**Chapter 5**

**Clinical Terminologies, Classifications, and Code Systems**

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**Real-World Case 5.1**

Clinical quality measure developers create evidence-based standards used to assess the performance of providers in the provision of care. Developers include government agencies, accreditation organizations, and physician specialty groups among others. They select terminologies, classifications, and code sets as a way to express healthcare performance data used in the measure. For example, the National Committee for Quality Assurance (NCQA) may want to author an electronic Clinical Quality Measure (eCQM) for breast cancer screening. Using the web-based Measure Authoring Tool (MAT), NCQA decides to include mammograms as a population criterion. Having identified mammogram as one of the criteria, NCQA determines LOINC and HCPCS are necessary for the measure. Mammogram codes from these two systems are then selected to create the content for the breast cancer screening eCQM.

# Real-World Case Discussion Questions

1. What purpose do terminologies, classifications, and code systems serve in an electronic Clinical Quality Measure (eCQM)?It is a way to express healthcare performance data that is used in the measure.

2. Why would NCQA choose LOINC and HCPCS for the electronic Clinical Quality Measure (eCQM) for breast cancer screening?Because they determined that they are necessary for the measure. The codes from these 2 systems are selected to create content for the eCOM.

3. Why are the various types of organizations important to the development of the clinical quality measures?Because each organization has their own purpose and criteria.

**Real-World Case 5.2**

The 2015 Edition EHR technology certification criteria states the following:

*Smoking status*: Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified.

45 CFR 170.315(a)(11).Coded to one of the following SNOMED CT codes:

* Current every day smoker. 449868002
* Current some day smoker. 428041000124106
* Former smoker. 8517006
* Never smoker. 266919005
* Smoker, current status unknown. 77176002
* Unknown if ever smoked. 266927001
* Heavy tobacco smoker. 428071000124103
* Light tobacco smoker. 428061000124105

*Objective*: Record smoking status for patients 13 years or older.

*Measure*: More than 85 percent of all unique patients 13-years-old or older seen by the eligible professional or admitted to the eligible hospital’s or critical care hospital’s inpatient or emergency department during the EHR reporting period have smoking status records as structured data.

Included in the National Learning Consortium’s resources is a quick reference guide from the American Academy of Family Physicians (AAFP) for meeting the smoking status Meaningful Use requirement. The AAFP supports the incorporation of tobacco cessation into EHR templates (AAFP n.d.). The quick reference provides guidance on what should be included in a tobacco cessation EHR template.

# Real-World Case Discussion Questions

1. Why would SNOMED CT be used to record the smoking status of a patient on an EHR template? a core EHR terminology, SNOMED CT is essential for recording clinical data such as patient problem lists and family, medical and social histories in electronic health records in a consistent, reproducible manner.SNOMED CT can be mapped to other coding systems, such as ICD-9 and ICD-10, which helps facilitate semantic interoperability.It is easier to produce accurate electronic health information.

2. Why was ICD-10-CM not chosen as the system to capture smoking status?ICD 10 codes are applied to any diagnosis, symptom, or cause of death for billing purposes.

3. Review the SNOMED CT codes. What else related to smoking would you recommend should be collected?I feel chewing tobacco should also have to be reported.

# Application Exercises

*Instructions:* Answer the following questions.

1. Choose one clinical terminology, one classification, and one code system mentioned in this chapter and compare and contrast its general characteristics, purpose, use, content, and structure. SNOMED CT is a comprehensive clinical terminology that provides clinical content and expressivity for clinical documentation and reporting. CT is the most comprehensive multilingual clinical terminology in the world. Its purpose is to standaradize clinical phrases making it easier to produce accurate EHI. It is made up of 3 components- concepts,descriptions and relationships. ICD-10-CM is the classification of diseases for morbidity. Intended to classify diagnosises established by physicians ats the conclusion of a patient encounter. It contains three to seven character codes and descriptions for patient conditions which included symptoms, syndromes, diseases and other reasons for patients requiring healthcare services. RxNorm- allows computer systems to efficiently and unambiguously communicate drug related information between hospitals, pharmacies and other organizations. Its structure is a combination of ingredients plus strength and dose form. Its objective is to normalize names of generic and branded drugs and also to attach a unique identifier to that name.

2. Search the Internet and **locate information** on the Common Clinical Data Set in order to determine which terminologies, classifications, and code systems **mentioned in this chapter** are used for the individual data elements in table 5.4. Duplicate table 5.4 and adds three columns. See below. Once completed, draw a conclusion about what the table shows with regards to terminology, classification, and code system use in the Common Clinical Data Set.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria** | **Clinical Terminology** | **Classification** | **Code System** |
| Patient name |

|  |
| --- |
| SNOMED CT |

 | ICD-10-CM | LOINC |
| Date of birth |  | ICD-10-CM |  |
| Ethnicity |  | ICD-10-CM |  |
| Smoking status | SNOMED CT |  |  |
| Medications |  |  | RxNorm |
| Laboratory test(s) |  |  | LOINC |
| Vital signs (body height, body weight, diastolic blood pressure, systolic blood pressure, heart rate, respiratory rate, body temperature, pulse oximetry, and inhaled oxygen saturation, body mass index (ratio), and mean blood pressure) |  | ICD-10-PCS | LOINC |
| Procedures | SNOMED CT, CPT | ICD-10-CM | HCPCS Level II |
| Immunizations |  |  |  |
| Assessment and plan of treatment |  |  |  |
| Health concerns |  |  |  |
| Sex |  |  |  |
| Race |  |  |  |
| Preferred language |  |  |  |
| Problems | SNOMED CT |  |  |
| Medication allergies  |  |  | RxNorm |
| Laboratory value(s)/result(s) | CPT |  | LOINC |
| Care plan field(s), including goals and instructions | CPT | ICD-O-3 |  |
| Care team member(s) |  | ICD-O-3 |  |
| Unique device identifier(s) for a patient’s implantable device |  |  | HCPCS II |
| Goals |  |  |  |

**Review Quiz**

*Instructions:* For each item, complete the statement correctly or choose the most appropriate answer.

