalbumin/Creatinine [Mass ratio] in 24 hour Urine
- Microalbumin/Creatinine [Mass ratio] in Urine
- Albumin [Presence] in Urine
- Albumin [Mass/volume] in Urine
- Albumin [Mass/time] in 24 hour Urine
- Albumin renal clearance in 24 hour
- Protein [Mass/time] in 6 hour Urine
- Albumin/Creatinine [Presence] in Urine by Test strip
- Albumin [Mass/volume] in 24 hour Urine
- Protein [Mass/volume] in 24 hour Urine
- Protein [Mass/time] in 12 hour Urine
- Protein [Units/volume] in Urine
- Protein [Presence] in Urine
- Protein [Mass/volume] in Urine
- Protein [Mass/time] in 24 hour Urine
- Protein/Creatinine [Mass ratio] in Urine
- Microalbumin/Creatinine [Ratio] in Urine
- Microalbumin/Creatinine [Ratio] in Urine by Test strip
- Microalbumin [Mass/volume] in 24 hour Urine
- Protein [Presence] in 24 hour Urine by Test strip
- Albumin/Creatinine [Ratio] in Urine
- Protein [Mass] in unspecified time Urine
- Protein/Creatinine [Ratio] in Urine
- Protein [Mass/volume] in unspecified time Urine
- Protein/Creatinine [Ratio] in 24 hour Urine
- Protein [Mass/time] in 12 hour Urine --resting

What constitutes nephropathy screening? (LOINC codes)

- Protein [Mass/time] in 12 hour Urine --upright
- Microalbumin [Mass/volume] in 4 hour Urine
- Microalbumin [Mass/time] in 4 hour Urine
- Microalbumin [Mass/time] in 12 hour Urine
- Microalbumin/Creatinine [Mass ratio] in 12 hour Urine
- Microalbumin/Protein.total in 24 hour Urine
- Microalbumin [Mass/time] in unspecified time Urine
- Albumin [Presence] in Urine by Test strip
- Protein [Mass/time] in 1 hour Urine
- Microalbumin [Mass/volume] in 24 hour Urine by Detection limit ≤ 1.0 mg/L
- Microalbumin [Mass/volume] in Urine by Detection limit ≤ 1.0 mg/L
- Microalbumin [Mass/time] in 24 hour Urine by Detection limit ≤ 1.0 mg/L
- Albumin/Creatinine [Mass ratio] in Urine

What constitutes nephropathy screening? (SNOMED-CT codes)

- Nephropathy screening (procedure)

What constitutes a nephropathy-related procedure? (CPT codes)

- Arteriovenous anastomosis, open; by forearm vein transposition
- Arteriovenous anastomosis, open; by upper arm basilic vein transposition
- Arteriovenous anastomosis, open; by upper arm cephalic vein transposition
- Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)
- Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician evaluations, with or without substantial revision of dialysis prescription
- Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation
- Dialysis training, patient, including helper where applicable, any mode, completed course
- Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session
- Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral
- Donor nephrectomy (including cold preservation); open, from living donor
- End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
- End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
- End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
- End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
- End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
- End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face physician visits per month

What constitutes a nephropathy-related procedure? (CPT codes)

- End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
- End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month
- End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face physician visits per month
- End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month
- Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method
- Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
- Hemodialysis procedure with single physician evaluation
- Hemoperfusion (eg, with activated charcoal or resin)
- Home visit for hemodialysis
- Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external (Scribner type)
- Insertion of cannula for hemodialysis, other purpose (separate procedure); arteriovenous, external revision, or closure
- Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein
- Recipient nephrectomy (separate procedure)
- Removal of transplanted renal allograft
- Renal allotransplantation, implantation of graft; with recipient nephrectomy
- Renal allotransplantation, implantation of graft; without recipient nephrectomy
- Renal autotransplantation, reimplantation of kidney
- Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)
- Unlisted dialysis procedure, inpatient or outpatient
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
- Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
- Urinalysis; qualitative or semiquantitative, except immunoassays

What constitutes a nephropathy-related procedure? (HCPCS codes)

- Unscheduled or emergency dialysis treatment for an esrd patient in a hospital outpatient department that is not certified as an esrd facility
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services, during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits per month
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2 or 3 face-to-face physician visits per month

