



Allscripts™

Allscripts Enterprise

Meaningful Use Quality Measures

Report ambulatory clinical quality measures to CMS (or for EPs seeking the Medicaid incentive payment, to the states)

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Final Rule

Generate at least one report listing patients of the EP with a specific condition.

Core: ✓ **Menu:**

Numerator: N/A – Aggregate numerator and denominator through Attestation.

Denominator: N/A – Aggregate numerator and denominator through Attestation.

Exclusion: None.

Reporting

Reporting will be done through the implementation of CQS or Stimulus Set (Basic Clinical Quality Measures). Physicians will need to select those Quality Measures that he/she will report on. The physicians are required to choose 6 Measures for 2011 - 3 core or alternate core / 3 from additional 3. The additional 3 CANNOT be from the Core or Alternative Core list, only from the list of 38 quality Measures as noted below

Please review below workflows for the setup required for Quality Measure Reporting – including review of Appendices.

Core

NQF 0421 | PQRI 128 Title: Adult Weight Screening and Follow-Up

Description: 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.

Workflow

- Document Vital Signs via Vital Signs Panel
 - Enter Weight for every Appointment Encounter
 - Height does not need to be documented at every visit once a patient is 25 years of age
 - New Encounter Summary Alert in 11.2 to remind clinical support staff/provider if Height or Weight is missing for the Encounter
 - New Preference value to only prompt for Encounter Summary when My Alerts exist
- If patient is between (age) ≥ 18 years AND ≤ 64 years and BMI is <18.5 kg/m² or ≥ 25 kg/m² or if patient is ≥ 65 years and BMI is <22 kg/m² or ≥ 30 kg/m² there will need to be a documented “Care goal: follow-up plan BMI management” OR: “Communication provider to provider: dietary consultation order”
 - Place a Referral Order: Dietary Consultation
 - OR Place a Follow Up Order: BMI Management Follow Up
 - OR Document Any of the related Procedures in Surgical History
- Recommend to create an Order Reminder for BMI Management Follow Up Order to occur every 6 months for the patient
- Provider submits appropriate Charges for Patient Visit



- Exclusions
 - Use CQS Note to document if Physical Exam was not done on patient for patient or system reasons
 - Active Problem: Pregnancy

Reporting & Setup Considerations

- Dietary Consult Orders (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 103699006 - Patient Referred to dietitian (procedure)
 - 306163007 - Referral to dietetics service
 - 408289007 - Referral to Weight Management Program
- BMI Management Follow Up Surgical History CPT Codes
 - 43644, 43645, 43770, 43771, 43772, 43773, 43774 - Laparosc Codes
 - 43842, 43843, 43845, 43846, 43847, 43848 - Gastric Surgery Codes
- BMI Management Follow Up Orders (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 97804 - Medical Nutrition Therapy
 - 98961 or 98962 - Education and Training for Patient Self-Management
 - 99078 - Physician Educational Services (in a group setting)
- Consider adding new Orderables to provider's favorite lists

NQF 0013 Title: Hypertension: Blood Pressure Measurement

Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.

Workflow

- For Patients 18 and older with an Active Problem of Hypertension, document Systolic and Diastolic Blood Pressure at each office visit.
 - Document Systolic and Diastolic Blood Pressure via Vital Sign Panels or Flowsheets
 - New Encounter Summary Alert in 11.2 to remind clinical support staff/provider if Blood Pressure is missing for the Encounter
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None

Report & Setup Considerations

- The Allscripts delivered Systolic & Diastolic Blood Pressure Vital Sign Values will be used for the calculation
 - Systolic Blood Pressure = Result Code: 0-1
 - Delivered EEHR RID entry that should be used
 - Diastolic Blood Pressure = Result Code: 0-2
 - Delivered EEHR RID entry that should be used



**NQF 0028 Title: Preventive Care and Screening Measure Pair:
a. Tobacco Use Assessment, b. Tobacco Cessation Intervention**

Description:

- a. Percentage of patients aged 18 years and 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.

Workflow

- For Patients 18 and older, Smoking Status needs to be documented and assessed every 2 years for the patient
 - Smoking Status can be documented via Active Problems or Social History
 - New Encounter Summary Alert to remind clinical support staff/provider if Smoking Status has not been documented for the patient

The following Problems can be used to identify if the patient is or is not a Tobacco User

| Medcin Description | Comment |
|---|---|
| Document in Social History or Active Problem | |
| Tobacco use | If Status = Denied, term alone does not mean tobacco user |
| History of: Smoking | |
| Former smoker | If Status = Denied, term alone does not mean tobacco user |
| Previous History of smoking | Does not meet measure if only entry on patient record |
| Recently Stopped Smoking | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Smoking | |
| Smoking (V15.82) | If Status = Denied, term alone does not mean tobacco user |
| Current smoker | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes | If Status = Denied, term alone does not mean tobacco user |



| Medcin Description | Comment |
|---|---|
| Smoking cigarettes starting upon awakening | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting with first beverage/food of day | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting only after first meal of day | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting only in the afternoon/evening | If Status = Denied, term alone does not mean tobacco user |
| Leaving a social or work setting for a cigarette | If Status = Denied, term alone does not mean tobacco user |
| Recent increase in cigarettes per day | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes for ___ pack-years | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes with a greater than 50 pack-year history | If Status = Denied, term alone does not mean tobacco user |
| Cigars (___ a day) | If Status = Denied, term alone does not mean tobacco user |
| Smoking a pipe | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking due to family pressure | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking due to social pressure | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking for health reasons | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking due to urging at work | If Status = Denied, term alone does not mean tobacco user |



| Medcin Description | Comment |
|--|---|
| Unsuccessful attempt(s) to stop smoking | If Status = Denied, term alone does not mean tobacco user |
| Smoking while wearing nicotine patch | If Status = Denied, term alone does not mean tobacco user |
| Recently stopping smoking | If Status = Denied, term alone does not mean tobacco user |
| Current every day smoker | If Status = Denied, term alone does not mean tobacco user |
| Current some day smoker | If Status = Denied, term alone does not mean tobacco user |
| Smoker, current status unknown | If Status = Denied, term alone does not mean tobacco user |
| Never smoked (Status of denied) | Status of Denied = tobacco user |
| Unknown if ever smoked | Does not meet measure if only entry on patient record |
| Middle-night awakening having a cigarette | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Chewing | |
| Chewing nicotine-containing substances | If Status = Denied, term alone does not mean tobacco user |
| Chewing nicotine-containing substances tobacco | If Status = Denied, term alone does not mean tobacco user |
| Chewing nicotine-containing substances gum | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Snuff | |
| Using nasal snuff | If Status = Denied, term alone does not mean tobacco user |
| Smoking during pregnancy | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Nicotine dependence | |



| Medcin Description | Comment |
|--|---|
| Nicotine-related disorders | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence - Continuous | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence - episodic | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence – in remission | If Status = Denied, term alone does not mean tobacco user |
| Tobacco Use: Assessment | |
| Assessment & Intervention Use of tobacco assessed | Means Tobacco Assessment Done |
| Assessment & Intervention Use of smoking tobacco assessed | Means Tobacco Assessment Done |
| Assessment & Intervention Use of nonsmoking tobacco assessed | Means Tobacco Assessment Done |
| Tobacco Use: Treatment | |
| Pharmacologic therapy for cessation of tobacco use | Means Tobacco Assessment Done |
| Intervention and counseling on cessation of tobacco use | Means Tobacco Assessment Done |
| Intervention & Counseling cessation of tobacco use 3-10 min. | Means Tobacco Assessment Done |
| Intervention & Counseling cessation of tobacco use > 10 min. | Means Tobacco Assessment Done |
| Anticipatory Guidance: Tobacco Use | |
| Self-help group – Smoking Cessation | |
| CNS stimulants nicotine Polacrilex (Nicorette Gum) | |
| CNS stimulants nicotine Transdermal patch | |

- Document all Smoking Cessations Agents prescribed to the patient
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Document all Tobacco Use Cessation Counseling
 - This can be done via Patient Instructions



- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for “Tobacco Assessment Follow Up” every 2 years for patients 18 years and older
 - Create Order “Smoking Assessment Follow Up” with CPT = 1000F
- Tobacco Use Cessation Counseling (Appropriate Orderable Item Dictionary Instruction Entries should be built or updated with below CPT Codes)
 - 99406 - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
 - 99407 - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

Alternate Core

NQF 0041| PQRI 110 Title: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old

Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).

This measurement is looking at the prior flu season for the Measurement Period

Ex. Measurement Period = Jan 1st 2010 – Dec 31st 2010

Flu Season being reported = Sept 2009 – Feb 2010

Workflow

- For Patients 50 or older, document an administration of Influenza
 - If ordered during visit, order Influenza immunization in Immun tab in ACI in EHR and document administration (via Immun Admin task or Record Administration tab in Order)
 - If not done in office, any immunization history should be documented via Immun Hx in ACI. Choose an Administration Date (Month, Day and Year) for correct reporting calculation
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Permanent or Temporary Deferral of Influenza
 - Indicate reason for deferral
 - Document any allergy to eggs or allergy to influenza immunization
 - Best Practice is to document as an Allergy and not as an ICD-9 in Active Problems

Reporting & Setup Considerations

- Allergies
 - Clients will need to ensure all their Allergen Dictionary Egg entries have the same UNII Code: 291P45F896
 - Allergen History items do not participate in DUR checking
 - There is also a Medication Allergy entry for Chicken-Derived Products
 - This will participate in DUR checking
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0024 Title: Weight Assessment and Counseling for Children and Adolescents

Description: Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Workflow

- For Patients who are between the ages of 2 and 17 that have had an appointment with a PCP or OBGYN who are NOT pregnant, document height and weight at every visit as well as Counseling for Nutrition and/or Physical Activity
 - Document Height and Weight via Vital Signs Panel at every visit to obtain BMI percentile
 - New Encounter Summary Alert in 11.2 to remind clinical support staff/provider if Height or Weight is missing for the Encounter
 - New Preference value to only prompt for Encounter Summary when My Alerts exist
 - Document that you have counseled the patient on nutrition and physical activity, ensure these are tied to the appointment encounter for the patient
 - Add and Assess V65.3 for Counseling for Nutrition
 - Add and Assess V65.41 for Counseling for Physical Activity
- Provider submits appropriate Charges for Patient Visit
- Denominator Exclusions
 - Active Problem: Pregnancy
 - Encounter: Pregnancy

Reporting & Setup Considerations

- Ensure that V65.3 and V65.41 are added to the provider's favorite lists (QuickList) and that they are set to default to "Health/Maintenance" Type

NQF 0038 Title: Childhood Immunization Status

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Workflow

- For all children who are 1 year old or older, ensure that the following immunizations have been documented
 - If ordered during visit, order immunization in Immun tab in ACI in EHR and document administration (via Immun Admin task or Record Administration tab in Order).



