

NQF 0073: Ischemic Vascular Disease (IVD): Blood Pressure Management

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, 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 0068: Ischemic Vascular Disease (IVD): Blood Pressure Management	4
Technical Supplement.....	TS-1
Denominator Inclusion Criteria	TS-2
Numerator Inclusion Criteria	TS-7
Types of codes required from your EHR for calculating this clinical quality measure	TS-9

NQF 0068: Ischemic Vascular Disease (IVD): Blood Pressure Management

The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1– November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

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 measure: <ul style="list-style-type: none"> Hypertension: Blood Pressure Measurement (NQF 0013) Controlling High Blood Pressure (NQF 0018) Diabetes: Blood Pressure Management (NQF 0061) Ischemic Vascular Disease (IVD): Use of Aspirin (NQF 0068) Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (NQF 0075)
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Inpatient or outpatient encounter code¹ Active diagnosis of ischemic vascular disease Inpatient discharge for acute myocardial infarction, PTCA, or CABG²
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Systolic blood pressure Diastolic Blood Pressure
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> None

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 occur ≤ 2 years before the end of the measurement period

² This data element(s) must be 14 to 24 months before the end of 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 at least 18 years of age during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Date of birth 	
2. Record the type and date of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. 	<ul style="list-style-type: none"> Date of visit³ Encounter code 	
3. Check patient record or an active diagnosis of ischemic vascular disease (IVD)	<ul style="list-style-type: none"> Ensures patients with an active IVD diagnosis are included in the denominator. 	<ul style="list-style-type: none"> Diagnosis code for IVD⁴ Date of IVD diagnosis 	
4. Check patient record for CABG, PTCA, or AMI discharge	<ul style="list-style-type: none"> Ensure patients who have had a PTCA, CABG, or AMI hospitalization are captured in the denominator 	<ul style="list-style-type: none"> Procedure code for PTCA⁵ or CABG⁶ Date of procedure Date of discharge Diagnosis code for AMI⁷ 	
5. Take patient's blood pressure reading	<ul style="list-style-type: none"> Ensures all patients with blood pressure readings are included in the numerator. 	<ul style="list-style-type: none"> Documentation minimum systolic blood pressure value⁸ Documentation of minimum diastolic blood pressure value 	

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

⁴ See the Technical Supplement for denominator inclusion details (IVD Diagnosis): [pp. TS-6](#)

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

⁶ See the Technical Supplement for denominator inclusion details (CABG): [pp. TS-4](#)

⁷ See the Technical Supplement for denominator inclusion details (AMI): [pp. TS-4](#)

⁸ See the Technical Supplement for numerator inclusion details (blood pressure): [pp. TS-7](#)

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 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

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 examination and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.
- Observation care discharge day management
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an examination, and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an examination, and medical decision making.
- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient.
- 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) provided to individuals in a group setting (separate procedure)
- Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- Unlisted preventive medicine
- Work related or medical disability examination by the treating physician or other than treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report

What counts as percutaneous transluminal coronary angioplasty? (CPT codes)

- Transmyocardial laser revascularization, by thoracotomy; (separate procedure)
- Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
- Percutaneous transluminal coronary balloon angioplasty; single vessel

What counts as percutaneous transluminal coronary angioplasty? (CPT codes)

- Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel

What counts as a percutaneous transluminal angioplasty? (SNOMED CT codes)