What constitutes a nephropathy-related procedure? (HCPCS codes)

- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face physician visit per month
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services during the course of treatment, for patients 20 years of age and over; with 4 or more face-to-face physician visits per month
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services during the course of treatment, for patients 20 years of age and over; with 2 or 3 face-to-face physician visits per month
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services during the course of treatment, for patients 20 years of age and over; with 1 face-to-face physician visit per month
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services for home dialysis patients per full month; for patients twelve to nineteen years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services for home dialysis patients per full month; for patients twenty years of age and older
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services less than full month, per day; for patients between twelve and nineteen years of age
- TERMINATED 12/31/2008 : End stage renal disease (esrd) related services less than full month, per day; for patients twenty years of age and over
- TERMINATED 12/31/2009 : Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial
- TERMINATED 12/31/2009 : Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous
- Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

What constitutes a nephropathy-related procedure? (ICD-9 CM codes)

• Venous catheterization for renal dialysis	38.95
• Arteriovenostomy for renal dialysis	39.27
• Revision of arteriovenous shunt for renal dialysis	39.42
• Removal of arteriovenous shunt for renal dialysis	39.43
• Repair of arteriovenous fistula	39.53
• Insertion of vessel-to-vessel cannula	39.93
• Replacement of vessel-to-vessel cannula	39.94
• Hemodialysis	39.95
• Peritoneal dialysis	54.98
• Partial nephrectomy	55.4
• Complete nephrectomy	55.5
• Transplant of kidney	55.6

What constitutes a nephropathy-related procedure? (ICD-10 CM codes)

- Encounter for care involving renal dialysis
- Preparatory care for renal dialysis
- Encounter for fitting and adjustment of extracorporeal dialysis catheter
- Encounter for fitting and adjustment of peritoneal dialysis cathet

What constitutes a nephropathy-related procedure? (ICD-10 CM codes)

- Encounter for adequacy testing for dialysis
- Encounter for adequacy testing for hemodialysis
- Encounter for adequacy testing for peritoneal dialysis
- Dependence on renal dialysis
- Encounter for care involving renal dialysis
- Preparatory care for renal dialysis
- Encounter for fitting and adjustment of extracorporeal dialysis catheter

What constitutes a nephropathy-related procedure? (SNOMED-CT codes)

- Automated peritoneal dialysis (procedure)
- Chronic peritoneal dialysis (procedure)
- Continuous ambulatory peritoneal dialysis (procedure)
- Continuous arteriovenous hemodiafiltration (procedure)
- Continuous arteriovenous hemofiltration (procedure)
- Continuous cycling peritoneal dialysis (procedure)
- Continuous hemodiafiltration (procedure)
- Continuous hemodialysis (procedure)
- Continuous hemofiltration (procedure)
- Continuous venovenous hemodiafiltration (procedure)
- Continuous venovenous hemofiltration (procedure)
- End stage renal disease (procedure)
- End stage renal failure on dialysis (procedure)
- End stage renal failure untreated by renal replacement therapy (procedure)
- Extracorporeal albumin hemodialysis (procedure)
- Hemodiafiltration (procedure)
- Hemodialysis (procedure)
- Hemodialysis, maintenance at home (procedure)
- Hemodialysis, maintenance in hospital (procedure)
- Hemodialysis, supervision at home (procedure)
- Hemofiltration (procedure)
- Initial hemodialysis (procedure)
- Intermittent hemodiafiltration (procedure)
- Intermittent hemodialysis (procedure)
- Intermittent hemofiltration (procedure)
- Intermittent peritoneal dialysis (procedure)
- Night-time intermittent peritoneal dialysis (procedure)
- Peritoneal dialysis (procedure)
- Peritoneal dialysis catheter maintenance (procedure)
- Peritoneal dialysis excluding cannulation (procedure)
- Peritoneal dialysis including cannulation (procedure)
- Renal dialysis (procedure)
- Stab peritoneal dialysis (procedure)

What constitutes a nephropathy-related procedure? (SNOMED-CT codes)