- If not done in office, any immunization history should be documented via Immun Hx in ACI. Choose an Administration Date (Month, Day and Year) for correct reporting calculation.
 - DTaP Vaccine: 4 Counts with different administration dates
 - IPV: 3 Counts with different administration dates
 - MMR or Mumps Vaccine, Measles Vaccine, and Rubella Vaccine separately
 - HiB: 2 Counts with different administration dates
 - Hepatitis B Vaccine: 3 Counts with different administration dates
 - VZV: 1 Count
 - Pneumococcal Vaccine: 4 Counts with different administration dates
 - Hepatitis A Vaccine: 2 Counts with different administration dates
 - Rotavirus Vaccine: 2 Counts with different administration dates
 - Influenza Vaccine: 2 Counts with different administration dates

- Document Active or Past Medical History of the following problems
 - Measles
 - Mumps
 - Rubella
 - Hepatitis B
 - Hepatitis A
 - VZV

- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - Medication Allergy: DTaP Vaccine, IPV, Mumps Vaccine, Measles Vaccine, Rubella, MMR, HiB, Hepatitis B Vaccine, VZV, Pneumococcal Vaccine, Hepatitis A Vaccine, Rotavirus Vaccine, Influenza Vaccine, Neomycin, Streptomycin, Polymyxin
 - Document any adverse reactions
 - Non Medication Allergy: Baker's Yeast
 - Document any adverse reactions
 - Active Problem:
 - Encephalopathy
 - Progressive Neurological Disorder
 - Cancer of Lymphoreticular or Histiocytic tissue
 - HIV Disease
 - Multiple Myeloma
 - Leukemia
 - Immunodeficiency
 - Resolved Problem (PMH):
 - Cancer of Lymphoreticular or Histiocytic

Reporting & Setup Considerations

- Ensure that Baker's Yeast exists in your Allergen Dictionary.
 - Add C2730259 as the UNII Code

Additional Measures

NQF 0043 | PQRI 111 Title: Pneumonia Vaccination for older adults

Description: The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Workflow

- For Patients who are 64 years of age and older, document any administered Pneumonia Vaccination
 - If ordered during visit, order Pneumonia in Immun tab in ACI in EHR and document administration (via Immun Admin task or Record Administration tab in Order).
 - If not done in office, any Pneumonia history should be documented via Immun Hx in ACI. Choose an Exact Administration Date (Month, Day and Year) for correct reporting calculation.
- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - None

Report & Setup Considerations

- None
-

NQF 0059 | PQRI 1 Title: Diabetes HbA1c Poor Control

Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%

Workflow

- For Patients older than 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, HbA1c test results need to be documented
 - Document HbA1c Results
 - If results come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - Active Problems
 - Polycystic Ovaries
 - Gestational Diabetes
 - Steroid Induced Diabetes

Reporting & Setup Considerations

- For all HbA1C Results add one of the following LOINC values in the RID



- 17856-6, 4548-4, 4549-2

NQF 0064 | PQRI 2 TITLE: Diabetes LDL Management & Control

Description: The percentage of patients 18-75 of age with diabetes (Type 1 or Type 2) who had LDL-C <100mg/dL.

Workflow

- For Patients older than 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, LDL-C test results need to be documented
 - Document LDL-C Results
 - If LDL-C result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Active Problems
 - Polycystic Ovaries
 - Gestational Diabetes
 - Steroid Induced Diabetes

Report & Setup Considerations

- For all LDL Results add one of the following LOINC values in the RID
 - 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4, 55440-2

Remaining Measures

NQF 0001 | PQRI 64 Title: Asthma Assessment

Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

Workflow

- For Patients aged 5 through 40 years, with an Active Problem of Asthma, daytime and nocturnal asthma symptoms must be documented every year
 - Document via an Asthma Flowsheet Daytime or Nocturnal Asthma Symptoms are present for the patient
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None



Reporting & Setup Considerations

- Asthma Nighttime Symptoms and Asthma Daytime Symptoms are being added to Q3 Medcin Release
 - Additionally, these can be documented in Active Problems, but there is not an ICD-9 Code associated to the terms
- Consider building an Asthma Flowsheet to easily capture symptom information
- If you are capturing Asthma Nighttime Symptoms as a result add the appropriate SNOMED code to the applicable OID
 - 170631002, 170632009, 170633004, 170634005, 395022009
- If you are capturing Asthma Daytime Symptoms as a result add the appropriate SNOMED code to the applicable OID
 - 370204008, 373899003

NQF 0002 | PQRI 66 Title: Appropriate Testing for Children with Pharyngitis

Description: The percentage of children 2-18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a Group A Streptococcus (Strep) test for the episode.

Workflow

- For Patients ages 2-18 with an Active Problem of “Pharyngitis” and have a documented Pharyngitis Antibiotic medication within 3 days of the patient visit (ambulatory including pediatric visits), order a “Group A Streptococcus test” within 3 days prior to the Pharyngitis Antibiotic being active.
 - Place an order for a “Group A Streptococcus test”
 - via Lab/Procedures, or the following CareGuides
 - Pharyngitis, Child
 - Pharyngitis, Adult
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None

Reporting & Setup Considerations

- Group A Streptococcus Test (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 87071: Strep a assay w/optic
 - 87081: Culture screen only
 - 87430: Strep a ag, eia
 - 87650: Strep a, dna, dir probe
 - 87651: Strep a, dna, amp probe
 - 87652: Strep a, dna, quant
 - 87880: Strep a assay w/optic

NQF 0004 Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Workflow

- For Patients older than 12 with a new diagnosis of “Alcohol or drug dependence” document for any of the following types of visits (ED, Non Acute Inpatient, Acute Inpatient, Outpatient BH, Outpatient BH req POS, Point of Service Modifier)
 - Provider places order via Lab/Procedure or Referral for “Alcohol, drug rehab and detox interventions” or “Detoxification Interventions”
- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - None

Reporting & Setup Considerations

- Detoxification Interventions (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes - This can be a procedure or a referral)
 - 67516001: Detoxification Therapy
- Alcohol, drug rehab and detox interventions (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes - These can be a procedure or a referral)
 - 20093000: Alcohol Rehabilitation and Detoxification
 - 23915005: Combined Alcohol and Drug Rehabilitation and Detoxification
 - 35637008: Alcohol Rehabilitation
 - 52052004: Rehabilitation Therapy
 - 56876005: Drug Rehabilitation and Detoxification
 - 62213004: Combined Alcohol and Drug Rehabilitation
 - 78092008: Drug Rehabilitation

NQF 0012 Title: Screening for Human Immunodeficiency Virus (HIV)

Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit.

Workflow

- For Patients with an Active “Delivery live births” diagnosis that have had a Prenatal Visit, document the “Estimated Date of Delivery” and document any “HIV screening” order and/or results



- To document “Estimated Date of Delivery”
 - Add one of the following Active Problems:
 - Date of Delivery = Problem Resolve Date

| Medcin Description |
|---|
| Pregnant EDC based on Certain LMP |
| Pregnant EDC based on Embryo Transfer Date |
| Pregnant EDC based on Intrauterine Insemination Date |
| Pregnant EDC based on LMP |
| Pregnant EDC based on LMP Preceded by Regular Periods |
| Pregnant EDC based on Ultrasound |
| Pregnant EDC based on Ultrasound At ___ Weeks GA |
| Pregnant EDC Final |
| Pregnant EDC Initial |
| Pregnant for ___ Weeks based on LMP |
| Ultrasound OB Expected Date of Delivery |

Note: EDC below is defined as Estimated Date of Confinement which is synonymous with Estimated Date of Delivery. For this measure, which looks to the Estimated Date of Conception, the Estimated Date of Conception will be calculated as the entered EDD minus 267 days.

- Document “HIV Screening”
 - Via Lab/Procedures record w/o ordering
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Active Problem: HIV
 - Permanent or Temporary Deferral for “HIV Screening”
 - Indicate reason for deferral

Reporting & Setup Considerations

- HIV Screening Test (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 87390, 87391, 87534, 87535, 87536, 87537, 87538, 87539
- Consider adding Orders and Estimated Date of Conception Problems to appropriate Provider’s favorite lists
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0014 Title: Prenatal Care: Anti D Immune Globulin

Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12 month period who received anti D immune globulin at 26-30 weeks gestation.

Workflow

- For Patients with an active diagnosis or completed procedure of “delivery live births”
 - Document D(RH) negative status is unsensitized
 - Add Active Problems with ICD-9s of 656.10, 656.11
 - Document Primigravida or Multigravida for the patient
 - Add Summary of Previous Pregnancies Gravida___(Total No.) **Medcin ID 123318**
 - Indicate the value of the problem corresponding to the following
 - = 1 indicates this is the patient’s first pregnancy i.e. Primigravida
 - > 1 indicates this is NOT the patient’s first pregnancy i.e. Multigravida
 - For Primigravida patients document the Rh status for mother OR for Multigravida patients document the Rh status for mother and child
 - If Rh status result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
 - To document “Estimated Date of Delivery”
 - Add one of the following Active Problems:
 - Date of Delivery = Problem Resolve Date

| Medcin Description |
|---|
| Pregnant EDC based on Certain LMP |
| Pregnant EDC based on Embryo Transfer Date |
| Pregnant EDC based on Intrauterine Insemination Date |
| Pregnant EDC based on LMP |
| Pregnant EDC based on LMP Preceded by Regular Periods |
| Pregnant EDC based on Ultrasound |
| Pregnant EDC based on Ultrasound At ___ Weeks GA |
| Pregnant EDC Final |
| Pregnant EDC Initial |
| Pregnant for ___ Weeks based on LMP |
| Ultrasound OB Expected Date of Delivery |

Note: EDC below is defined as Estimated Date of Confinement which is synonymous with Estimated Date of Delivery. For this measure, which looks to the Estimated Date of Conception, the Estimated Date of Conception will be calculated as the entered EDD minus 267 days.



