2010 EHR Warehouse Measure Specifications

The specifications listed in this document have been updated to reflect clinical practice guidelines and applicable health informatics standards that are the most current available as of July 31, 2009. These specifications may be available for potential use in physician quality initiatives, including but not limited to the Electronic Health Record (EHR) submission under the 2010 Physician Quality Reporting Initiative (PQRI). A measure's inclusion in this document does not guarantee that measure will be used in any specific CMS program in 2010 or any subsequent year.

In the case of measures that have been used in prior initiatives – such as the 2008 and 2009 PQRI EHR testing projects or the QIO-program's Doctor's Office Quality-Information Technology (DOQ-IT) project activities – the specifications detailed in this document supersede any specifications which may have been used in those prior activities.

To determine which measures are included in any specific CMS program or demonstration, interested parties should refer to the official documentation for that program or demonstration. Please refer to the Medicare Physician Fee Schedule 2010 Final Rule (to be published in the Federal Register in November, 2009) to identify the measures that will be available for data submission through EHRs under the 2010 PQRI, if an EHR-related program will exist in 2010.

2010 EHR Warehouse Measure Specifications

The 2010 PQRI program only allows covered services under the Medicare Physician Fee Schedule (MPFS) for inclusion. The 2010 EHR Warehouse Measure Specifications incorporates CPT Category I codes to define the denominator population for both covered and non-covered services (e.g., preventive visits). Non-covered service codes are included to remain consistent with the measure developer's EHR specifications. These non-covered services, identified by the ➢ (arrow) symbol, will not be counted in the denominator population for PQRI reporting calculations.

List of 2010 EHR Measures containing CPT Category I codes for **non-covered services** from the PFS:

Diabetes Measures 1, 2 and 3:
CPT E/M: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429
NDC Codes: Insulin or oral hypoglycemics/antihyperglycemics

Heart Failure Measure 5:
CPT E/M: 99385, 99386, 99387, 99395, 99396, 99397

Coronary Artery Disease Measure 7:
CPT E/M: 99385, 99386, 99387, 99395, 99396, 99397

Preventive Measures 110, 111, 112 and 113:
CPT E/M: 99386, 99387, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429

HIT Measure 124:
CPT E/M: 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397

Note: *CPT Category II codes will be included in the 2010 EHR Warehouse Measure Specifications only when other standard coding systems are not available (e.g. medical, patient, system reasons for not performing the recommended care) as determined appropriate by the measure owners.*

2010 EHR Warehouse Measure Specifications

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Measure Owner Designation	
▲	AMA-PCPI is the measure owner
♦	NCQA is the measure owner
♠	QIP/CMS is the measure owner

2010 EHR Warehouse Measure Specifications
ANALYTIC NARRATIVES

Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

Description: **Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%**

Denominator: **Patients aged 18 through 75 years with the diagnosis of diabetes**

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time in the patient's medical history and patient is ≥ 18 and ≤ 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and HCPCS (HCPCS) codes for inclusion:

ENCOUNTER CODE (C4)
92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385➤, 99386➤, 99387➤, 99395➤, 99396➤, 99397➤, 99401➤, 99402➤, 99403➤, 99404➤, 99411➤, 99412➤, 99420➤, 99429➤, 99455, 99456

OR

ENCOUNTER CODE (HCPCS)
G0270, G0271

AND

The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.

➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9) codes for inclusion:

DX CODE (I9)
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

OR

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics during the measurement period on an ambulatory basis and DRUG_EXCLUSION = N.

Numerator: Patients with most recent hemoglobin A1c level > 9.0%

Numerator Inclusions:

Patients with most recent A1c > 9.0% during the measurement period.

TOPIC_EVALUATION_CODES Table lists an applicable CPT (C4) and LOINC (LN) code for inclusion:

A1C CODE (C4)
83036, 83037
OR
A1C CODE (LN)
4548-4, 4549-2, 17856-6

AND
Documentation of A1c > 9.0%

Denominator Exclusions: *(Exclusions only applied if patient did not receive A1c test)*

Diabetes patients with a diagnosis of * polycystic ovaries, gestational diabetes, and/or steroid induced diabetes.