- Coronary artery bypass with autogenous graft, three grafts (procedure)
- Percutaneous transluminal coronary angioplasty (procedure)
- Internal mammary-coronary artery bypass graft (procedure)
- Coronary artery bypass graft, anastomosis of artery of thorax to coronary artery (procedure)
- Saphenous vein graft replacement of one coronary artery (procedure)
- Saphenous vein graft replacement of two coronary arteries (procedure)
- Saphenous vein graft replacement of three coronary arteries (procedure)
- Saphenous vein graft replacement of four or more coronary arteries (procedure)
- Other specified saphenous vein graft replacement of coronary artery (procedure)
- Autograft replacement of three coronary arteries NEC (procedure)
- Allograft bypass of coronary artery (procedure)
- Allograft replacement of one coronary artery (procedure)
- Allograft replacement of two coronary arteries (procedure)
- Allograft replacement of three coronary arteries (procedure)
- Allograft replacement of four or more coronary arteries (procedure)
- Other specified allograft replacement of coronary artery (procedure)
- Prosthetic bypass of coronary artery (procedure)
- Prosthetic replacement of one coronary artery (procedure)
- Prosthetic replacement of two coronary arteries (procedure)
- Prosthetic replacement of three coronary arteries (procedure)
- Prosthetic replacement of four or more coronary arteries (procedure)
- Other specified prosthetic replacement of coronary artery (procedure)
- Revision of bypass for coronary artery (procedure)
- Revision of bypass for one coronary artery (procedure)
- Revision of bypass for two coronary arteries (procedure)
- Revision of bypass for three coronary arteries (procedure)
- Revision of bypass for four or more coronary arteries (procedure)
- Revision of connection of thoracic artery to coronary artery (procedure)
- Other specified revision of bypass for coronary artery (procedure)
- Connection of mammary artery to coronary artery (procedure)
- Double implantation of mammary arteries into coronary arteries (procedure)
- Single anastomosis of mammary artery to left anterior descending coronary artery (procedure)
- Single implantation of mammary artery into coronary artery (procedure)
- Other specified connection of mammary artery to coronary artery (procedure)
- Connection of other thoracic artery to coronary artery (procedure)
- Other specified connection of other thoracic artery to coronary artery (procedure)
- Percutaneous transluminal balloon angioplasty of bypass graft of coronary artery (procedure)
- Coronary artery bypass grafting (procedure)
- Coronary artery bypass graft(s)
- Double anastomosis of mammary arteries to coronary arteries (procedure)
- Left internal mammary artery single anastomosis (procedure)
- Right internal mammary artery (RIMA) single anastomosis (procedure)
- Left internal mammary artery (LIMA) sequential anastomosis (procedure)
- Right internal mammary artery (RIMA) sequential anastomosis (procedure)

What counts as a percutaneous transluminal angioplasty? (SNOMED CT codes)

- Anastomosis of thoracic artery to coronary artery, double (procedure)
- Aortocoronary bypass grafting (procedure)
- Aortocoronary artery bypass graft with saphenous vein graft (procedure)
- Single internal mammary-coronary artery bypass (procedure)
- Coronary artery bypass with autogenous graft of internal mammary artery, single graft (procedure)
- Coronary artery bypass with autogenous graft, four grafts (procedure)
- Percutaneous transluminal coronary angioplasty by rotoablation (procedure)
- Anastomosis of internal mammary artery to coronary artery, double vessel (procedure)
- Percutaneous transluminal coronary angioplasty with rotoablation, single vessel (procedure)
- Emergency coronary artery bypass graft (procedure)
- Anastomosis of thoracic artery to coronary artery, single (procedure)
- Coronary artery bypass with autogenous graft, two grafts (procedure)
- Infusion of intra-arterial thrombolytic agent with percutaneous transluminal coronary angioplasty (procedure)
- Infusion of intra-arterial thrombolytic agent with percutaneous transluminal coronary angioplasty, multiple vessels (procedure)

What counts as a coronary artery bypass graft? (CPT codes)

- Coronary artery bypass, vein only
- Coronary artery bypass, using venous graft(s) and arterial graft(s)
- Coronary artery bypass, using arterial graft(s)

What counts as a coronary artery bypass graft? (SNOMED CT codes)

- Coronary artery bypass with autogenous graft, three grafts (procedure)
- Evaluation AND/OR management - new patient (procedure)
- Evaluation AND/OR management - established patient (procedure)
- Subsequent hospital visit by physician (procedure)
- History and physical examination with management of domiciliary or rest home patient (procedure)
- Evaluation and management of established outpatient in office or other outpatient facility (procedure)
- Evaluation and management of new outpatient in office or other outpatient facility (procedure)
- Coronary artery bypass with autogenous graft, four grafts (procedure)
- Emergency department patient visit (procedure)
- Initial hospital visit by physician (procedure)
- Coronary artery bypass with autogenous graft, two grafts (procedure)
- Final inpatient visit with instructions at discharge (procedure)
- Evaluation and management of inpatient (procedure)