- Document any Anti-D immune Globulin Administrations
 - If ordered during visit, order medication in Med Admin tab in ACI in EHR and document administration (via Med Admin task or Record Administration tab in Order).
 - If not done in office, any medication history should be documented via Med Hx in ACI. Choose an Administration Date (Month, Day and Year) for correct reporting calculation.
- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - Permanent or Temporary Deferral for Anti-D immune Globulin
 - Indicate reason for deferral
 - Estimated Date of Conception <= 10 months

Reporting & Setup Considerations

- For Rh Status Results add one of the following LOINC values in the RID
 - 10331-7, 1314-4, 14906-2, 14907-0, 14908-8, 17531-5, 34961-3
- Consider adding Orders and Estimated Date of Conception to appropriate Provider's favorite lists
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0018 Title: Controlling High Blood Pressure

Description: The percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

Workflow

- For Patients 17 and older with an Active Problem of Hypertension, document Systolic and Diastolic Blood Pressure at each office visit.
 - Document Systolic and Diastolic Blood Pressure via Vital Sign Panels or Flowsheets
 - New Encounter Summary Alert in 11.2 to remind clinical support staff/provider if Blood Pressure is missing for the Encounter
- Provider submits appropriate Charges for Patient Visit

- Denominator Exclusions
 - Active Problem
 - Pregnancy
 - ESRD
 - Complete Procedure Order or Submitted Procedure Charge indicative of ESRD

Reporting & Setup Considerations –

- The Allscripts delivered Systolic & Diastolic Blood Pressure Vital Sign Values will be used for the calculation
 - Systolic Blood Pressure = Result Code: 0-1
 - Delivered EEHR RID entry that should be used



- Diastolic Blood Pressure = Result Code: 0-2
 - Delivered EEHR RID entry that should be used
- For ESRD Procedure Order, add one of the following SNOMED codes to the OID
 - 194780003, 194781004, 236434000, 236435004, 236436003

NQF 0027 PQRI 115 Title: 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

Description: The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies

Workflow

- For Patients 17 and older with a documented Smoking Status of “tobacco user”, document a “Tobacco Use Cessation Counseling” or Referral for “Tobacco Use Cessation Counseling”
 - Document Smoking Status via Active Problems or Social History
 - New Encounter Summary Alert to remind clinical support staff/provider if Smoking Status has not been documented for the patient

The following Problem codes can be used to identify if the patient is or is not a Tobacco User

| Medicin Description | Comment |
|---|---|
| Document in Social History or Active Problem | |
| Tobacco use | If Status = Denied, term alone does not mean tobacco user |
| History of: Smoking | |
| Former smoker | If Status = Denied, term alone does not mean tobacco user |
| Previous History of smoking | Does not meet measure if only entry on patient record |
| Recently Stopped Smoking | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Smoking | |



| Medcin Description | Comment |
|---|---|
| Smoking (V15.82) | If Status = Denied, term alone does not mean tobacco user |
| Current smoker | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting upon awakening | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting with first beverage/food of day | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting only after first meal of day | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes starting only in the afternoon/evening | If Status = Denied, term alone does not mean tobacco user |
| Leaving a social or work setting for a cigarette | If Status = Denied, term alone does not mean tobacco user |
| Recent increase in cigarettes per day | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes for ___ pack-years | If Status = Denied, term alone does not mean tobacco user |
| Smoking cigarettes with a greater than 50 pack-year history | If Status = Denied, term alone does not mean tobacco user |
| Cigars (___ a day) | If Status = Denied, term alone does not mean tobacco user |
| Smoking a pipe | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking due to family pressure | If Status = Denied, term alone does not mean tobacco user |



| Medcin Description | Comment |
|--|---|
| Wishing to stop smoking due to social pressure | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking for health reasons | If Status = Denied, term alone does not mean tobacco user |
| Wishing to stop smoking due to urging at work | If Status = Denied, term alone does not mean tobacco user |
| Unsuccessful attempt(s) to stop smoking | If Status = Denied, term alone does not mean tobacco user |
| Smoking while wearing nicotine patch | If Status = Denied, term alone does not mean tobacco user |
| Recently stopping smoking | If Status = Denied, term alone does not mean tobacco user |
| Current every day smoker | If Status = Denied, term alone does not mean tobacco user |
| Current some day smoker | If Status = Denied, term alone does not mean tobacco user |
| Smoker, current status unknown | If Status = Denied, term alone does not mean tobacco user |
| Never smoked (Status of denied) | Status of Denied = tobacco user |
| Unknown if ever smoked | Does not meet measure if only entry on patient record |
| Middle-night awakening having a cigarette | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Chewing | |
| Chewing nicotine-containing substances | If Status = Denied, term alone does not mean tobacco user |
| Chewing nicotine-containing substances tobacco | If Status = Denied, term alone does not mean tobacco user |
| Chewing nicotine-containing substances gum | If Status = Denied, term alone does not mean tobacco user |

| Medcin Description | Comment |
|--|---|
| Tobacco User: Snuff | |
| Using nasal snuff | If Status = Denied, term alone does not mean tobacco user |
| Smoking during pregnancy | If Status = Denied, term alone does not mean tobacco user |
| Tobacco User: Nicotine dependence | |
| Nicotine-related disorders | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence - Continuous | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence - episodic | If Status = Denied, term alone does not mean tobacco user |
| Nicotine Dependence – in remission | If Status = Denied, term alone does not mean tobacco user |
| Tobacco Use: Assessment | |
| Assessment & Intervention Use of tobacco assessed | Means Tobacco Assessment Done |
| Assessment & Intervention Use of smoking tobacco assessed | Means Tobacco Assessment Done |
| Assessment & Intervention Use of nonsmoking tobacco assessed | Means Tobacco Assessment Done |
| Tobacco Use: Treatment | |
| Pharmacologic therapy for cessation of tobacco use | Means Tobacco Assessment Done |
| Intervention and counseling on cessation of tobacco use | Means Tobacco Assessment Done |
| Intervention & Counseling cessation of tobacco use 3-10 min. | Means Tobacco Assessment Done |
| Intervention & Counseling cessation of tobacco use > 10 min. | Means Tobacco Assessment Done |
| Anticipatory Guidance: Tobacco Use | |
| Self-help group – Smoking Cessation | |
| CNS stimulants nicotine Polacrilex (Nicorette Gum) | |



| Medcin Description | Comment |
|---|---------|
| CNS stimulants nicotine Transdermal patch | |

- Document all Tobacco Use Cessation Counseling
 - This can be done via Patient Instructions or Referrals
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for “Tobacco Use Cessation Counseling” every 2 years for patients who have Active or Social Problems that indicate a tobacco user
 - Create Order “Smoking Assessment Follow Up” with CPT = 1000F
- Tobacco Use Cessation Counseling Follow Up CPT Codes (Appropriate Orderable Item Dictionary Follow Up Entries should be built or updated with below CPT Codes)
 - 99406- Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
 - 99407 - Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.
- Tobacco Use Cessation Counseling Patient Communication SNOMED Codes (Appropriate Orderable Item Dictionary Instruction Entries should be built or updated with below SNOMED Codes)
 - 171055003, 225323000, 225324006, 315232003, 384742004, 395700008

NQF 0031 Title: Breast Cancer Screening

Description: The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.

Workflow

- For female Patients between 40 and 69 years old that have been seen in the past two years, document Breast Cancer Screening
 - Document Breast Cancer Screening
 - Via Lab/Procedures record w/o ordering Breast Cancer Screening
 - Or complete reminder on HMP
 - Or Submit Procedure Charges
- Provider submits appropriate Charges for Patient Visit
- Denominator Exclusion
 - Document Unilateral or Bilateral Mastectomy via Past Surgical History

| Medcin Description | Comment |
|--|---------------------------------------|
| Breast Surgery Mastectomy (v45.71) | Indicate laterality in problem detail |
| Breast Surgery Radical Mastectomy (v45.71) | Indicate laterality in problem detail |



| Medcin Description | Comment |
|---|---------------------------------------|
| Breast Surgery Simple Mastectomy (v45.71) | |
| Modified Radical Mastectomy Bilateral (v45.71) | |
| Modified Radical Mastectomy Left Breast (v45.71) | |
| Modified Radical Mastectomy Right Breast (v45.71) | |
| Prophylactic Mastectomy Bilateral (v45.71, v50.41) | |
| Prophylactic Mastectomy Left Breast (v45.71, v50.41) | |
| Prophylactic Mastectomy Right Breast (v45.71, v50.41) | |
| Radical Mastectomy Bilateral (v45.71) | |
| Radical Mastectomy Left Breast (v45.71) | |
| Radical Mastectomy Right Breast (v45.71) | |
| Simple Mastectomy Bilateral (v45.71) | |
| Simple Mastectomy Left Breast (v45.71) | |
| Simple Mastectomy Right Breast (v45.71) | |
| Breast Surgery Mastectomy Prophylactic (v50.41) | Indicate laterality in problem detail |

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for “Breast Cancer Screening” for female patients between ages of 40-69, excluding diagnosis of “Bilateral Mastectomy”
- Breast Cancer Screening (Appropriate Orderable Item Dictionary Entries should be built or updated with below CPT Codes)
 - 76090, 76091, 76092, 77055, 77056, 77057

NQF 0032 Title: Cervical Cancer Screening

Description: The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

Workflow

- For female Patients between 21 and 64 years old that have been seen in the past two years for an Outpatient or OB/GYN visit, document Pap Test
 - Document Pap Test Order
 - Via Lab/Procedures record w/o ordering Breast Cancer Screening
 - Or complete reminder on HMP
 - Or Submit Procedure Charges
 - Document Pap Test Results
 - If results result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Provider submits appropriate Charges for Patient Visit



- Denominator Exclusion
 - Past Surgical History “Hysterectomy”

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for “Cervical Cancer Screening” for female patients between ages of 21-64, excluding diagnosis of “Hysterectomy”
- Cervical Cancer Screening/Pap Test CPT Codes (Appropriate Orderable Item Dictionary Entries should be built or updated with below CPT Codes)
 - 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175