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for medical reason exclusion:

EXCLUSION CODE (I9)
251.8, 256.4, 648.80, 648.81, 648.82, 648.83, 648.84, 962.0

* *Diagnosis of polycystic ovaries can occur anytime in the patient's history*

Rationale:
Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

Clinical Recommendation Statements:
A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. (AACE/ACE)

The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values ≤6.5%. (AACE/ACE)

Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of evidence: E) (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c <7%. (Level of evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1C of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered. (AGS)

- ***List of Data Elements located in Appendix A***

Measure #2: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)

Denominator: Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time in the patient's medical history and patient is ≥ 18 and ≤ 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and HCPCS (HCPCS) codes for inclusion:

ENCOUNTER CODE (C4)

92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385➤, 99386➤, 99387➤, 99395➤, 99396➤, 99397➤, 99401➤, 99402➤, 99403➤, 99404➤, 99411➤, 99412➤, 99420➤, 99429➤, 99455, 99456

OR

ENCOUNTER CODE (HCPCS)

G0270, G0271

AND

† *The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.*

➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9) codes for inclusion:

DX CODE (I9)
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

OR

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics during the measurement period on an ambulatory basis and DRUG_EXCLUSION = N.

Numerator: Patients with most recent LDL-C < 100 mg/dL

Numerator Inclusions:

Patients with most recent LDL-C < 100 mg/dL during the measurement period.

TOPIC_EVALUATION_CODES Table lists an applicable CPT (C4) and LOINC (LN) code for inclusion:

LDL CODE (C4)
80061, 83700, 83701, 83704, 83721

OR

LDL CODE (LN)
12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4

AND

Documentation of LDL < 100 mg/dL

Denominator Exclusions: *(Exclusions only applied if LDL cholesterol test not obtained)*

Diabetes patients with a diagnosis of * polycystic ovaries, gestational diabetes, and/or steroid induced diabetes.

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for medical reason exclusion:

EXCLUSION CODE (I9)
251.8, 256.4, 648.80, 648.81, 648.82, 648.83, 648.84, 962.0

* *Diagnosis of polycystic ovaries can occur anytime in the patient's history*

Rationale:
Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.

Clinical Recommendation Statements:
A fasting lipid profile should be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module. (AACE/ACE)

A fasting lipid profile should be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years. (Level of evidence: E) (ADA)

Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy. Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. (Level of evidence: A)

Lipid-lowering therapy should be used for secondary prevention of cardiovascular mortality and morbidity for all patients with known coronary artery disease and type 2 diabetes. (ACP)

Statins should be used for primary prevention against macrovascular complications in patients with type 2 diabetes and other cardiovascular risk factors.

Once lipid-lowering therapy is initiated, patients with type 2 diabetes mellitus should be taking at least moderate doses of a statin.

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction; therefore, monitor and treat hypertension and dyslipidemias. (AGS)

- ***List of Data Elements located in Appendix A***

Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

Denominator: Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Inclusions:

All patients with a documented diagnosis of diabetes at any time in the patient's medical history and patient is ≥ 18 and ≤ 75 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and HCPCS (HCPCS) codes for inclusion:

ENCOUNTER CODE (C4)
92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385➤, 99386➤, 99387➤, 99395➤, 99396➤, 99397➤, 99401➤, 99402➤, 99403➤, 99404➤, 99411➤, 99412➤, 99420➤, 99429➤, 99455, 99456

OR

ENCOUNTER CODE (HCPCS)
G0270, G0271

AND

† *The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.*
➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9) codes for inclusion:

DX CODE (I9)
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

OR

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics during the measurement period on an ambulatory basis and DRUG_EXCLUSION = N.

Numerator: Patients whose most recent blood pressure < 140/80 mmHg

Numerator Inclusions:

Patients with most recent blood pressure measurement <140/80 mmHg during the measurement period.

> **Note:** *Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.*

TOPIC_EVALUATION_CODES Table lists applicable SNOMED (SNM) codes for inclusion:

SYSTOLIC CODE (SNM)
271649006, 72313002
AND
Documentation of Systolic BP < 140 mmHg

AND

DIASTOLIC CODE (SNM)
271650006
AND
Documentation of Diastolic BP < 80 mmHg

Denominator Exclusions: *(Exclusions only applied if most recent BP not recorded)*

Diabetes patients with a diagnosis of * polycystic ovaries, gestational diabetes, and/or steroid induced diabetes.

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for medical reason exclusion:

EXCLUSION CODE (I9)
251.8, 256.4, 648.80, 648.81, 648.82, 648.83, 648.84, 962.0

* *Diagnosis of polycystic ovaries can occur anytime in the patient's history*

Rationale:

Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.