What counts as an acute myocardial infarction? (ICD-9 codes)

- Acute myocardial infarction of anterolateral wall (initial episode of care)
- Acute myocardial infarction of other anterior wall (initial episode of care)
- Acute myocardial infarction of inferolateral wall (initial episode of care)
- Acute myocardial infarction of inferoposterior wall (initial episode of care)
- Acute myocardial infarction of other inferior wall (initial episode of care)

What counts as an acute myocardial infarction? (SNOMED CT codes)

- Acute infarction of papillary muscle (disorder)
- Acute myocardial infarction of posterolateral wall (disorder)

What counts as an acute myocardial infarction? (SNOMED CT codes)

- Acute anteroapical infarction (disorder)
- Acute atrial infarction (disorder)
- Myocardial infarction (disorder)
- Acute Q wave infarction - anteroseptal (disorder)
- Acute non-Q wave infarction - anteroseptal (disorder)
- Acute Q wave infarction - anterolateral (disorder)
- Acute non-Q wave infarction - anterolateral (disorder)
- Acute Q wave infarction - inferior (disorder)
- Acute non-Q wave infarction - inferior (disorder)
- Acute Q wave infarction - inferolateral (disorder)
- Acute non-Q wave infarction - inferolateral (disorder)
- Acute Q wave infarction - lateral (disorder)
- Acute non-Q wave infarction - lateral (disorder)
- Acute widespread myocardial infarction (disorder)
- Acute Q wave infarction - widespread (disorder)
- Acute non-Q wave infarction - widespread (disorder)
- Acute posterior myocardial infarction (disorder)
- Acute myocardial infarction of basal-lateral wall (disorder)
- Acute myocardial infarction with rupture of ventricle (disorder)
- Acute Q wave myocardial infarction (disorder)
- Acute non-Q wave infarction (disorder)
- Acute ST segment elevation myocardial infarction (disorder)
- Acute non-ST segment elevation myocardial infarction (disorder)
- Acute anteroapical myocardial infarction (disorder)
- Acute myocardial infarction of anterior wall (disorder)
- Acute myocardial infarction (disorder)
- Acute myocardial infarction of lateral wall (disorder)
- Acute myocardial infarction of apical-lateral wall (disorder)
- Acute anteroseptal myocardial infarction (disorder)
- Acute myocardial infarction of high lateral wall (disorder)
- Acute myocardial infarction of inferolateral wall (disorder)
- Acute myocardial infarction of anterolateral wall (disorder)
- Acute subendocardial infarction (disorder)
- Acute myocardial infarction of posterobasal wall (disorder)
- Acute myocardial infarction of inferior wall (disorder)
- Acute myocardial infarction of inferoposterior wall (disorder)
- Acute myocardial infarction of septum (disorder)
- Occlusion of cerebral arteries without mention of cerebral infarction
- Postmyocardial infarction syndrome
- Intermediate coronary syndrome
- Other coronary insufficiency or subendocardial ischemia
- Angina decubitus
- Prinzmetal angina
- Other and unspecified angina pectoris
- Ischemic heart disease of unspecified type of vessel, native or graft
- Ischemic heart disease of autologous biological bypass graft
- Ischemic heart disease of nonautologous biological bypass graft
- Ischemic heart disease of artery bypass graft

What counts as an acute myocardial infarction? (SNOMED CT codes)