- Stabilizing hemodialysis (procedure)
- Tidal peritoneal dialysis (procedure)
- Decreased albumin (finding)
- Albuminuria (finding)
- Abnormal presence of albumin (finding)

What constitutes an active diagnosis of nephropathy? (ICD-9 CM codes)

- | | |
|---|--------|
| • Diabetes with renal manifestations | 250.4 |
| • Hypertensive kidney disease | 403 |
| • Hypertensive heart and kidney disease | 404 |
| • Malignant renovascular hypertension | 405.01 |
| • Benign renovascular hypertension | 405.11 |
| • Unspecified renovascular hypertension | 405.91 |
| • Nephrotic syndrome | 581 |
| • Chronic glomerulonephritis | 582 |
| • Nephritis and nephropathy not specified as acute or chronic | 583 |
| • Acute kidney failure | 584 |
| • Chronic kidney disease (ckd) | 585 |
| • Renal failure unspecified | 586 |
| • Renal sclerosis unspecified | 587 |
| • Disorders resulting from impaired renal function | 588 |
| • Congenital anomalies of urinary system | 753 |
| • Nonspecific findings on examination of urine | 791 |
| • Kidney replaced by transplant | V42.0 |
| • Postsurgical renal dialysis status | V45.1 |
| • Renal dialysis status | V45.11 |
| • Noncompliance with renal dialysis | V45.12 |
| • Encounter for dialysis and dialysis catheter care | V56 |
| • Aftercare involving extracorporeal dialysis | V56.0 |
| • Fitting and adjustment of extracorporeal dialysis catheter | V56.1 |
| • Fitting and adjustment of peritoneal dialysis catheter | V56.2 |
| • Encounter for adequacy testing for dialysis | V56.3 |
| • Encounter for adequacy testing for hemodialysis | V56.31 |
| • Encounter for adequacy testing for peritoneal dialysis | V56.32 |
| • Aftercare involving other dialysis | V56.8 |

What constitutes an active diagnosis of nephropathy? (ICD-10 CM codes)

- Mononeuropathies of upper limb
- Other specified mononeuropathies of upper limb
- Other specified mononeuropathies of unspecified upper limb
- Other specified mononeuropathies of right upper limb
- Other specified mononeuropathies of left upper limb

What constitutes an active diagnosis of nephropathy? (ICD-10 CM codes)

- Unspecified mononeuropathy of upper limb
- Unspecified mononeuropathy of unspecified upper limb
- Unspecified mononeuropathy of right upper limb
- Unspecified mononeuropathy of left upper limb
- Mononeuropathies of lower limb
- Other specified mononeuropathies of lower limb
- Other specified mononeuropathies of unspecified lower limb
- Other specified mononeuropathies of right lower limb
- Other specified mononeuropathies of left lower limb
- Unspecified mononeuropathy of lower limb
- Unspecified mononeuropathy of unspecified lower limb
- Unspecified mononeuropathy of right lower limb
- Unspecified mononeuropathy of left lower limb
- Other mononeuropathies
- Intercostal neuropathy
- Mononeuritis multiplex
- Other specified mononeuropathies
- Mononeuropathy, unspecified
- Mononeuropathy in diseases classified elsewhere
- Inflammatory polyneuropathy
- Guillain-Barre syndrome
- Serum neuropathy
- Other inflammatory polyneuropathies
- Chronic inflammatory demyelinating polyneuritis
- Other inflammatory polyneuropathies
- Inflammatory polyneuropathy, unspecified
- Other and unspecified polyneuropathies
- Drug-induced polyneuropathy
- Polyneuropathy, unspecified

What constitutes an active diagnosis of nephropathy? (ICD-10 CM codes)

- Diabetes mellitus without complication (disorder)
- Insulin coma (disorder)
- Brittle diabetes mellitus (disorder)
- Houssay's syndrome (disorder)
- Diabetic renal disease (disorder)
- Diabetic peripheral angiopathy (disorder)
- Diabetes mellitus with no mention of complication (disorder)
- Diabetes mellitus NOS with ketoacidosis (disorder)
- Diabetes mellitus, juvenile type, with hyperosmolar coma (disorder)
- Diabetes mellitus, adult onset, with hyperosmolar coma (disorder)
- Other specified diabetes mellitus with coma (disorder)