Clinical Recommendation Statements:

Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. (AACE/ACE)

Blood pressure control must be a priority in the management of persons with hypertension and type 2 diabetes. (ACP)

Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure >130 mmHg or diastolic >80 mmHg should have blood pressure confirmed on a separate day. Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy. (Level of Evidence: E) (ADA)

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction; therefore, monitor and treat hypertension and dyslipidemias. (AGS)

Measurement of blood pressure in the standing position is indicated periodically, especially in those at risk for postural hypotension. At least two measurements should be made and the average recorded. After BP is at goal and stable, follow-up visits can usually be at 3- to 6-month intervals. Comorbidities such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. (JNC)

All individuals should be evaluated during health encounters to determine whether they are at increased risk of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement. (NKF)

- ***List of Data Elements located in Appendix A***

2010 EHR Warehouse Measure Specifications
ANALYTIC NARRATIVES

▲Measure #5: Heart Failure: 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 who were prescribed ACE inhibitor or ARB therapy

Denominator: Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

Denominator Inclusions:

All patients with a documented diagnosis of heart failure at any time in the patient's medical history, patient is ≥ 18 years of age at the beginning of the measurement period, and who also have LVSD (defined as ejection fraction < 40% - use most recent value) or with moderately or severely depressed left ventricular systolic function. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385➤, 99386➤, 99387➤, 99395➤, 99396➤, 99397➤

AND

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9) codes for inclusion:

DX CODE (I9)
402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

AND

† *The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.*

➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and SNOMED (SNM) codes for inclusion:

EJEC FRAC CODE (C4)
78414, 78468, 78472, 78473, 78480, 78494, 93303, 93304, 93306, 93307, 93308, 93312, 93314, 93315, 93317, 93318, 93350, 93543

OR

EJEC FRAC CODE (SNM)
250907009, 250908004, 366188009, 371862006, 41466009, 46258004, 70822001

AND

Documentation of LVEF < 40%

Numerator: Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Inclusions:

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed ACE inhibitor or ARB therapy during the measurement period and DRUG_EXCLUSION = N.

Denominator Exclusions: *(Exclusions only applied if the patient did not receive ACE inhibitor or ARB therapy)*

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for medical reason exclusion. The EXCLUSION code can occur anytime before the end of the measurement period.

EXCLUSION CODE (I9)
39.95, 54.98, 277.6, 395.0, 395.2, 396.0, 396.2, 396.8, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 425.1, 440.1, 584.5, 584.6, 584.7, 584.8, 584.9, 585.5, 585.6, 586, 747.22, 788.5, V56.0, V56.8

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for medical reason exclusion. The PREGNANCY codes must occur during the measurement period.

PREGNANCY CODE (I9)
V22.0, V22.1, V22.2, V23.0, V23.1, V23.2, V23.3, V23.41, V23.49, V23.5, V23.7, V23.81, V23.82, V23.83, V23.84, V23.85, V23.86, V23.89, V23.9

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable SNOMED (SNM) codes for allergy or intolerance to ACE inhibitor and ARB therapy:

ACE ALLERGY CODE (SNM)
293500009, 295036000, 315364008,
403607004, 407564000, 407578004, 407595007
AND
ARB ALLERGY CODE (SNM)
407579007, 407590002, 407593000

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for medical reason exclusion:

MEDICAL REASON (C4)
4009F-1P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for patient reason exclusion:

PATIENT REASON (C4)
4009F-2P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for system reason exclusion:

SYSTEM REASON (C4)
4009F-3P

Rationale:

In the absence of contraindications, ACE Inhibitors or ARBs are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function, as measured by left ventricular ejection fraction (LVEF). Both drugs have been shown to decrease mortality and hospitalizations.

Clinical Recommendation Statements:

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A)(ACC/AHA)

Angiotensin II receptor blockers approved for the treatment of HF are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

- ***List of Data Elements located in Appendix A***

▲Measure #7: 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 coronary artery disease and prior MI who were prescribed beta-blocker therapy

Denominator: Patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior myocardial infarction (MI) at any time

Denominator Inclusions:

All patients with a documented diagnosis of CAD at any time in the patient's medical history who also had prior MI at any time and patient is ≥ 18 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

Note: *Eligible patients for this measure require the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.*

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and ICD-9-CM (I9) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213,
99214, 99215, 99238, 99239, 99241, 99242, 99243,
99244, 99245, 99304, 99305, 99306, 99307, 99308,
99309, 99310, 99324, 99325, 99326, 99327, 99328,
99334, 99335, 99336, 99337, 99341, 99342, 99343,
99344, 99345, 99347, 99348, 99349, 99350,
99385➤, 99386➤, 99387➤, 99395➤, 99396➤, 99397➤

AND

DX CODE (I9)
411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9,
414.00, 414.01, 414.02, 414.03, 414.04, 414.05,
414.06, 414.07, 414.8, 414.9, V45.81, V45.82,
OR
DX CODE (C4)
33140, 33510, 33511, 33512, 33513, 33514, 33516,
33533, 33534, 33535, 33536, 92980, 92982, 92995

AND

† *The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.*
➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

MI DX CODE (I9)
410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

OR

All patients with a documented diagnosis of a prior MI at any time and patient is ≥ 18 years of age at the beginning of the measurement period.