NQF 0033 Title: Chlamydia Screening for Women

Description: The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Workflow

- For female Patients between 15 and 24 years old that are sexual active (see below list), document Chlamydia Screening:
 - Document Chlamydia Screening
 - Via Lab/Procedures record w/o ordering
 - Or complete reminder on HMP
 - Verify any Results
 - Document any Procedures indicative of sexually active women
 - Via Lab/Procedures record w/o ordering
 - Or Submit Procedure Charges
 - Verify any Results
 - Document Pregnancy Test Orders
 - Via Lab/Procedures record w/o ordering
 - Verify any Results
 - Document Pregnancy Test Results or any lab tests indicative of sexually active women
 - If results result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
 - Document IUD Use via problems module with one of the following items:

| Medcin Description |
|---|
| Active Problem |
| Gynecologic Services Intrauterine Device (IUD) (v25.42) |
| Gynecologic Services Intrauterine Device (IUD) Insertion (v25.1) |
| Gynecologic Services Intrauterine Device (IUD) Checking (v25.42) |
| Gynecologic Services Intrauterine Device (IUD) Removal (v25.42) |
| Gynecologic Services Intrauterine Device (IUD) Reinsertion (v25.42) |
| Social History |



Birth Control Method – Intrauterine Device (IUD) (v45.51)

- Document IUD Allergy
 - Via Medication Allergy Mirena IUD
 - Via Non-Medication Allergy for IUD
- Document any Contraceptive Use Education
 - Add via Patient Instructions
- Document any Contraceptive Medications Patient is Taking
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Document Active Problems: Pregnancy
- Document Social History of Sexual Activity

| Medicin Description |
|--|
| Sexually Active |
| Sexually Active – Partner Had Recent Genitourinary Tract Infection |
| Sexually Active And Practicing ‘Safer Sex’ |
| Sexually Active As A Prostitute |
| Sexually Active High Risk (v69.2) |
| Sexually Active Monogamous Relation Partner Also Monogamous |
| Sexually Active Monogamous Relationship |
| Sexually Active Post Surgery (__Weeks) |
| Sexually Active Postpartum (__Weeks) |
| Sexually Active With __Partners in the Last Year |
| Sexually Active With Lack Of Responsibility (v69.2) |
| Sexually Active With Persons At Risk For HIV-related Disease (v69.2) |
| Sexually Active With Prostitutes (v69.2) |
| Sexually Active With Varying New Partners And Unconcerned (v69.2) |
| Sexually Active, Attempting to Conceive |
| Sexually Active, Contraception Desired |
| Sexually Active, Frequently With New Partners (v69.2) |
| Sexually Active, Trying to Become Pregnant |
| Trying to Become Pregnant More Than A Year Without Success |

- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Pregnancy Test Result OR Pregnancy Test Ordered AND Retinoid is prescribed within 7 days of the order/result OR X-Ray is performed within 7 days of order/result

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for “Chlamydia Screening” for female patients between ages of 15-24
- Chlamydia Screening (Appropriate Orderable Item Dictionary Laboratory Entries should be built or updated with below CPT Codes)
 - 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87492, 87810



- Contraceptive Use Education (Appropriate Orderable Item Dictionary Instruction Entries should be built or updated with below SNOMED Codes)
 - 16311004, 398780007, 40176008, 44651004
- Pregnancy Test (Appropriate Orderable Item Dictionary Diagnostic Entries should be built or updated with below CPT Codes)
 - 81025, 84702, 84703
- Add IUD as Non Medication Allergy with the entrycode IUD
 - Add IUD to the Uniicode
- X-Ray Studies: (Appropriate Orderable Item Dictionary Laboratory Entries should be built or updated with below CPT Codes)
 - 70010, 70015, 70030, 70100, 70110, 70120, 70130, 70134, 70140, 70150, 70160, 70170, 70190, 70200, 70210, 70220, 70240, 70250, 70260, 70300, 70310, 70320, 70328, 70330, 70332, 70336, 70350, 70355, 70360, 70370, 70371, 70373, 70380, 70390, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 70557, 70558, 70559, 71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034, 71035, 71040, 71060, 71090, 71100, 71101, 71110, 71111, 71120, 71130, 71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555, 72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072, 72074, 72080, 72090, 72100, 72110, 72114, 72120, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72170, 72190, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 72200, 72202, 72220, 72240, 72255, 72265, 72270, 72275, 72285, 72291, 72292, 72295, 73000, 73010, 73020, 73030, 73040, 73050, 73060, 73070, 73080, 73085, 73090, 73092, 73100, 73110, 73115, 73120, 73130, 73140, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73500, 73510, 73520, 73525, 73530, 73540, 73542, 73550, 73560, 73562, 73564, 73565, 73580, 73590, 73592, 73600, 73610, 73615, 73620, 73630, 73650, 73660, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74000, 74010, 74020, 74022, 74150, 74160, 74170, 74175, 74181, 74182, 74183, 74185, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74301, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74350, 74355, 74360, 74363, 74400, 74410, 74415, 74420, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74710, 74740, 74742, 74775, 75557, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75600, 75605, 75625, 75630, 75635, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75790, 75801, 75803, 75805, 75807, 75809, 75810, 75820, 75822, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75900, 75901, 75902, 75940, 75945, 75946, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75960, 75961, 75962, 75964, 75966, 75968, 75970, 75978, 75980, 75982, 75984, 75989, 75992, 75993, 75994, 75995, 75996, 76000, 76001, 76010, 76080, 76098, 76100, 76101, 76102, 76120, 76125, 76140, 76150, 76376, 76377, 76380, 76390, 76496, 76497, 76498, 76499



NQF 0034 | PQRI 113 Title: Colorectal Cancer Screening

Description: The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.

Workflow

- For Patients between 50 and 75 years old, document Colonoscopy, or Flexible Sigmoidoscopy, or Fecal Occult Blood testing
 - Colonoscopy
 - Via Lab/Procedures record w/o ordering
 - Or Past Surgical History
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
 - Flexible Sigmoidoscopy
 - Via Lab/Procedures record w/o ordering
 - Or Past Surgical History
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
 - Fecal Occult Blood testing
 - Via Lab/Procedures record w/o ordering
 - Or complete reminder on HMP
 - Verify any Results
 - If result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Provider submits appropriate Charges for Patient Visit
- Denominator Exclusions
 - Total Colectomy
 - Via Lab/Procedures record w/o ordering
 - Past Surgical History
 - Submit Procedure Charges
- Exclusions
 - Active Problem or Past Medical History: Colorectal Cancer

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for Colonoscopy for patients 50-75 every 10 years
 - OR Create an Order Reminder for Flexible Sigmoidoscopy for patients 50-75 every 5 years
 - OR Create an Order Reminder for Fecal Occult Blood testing for patients 50-75 every year
- Colonoscopy (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)



- 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392
- Flexible Sigmoidoscopy (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345
- Fecal Occult Blood testing (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 82270, 82274
- Total Colectomy (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 44150, 44151, 44152, 44153, 44155, 44156, 44157, 44158, 44210, 44211, 44212

NQF 0036 Title: Use of Appropriate Medications for Asthma

Description: The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).

Workflow

- For Patients between 4 through 50 years of age, with an Active Problem of Asthma, document any Medications that the patient is taking
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - Active Problem: COPD
 - Active Problem: Cystic Fibrosis
 - Active Problem: Emphysema
 - Active Problem: Acute Respiratory Failure

Reporting & Setup Considerations

- None

NQF 0047 | PQRI 53 Title: Asthma Pharmacologic Therapy

Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

Workflow



- For Patients ages 5 through 40 years with an Active Problem of Persistent Asthma with 2 or more office visits, document any Medications that the patient is taking (corticosteroid, inhaled, or alternative asthma medications)
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
 - The following Active Problems will count as Persistent
 - Asthma Mild Persistent
 - Asthma Moderate Persistent
 - Asthma Severe Persistent
 - CareGuides
 - Asthma, Mild Persistent, Adult
 - Asthma, Moderate Persistent, Adult
 - Asthma, Severe Persistent, Adult
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Medication Allergy: corticosteroid, inhaled, or alternative asthma medication
 - Document any adverse reactions
 - Permanent or Temporary Deferral Asthma Medications
 - Indicate reason for deferral

Reporting & Setup Considerations

- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0052 Title: Low Back Pain: Use of Imaging Studies

Description: The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X ray, MRI, CT scan) within 28 days of diagnosis.

Workflow

- For Patients between 18 and 50 years old with an Active Problem of Low Back Pain or Cancer or Trauma or IV Drug Abuse or Neurologic Impairment (within 2 years of the measurement date) document if patient received a “Imaging Study- Spinal”
 - Imaging Study- Spinal
 - Via Diagnostic record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Denominator Exclusions (within 2 years of the measurement end date)
 - Cancer



- Trauma
- IV Drug Abuse
- Neurologic Impairment

Reporting & Setup Considerations

- Imaging Study- Spinal (Appropriate Orderable Item Dictionary Diagnostic Entries should be built or updated with below CPT Codes)
 - 72010, 72020, 72052, 72100, 72110, 72114, 72120, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158, 72200, 72202, 72220
-

NQF 0055 | PQRI 117 Title: Eye Exam

Description: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional .

Workflow

- For Patients between 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, document if patient received an eye exam
 - Eye Exam
 - Via Diagnostic record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Active Problem: Polycystic Ovaries
 - Active Problem: Gestational Diabetes
 - Active Problem: Steroid Induced Diabetes

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for Eye Exam every 1 year for patients with Diabetes
 - Eye Exam (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 67028, 67030, 67031, 67036, 67038, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260
-



NQF 0056 | PQRI 163 Title: Foot Exam

Description: The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

Workflow

- For Patients older than 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, document if patient received a foot exam
 - Foot Exam
 - Via Diagnostic record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Active Problem: Polycystic Ovaries
 - Active Problem: Gestational Diabetes
 - Active Problem: Steroid Induced Diabetes
- Provider submits appropriate Charges for Patient Visit

Reporting & Setup Considerations

- Population Management Considerations
 - Create an Order Reminder for Foot Exam every 1 year for patients with Diabetes
- Foot Exam (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below SNOMED Codes)
 - 401191002, 80314008, 89521000, 91161007

NQF 0061 | PQRI 3 Title: Blood Pressure Management

Description: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.

