



NQF 0028A: Tobacco Use Assessment, NQF 0028B: Cessation Intervention

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

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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 exceptions or exclusions.

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 0028a: Tobacco Use Assessment, NQF 0028b: Tobacco Cessation Intervention

Preventive Care and Screening Measure Pair:

- a. Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.
- b. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> • Core measure
Related to other measures?	<ul style="list-style-type: none"> • Some of the information entered for this clinical quality measure is related to the following measure: <ul style="list-style-type: none"> – Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies (NQF 0027)
Data required to identify the denominator (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> • Age • Office visit, health and behavior assessment, occupational therapy, psychiatric & psychologic, or preventive medicine services 18 and older encounter codes¹ • Patient characteristic: Tobacco user (NQF 0028b)²
Data required to identify the exceptions or exclusions	<ul style="list-style-type: none"> • None
Data required to identify the numerator (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> • Patient characteristic: tobacco user or non-user (NQF 0028a)³ • Tobacco use cessation counseling or smoking cessation medication (NQF 0028b)²

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>

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

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

³ This data element(s) must be documented no more than 24 months before and no later than the encounter.

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"> Ensure only patients who are 18 years and over at the start of the measurement period are included in the denominator 	<ul style="list-style-type: none"> Date of birth 	
2. Record the date and type of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. For this measure, 2 or more encounters are required within the measurement period. 	<ul style="list-style-type: none"> Date of visit Code for office visit, health and behavior assessment, occupational therapy, psychiatric and psychologic encounter or preventive medicine service⁴ 	
3. Ascertain whether the patient is a tobacco user or not in the past 24 months	<ul style="list-style-type: none"> Documentation captures the querying activity for the numerator (NQF0028a). 	<ul style="list-style-type: none"> Document tobacco use or non-use as appropriate⁵ 	
4. If patient is a tobacco user, document use	<ul style="list-style-type: none"> Ensures the appropriate population is included in the denominator (NQF0028b). 	<ul style="list-style-type: none"> Document tobacco use as appropriate⁵ 	
5. If patient is a tobacco user, provide smoking cessation counseling and/or prescribe smoking cessation agent	<ul style="list-style-type: none"> Documentation in your EHR captures the counseling/prescribing activity in the numerator (NQF0028b). 	<ul style="list-style-type: none"> Document tobacco cessation counseling or the prescribed/ active smoking cessation agent⁶ 	

⁴ See Technical Supplement for denominator inclusion details (encounter types): [pp. TS-2](#)

⁵ See Technical Supplement for numerator inclusion details for NQF0028a (tobacco non-user): [pp. TS-3](#)

⁶ See Technical Supplement for numerator inclusion details for NQF0028b (tobacco cessation): [pp. TS-4](#)

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure numerator and denominator.

DENOMINATOR INCLUSION CRITERIA – NQF0028 A & B

What constitutes a visit? (CPT codes)

- Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
- Health and behavior intervention, each 15 minutes, face-to-face; individual
- Occupational therapy evaluation
- Occupational therapy re-evaluation
- 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, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (distinct from evaluation and management)
- Unlisted preventive medicine service
- 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 (distinct from evaluation and management).
- 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, with face to face time with patient
- Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with face to face time with patient and medical evaluation and management services
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with face-to-face with the patient
- Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with face-to-face with the patient and medical evaluation and management services
- Psychoanalysis
- Pharmacologic management, including prescription, use, and review of medication with no more than minimal psychotherapy

DENOMINATOR INCLUSION CRITERIA – NQF0028B ONLY

Who constitutes a smoker? (SNOMED CT Codes)

- Light cigarette smoker (1-9 cigs/day) (finding)
- Moderate cigarette smoker (10-19 cigs/day) (finding)
- Heavy cigarette smoker (20-39 cigs/day) (finding)
- Very heavy cigarette smoker (40+ cigs/day) (finding)
- Rolls own cigarettes (finding)
- Snuff user (finding)

Who constitutes a smoker? (SNOMED CT Codes)

- User of moist powdered tobacco (finding)
- Chews plug tobacco (finding)
- Chews twist tobacco (finding)
- Chews loose leaf tobacco (finding)
- Chews fine cut tobacco (finding)
- Chews products containing tobacco (finding)
- Occasional cigarette smoker (finding)
- Light cigarette smoker (finding)
- Moderate cigarette smoker (finding)
- Heavy cigarette smoker (finding)
- Very heavy cigarette smoker (finding)
- Chain smoker (finding)
- Occasional cigarette smoker (less than one cigarette/day) (finding)
- Cigarette smoker (finding)
- Chews tobacco (finding)
- Pipe smoker (finding)

NUMERATOR INCLUSION CRITERIA – NQF0028A

What constitutes a tobacco non-user? (SNOMED CT Codes)