1. If data aggregation is the goal of collecting the data, \_A\_\_\_ are the best choice.

a. Classifications

b. Code systems

c. Clinical terminologies

d. Nomenclatures

2. The SNOMED CT \_\_\_B\_\_\_\_\_\_ includes the semantic tag.

a. Definition

b. Preferred term

c. Synonym

d. Fully specified name

3. The \_\_\_\_\_\_\_\_\_\_\_ is a core component of SNOMED CT.

a. Identifier

b. Hierarchy

c. Concept

d. Definition

4. \_\_\_\_\_\_\_\_\_\_\_ is a nursing terminology.

a. International Classification of Procedures

b. Clinical Care Classification

c. International Classification of Functioning

d. International Classification of Diseases

5. Category I CPT includes which of the following? B, C

a. HCPCS Level II

b. Surgery

c. Drugs

d. Durable medical equipment

6. A \_\_\_\_C\_\_\_\_\_\_\_ is a set of terms representing the system of concepts for the medical field.

a. Clinical terminology

b. Code system

c. Nomenclature

d. Classification

7. ICD-10-PCS is a classification of \_\_\_\_\_\_C\_\_\_.

a. Emergency room procedures

b. Nursing procedures

c. Inpatient procedures

d. Outpatient procedures

8. Which of the following developed the Diagnostic and Statistical Manual of Mental Disorders

a. Mental Health Association

b. American Psychiatric Association

c. Mental Health Foundation

d. World Psychiatric Association

9. A classification provides clinical data to \_\_\_\_\_\_\_\_\_\_\_\_\_.

a. Allow collection and reporting of healthcare statistics

b. Indicate smoking status in the Common Clinical Data Set

c. Facilitate electronic data collection at the point of care

D. Use for primary data purposes

10. The \_\_\_\_\_\_\_\_\_\_ is responsible for the development and maintenance of ICD-10-CM.

a. NCHS

b. CMS

c. ICD-10 C&M Committee

d. NCHS and CMS

11. The \_\_\_\_\_\_\_\_ is a system for classifying the topography and morphology of neoplasm.

a. ICD-O-3

b. ICD-10-CM

c. ICD-10

d. SNOMED CT

12. WHO defines \_\_\_\_\_\_\_C\_\_\_\_ as a reference classification.

a. SNOMED CT

b. DSM-5

c. ICF

d. ICD-O-3

13. An accumulation of numeric or alphanumeric representations or codes for exchanging or storing information is a \_\_\_\_\_\_\_\_\_\_\_.

a. Nomenclature

b. Code system

c. Concept system

d. Data set

14. Which of the following is the standard for clinical lab test results under the Meaningful Use program?

a. CPT

b. LOINC

c. ICD-10-PCS

d. HCPCS Level II

15. HCPCS is made up of which code systems?A

a. CPT and HCPCS Level II

b. Dental codes and HCPCS Level II

c. ICD-10-PCS, CPT and HCPCS Level II

d. CPT, HCPCS Level II and HCPCS Level III

16. If you were looking for a code for a medication taken orally, in which system is it found?C

a. ICD-10-CM

b. HCPCS Level II

c. RxNorm

d. ICD-10-PCS

17. The \_\_\_\_\_\_\_ is responsible for development and maintenance of RxNorm

a. AMA

b. ONC

c. FDA

d. NLM

18. One of the two major groups of LOINC content is \_\_\_\_C\_\_\_\_\_.

a. Clinical drugs

b. Clinical diagnoses

c. Clinical observations

d. Clinical interventions

19. The \_\_\_\_\_\_\_\_\_\_\_ is responsible for the publishing and maintaining HCPCS Level II.

a. CMS

b. AMA

c. NCHS

d. ADA

20. The \_\_\_\_\_D\_\_\_ originated from federal reporting requirements tied to certification criteria found in the Meaningful Use regulations.

a. Outcomes and Assessment Information Set

b. Healthcare Effectiveness Data and Information Set

c. Common Clinical Data Set

d. Uniform Hospital Discharge Data Set

21. Home health agency process and improvement outcome measures are based on data from the \_\_\_\_C\_.

a. Home Health Compare Data Set

b. Outcomes and Assessment Information Set

c. Uniform Hospital Discharge Data Set

d. Common Clinical Data Set

22. The standardized HEDIS data elements are collected by \_\_\_\_\_\_\_\_\_.

a. Acute care hospitals

b. Certified survey vendors

c. Healthcare purchasers

d. Consumers

23. The UHDDS’s core data elements were incorporated into the \_\_\_\_\_\_\_\_\_\_\_ prospective payment system.

a. Outpatient

b. Long-term care

c. Inpatient rehabilitation

d. Acute inpatient

24. Which standard is attached to the data element smoking status contained in the Common Clinical Data Set?

a. ICD-10-CM

b. HCPCS Level II

c. ICD-10-PCS

d. SNOMED CT

25. LOINC would be found in the UMLS \_\_\_\_\_\_\_\_\_\_\_D\_.

a. Terminology Network

b. SPECIALIST Lexicon

c. Semantic Network

d. Metathesaurus