Workflow

- For Patients older than 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, document Systolic and Diastolic Blood Pressure at each office visit.
 - Document Systolic and Diastolic Blood Pressure via Vital Sign Panels or Flowsheets
 - New Encounter Summary Alert in 11.2 to remind clinical support staff/provider if Blood Pressure is missing for the Encounter
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Active Problem: Polycystic Ovaries



- Active Problem: Gestational Diabetes
- Active Problem: Steroid Induced Diabetes

Reporting & Setup Considerations

- The Allscripts delivered Systolic & Diastolic Blood Pressure Vital Sign Values will be used for the calculation
 - Systolic Blood Pressure = Result Code: 0-1
 - Delivered EEHR RID entry that should be used
 - Diastolic Blood Pressure = Result Code: 0-2
 - Delivered EEHR RID entry that should be used

NQF 0062 | PQRI 119 Title: Urine Screening

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

Workflow

- For Patients older than 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, document if any of the following:
 - Active Problem of Nephropathy
 - Nephropathy related procedures
 - Via Diagnostic record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
 - Nephropathy Screening or Urine Microalbumin Lab Test
 - Via Diagnostic record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
 - Medication ACE Inhibitors/ARBs
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - Active Problem: Polycystic Ovaries
 - Active Problem: Gestational Diabetes
 - Active Problem: Steroid Induced Diabetes

Reporting & Setup Considerations

- Population Management Considerations



- Create an Order Reminder for Nephropathy Screening or Urine Microalbumin Lab Test every 1 year for patients with Diabetes
 - Nephropathy-related Procedures (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 36145, 36800, 36810, 36815, 36818, 36819-36821, 36831, 36832, 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90940, 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512
 - Nephropathy Screening (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 82042, 82043, 82044, 84156
 - Urine Microalbumin Lab Test (Appropriate Orderable Item Dictionary Lab/Procedure Entries should be built or updated with below CPT Codes)
 - 81000, 81002, 81003, 81005
-

NQF 0067 | PQRI 6 Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.

Workflow

- For Patients 18 years and older who have an Active Problem of Coronary Artery Disease including MI or whom had a procedure of Cardiac Surgery, with either more than 2 counts of an Outpatient or Nursing Facility Encounter or 1 count of Inpatient Discharge Encounter, document if taking any Antiplatelet Therapy Medications
 - Cardiac Surgery
 - Document via Past Surgical History
 - Antiplatelet Therapy Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
 - Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Medication Allergy: Antiplatelet Therapy
 - Document any allergy reactions
 - Active Problem: Bleeding Coagulation Disorders
 - Permanent or Temporary Deferral of Antiplatelet Therapy Medications
 - Indicate reason for deferral

Reporting & Setup Considerations

- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0068 | PQRI 204 Title: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic

Description: 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 who had documentation of use of aspirin or another antithrombotic during the measurement year.

Workflow

- For Patients 17 years and older who have had a PTCA (Percutaneous Transluminal Coronary Angioplasty) procedure performed or whom have an Active Problem of IVD (Ischemic Vascular Disease), document all Oral Anti-Platelet Therapy Medications the patient is taking
 - PTCA (Percutaneous Transluminal Coronary Angioplasty)
 - Document via PSH
 - IVD (Ischemic Vascular Disease)
 - Document via Active or PMH (include resolve date for PMH)
 - Oral Anti-Platelet Therapy Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit

- Exclusions
 - None

Reporting & Setup Considerations

- None
-

NQF 0070 | PQRI 7 Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.

Workflow

- For Patients 18 years and older who have an Active Problem of Coronary Artery Disease not including MI or whom had a procedure of Cardiac Surgery, with a Past Medical History of Myocardial Infarction with either more than 2 counts of an Outpatient or Nursing Facility Encounter or 1 count of Inpatient Discharge Encounter, document if taking any Beta Blocker Therapy Medications
 - Myocardial Infarction
 - Document via Past Medical History or resolve the Active Problem
 - Cardiac Surgery



- Document via Past Surgical History
 - Beta Blocker Therapy Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Active Problem: Arrhythmia, Hypotension, Asthma, Bradycardia, Atresia and Stenosis of Aorta
 - Active Problem: Atrioventricular Block AND NOT cardiac pacer in situ or cardiac pacer

Cardiac Pacer can be document in Active Problems via the following:

| Medcin Description | Medcin ID |
|---|-----------|
| Cardiac Devices Pacemaker Present (v45.01) | 290962 |
| Cardiac Pacemaker Epigastric (v45.01) | 290971 |
| Cardiac Pacemaker Left Subclavian (v45.01) | 290963 |
| Cardiac Pacemaker Right Subclavian (v45.01) | 290967 |
| Monitor Pacemaker (v45.01) | 73966 |

- Complete Order Procedure or Charge: Cardiac monitoring
- Medication Allergy: Beta Blocker Therapy
 - Document any adverse reactions
- Permanent or Temporary Deferral of Beta Blocker Therapy Medications
 - Indicate reason for deferral
- >1 consecutive count(s) of “Physical exam finding: heart rate”, < 50 bpm

Reporting & Setup Considerations

- Cardiac Surgery Surgical History CPT Codes
 - 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92980, 92981, 92982, 92984, 92995, 92996
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0073 | PQRI 201 Title: Ischemic Vascular Disease (IVD): Blood Pressure Management

Description: 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).



Workflow

- For Patients 17 years and older who have had a PTCA (Percutaneous Transluminal Coronary Angioplasty) procedure performed or whom have an Active Problem of IVD (Ischemic Vascular Disease), document Systolic and Diastolic Blood Pressure at each office visit.
 - PTCA (Percutaneous Transluminal Coronary Angioplasty)
 - Document via PSH
 - IVD (Ischemic Vascular Disease)
 - Document via Active or PMH (include resolve date for PMH)
 - Document Systolic and Diastolic Blood Pressure via Vital Sign Panels or Flowsheets
 - New Encounter Summary Alert in 11.2 to remind clinical support staff/provider if Blood Pressure is missing for the Encounter
- Provider submits appropriate Charges for Patient Visit
- Exclusions
 - None

Reporting & Setup Considerations

- The Allscripts delivered Systolic & Diastolic Blood Pressure Vital Sign Values will be used for the calculation
 - Systolic Blood Pressure = Result Code: 0-1
 - Delivered EEHR RID entry that should be used
 - Diastolic Blood Pressure = Result Code: 0-2
 - Delivered EEHR RID entry that should be used

NQF 0074 | PQRI 197 Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid lowering therapy (based on current ACC/AHA guidelines).

Workflow

- For Patients 18 years and older who have an Active Problem of Coronary Artery Disease including MI or whom had a procedure of Cardiac Surgery, with either more than 2 counts of an Outpatient or Nursing Facility Encounter, document if taking any Lipid Lowering Therapy Medications
 - Cardiac Surgery
 - Document via Past Surgical History
 - Lipid Lowering Therapy Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit
- Exclusions:



- Last LDL Laboratory result < 130 mg/dL before or during Outpatient Encounter OR Nursing Facility Encounter and dated no longer than one year ago
 - If result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Medication Allergy: Lipid Lowering Therapy
 - Document any allergy reactions
- Permanent or Temporary Deferral of Lipid Lowering Therapy Medications
 - Indicate reason for deferral

Reporting & Setup Considerations

- For all LDL Results add one of the following LOINC values in the RID
 - 12773-8, 13457-7, 13458-5, 14155-6, 16615-7, 16616-5, 18261-8, 18262-6, 2089-1, 2090-9, 2091-7, 2092-5, 22748-8, 24331-1, 25371-6, 2569-2, 3046-0, 3047-8, 35198-1, 35199-9, 39229-0, 39469-2
- Cardiac Surgery Surgical History CPT Codes
 - 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92980, 92981, 92982, 92984, 92995, 92996
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0075 Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

Description: 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 who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.

Workflow

- For Patients 17 years and older who have had a PTCA (Percutaneous Transluminal Coronary Angioplasty) procedure performed or whom have an Active Problem of IVD (Ischemic Vascular Disease), document their LDL or HDL, Triglycerides, and Total Cholesterol results
 - PTCA (Percutaneous Transluminal Coronary Angioplasty)
 - Document via PSH
 - IVD (Ischemic Vascular Disease)
 - Document via Active or PMH (include resolve date for PMH)
 - LDL, HDL, Triglycerides, Total Cholesterol
 - If result values come back via paper, there should be a process in place to enter these values into the EEHR



- This can be done via a Flowsheet or by manually entering in results on the order
- Provider submits appropriate Charges for Patient Visit
- Exclusions: None

Reporting & Setup Considerations

- For all LDL Results add one of the following LOINC values in the RID
 - 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4, 55440-2
- For all HDL Results add one of the following LOINC values in the RID
 - 14646-4, 18263-4, 2085-9
- For all Triglycerides Results add one of the following LOINC values in the RID
 - 12951-0, 14927-8, 2571-8, 47210-0
- For all Total Cholesterol Results add one of the following LOINC values in the RID
 - 14647-2, 2093-3

NQF 0081 Title: Heart Failure (HF): Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.

Workflow

- For Patients 18 years and older who have an Active Problem of Heart Failure with more than 2 counts of an Outpatient or Nursing Facility Encounter or one count of Nursing Facility Encounter, whose LVEF assessment or Ejection Fraction result is less than 40%, document if taking any ACE inhibitor or ARB Medications
 - LVEF Assessment Result
 - If results result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
 - Ejection Fraction Result
 - If results result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
 - ACE inhibitor or ARB Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Medication Allergy: ACE inhibitor or ARB
 - Document any allergy reactions



- Active Problems:
 - Pregnancy
 - Deficiencies of Circulating Enzymes
 - Disease of Aortic and Mitral Valves
 - Non Rheumatic Mitral (valve) Disease
 - Chronic Kidney Disease with or without Hypertension
 - Hypertensive Renal Disease with Renal Failure
 - Atherosclerosis of Renal Artery
 - Renal Failure and ESRD
 - Acute Renal Failure
 - Atresia and Stenosis of Aorta
- Permanent or Temporary Deferral of ACE inhibitor or ARB Medications
 - Indicate reason for deferral

Reporting & Setup Considerations

- LVF Assessment (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 78414, 78451, 78452, 78453, 78454, 78468, 78472, 78473, 78481, 78483, 78494, 78496, 93303, 93304, 93306, 93307, 93308, 93312, 93313, 93314, 93315, 93316, 93317, 93350, 93351, 93352, 93543
- For all Ejection Fraction Result add one of the following SNOMED values in the OID
 - 250907009, 250908004, 70822001
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0083 | PQRI 8 Title: Heart Failure (HF): Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta blocker therapy.