What constitutes an active diagnosis of nephropathy? (ICD-10 CM codes)

- Diabetes mellitus NOS with neurological manifestation (disorder)
- Diabetes mellitus NOS with peripheral circulatory disorder (disorder)
- Type I diabetes mellitus with ulcer (disorder)
- Type I diabetes mellitus with gangrene (disorder)
- Type I diabetes mellitus - poor control (disorder)
- Type I diabetes mellitus maturity onset (disorder)
- Unspecified diabetes mellitus with multiple complications (disorder)
- Type II diabetes mellitus with ulcer (disorder)
- Type II diabetes mellitus with gangrene (disorder)
- Type II diabetes mellitus - poor control (disorder)
- Malnutrition-related diabetes mellitus with ketoacidosis (disorder)
- Malnutrition-related diabetes mellitus with renal complications (disorder)
- Malnutrition-related diabetes mellitus with peripheral circulatory complications (disorder)
- Malnutrition-related diabetes mellitus with multiple complications (disorder)
- Malnutrition-related diabetes mellitus without complications (disorder)
- Diabetes mellitus with other specified manifestation (disorder)
- Diabetes mellitus, juvenile type, with other specified manifestation (disorder)
- Diabetes mellitus, adult onset, with other specified manifestation (disorder)
- Diabetes mellitus with unspecified complication (disorder)
- Chronic painful diabetic neuropathy (disorder)
- Nephrotic syndrome in diabetes mellitus (disorder)
- Complications of pregnancy, childbirth and the puerperium (disorder)
- Diabetes mellitus during pregnancy, childbirth and the puerperium (disorder)
- Diabetes mellitus during pregnancy - baby not yet delivered (disorder)
- Pre-existing diabetes mellitus, insulin-dependent (disorder)
- Pre-existing diabetes mellitus, non-insulin-dependent (disorder)
- Pre-existing malnutrition-related diabetes mellitus (disorder)
- Diabetes mellitus during pregnancy, childbirth or the puerperium NOS (disorder)
- Ischemic ulcer diabetic foot (disorder)
- Neuropathic diabetic ulcer - foot (disorder)
- Mixed diabetic ulcer - foot (disorder)
- Insulin dependent diabetes mellitus type IA (disorder)
- Diabetic neuropathy (disorder)
- Diabetic mononeuropathy (disorder)
- Insulin-treated non-insulin-dependent diabetes mellitus (disorder)
- Malnutrition-related diabetes mellitus - fibrocalculus (disorder)
- Secondary endocrine diabetes mellitus (disorder)
- Diabetes mellitus autosomal dominant type II (disorder)
- Hyperproinsulinemia (disorder)
- Insulin-dependent diabetes mellitus secretory diarrhea syndrome (disorder)
- Diabetes-deafness syndrome maternally transmitted (disorder)
- Pregnancy and non-insulin-dependent diabetes mellitus (disorder)

What constitutes an active diagnosis of nephropathy? (ICD-10 CM codes)