Note: *Eligible patients for this measure require the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.*

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and ICD-9-CM (I9) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385➤, 99386➤, 99387➤, 99395➤, 99396➤, 99397➤

AND

MI DX CODE (I9)
410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

Numerator: Patients who were prescribed beta-blocker therapy

Numerator Inclusions:

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed beta-blocker therapy during the measurement period and DRUG_EXCLUSION = N.

➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

Denominator Exclusions: ***(Exclusions only applied if the patient did not receive beta-blocker therapy)***

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) and SNOMED (SNM) codes for medical reason exclusion:

EXCLUSION CODE (I9)
427.81, 427.89, 458.0, 458.1, 458.21, 458.29, 458.8, 458.9, 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

OR

EXCLUSION CODE (SNM)
195100002, 195508000, 195949008, 195972005, 195976008, 207585002, 233681001, 266361008, 28651003, 293963004, 309746001, 36083008, 389145006, 407577009, 407591003, 408667000, 408668005, 42177007, 44602002, 45007003, 48867003, 49044005, 49710005, 60423000, 63088003, 77545000, 91340006

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable SNOMED (SNM) code for documentation of bradycardia as defined by two consecutive heart rate readings < 50 bpm that occur during the measurement period for medical reason exclusion:

HEART RATE CODE (SNM)
364075005

AND

Documentation of two consecutive Heart Rates < 50 bpm

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for history of 2nd or 3rd degree AV block without permanent pacemaker for medical reason exclusion. An AV_BLOCK_CODE must be present without the PERM_PACEMAKER_CODE:

AV BLOCK CODE (I9)
426.0, 426.12, 426.13

WITHOUT

PERM PACEMAKER CODE (I9)
V45.01

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for medical reason exclusion:

MEDICAL REASON (C4)
4006F-1P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for patient reason exclusion:

PATIENT REASON (C4)
4006F-2P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for system reason exclusion:

SYSTEM REASON (C4)
4006F-3P

Rationale:

In the absence of contraindications, beta-blocker therapy has been shown to reduce the risk of a recurrent MI and decrease mortality for those patients with a prior MI.

Clinical Recommendation Statements:

Chronic Stable Angina: Class I – Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI. Class I – Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Drugs required in the hospital to control ischemia should be continued after hospital discharge in patients who do not undergo coronary revascularization, patients with unsuccessful revascularization, or patients with recurrent symptoms after revascularization. Upward or downward titration of the doses may be required. Class I – Beta-blockers in the absence of contraindications. (ACC/AHA)

Acute Myocardial Infarction: Class I – All but low-risk patients without a clear contraindication to ß-adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely. Class IIa – Low-risk patients without a clear contraindication to ß-adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to ß-adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

Although no study has determined if long-term ß-adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have successfully undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

- ***List of Data Elements located in Appendix A***

▲Measure #110: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years

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

Denominator: All patients aged 50 years and older

Denominator Inclusions:

All patients ≥ 50 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99386➢, 99387➢, 99396➢, 99397➢, 99401➢, 99402➢, 99403➢, 99404➢, 99411➢, 99412➢, 99420➢, 99429➢

† *The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.*

➢ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

Numerator: Patients who received an influenza immunization during the flu season (September through February)

Numerator Inclusions:

Patients who received an influenza vaccination from September through February of the year prior to the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9), CPT (C4), HL7 Vaccination (CVX), HCPCS (HCPCS) and SNOMED (SNM) codes for inclusion:

INFLUENZA CODE (I9)
V04.81, V06.6
OR
INFLUENZA CODE (C4)
90656, 90658, 90660, 90661, 90662, 90663
OR
INFLUENZA CODE (CVX)
15, 16, 88
OR
INFLUENZA CODE (HCPCS)
G0008
OR
INFLUENZA CODE (SNM)
396425006, 46233009, 86198006

Denominator Exclusions: *(Exclusions only applied if influenza vaccination not received)*

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for medical reason exclusion:

EXCLUSION CODE (I9)
995.68, V15.03

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable SNOMED (SNM) codes for allergy or contraindication to influenza immunization:

ALLERGY CODE (SNM)
293112000, 293113005, 294647003,
315631004, 407594006, 91930004

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for adverse effects exclusion where an ADVERSE_EFFECT_1 code must be accompanied by an ADVERSE_EFFECT_2 code:

ADVERSE EFFECT 1 CODE (I9)
995.0, 995.1, 995.27, 995.29, 999.5
AND
ADVERSE EFFECT 2 CODE (I9)
E949.6

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) and SNOMED (SNM) codes for medical reason exclusion:

MEDICAL REASON (C4)
4037F-1P
OR
MEDICAL REASON (SNM)
390796006

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) and SNOMED (SNM) codes for patient reason exclusion:

PATIENT REASON (C4)
4037F-2P
OR
PATIENT REASON (SNM)
315640000

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) codes for system reason exclusion:

SYSTEM REASON (C4)
4037F-3P

Rationale:

Influenza vaccination has shown to decrease hospitalizations for influenza, especially for those with risk factors, however annual influenza vaccination rates remain low.