Workflow

- For Patients 18 years and older who have an Active Problem of Heart Failure with more than 2 counts of an Outpatient or Nursing Facility Encounter, whose LVF assessment or Ejection Fraction result is less than 40%, document if taking any Beta Blocker Medications
 - LVF Assessment Result
 - If results result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
 - Ejection Fraction Result
 - If results result values come back via paper, there should be a process in place to enter these values into the EEHR



- This can be done via a Flowsheet or by manually entering in results on the order
 - Beta Blocker Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Medication Allergy: Beta Blocker
 - Document any allergy reactions
 - Active Problems:
 - Arrhythmia
 - Hypotension
 - Asthma
 - Bradycardia
 - Atrioventricular Block and NOT Active Diagnosis Cardiac pacer in Situ or Cardiac Pacer
 - Cardiac Pacer can be document in Active Problems via the following:

| Medcin Description | Medcin ID |
|---|-----------|
| Cardiac Devices Pacemaker Present (v45.01) | 290962 |
| Cardiac Pacemaker Epigastric (v45.01) | 290971 |
| Cardiac Pacemaker Left Subclavian (v45.01) | 290963 |
| Cardiac Pacemaker Right Subclavian (v45.01) | 290967 |
| Monitor Pacemaker (v45.01) | 73966 |

- Permanent or Temporary Deferral of Beta Blocker Medications
 - Indicate reason for deferral
 - Physical exam finding: heart rate
 - via Vital Signs panel Or flowsheet
- Reporting & Setup Considerations
- LVF Assessment (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 78414, 78451, 78452, 78453, 78454, 78468, 78472, 78473, 78481, 78483, 78494, 78496, 93303, 93304, 93306, 93307, 93308, 93312, 93313, 93314, 93315, 93316, 93317, 93350, 93351, 93352, 93543
- Ejection Fraction (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 250907009, 250908004, 70822001
- Heart Rate
 - Use delivered Vital Sign with RID value: 0-5
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason



NQF 0084 | PQRI 200 Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation

Description: Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.

Workflow

- For Patients 18 years and older who have an Active Problem of Heart Failure and Atrial Fibrillation with more than 2 counts of an Outpatient or Nursing Facility Encounter, document if taking any Warfarin Therapy Medications
 - Warfarin Therapy Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Medication Allergy: Warfarin Therapy
 - Document any allergy reactions
 - Active Problems:
 - Anemias and Bleeding Disorders
 - Esophageal and GI Bleed
 - Intracranial Hemorrhage
 - Leukemias/Myeloproliferative Disorders
 - Hematuria
 - Hemoptysis
 - Hemorrhage
 - Liver Disorders
 - Permanent or Temporary Deferral of Warfarin Therapy Medications
 - Indicate reason for deferral

Reporting & Setup Considerations

- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0086 | PQRI 12 Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.

Workflow



- For Patients 18 years and older who have an Active Problem of Primary Open Angle Glaucoma (POAG) with more than 2 counts of Domiciliary or Nursing Facility or Office/Outpatient Consult or Ophthalmological Service Encounters, document if performed Optic Nerve Head Evaluation
 - Optic Nerve Head Evaluation
 - Via Lab/Procedures record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Permanent or Temporary Deferral of Optic Nerve Head Evaluation
 - Indicate reason for deferral

Reporting & Setup Considerations

- Optic Nerve Head Evaluation (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 171671002, 36228007
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0088 | PQRI 18 Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

Workflow

- For Patients 18 years and older who have an Active Problem of Diabetic Retinopathy with more than 2 counts of Domiciliary or Nursing Facility or Office/Outpatient Consult or Ophthalmological Service Visits, document if performed Macular or Fundus Exam
 - Macular or Fundus Exam
 - Via Lab/Procedures record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Permanent or Temporary Deferral of Macular or Fundus Exam
 - Indicate reason for deferral



Reporting & Setup Considerations

- Macular or Fundus Exam (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 410455004
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0089 | PQRI 19 Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

Workflow

- For Patients 18 years and older who have an Active Problem of Diabetic Retinopathy with more than 2 counts of Domiciliary or Nursing Facility or Office/Outpatient Consult or Ophthalmological Service Encounters, document if performed Macular or Fundus Exam AND “Communication: provider to provider macular exam finding” AND “Communication: provider to provider level of severity of retinopathy findings” OR “Communication: provider to provider: severity of retinopathy and macular edema findings”
 - Communication: provider to provider macular exam finding
 - Via Lab/Procedures record w/o ordering
 - Communication: provider to provider level of severity of retinopathy findings
 - Via Lab/Procedures record w/o ordering
 - Communication: provider to provider: severity of retinopathy and macular edema findings
 - Via Lab/Procedures record w/o ordering
 - Macular or Fundus Exam
 - Via Lab/Procedures record w/o ordering
 - Or Submit Procedure Charges
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Permanent or Temporary Deferral of Macular or Fundus Exam
 - Indicate reason for deferral



Reporting & Setup Considerations

- Communication: provider to provider macular exam finding (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 193350004, 193387007, 232020009, 312911008, 312912001, 312920004, 312921000, 312922007, 314010006, 314011005, 314014002, 314015001, 37231002, 399864000, 408415007, 408416008, 414892004, 414908005, 420486006, 421779007, 432789001
- Communication: provider to provider level of severity of retinopathy findings (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 193349004, 312903003, 312904009, 312905005, 390834004, 408411003, 408412005
- Communication: provider to provider: severity of retinopathy and macular edema findings (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 399872003, 399873008, 399874002, 399875001, 399877009
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0105 | PQRI 9 Title: Antidepressant medication management:(a) Effective Acute Phase Treatment, (b)Effective Continuation Phase Treatment

Description: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Workflow

- For all patients who are or will be 18 or older as of April 30th of the measurement year where the FIRST Active Problem of 'Major Depression' is the principal diagnosis during one or more counts of an ED, BH, or BH with POS modifier encounter OR where the FIRST Active Problem of 'Major Depression' is a non-principal diagnosis during two or more counts of an ED, BH, or BH with POS modifier encounter, document all Antidepressant Medications the patient is taking, including the date of Rx
 - Document Major Depression diagnosis
 - Via Active Problem

Note: If not using EHR Charge, document 'Principal Diagnosis for Encounter' via the Category dropdown in the Problem Edit Dialog each time Problem is assessed

| Problem Category Dropdown Value | Measure Value |
|---------------------------------|--------------------------------|
| Primary Diagnosis of | Principal Dx for Encounter |
| Secondary Diagnosis of | Not Principal Dx for Encounter |

- Document Anti-Depressant Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
 - Indicate date of Rx
- Provider submits appropriate Charges for Patient Visit



- Exclusions:
 - None

Reporting & Setup Considerations

- None

NQF 0385 | PQRI 72 Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.

Workflow

- For Patients 18 years and older who have an Active Problem of Colon Cancer or Past Medical History of Colon Cancer with 2 or more Office Visit Encounters, where Procedure Results shows Colon Cancer Stage III, document if prescribing or if the patient is being administered Chemotherapy for Colon Cancer.
 - Document Chemotherapy for Colon Cancer
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
 - Document Colon Cancer Stage III
 - Via Lab/Procedures record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP
 - Verify any Results
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Active Problem:
 - Metastatic Sites Common to Colon Cancer
 - Acute Renal Insufficiency
 - Neutropenia
 - Leukopenia
 - ECOG performance status-poor
 - Via Lab/Procedures record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP



- Verify any Results
- Medication Allergy to Chemotherapy for Colon Cancer
 - Document adverse reaction
- Permanent or Temporary Deferral of Chemotherapy for Colon Cancer
 - Indicate reason for deferral

Reporting & Setup Considerations

- ECOG performance status-poor (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 422894000, 423053003, 423237006
- Colon Cancer Stage III Procedures (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 261654001, 261656004, 261657008, 261658003, 369921003, 370046006
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0387 Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer

Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period.

Workflow

- For female Patients 18 years and older with an Active Problem of Breast Cancer or Past Medical History of Breast Cancer with 2 or more Office Visit Encounters and with a procedure result indicating Breast Cancer Stage IC-IIIC and a procedure result indicating Breast Cancer ER or PR positive, document any Tamoxifen or Aromatase Inhibitor Therapy the patient is taking
 - Document Breast Cancer Stage IC-IIIC
 - Via Lab/Procedures record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP
 - Verify any Results
 - Document Breast Cancer ER or PR positive
 - Via Lab/Procedures record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP
 - Verify any Results
 - Document any Tamoxifen or Aromatase Inhibitor Therapy Medications
 - If ordered in office, document via Ad Hoc Medications, CareGuides, or Quicksets
 - If ordered outside of the office visit, document via Med Hx
- Provider submits appropriate Charges for Patient Visit



- Exclusions
 - Medication Allergy: Tamoxifen or Aromatase Inhibitor Therapy
 - Document adverse reaction
 - Medication Active: Gonadotropin-releasing Hormone Analogue Medication
 - Permanent or Temporary Deferral of Tamoxifen or Aromatase Inhibitor Therapy
 - Indicate reason for deferral
 - Past Surgical History or Procedure Charge: Bilateral Oophorectomy
 - Past Surgical History or Procedure Charge: Radiation Therapy
 - Past Surgical History or Procedure Charge: Chemotherapy
 - Active Problem: Metastatic Sites Common to Breast Cancer

Reporting & Setup Considerations

- Breast Cancer ER or PR positive (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 416053008, 416561008, 417181009, 417742002, 427685000
- Breast Cancer Stage IC-IIIC Procedures (Appropriate Orderable Item Dictionary entries should be built or updated with below SNOMED Codes)
 - 261650005, 261653007, 261658003, 369899008, 369900003, 369901004
- Bilateral Oophorectomy (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 58720, 58940, 58943, 58950, 58951, 58952, 58953, 58954, 58956
- Radiation Therapy (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 77427, 77435, 77470
- Chemotherapy (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0389 Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Workflow

- For all Patients who have an Active Problem of Prostate Cancer, with Prostate Cancer Treatment procedure performed, AND where results indicate AJCC Cancer Stage Low Risk Recurrence Prostate



Cancer, AND Prostate Specific Antigen Test is ≤ 10 mg/dL AND Gleason Score is ≤ 6 , document a Bone Scan has been performed.

