

# NQF 0421: Adult Weight Screening and Follow-Up

## 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 0421: Adult Weight Screening and Follow-Up

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> <li>Core measure</li> </ul>
Related to other measures?	<ul style="list-style-type: none"> <li>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"> <li>Weight Assessment and Counseling for Children and Adolescents (NQF 0024)</li> </ul> </li> </ul>
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> <li>Age</li> <li>Encounter code<sup>1</sup></li> </ul>
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> <li>Terminal illness active diagnosis<sup>2</sup></li> <li>Active diagnosis of pregnancy<sup>3</sup></li> <li>Rationale for physical exam not done</li> </ul>
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> <li>Body Mass Index (weight and height needed)<sup>2</sup></li> <li>Care plan: follow-up plan for BMI management<sup>3</sup></li> <li>Communication provider to provider: dietary consultation order<sup>3</sup></li> </ul>

**Note:** This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, visit : <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> <li>Ensures only patients who are 18 years and over at the start of the measurement period are included in the denominator.</li> </ul>	<ul style="list-style-type: none"> <li>Date of birth</li> </ul>	
2. Record date and type of visit	<ul style="list-style-type: none"> <li>Ensures only appropriate visits are captured in the denominator.</li> </ul>	<ul style="list-style-type: none"> <li>Date of visit</li> <li>Code for an outpatient encounter<sup>4</sup></li> </ul>	

<sup>1</sup> This data element(s) must be documented during the measurement period

<sup>2</sup> This data element(s) must be documented before or simultaneous to the encounter

<sup>3</sup> This data element(s) must be documented during the encounter

<sup>4</sup> See Technical Supplement for denominator inclusion details (encounter types): pp. TS-2

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
3. Check patient record for terminal illness documentation no more than 6 months before outpatient encounter.	<ul style="list-style-type: none"> <li>Ensures appropriate patients are captured as <b>exclusions or exceptions</b></li> </ul>	<ul style="list-style-type: none"> <li>Document terminal illness (early stage, late stage, liver disease)<sup>5</sup></li> </ul>	
4. Check patient record for active diagnosis of pregnancy.	<ul style="list-style-type: none"> <li>Ensures appropriate patients are captured as <b>exclusions or exceptions</b><sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>Document active pregnancy diagnosis</li> </ul>	
5. If physical exam is not completed, document reason	<ul style="list-style-type: none"> <li>Ensures appropriate patients are captured as <b>exclusions or exceptions</b><sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>Document the patient reason, medical reason or system reason why the exam was not done.</li> </ul>	
6. Check patient record for BMI measurement no more than 6 months before visit. If no data, measure and the patient's weight and height. Record patient's height and weight.	<ul style="list-style-type: none"> <li>Identifies both patients who should be included in the <b>numerator</b>, and those who need their BMI calculated.</li> </ul>	<ul style="list-style-type: none"> <li>Weight in kilograms (kg) or pounds (lb)</li> <li>Height in meters (m) or inches (in)</li> </ul>	
7. Calculate patient's BMI using height and weight data.	<ul style="list-style-type: none"> <li>Documentation captures the BMI calculating activity for <b>numerator</b> and identifies patients who require a follow-up plan.</li> </ul>	<ul style="list-style-type: none"> <li>Body Mass Index (BMI)<sup>6</sup></li> </ul>	
8. Assess if the patient requires BMI management or referral to a dietitian	<ul style="list-style-type: none"> <li>Documentation captures follow up plan for inclusion in the <b>numerator</b> where applicable.</li> </ul>	<ul style="list-style-type: none"> <li>Document follow-up care goal plan for BMI management and/or referral for dietary consultation<sup>7,8</sup></li> </ul>	

<sup>5</sup> See Technical Supplement for exclusion or exception details (terminal illness): [pp. TS-2](#)

<sup>6</sup> If manual calculation of body mass index is needed, use one of the formulae below:

[English BMI Formula] BMI = [Weight in Pounds / (Height in Inches x Height in Inches)] x 703; or

[Metric BMI Formula] BMI = [Weight in Kilograms / (Height in Meters x Height in Meters)]

<sup>7</sup> If a) Patient is 65 years or older and BMI is <22 kg/m<sup>2</sup> or >=30 kg/m<sup>2</sup>; or b) Patient is between 18 and 64 years of age, inclusively, and BMI is <18.5 kg/m<sup>2</sup> or >=25 kg/m<sup>2</sup>

<sup>8</sup> See Technical Supplement for numerator inclusion details (follow-up care): [pp. TS-5](#)

## Technical Supplement

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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 a visit? (CPT Codes)

- Psychiatric diagnostic interview examination
- Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face-to-face with the patient
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services
- Physical therapy evaluation
- Occupational therapy evaluation
- Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient
- Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- Medical nutrition therapy; group (2 or more individual(s))
- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, & 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.
- 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.
- 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.