Clinical Recommendation Statements:

Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged ≥ 50 years. (CDC, USPSTF)

- ***List of Data Elements located in Appendix A***

Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older

Description: Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

Denominator: All patients 65 years and older

Denominator Inclusions:

All patients ≥ 65 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99386➤, 99387➤, 99396➤, 99397➤, 99401➤, 99402➤, 99403➤, 99404➤, 99411➤, 99412➤, 99420➤, 99429➤

The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.

➤ Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.

Numerator: Patients who have ever received a pneumococcal vaccination

Numerator Inclusions:

Patients who received a pneumococcal vaccination before the end of the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9), CPT (C4), HL7 Vaccination (CVX), HCPCS (HCPCS), and SNOMED (SNM) codes for inclusion:

PNEUMO CODE (I9)
V03.82, V06.6
OR
PNEUMO CODE (C4)
90732
OR
PNEUMO CODE (CVX)
33, 100, 109
OR
PNEUMO CODE (HCPCS)
G0009
OR
PNEUMO CODE (SNM)
12866006, 333598008, 398730001

Denominator Exclusions: *(Exclusions only applied if the patient has never received a pneumococcal vaccination)*

TOPIC_MEDICAL_EXCLUSION Table lists applicable SNOMED (SNM) codes for medical reason exclusion:

ALLERGY CODE (SNM)
293116002, 294652008, 413378005, 414373006

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) codes for adverse effects exclusion where an ADVERSE_EFFECT_1 code must be accompanied by an ADVERSE_EFFECT_2 code:

ADVERSE EFFECT 1 CODE (I9)
995.0, 995.1, 995.27, 995.29, 999.5
AND
ADVERSE EFFECT 2 CODE (I9)
E948.8

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) and SNOMED (SNM) code for medical reason exclusion:

MEDICAL REASON (C4)
4040F-1P
OR
MEDICAL REASON (SNM)
390795005

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) and SNOMED (SNM) code for patient reason exclusion:

PATIENT REASON (C4)
4040F-2P
OR
PATIENT REASON (SNM)
401086001

Rationale:

The elderly have a much higher mortality from community-acquired pneumonia due to increased risk factors such as comorbidities, an increase in the number of medications taken and weaknesses or disease of lung tissue. Pneumonia accounts for an estimated 20 percent of nosocomial infections among the elderly, second only to urinary tract infections. The disease burden is large for older adults and the potential for prevention is high. (Ely, E., 1997)

Drugs such as penicillin were once effective in treating these infections; but the disease has become more resistant, making treatment of pneumococcal infections more difficult. This makes prevention of the disease through vaccination even more important. (CDC. National Immunization Program—*Pneumococcal Disease.,* 2005)

Clinical Recommendation Statements:

The U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but may be appropriate in immunocompetent individuals at high risk for morbidity and mortality from pneumococcal disease (e.g., persons ≥ 75 years of age or with severe chronic disease) who were vaccinated more than five years previously. Medicare Part B fully covers the cost of the vaccine and its administration every five years. (United States Preventive Services Task Force, 1998)
Pneumococcal infection is a common cause of illness and death in the elderly and persons with certain underlying conditions. In 1998, an estimated 3,400 adults aged ≥ 65 years died as a result of invasive pneumococcal disease. Pneumococcal infection accounts for more deaths than any other vaccine-preventable bacterial disease. (CDC, 2002; Pneumococcal Pneumonia, NIAID Fact Sheet, December 2004.)

One of the *Healthy People 2010* objectives is to increase pneumococcal immunization levels for the non-institutionalized, high-risk populations to at least 90 percent (objective no. 14.29). While the percent of persons 65 years and older receiving the pneumococcal vaccine has increased, it still remains considerably below the *Health People 2010* objective. According to the National Health Interview Survey (NHIS), which is used to track performance on year 2010 objectives, in 1998 only 46 percent of adults age 65 years and older report receiving the vaccine. The figure was 45 percent based on the 1997 Behavioral Risk Factor Surveillance System (BRFSS) survey. (National Center for Health Statistics., 2005; CDC, 1997)
A particular strength of this measure is that it provides an opportunity to compare performance against national, state and/or regional benchmarks, which are collected through nationally organized and administered surveys.