- Non-smoker for personal reasons (finding)
- Non-smoker for religious reasons (finding)
- Non-smoker for medical reasons (finding)
- Current non-smoker (finding)
- Ex-pipe smoker (finding)
- Ex-cigar smoker (finding)
- Does not use moist powdered tobacco (finding)
- Never used moist powdered tobacco (finding)
- Ex-user of moist powdered tobacco (finding)
- Never chewed tobacco (finding)
- Never smoked tobacco (finding)
- Ex-trivial cigarette smoker (<1/day) (finding)
- Ex-light cigarette smoker (1-9/day) (finding)
- Ex-moderate cigarette smoker (10-19/day) (finding)
- Ex-heavy cigarette smoker (20-39/day) (finding)
- Ex-very heavy cigarette smoker (40+/day) (finding)
- Ex-cigarette smoker amount unknown (finding)
- Ex-trivial cigarette smoker (<1/day) (finding)
- Ex-cigarette smoker (finding)
- Intolerant ex-smoker (finding)
- Aggressive ex-smoker (finding)
- Aggressive non-smoker (finding)

What constitutes a tobacco non-user? (SNOMED CT Codes)

- Intolerant non-smoker (finding)
- Current non smoker but past smoking history unknown (finding)
- Tolerant ex-smoker (finding)
- Non-smoker (finding)
- Ex-smoker (finding)
- Tolerant non-smoker (finding)

What constitutes a tobacco user? (SNOMED CT Codes)

- Light cigarette smoker (1-9 cigs/day) (finding)
- Moderate cigarette smoker (10-19 cigs/day) (finding)
- Heavy cigarette smoker (20-39 cigs/day) (finding)
- Very heavy cigarette smoker (40+ cigs/day) (finding)
- Rolls own cigarettes (finding)
- Snuff user (finding)
- User of moist powdered tobacco (finding)
- Chews plug tobacco (finding)
- Chews twist tobacco (finding)
- Chews loose leaf tobacco (finding)
- Chews fine cut tobacco (finding)
- Chews products containing tobacco (finding)
- Occasional cigarette smoker (finding)
- Light cigarette smoker (finding)
- Moderate cigarette smoker (finding)
- Heavy cigarette smoker (finding)
- Very heavy cigarette smoker (finding)
- Chain smoker (finding)
- Occasional cigarette smoker (less than one cigarette/day) (finding)
- Cigarette smoker (finding)
- Chews tobacco (finding)
- Pipe smoker (finding)

NUMERATOR INCLUSION CRITERIA – NQF0028B

What constitutes smoking a cessation intervention? (SNOMED-CT codes)

- Pregnancy smoking education (procedure)
- Stop smoking monitoring first letter
- Stop smoking monitoring second letter
- Stop smoking monitoring third letter
- Stop smoking monitoring verbal invite
- Stop smoking monitoring telephone invite
- Smoking cessation education
- Smoking effects education

What constitutes smoking a cessation intervention? (SNOMED-CT codes)

- Smoking monitoring invitation
- Referral to stop-smoking clinic
- Smoking cessation assistance (regime/therapy)

What constitutes a smoking cessation intervention? (CPT codes)

- Smoking and tobacco use cessation counseling visit; intermediate
- Smoking and tobacco use cessation counseling visit; intensive

What constitutes smoking a cessation intervention? (RxNorm codes)

- 16 hr. nicotine 0.313 mg/hr. transdermal patch
- Nicotine 14mg/24hrs patch
- Nicotine 21mg/24hrs patch
- Nicotine 7mg/24hrs patch
- Nicotine 10mg/16hrs patch
- Nicotine 15mg/16hrs patch
- Bupropion HCl 150mg tab, SA
- Nicotine 2 mg sublingual tablet
- Nicotine 10 mg inhalation cartridge
- Nicotine polacrilex 4mg tab, chewing gum
- Nicotine polacrilex 2mg tab, chewing gum
- Nicotine polacrilex 2mg lozenge
- Nicotine polacrilex 4mg lozenge
- Nicotine 1 mg lozenge
- Bupropion SR 150 mg 12 hr. extended release

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

NQF0028	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x			x						x	x
Denominator ²	x					x					
Exceptions or exclusions											

- Codes with an asterisk (*) are required from certified EHRs
- ¹ To identify the numerator for 0028a, the following standard code is required: one of the "individual characteristic" SNOMED code. To identify the numerator for 0028b, the following standard code is required: an "individual characteristic" SNOMED code, a "procedure" CPT or GROUPING code, OR a "medication" RxNorm code.

- ²To identify the denominator in this CQM, the following standard codes are required: an "individual characteristic" code from HL7, AND an "encounter" code from CPT.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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