### What counts as a visit? (HCPCS Codes)

- Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- Cervical or vaginal cancer screening; pelvic and clinical breast examination
- Diabetes outpatient self-management training services, individual
- Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient

## EXCLUSION OR EXCEPTION CRITERIA

### What constitutes a diagnosis of pregnancy? (SNOMED-CT codes)

- Multiple pregnancy (disorder)
- Membranous pregnancy (disorder)
- Mesenteric pregnancy (disorder)

#### What constitutes a diagnosis of pregnancy? (SNOMED-CT codes)

- Angular pregnancy (disorder)
- Pregnancy eruption (disorder)
- Pregnancy, function (observable entity)
- Combined pregnancy (disorder)
- Ectopic pregnancy (disorder)
- Septuplet pregnancy (disorder)
- Angiectasis pregnancy (disorder)
- Sextuplet pregnancy (disorder)
- Molar pregnancy (disorder)
- Mesometric pregnancy (disorder)
- Quadruplet pregnancy (disorder)
- Triplet pregnancy (disorder)
- Twin pregnancy (disorder)
- Mural pregnancy (disorder)
- Cervical pregnancy (disorder)
- Tubal pregnancy (disorder)
- Quintuplet pregnancy (disorder)
- Abdominal pregnancy (disorder)
- Cornual pregnancy (disorder)
- Prolonged pregnancy (disorder)
- Ovarian pregnancy (disorder)

#### What constitutes a diagnosis of terminal illness? (SNOMED-CT codes)

- Terminal illness - early stage (finding)
- Terminal illness - late stage (finding)
- Terminal illness (finding)

#### What constitutes a medical reason for patient exclusion? (HL7 codes)

- The therapy has been found to not have the desired therapeutic benefit on the patient.
- The underlying condition has been resolved or has evolved such that a different treatment is no longer needed.
- A new therapy will be commenced when current supply exhausted.
- Testing has shown that the patient already has immunity to the agent targeted by the immunization.
- The patient currently has a medical condition for which the vaccine is contraindicated or for which precaution is warranted.
- The prescribed product has specific clinical release or other therapeutic characteristics not shared by other substitutable medications.
- The patient has intolerance to the medication.
- Patient has had a prior allergic intolerance response to alternate product or one of its components.
- The specific manufactured drug is part of a clinical trial.
- Contraindication identified.



#### What constitutes a patient reason for exclusion? (HL7 codes)

- The Patient requested the action.
- Moved at the request of the patient.
- Client deceased.
- The patient is not (or is no longer) able to use the medication in a manner prescribed. Example: Can't swallow.
- The patient refused to take the product.
- The patient or their guardian objects to receiving the vaccine on religious grounds.
- The patient or their guardian objects to receiving the vaccine because of concerns over its safety.
- The intended vaccine has expired or is otherwise believed to no longer be effective. Example: Due to temperature exposure.
- Patient has compliance issues with medication such as differing appearance, flavor, size, shape or consistency.
- Patient changed their mind regarding obtaining medication.

#### What constitutes a system reason for patient exclusion? (HL7 codes)

- Client was registered in error.
- When a client has no contact with the health system for an extended period, coverage is suspended. Client will be reinstated to original start date upon proof of identification, residency etc. Example: Coverage may be suspended during a strike situation, when employer benefits for employees are not covered (i.e. not in effect).
- The covered party (patient) specified with the Invoice is not correct.
- The policy specified with the Invoice is not correct. For example, it may belong to another Adjudicator or Covered Party.
- The billing information, specified in the Invoice Elements, is not correct. This could include incorrect costing for items included in the Invoice.
- The provider specified with the Invoice is not correct.
- In the case of 'substitution', indicates that the substitution occurred because the ordered item was not in stock. In the case of 'no substitution', indicates that a cheaper equivalent was not substituted because it was not in stock.
- Indicates that the decision to substitute or to not substitute was driven by a jurisdictional regulatory requirement mandating or prohibiting substitution.
- Indicates that the decision to substitute or to not substitute was driven by a desire to maintain consistency with a pre-existing therapy. I.e. The performer provided the same item/service as had been previously provided rather than providing exactly what was ordered, or rather than substituting with a lower-cost equivalent.
- Indicates that the decision to substitute or to not substitute was driven by a policy expressed within the formulary.
- Code assigned to indicate the rationale for not performing an evaluation investigation on a device for which a defect has been reported. Examples include: device received in a condition that made analysis impossible, device evaluation anticipated but not yet begun, device not made by company.
- Identifies the reason or rational for why a person is eligible for benefits under an insurance policy or program. Examples: A person is a claimant under an automobile insurance policy are client deceased & adopted client has been given a new policy identifier. A new employee is eligible for health insurance as an employment benefit. A person meets a government program eligibility criteria for financial, age or health status.
- The reason a referral was made. Examples: Specialized Medical Assistance, Other Care Requirements.
- The medication is no longer being manufactured or is otherwise no longer available.
- The manufacturer or other agency has requested that stocks of a medication be removed from circulation.
- The product does not have (or no longer has) coverage under the patients insurance policy.
- Patient must see prescriber prior to further fills.
- Patient no longer or has never been under this prescribers care.
- Original prescriber is no longer available to prescribe and no other prescriber has taken responsibility for the patient.