At the physician practice level where a patient survey may not be feasible, data collection on pneumonia vaccination status through chart abstraction is a viable option.

- ***List of Data Elements located in Appendix A***

2010 EHR Warehouse Measure Specifications
ANALYTIC NARRATIVES

Measure #112: Preventive Care and Screening: Screening Mammography

Description: Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months

Denominator: All female patients aged 40 through 69 years

Denominator Inclusions:

All female patients ≥ 40 and ≤ 69 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99386➤, 99387➤, 99396➤, 99397➤, 99401➤, 99402➤, 99403➤, 99404➤, 99411➤, 99412➤, 99420➤, 99429➤

Numerator: Patients who had a mammogram at least once within 24 months

Numerator Inclusions:

Female patients who had a mammogram during the measurement period or year prior to the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable ICD-9-CM (I9), CPT (C4), HCPCS (HCPCS), and SNOMED (SNM) codes for inclusion:

MAMMO CODE (I9)
87.36, 87.37, V76.11, V76.12
OR
MAMMO CODE (C4)
77051, 77052, 77055, 77056, 77057
OR
MAMMO CODE (HCPCS)
G0202, G0204, G0206
OR
MAMMO CODE (SNM)
24623002

† *The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.*
➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

Denominator Exclusions: ***(Exclusions only applied if mammogram not performed)***

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9) and CPT (C4) codes for medical reason exclusion:

EXCLUSION CODE (I9)
85.41, 85.42, 85.43, 85.44, 85.45, 85.46, 85.47, 85.48
OR
EXCLUSION CODE (C4)
19303, 19304, 19305, 19306, 19307, 19303-50*, 19304-50*, 19305-50*, 19306-50*, 19307-50*

**-50 modifier indicates the procedure was performed bilaterally*

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for medical reason exclusion:

MEDICAL REASON (C4)
3014F-1P

Rationale:

Breast cancer ranks as the second leading cause of death in women. For women 40 to 49 years of age mammography can reduce mortality by 17 percent. (AMA, 2003)

Clinical Recommendation Statement:

The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older. (USPSTF, 2002)

- The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50-69, the age group generally included in screening trials. (USPSTF, 2002)
- For women aged 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50. (USPSTF, 2002)
- The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. (USPSTF, 2002)

The USPSTF concluded that the evidence is also generalizable to women aged 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminishes from ages 40-70. The balance of benefits and potential harms; therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. (USPSTF, 2002)

American Cancer Society: Yearly Mammograms starting at age 40 and continuing for as long as a woman is in good health. (Smith, 2003)

American College of Preventative Medicine (ACPM):

- Low-risk women (no family history, familial cancer syndrome, or prior cancer). There is inadequate evidence for or against mammography screening of women under the age of 50. Women between the ages of 50-69 should have annual or biennial, high-quality, two-view mammography. Women aged 70 and older should continue undergoing mammography screening provided their health status permits breast cancer treatment. (Ferrini, 1996)
- Higher-risk women: Women with a family history of pre-menopausal breast cancer in a first-degree relative or those with a history of breast and/or gynecologic cancer may warrant more aggressive screening. Women with these histories often begin screening at an earlier age, although there is no direct evidence of effectiveness to support this practice. The future availability of genetic screening may define new recommendations for screening high-risk women. (Ferrini, 1996)

The American Medical Association (AMA), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Radiology (ACR), all support screening with mammography and CBE beginning at age 40. (AMA, 1999; ACOG, 2000; Feig, 1998)

The Canadian Task Force on Preventive Health Care (CTFPHC), and the American Academy of Family Physicians (AAFP), recommends beginning mammography for average-risk women at age 50. (Canadian Task Force on the Periodic Health Examination, 1999; AAFP, 2005)
AAFP recommends that mammography in high-risk women begin at age 40, and recommends that all women aged 40-49 be counseled about the risks and benefits of mammography before making decisions about screening. (AAFP, 2005)

- ***List of Data Elements located in Appendix A***

2010 EHR Warehouse Measure Specifications
ANALYTIC NARRATIVES

Measure #113: Preventive Care and Screening: Colorectal Cancer Screening

Description: Percentage of patients aged 50 through 80 years who received the appropriate colorectal cancer screening

Denominator: All patients aged 50 through 80 years

Denominator Inclusions:

All patients ≥ 50 and ≤ 80 years of age at the beginning of the measurement period. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99386➢, 99387➢, 99396➢, 99397➢, 99401➢, 99402➢, 99403➢, 99404➢, 99411➢, 99412➢, 99420➢, 99429➢

The "Percentage of patients…" who meet the criteria for this measure will be calculated by the EHR Warehouse. All measure-related EHR coding/data should be submitted to the EHR Warehouse to ensure accurate performance rates.