- Diabetic gangrene (disorder)
- Diabetic coma with ketoacidosis (disorder)
- Diabetes mellitus, juvenile type, with no mention of complication (disorder)
- Diabetes mellitus, adult onset, with no mention of complication (disorder)
- Fibrocalculous pancreatic diabetes (disorder)
- Unstable diabetes (disorder)
- Insulin dependent diabetes mellitus type IB (disorder)
- Maturity onset diabetes mellitus in young (disorder)
- Brittle type I diabetes mellitus (disorder)
- Diabetic glomerulopathy (disorder)
- Diabetic intracapillary glomerulosclerosis (disorder)
- Kimmelstiel-Wilson syndrome (disorder)
- Diabetic macular edema (disorder)
- Type I diabetes mellitus without complication (disorder)
- Type II diabetes mellitus without complication (disorder)
- Diabetic optic papillopathy (disorder)
- Type I diabetes mellitus with hypoglycemic coma (disorder)
- Type II diabetes mellitus with hypoglycemic coma (disorder)
- Type I diabetes mellitus with arthropathy (disorder)
- Type II diabetes mellitus with peripheral angiopathy (disorder)
- Type II diabetes mellitus with arthropathy (disorder)
- Pineal hyperplasia AND diabetes mellitus syndrome (disorder)
- Diabetic gastroparesis (disorder)
- Diabetic neuropathy with neurologic complication (disorder)
- Non -insulin-dependent diabetes mellitus in nonobese (disorder)
- Diabetes mellitus type 2 in nonobese (disorder)
- Hypoglycemic shock (disorder)
- Diabetic foot ulcer (disorder)
- Nodular glomerulosclerosis (disorder)
- Diabetic amyotrophy (disorder)
- Diabetic radiculopathy (disorder)
- Insulin autoimmune syndrome (disorder)
- Diabetes mellitus induced by non-steroid drugs (disorder)
- Diabetes mellitus induced by non-steroid drugs without complication (disorder)
- On examination - left chronic diabetic foot ulcer (finding)
- On examination - right chronic diabetic foot ulcer (finding)
- Multiple complications of type II diabetes mellitus (disorder)
- Ketoacidosis in diabetes mellitus (disorder)
- Ketoacidosis in type II diabetes mellitus (disorder)
- Ketoacidotic coma in type II diabetes mellitus (disorder)
- Peripheral circulatory disorder associated with diabetes mellitus (disorder)
- Skin ulcer associated with diabetes mellitus (disorder)

What constitutes an active diagnosis of nephropathy? (ICD-10 CM codes)

- Multiple complications of type I diabetes mellitus (disorder)
- Gangrene associated with diabetes mellitus (disorder)
- Diabetic autonomic neuropathy associated with type 2 diabetes mellitus (disorder)
- Diabetic peripheral neuropathy (disorder)
- Diabetic gastroparesis associated with type 2 diabetes mellitus (disorder)
- Diabetic gastroparesis associated with type 1 diabetes mellitus (disorder)
- Diabetic autonomic neuropathy associated with type 1 diabetes mellitus (disorder)
- Diabetes mellitus associated with cystic fibrosis (disorder)
- Latent autoimmune diabetes mellitus in adult (disorder)
- Diabetes mellitus due to cystic fibrosis (disorder)
- Hyperosmolality due to uncontrolled type 1 diabetes mellitus (disorder)
- Diabetes mellitus associated with receptor abnormality (disorder)
- Diabetes mellitus type 2 (disorder)
- Diabetes mellitus type 1 (disorder)
- Diabetic autonomic neuropathy (disorder)
- Diabetes mellitus associated with pancreatic disease (disorder)
- Drug-induced diabetes mellitus (disorder)
- Diabetes-nephrosis syndrome (disorder)
- Protein-deficient diabetes mellitus (disorder)
- Diabetes mellitus associated with hormonal etiology (disorder)
- Diabetes mellitus associated with genetic syndrome (disorder)
- Diabetes mellitus AND insipidus with optic atrophy AND deafness (disorder)
- Diabetes mellitus (disorder)
- Carpenter syndrome (disorder)
- Malnutrition related diabetes mellitus (disorder)
- Diabetes mellitus due to insulin receptor antibodies (disorder)
- Diabetes mellitus in mother complicating pregnancy, childbirth AND/OR puerperium (disorder)
- Diabetes mellitus type 2 in obese (disorder)
- Diabetic mononeuropathy simplex (disorder)
- Secondary diabetes mellitus (disorder)
- Diabetes mellitus due to structurally abnormal insulin (disorder)
- Insulin-resistant diabetes mellitus AND acanthosis nigricans (disorder)

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

NQF0061	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	×			×	×		×	×	×	×	×
Denominator ²	×			×		×	×	×		×	×
Exceptions or exclusions ³				×			×	×		×	×

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerator in this CQM, the following standard code is required: (1) one "diagnosis/condition/problem" code from ICD-9, ICD-10 or SNOMED, (2) one "laboratory test" code from CPT, LOINC, SNOMED, or GROUPING, (3) one "procedure" code from CPT, HCPCS, ICD-9, ICD-10, SNOMED, or GROUPING, OR (4) a "medication" code from RxNorm or GROUPING.
- 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)
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)

Abbreviation	Long Name	Definition/Description
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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