#### What constitutes a system reason for patient exclusion? (HL7 codes)

- Request for further authorization must be done through patient's family physician.
- Patient has already been given a new (renewal) prescription.
- Therapy has been changed and new prescription issued.
- This medication is on hold.
- The patient should have medication remaining.
- There was no supply of the product on hand to perform the service.
- The information was recorded incorrectly or was recorded in the wrong record.
- The decision on which the recorded information was based was changed before the decision had an effect. Example: Aborted prescription before patient left office, released prescription before suspend took effect.
- Identifies the reason or rationale for coverage of a service or product based on coverage exclusions related to the risk of adverse selection by covered parties.
- Identifies the reason or rationale for coverage of a service or product based on financial participation responsibilities of the covered party.
- Identifies the reason or rationale for limitations on the coverage of a service or product based on coverage contract provisions. Example: The maximum cost per unit; or the maximum number of units per period, which is typically the policy or program effective time.
- Identifies the reason or rationale for coverage of a service or product based on characteristics of the provider, e.g., contractual relationship to payer, such as in or out-of-network; relationship of the covered party to the provider. Example: In closed managed care plan, a covered party is assigned a primary care provider who provides primary care services and authorizes referrals and ancillary and non-primary care services.
- Identifies the reason or rationale for coverage of a service or product based on clinical efficacy criteria or practices prescribed by the payer.
- Patient does not meet required protocol
- Patient not eligible for drug
- Provider is not authorized to prescribe or dispense
- The user does not have permission
- The target facility does not recognize the dispensing facility
- This product is not available or manufactured
- There is no match
- There is no match for the product in the master file repository
- There is no permission
- The agent does not have permission

## NUMERATOR INCLUSION CRITERIA

#### What constitutes a care goal: follow up plan for BMI management? (SNOMED-CT codes)

- Vitamin/diet support therapy (product)
- Follow-up obesity assessment (regime/therapy)
- Weight and body mass assessment procedure (procedure)
- Target weight discussed (regime/therapy)
- Weight loss advised (situation)
- Seen by dietetics - service (finding)
- Weight monitoring (regime/therapy)
- Weight loss from baseline weight (observable entity)

#### What constitutes a care goal: follow up plan for BMI management? (CPT codes)

- Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less), including esophagogastroduodenoscopy [EGD]
- Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) with gastric bypass and small intestine reconstruction to limit absorption
- Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
- Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
- Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
- Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
- Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
- Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
- Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
- Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
- Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
- Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
- Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
- Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
- Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
- Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)

#### What constitutes a care goal: follow up plan for BMI management? (HCPCS codes)

- Calculated bmi above the upper parameter and a follow-up plan was documented in the medical record
- Weight management classes, non-physician provider, per session
- Exercise classes, non-physician provider, per session
- Nutrition classes, non-physician provider, per session
- Nutritional counseling, dietitian visit

#### What constitutes a care goal: follow up plan for BMI management? (ICD-9-CM code)

- Dietary surveillance and counseling (in): NOS, colitis, diabetes mellitus, food allergies or intolerance, gastritis, hypercholesterolemia, hypoglycemia, obesity. Use additional code to identify Body Mass Index (BMI), if known

#### What constitutes a Dietary Consultation Order? (SNOMED-CT codes)

- Patient referral to dietitian (procedure)
- Referral to dietetics service (procedure)
- Refer to weight management program (procedure)

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

NQF0421	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator <sup>1</sup>	×			×	×		×		×		×
Denominator <sup>2</sup>	×			×	×	×					×
Exceptions or exclusions <sup>3</sup>	×					×	×				×

- Codes with an asterisk (\*) are required from certified EHRs
- <sup>1</sup> To identify the numerator in this CQM, the following standard codes are required: one "physical exam" code from LOINC or SNOMED AND/OR a "communication" code from SNOMED OR "care goal" code from CPT, HCPCS, ICD-9, SNOMED or GROUPING.
- <sup>2</sup> To identify the denominator in this CQM, the following standard codes are required: an "individual characteristic" code from HL7, AND an "encounter" code from CPT, HCPCS, or Grouping.
- <sup>3</sup> To identify the exclusions in this CQM, the following standard codes are required: an "individual characteristic" code from SNOMED, OR a "diagnosis/condition/problem" code from ICD-9, SNOMED or Grouping, OR a "negation rationale" code from HL7.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)

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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