➢ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

Numerator: Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

Numerator Inclusions:

Patients with any of the recommended colorectal cancer screening test(s) performed.

Current colorectal cancer screening is defined as performing any of the following:

- *Fecal occult blood test during the measurement period*
- *Flexible sigmoidoscopy during the measurement period or four years prior*
- *Double contrast barium enema during the measurement period or four years prior*
- *Colonoscopy during the measurement period or nine years prior*

TOPIC_EVALUATION_CODES Table lists applicable LOINC (LN), CPT (C4), HCPCS (HCPCS), ICD-9-CM (I9) and SNOMED (SNM) codes for inclusion:

FOBT CODE (LN)
12503-9, 12504-7, 14563-1, 14564-9, 14565-6,
2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3
OR
FOBT CODE (C4)
82270, 82274
OR
FOBT CODE (HCPCS)
G0328
OR
FOBT CODE (I9)
V76.51

OR

FLEX SIG CODE (C4)
45330, 45331, 45332, 45333, 45334, 45335, 45337,
45338, 45339, 45340, 45341, 45342, 45345
OR
FLEX SIG CODE (HCPCS)
G0104
OR
FLEX SIG CODE (I9)
45.24, 45.42

OR

DCBE CODE (C4)
74270, 74280
OR
DCBE CODE (HCPCS)
G0106

OR

COLOSCOPE CODE (C4)
44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392

OR

COLOSCOPE CODE (HCPCS)
G0105, G0120, G0121

OR

COLOSCOPE CODE (I9)
45.22, 45.23, 45.25, 45.43

OR

COLOREC SCREEN CODE (SNM)
275978004, 275979007, 316635002

Denominator Exclusions: ***(Exclusions only applied if screening for colorectal cancer not performed)***

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9-CM (I9), CPT (C4) and SNOMED (SNM) codes for medical reason exclusion:

EXCLUSION CODE (I9)
45.8, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 197.5, V10.05, V10.06

OR

EXCLUSION CODE (C4)
44150, 44151, 44155, 44156, 44157, 44158, 44210, 44211, 44212

OR

EXCLUSION CODE (SNM)
300936002

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for medical reason exclusion:

MEDICAL REASON (C4)
3017F-1P

Rationale:

Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001. Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over $6.5 billion per year and, among malignancies, is second only to breast cancer at $6.6 billion per year (Schrag, 1999).

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Four tests are currently available for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, colonoscopy, and double contrast barium enema.

Clinical Recommendation Statements:

During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

Because of the accumulated evidence, broad consensus has emerged about the virtue of screening individuals aged 50 years or older for colorectal cancer. In 1996, the U.S. Preventive Services Task Force (USPSTF) published guidelines that recommended screening all persons aged 50 and older for colorectal cancer by annual FOBT or sigmoidoscopy (at unspecified periodicity) or both (USPSTF, 1997). In February 1997, clinical practice recommendations were issued by an interdisciplinary task force originally convened by the Agency for Health Care Policy and Research (AHCPR; the agency has since been renamed the Agency for Healthcare Research and Quality) and supported by a consortium of professional organizations including the American Gastroenterological Association (Winawer, 1997). The American Cancer Society (ACS) has recommended screening for colorectal cancer since 1980 and recently updated its guidelines in January, 2002 (Smith et al., 2002). These updated guidelines recommend colorectal cancer screening starting at age 50 for all persons at average risk of developing colorectal cancer using one of five options for screening: (1) annual FOBT; (2) flexible sigmoidoscopy every 5 years; (3) annual FOBT plus flexible sigmoidoscopy every 5 years; (4) double contrast barium enema (DCBE) every five years; or (5) colonoscopy every 10 years.

The USPSTF released its updated recommendations for colorectal cancer screening in July 2002. The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer (A recommendation). The USPSTF found good evidence for FOBT screening, fair evidence for sigmoidoscopy (alone or in combination with FOBT), and no direct evidence for colonoscopy or double contrast barium enema. The USPSTF found insufficient evidence to recommend new technologies, such as virtual colonoscopy. The recommended periodicity is annually for FOBT, every 5 years for sigmoidoscopy and double contrast barium enema, and every 10 years for

colonoscopy. FOBT is the only test for which direct evidence on periodicity exists. The intervals for the other tests are based on their sensitivity and the natural course of the disease.