- Document AJCC Cancer Stage Low Risk Recurrence Prostate Cancer
 - Via Lab/Procedures record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP
 - Verify any Results
- Document Prostate Specific Antigen Test Results
 - Verify Any Results
 - If result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Document Gleason Score
 - Verify Any Results
 - If result values come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Document Bone Scan
 - Via Imaging record w/o ordering
 - Any charges for Procedures
 - Or complete reminder on HMP
 - Verify any Results
- Exclusions:
 - Active Problem: Pain Related to Prostate Cancer
 - Order or Charge Procedure: Salvage Therapy
 - Permanent or Temporary Deferral of Bone Scan
 - Indicate reason for deferral

Reporting & Setup Considerations

- AJCC Cancer Stage Low Risk Recurrence Prostate Cancer
 - SNOMED: 261650005, 261651009
- Bone Scan OID CPT Codes (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 78300, 78305, 78306, 78315, 78320, 78350, 78351
- For all Gleason Score Results add the following LOINC values in the RID
 - 35266-6
- Prostate Cancer Treatment OID CPT Codes (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77427, 77776, 77777, 77778, 77787
- For all Prostate Specific Antigen Test Results add one of the following LOINC values in the RID
 - 10508-0, 10886-0, 12841-3, 14120-0, 15323-9, 15324-7, 15325-4, 19195-7, 19197-3, 19198-1, 19199-9, 19200-5, 19201-3, 19203-9, 19204-7, 19205-4, 19206-2, 2857-1, 33667-7, 34611-4, 35741-8



- Salvage Therapy OID CPT Codes (Appropriate Orderable Item Dictionary entries should be built or updated with below CPT Codes)
 - 55860, 55862, 55865, 55875, 55876
- Consider setting the following Med/Orders preferences to Prompt or Required
 - Order Defer Reason
 - Order Permanent Defer Reason

NQF 0575 Title: Diabetes: HbA1c Control < 8%

Description: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%.

Workflow

- For Patients older than 17 through 75 years old who have a Current Problem of Diabetes with 2 or more Outpatient OR Ophthalmology visits OR are taking a Diabetic Medication, document HbA1c test results.
 - Document HbA1c Results
 - If results come back via paper, there should be a process in place to enter these values into the EEHR
 - This can be done via a Flowsheet or by manually entering in results on the order
- Provider submits appropriate Charges for Patient Visit
- Exclusions:
 - Active Problems
 - Polycystic Ovaries
 - Gestational Diabetes
 - Steroid Induced Diabetes

Reporting & Setup Considerations

- Population Management
 - Consider setting up Order Reminders to order HbA1c for Diabetic Population
- For all HbA1C Results add one of the following LOINC values in the RID
 - 17856-6, 4548-4, 4549-2



Appendices

Appendix A: How to associate a SNOMED code to an OID item in v11.2 GA

1. Log into SSMT
2. Pick the Category of OID – Orderable Item
3. Check the checkbox 'Show Headers in Extracted Data'
4. Choose a Order Type and Parent Class Filter
5. Click Extract Data
6. Open an Excel spreadsheet, ensure the entire spreadsheet is formatted as data type Text
7. Copy entire extract data contents from SSMT and paste in Excel
8. Modify column SnoTermCode with appropriate SNOMED Code
9. Copy single modified row or Excel spreadsheet
10. Paste into SSMT
11. Click Load Data

Note: The SNOMED code can only be seen via an SSMT Extract of the OID – Orderable Item category in v11.2 GA. The OID dictionary UI will be updated in v11.2 SP 1 to view the SNOMED from the Dictionary Admin workspace.



Appendix B: MU Charge Capture Options

The following two options are available for the population of the visit charge code on the patient visit encounter.

Option 1: Utilizing Charge Module in a Full or Lite capacity

The only difference between utilizing charge in a full or lite capacity is whether there is an interface from EEHR Charge to the client PM System.

Setup:

Charge Code Dictionary – typically this is populated from the client's Practice Management System

Charge Lite:

Consider activating the Submit Enc Form task. This can serve as a reminder to the provider that they have not yet documented their visit code for the patient visit. Also note that for this task to generate the provider's account should be set as a Billing Provider and the 'Don't Generate Send Charge Tasks' is unchecked.

Consider inactivating the following tasks so that they do not appear when viewing tasks by the patient:

- Manage Charge Edits
- Review Enc Form

Workflow:

Step 1: Provider documents patient visit preferably in v10 or v11 EEHR Note

Step 2: Provider determines what the visit charge should be and utilizes EM Coder within the structured note

OR

Step 3: Provider manually enters in appropriate visit charge into the Charge Encounter form

[Daily](#) [Clinical Desktop](#) [Note](#) [Task List](#) [Documents](#) [Encounter Form](#) [Diagnosis](#) [Visit Charges](#) [Procedure Charge](#)

Patient1,PTB MRN: 101006084910000 Sex: F Security: No Restricted Data
 Select Patient *i* *!* DOB: 10/05/2010 AKA: PTB Note: [Select](#)
 Age: 1 Day FYI: FYI Pri Ins:

Visit Charge Selector (Sorted by Code) [Select Encounter](#) [Audit Log](#) [Personalize](#)
 View:

No entries in list

Pages:

| | |
|---|--|
| Modifier Group: <input type="text" value="Linked Modifiers"/> <input type="button" value="v"/> No entries in list | Diagnosis No entries in list |
|---|--|

| CPT Code@ | Modifier | Visit Charge | Linked Dx |
|-----------|----------|------------------------------|-----------|
| 99205 | | Office/outpatient Visit, New | |

Step 4: Provider clicks submit to indicate the charge is complete.

[Daily](#) [Clinical Desktop](#) [Note](#) [Task List](#) [Documents](#) [Encounter Form](#) [Diagnosis](#) [Visit Charges](#) [Procedure Charge](#)

Patient1,PTB MRN: 101006084910000 Age: 56 Days Security: No Restricted Data
 Select Patient *i* *!* Sex: F AKA: PTB Note: [Select](#) W Phone:
 DOB: 10/05/2010 FYI: FYI Pri Ins: Dash:

Encounter Form [Select Encounter](#) [Audit Log](#) [Personalize](#)
 Day Date Time Appt Provider Dept Appt Loc Type Appt No.
 WED 06 Oct 2010 07:00 AM Doctor,Nikila (Niki3) UC_A twappt 27659638

Billing Provider: Division:
 Performing Provider: Billing Area:
 Referring Provider: Location:
 Compliance Code: Pt Ins:

| Primary | # | ICD Code | Diagnosis |
|---------|---|----------|------------------------------------|
| Yes | 1 | 789.00 | Symptom, Pain, Abdominal, Site Nos |

| Status | CPT Code@ | Mod. | Units | RVU | Charge | Linked |
|---|-----------|------|-------|------|------------------------------|--------|
| <input checked="" type="checkbox"/> Submitted | 99205 | | 1.0 | 5.28 | Office/outpatient Visit, New | 1 |

Special Billing:



Option 2: Utilize Order Module

While EEHR Charge is the ideal module to capture visit as well as procedure charges EEHR Charge is not currently utilized by all EEHR clients. As a second option EEHR Orders module can be used to capture visit charges used to help determine the type of patient encounter. Below are suggestions on how to set up orders to accomplish this.

In the OID setup a set of orderable items setting the when to charge flag to NEVER and populating the appropriate visit CPT4 code into the 1st red box below. Also recommend setting the item to auto complete upon being active to avoid unnecessary outstanding orders in the patient's chart.

The image shows two configuration screens. The top screen, titled 'Charge/MN', has a 'When to Charge' dropdown set to 'Never'. Below it are three input fields: 'CPT4 Code' (highlighted with a red box), 'CPT4 Desc', and 'Charge Code'. The bottom screen, titled 'Behavior', has several dropdowns and checkboxes. The checkbox 'Automatically Complete Upon Order Becoming Active' is checked and highlighted with a red box. Other checkboxes include 'Always Display Order Detail on Selection?'.

Documentation of CPT Modifiers for measures 0004 and 0105 when using Order to document visit charges

The best way to indicate a single modifier associated to a visit charge in the Orders module is via an Item Modifier. An item modifier is a picklist of items available on the order detail screen in the application.

Each OID item can have up to three modifier picklist assigned to it.

1. Entries
 - a. Add the desired picklist entries to the Item Modifier Dictionary
 - i. Code = Modifier Number
 - ii. Name = Modifier Description
2. Picklists
 - a. Create a Item Modifier Picklist of the desired modifiers
 - i. Click on Picklist in the Item Modifier Dictionary
 - ii. Click Add Picklist to create a new picklist
 1. Enter the desired name for the picklist, click OK
 - iii. Click on Add Entries to associate Item Modifier Dictionary Entries to the newly created picklist
 1. Locate the desired item by browsing or searching



2. Highlight the entry and click the Add arrow
 3. Once all entries have been added, click OK
 - b. Assign Picklist to OID
 - i. Go to the Orderable Item Dictionary
 - ii. Locate the OID entry that the picklist should be added to
 - iii. Go to the Initial Section and click the Modifier dropdown for the lowest number modifier picklist available and choose the desired picklist
 - iv. Save the change
3. Choose Item Modifier in UI
 - a. Log into the EEHR
 - b. Choose a patient
 - c. Go to the ACI, Orders section
 - d. Right click the order that has the modifier picklist associated to it and choose edit
 - e. In the Clinical Questions section choose the desired item from the modifier picklist
 - f. Commit the Order



Appendix C: Mapping CVX and MVX codes to dictionary entries

The below instructions are from the v11.2 Immunization Registries Enhancement Supplement

Map an immunization to a CVX code

The Orderable Items dictionary includes a **CVX** field that enables you to map immunizations and their current CPT-4 codes to the corresponding **CVX** code. You are not required to map immunization to **CVX** codes, but if you want to be fully compliant with the Meaningful Use guidelines in the EHR Stimulus program, you should do so.

Immunizations that Allscripts or Medispan defines are delivered already mapped to the appropriate **CVX** code and you cannot change this mapping. You only need to map immunizations that you have defined to the appropriate **CVX** code.