- Ischemic heart disease of unspecified type of bypass graft
- Ischemic heart disease of native coronary artery of transplanted heart
- Ischemic heart disease of bypass graft of artery or vein of transplanted heart
- Chronic total occlusion of coronary artery
- Other specified forms of chronic ischemic heart disease
- Chronic ischemic heart disease, unspecified
- Cardiovascular disease, unspecified
- Occlusion and stenosis of precerebral basilar artery
- Occlusion and stenosis of precerebral basilar artery with cerebral infarction
- Occlusion and stenosis of carotid artery with cerebral infarction
- Occlusion and stenosis of vertebral artery without mention of cerebral infarction
- Occlusion and stenosis of vertebral artery with cerebral infarction
- Occlusion and stenosis of multiple and bilateral arteries without mention of cerebral infarction
- Occlusion and stenosis of multiple and vertebral arteries with cerebral infarction
- Occlusion and stenosis of other specified precerebral artery without mention of cerebral infarction
- Occlusion and stenosis of other specified precerebral artery with cerebral infarction
- Occlusion and stenosis of unspecified precerebral artery without mention of cerebral infarction
- Occlusion and stenosis of unspecified cerebral artery with cerebral infarction
- Cerebral thrombosis with cerebral infarction
- Cerebral embolism without mention of cerebral infarction
- Cerebral embolism with cerebral infarction
- Cerebral artery occlusion, unspecified without mention of cerebral infarction
- Cerebral artery occlusion, unspecified with cerebral infarction
- Atherosclerosis of renal artery
- Atherosclerosis of the extremities, unspecified
- Atherosclerosis of the extremities with intermittent claudication
- Atherosclerosis of the extremities with rest pain
- Atherosclerosis of the extremities with ulceration
- Atherosclerosis of extremities with gangrene
- Other atherosclerosis
- Chronic total occlusion of the artery of the extremities
- Atherosclerosis of aorta
- Arterial embolism and thrombosis of thoracic aorta
- Arterial embolism and thrombosis of upper extremity
- Arterial embolism and thrombosis of lower extremity
- Arterial embolism and thrombosis of iliac artery
- Other arterial embolism and thrombosis
- Arterial embolism and thrombosis of unspecified artery
- Atheroembolism of upper extremity
- Atheroembolism of lower extremity
- Atheroembolism of other sites
- Atheroembolism of kidney

What counts as ischemic vascular disease? (SNOMED CT codes)

- Chronic cerebral ischemia (disorder)
- Carotid artery syndrome hemispheric (disorder)
- Intermittent cerebral ischemia (disorder)
- Neonatal cerebral ischemia (disorder)

What counts as ischemic vascular disease? (SNOMED CT codes)

- Carotid territory transient ischemic attack (disorder)
- Vertebrobasilar territory transient ischemic attack (disorder)
- Stagnated internal hemorrhoids (disorder)
- Peripheral ischemia (disorder)
- Upper limb ischemia (disorder)
- Critical upper limb ischemia (disorder)
- Lower limb ischemia (disorder)
- Critical lower limb ischemia (disorder)
- Ischemia of stoma (disorder)
- Gangrenous pile (disorder)
- Perinatal cerebral ischemia (disorder)
- Cerebral ischemia (disorder)
- Ischemia of feet (disorder)
- Ischemic foot (disorder)
- Trash foot (disorder)
- Ischemic hand (disorder)
- Ischemic toe (disorder)
- Ischemic finger (disorder)
- Critical ischemia of foot (disorder)
- Choroidal ischemia (disorder)
- Ischemic disorder of spinal cord (disorder)
- Ischemic gangrene (disorder)
- Anterior segment ischemia (disorder)
- Orbital ischemic syndrome (disorder)
- Infarction of spinal cord (disorder)
- Ischemia (disorder)
- Transient ischemia (disorder)
- Acute infarction of spinal cord (disorder)
- Basilar artery syndrome (disorder)
- Strangulated external hemorrhoids (disorder)
- Strangulated hemorrhoids (disorder)
- Amaurosis fugax (disorder)
- Brain stem ischemia (disorder)

NUMERATOR INCLUSION CRITERIA

What counts as a systolic blood pressure measurement? (SNOMED CT codes)