*Note: You can map a single **CVX** code to more than one immunization.*

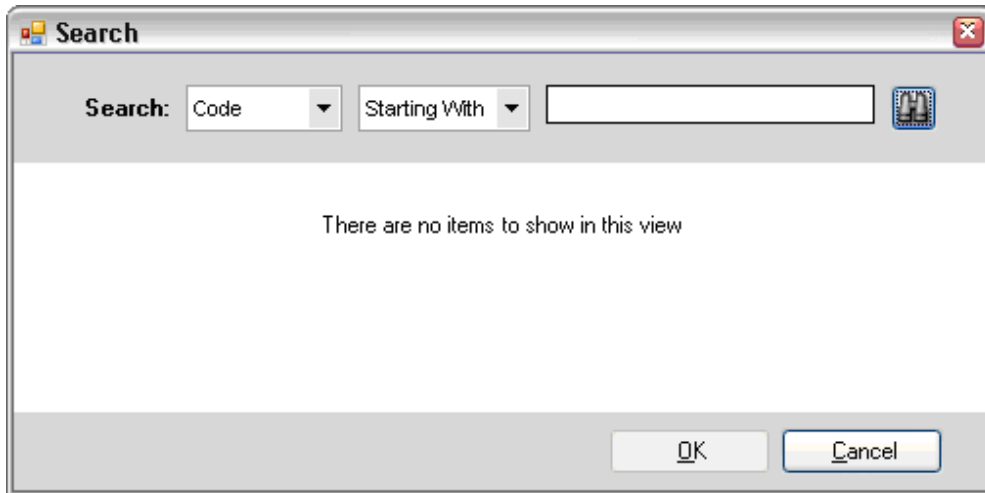
1. Log into Allscripts Enterprise EHR™ using the TWAdmin username and password.
2. Select Dictionaries from the Vertical Toolbar.
3. From the Dictionary drop-down, select Orderable Item.
4. Under Medication, Immunization and Pharmacy Supplies, select the appropriate vaccine category.
*This category is likely “Locally Defined Vaccines,” as vaccines defined by Medispan or Allscripts already have the appropriate **CVX** code associated and you cannot change it.*
5. Select the immunization you want to map to a **CVX** code.
6. Scroll to the Medication section of the form.
7. In the **CVX** field, click the ellipses to search for the appropriate **CVX** code.

The **CVX** field is available only for immunizations that are client defined i.e. whose code begins with U.

The screenshot shows the 'Medication' form with the following fields and values:

- NDC: 54868057106
- Control Substance Code: [Dropdown]
- Overdue Important?:
- DDI: 0
- Route of Admin: Intramuscular
- Keep on Person Prohibited?:
- Drug Name: Diphtheria-Tetanus Toxoids
- Labeler Name: [Text]
- RePackager Name: [Text]
- CVX: [Dropdown] (highlighted with an orange box)
- GP1_TC3: 189900
- HRI: [Text]
- Package Sizes: [Text]

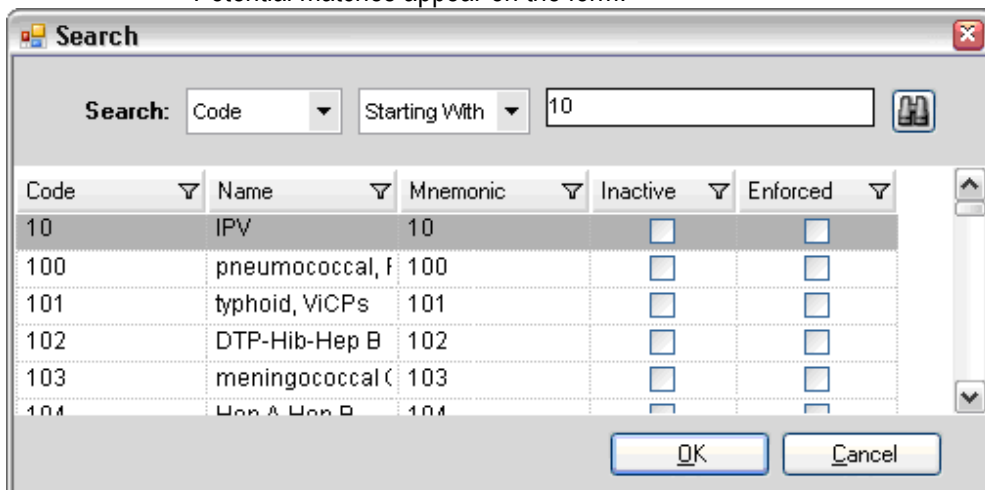
A search window appears.



8. Search for the appropriate **CVX** code.

Note: If you are familiar with the LOINC code search in the Resultable Item dictionary, the CVX code search is identical.

- a. In the Search drop-down, select Code, Mnemonic or Name, depending on which piece of information you want to use as your search criterion.
- b. In the second drop-down, select Starting With or Contains, as appropriate.
- c. In the third field, enter the code, mnemonic or name (entire or part) you want to search on.
- d. Click the binoculars icon.
Potential matches appear on the form.



- e. Double-click the appropriate code to select it.
The selected **CVX** code appears in the **CVX** field in the Orderable Items dictionary.

Map an MVX code to a manufacturer



The Manufacturer dictionary includes a **MVX** field that enables you to map manufacturers to the corresponding **MVX** code. You are not required to map immunization to **MVX** codes, but if you want to be fully compliant with the Meaningful Use guidelines in the EHR Stimulus program, you should do so.

Manufacturers that Allscripts or Medispan defines are delivered already mapped to the appropriate **MVX** code and you cannot change this mapping. You only need to map manufacturers that you have defined to the appropriate **MVX** code.

Note: You can map a single **MVX** code to more than one manufacturer.

1. Log into Allscripts Enterprise EHR™ using the TWAdmin username and password.
2. Select Dictionaries from the Vertical Toolbar.
3. From the Dictionary drop-down, select Manufacturer.
4. Search for and select the manufacturer you want to map to an **MVX** code.
5. Scroll to the Detail1 section of the form.
6. In the **MVX** field, click the ellipses to search for the appropriate **MVX** code.
The **MVX** field is available only for manufacturers that are client defined.

Dictionary: Manufacturer 7 of 2151 Total Items

Search: Name Starting With Database

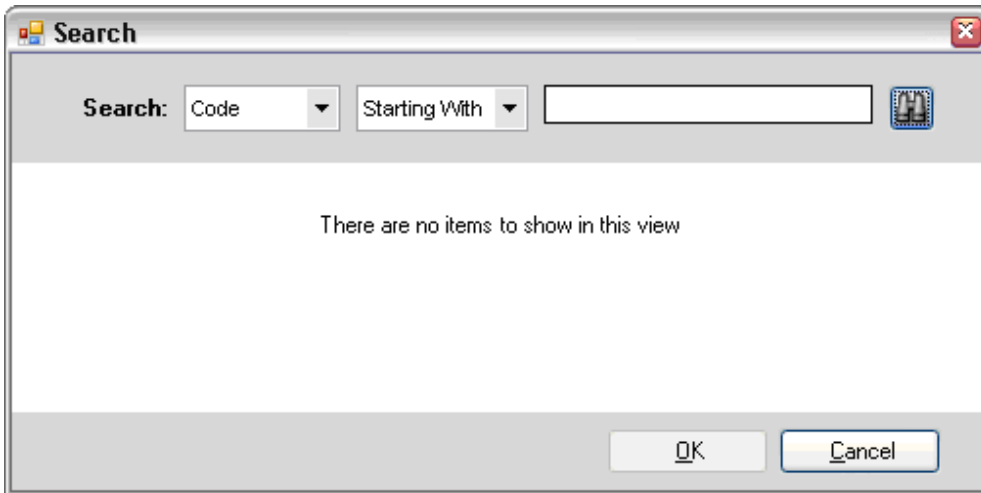
| Code | Name | Mnemonic | Inactive | Enforced |
|--------|-----------------|----------|-------------------------------------|-------------------------------------|
| 10 | Bayer Allergy | Bayer | <input type="checkbox"/> | <input type="checkbox"/> |
| M85 | BAYER BIOLOGIC | M85 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| M26 | BAYER BIOLOGIC | M26 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| M99906 | BAYER BIOLOGIC | M99906 | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| M280 | BAYER CONSUMER | M280 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| M193 | BAYER DIAG DIV | M193 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| M13533 | BAYER,PHARM DIV | M13533 | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Detail 1

MVX:

Add Picklist Report Search

A search window appears.

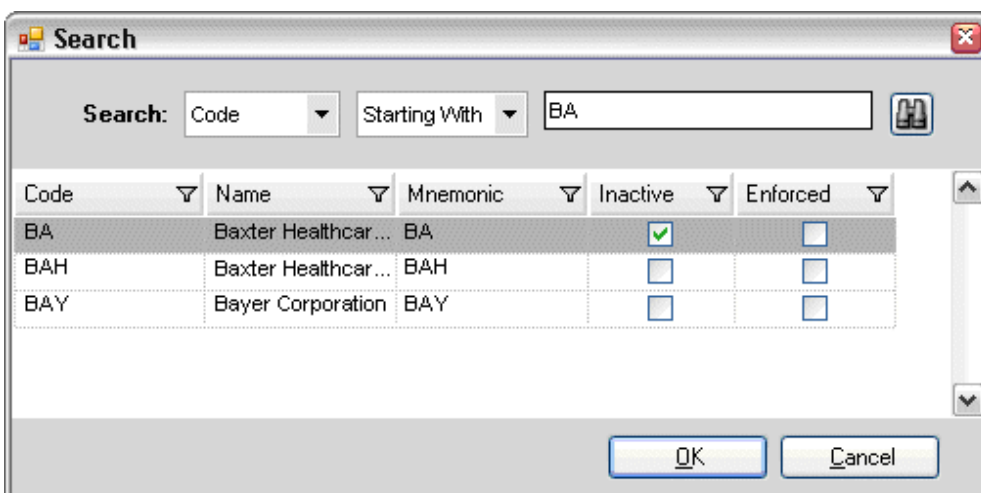


7. Search for the appropriate **MX** code.

Note: If you are familiar with the LOINC code search in the Resultable Item dictionary, the **MX** code search is identical.

- In the Search drop-down, select Code, Mnemonic or Name, depending on which piece of information you want to use as your search criterion.
- In the second drop-down, select Starting With or Contains, as appropriate.
- In the third field, enter the code, mnemonic or name (entire or part) you want to search on.
- Click the binoculars icon.

Potential matches appear on the form.



- Double-click the appropriate code to select it.
The selected **MX** code appears in the **MX** field in the Manufacturer dictionary.