- Normal systolic arterial pressure (finding)
- On examination - Systolic BP reading (finding)
- Non-invasive systolic arterial pressure (observable entity)
- Invasive systolic arterial pressure (observable entity)
- Systolic blood pressure (observable entity)
- Minimum systolic blood pressure (observable entity)
- Maximum systolic blood pressure (observable entity)
- Average systolic blood pressure (observable entity)
- Minimum day interval systolic blood pressure (observable entity)
- Minimum night interval systolic blood pressure (observable entity)

What counts as a systolic blood pressure measurement? (SNOMED CT codes)

- Maximum night interval systolic blood pressure (observable entity)
- Maximum day interval systolic blood pressure (observable entity)
- Average night interval systolic blood pressure (observable entity)
- Average day interval systolic blood pressure (observable entity)
- Minimum 24 hour systolic blood pressure (observable entity)
- Maximum 24 hour systolic blood pressure (observable entity)
- Average 24 hour systolic blood pressure (observable entity)
- 24 hour systolic blood pressure (observable entity)
- Target systolic blood pressure (observable entity)
- Systolic blood pressure on admission (observable entity)
- Standing systolic blood pressure (observable entity)
- Sitting systolic blood pressure (observable entity)
- Lying systolic blood pressure (observable entity)
- Systolic arterial pressure (observable entity)
- Decreased systolic arterial pressure (finding)
- Normal systolic arterial pressure (finding)
- On examination - Systolic BP reading (finding)
- Non-invasive systolic arterial pressure (observable entity)
- Invasive systolic arterial pressure (observable entity)
- Systolic blood pressure (observable entity)
- Minimum systolic blood pressure (observable entity)
- Maximum systolic blood pressure (observable entity)
- Average systolic blood pressure (observable entity)
- Minimum day interval systolic blood pressure (observable entity)
- Minimum night interval systolic blood pressure (observable entity)
- Maximum night interval systolic blood pressure (observable entity)
- Maximum day interval systolic blood pressure (observable entity)
- Average night interval systolic blood pressure (observable entity)
- Average day interval systolic blood pressure (observable entity)
- Minimum 24 hour systolic blood pressure (observable entity)
- Maximum 24 hour systolic blood pressure (observable entity)
- Average 24 hour systolic blood pressure (observable entity)
- 24 hour systolic blood pressure (observable entity)
- Target systolic blood pressure (observable entity)
- Systolic blood pressure on admission (observable entity)
- Standing systolic blood pressure (observable entity)
- Sitting systolic blood pressure (observable entity)
- Lying systolic blood pressure (observable entity)
- Systolic arterial pressure (observable entity)
- Decreased systolic arterial pressure (finding)

What counts as diastolic blood pressure measurement? (SNOMED CT codes)

- Systolic blood pressure (observable entity)
- Minimum systolic blood pressure (observable entity)
- Maximum systolic blood pressure (observable entity)
- Average systolic blood pressure (observable entity)
- Minimum day interval systolic blood pressure (observable entity)
- Minimum night interval systolic blood pressure (observable entity)
- Maximum night interval systolic blood pressure (observable entity)
- Maximum day interval systolic blood pressure (observable entity)
- Average night interval systolic blood pressure (observable entity)
- Average day interval systolic blood pressure (observable entity)
- Systolic arterial pressure (observable entity)

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

NQF0073	CPT	CPT Modifier	CVX	Grouping	HCPSCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x						x				x
Denominator ²	x			x	x	x	x				x
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 "physical exam" code for Systolic BP and one "physical exam" code of Diastolic BP found in SNOMED, AND (2) one "encounter" code from CPT, ICD-9,
- ² To identify the denominator in this CQM, the following standard codes are required: (1) an "individual characteristic" code from HL7, AND (2) an "encounter" code from CPT, or ICD-9 AND a "procedure" code from CPT, HCPSCS, ICD-9, or SNOMED, OR a "diagnosis/condition/problem" code from ICD-9, ICD-10, or SNOMED, OR (3) a "procedure" code from CPT, ICD-9, or SNOMED.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPSCS	Healthcare Common Procedure Coding System	Level I of the HCPSCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPSCS 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)

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.