- ***List of Data Elements located in Appendix A***

Measure #124: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

Description: **Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified electronic health record (EHR).**

Denominator: **All patient encounters**

Denominator Inclusions:

All patient encounters. To be eligible for performance calculations, patients must have at least one face-to-face office visit with the clinician during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4) and HCPCS (HCPCS) codes for inclusion:

ENCOUNTER CODE (C4)
90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99381➤, 99382➤, 99383➤, 99384➤, 99385➤, 99386➤, 99387➤, 99391➤, 99392➤, 99393➤, 99394➤, 99395➤, 99396➤, 99397➤

OR

ENCOUNTER CODE (HCPCS)
D7140, D7210, G0101, G0108, G0109, G0270, G0271

Numerator: **Patient encounter documentation substantiates use of certified/qualified EHR**

Numerator Inclusions:

Patient encounters with documentation substantiating the use of a CCHIT certified or qualified (non-CCHIT certified) EHR during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable HCPCS (HCPCS) codes for inclusion:

EHR CODE (HCPCS)
G8447, G8448

➤ *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for PQRI reporting calculations.*

Denominator Exclusions:

None

Rationale:

The need for clinical information systems to provide high-quality, safe care is a well recognized fact, as publicized by Dr. Ed Wagner in his Chronic Care Model. A comprehensive clinical information system can enhance the care of individual patients by:

- Providing timely reminders about needed services
- Summarizing data to track and plan care
- Identifying groups of patients needing additional care
- Facilitating performance monitoring and quality improvement efforts

While it is preferable to encourage adoption of CCHIT certified EMRs, it became apparent during measure field testing that CCHIT certified EMRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. The following is an excerpt taken from the CCHIT website:

The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of significance for specialties and domains not yet addressed by CCHIT Criteria.

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: better patient care management, higher patient satisfaction, reduction of adverse drug events, better quality performance, and improved patient safety, but not consistently high quality evidence

Committee on Quality Health Care in America (2001). Crossing the Quality Chasm: A new health system for the 21st century. Washington, D.C., National Academy Press.

> This report explains the difficulty managing a patient's care using a written medical record, which can be cumbersome to navigate through, as well as illegible. Not only would an EMR be consistent and legible, it can provide reminders and prompts, allowing better management of patient care. In addition, patients who can access their provider using e-mail can have their needs met more quickly and cost effectively.
> Study quality level 2 (limited-quality patient-oriented evidence)

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117.

> This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized physician order entry (CPOE).
> Study quality level 2 (limited-quality patient-oriented evidence)

Jha, A. K., et al. (2003). "Effect of the transformation of the Veterans Affairs Health Care System on quality of care." NEJM 348(22): 2218-2227.

> The Veterans Health Administration medical system uses an EMR system-wide. The authors attribute the VHA's superior quality performance in part to "an emphasis on the use of information technology."

Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg.

This article highlights the impact that various components of HIT and EMR will have on improving patient safety. Additionally, Dr. Middleton enumerates the cost benefits of ambulatory computerized physician order entry (ACPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Mitchell, E., Sullivan, F. (2001). "A descriptive feast but an evaluative famine: systematic review of published articles on primary care computing during 1980-1997." BMJ 322(7281): 279-282.

This older systematic review documents the value of using ECI in a variety of primary care situations.

Study quality level 2 (limited-quality patient-oriented evidence; systematic review but older)

- ***List of Data Elements located in Appendix A***

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APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
Measure #1: Diabetes Mellitus: Hemoglobin A1cPoor Control in Diabetes Mellitus		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement year begins
	MEASURE END DATE	Date the measurement year ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD-9-CM)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	A1C CODING SYSTEM	Type of coding system applicable for A1C testing (CPT, LOINC)
	A1C CODE	Code used for A1C test performed
	A1C DATE	Date A1C testing was performed
	A1C RESULT	Numeric result for HbA1c value (%)
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for insulin or oral hypoglycemics/antihyperglycemics drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
Measure #2: Diabetes Mellitus: Low Density Liproprotein (LDL-C) Control in Diabetes Mellitus		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement year begins
	MEASURE END DATE	Date the measurement year ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD-9-CM)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	LDL CODING SYSTEM	Type of coding system applicable for a LDL-C test (CPT, LOINC)
	LDL CODE	Code used for LDL-C testing
	LDL DATE	Date LDL-C test was performed
	LDL RESULT	Numeric result for LDL-C value (mg/dL)
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for insulin or oral hypoglycemics/antihyperglycemics drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement year begins
	MEASURE END DATE	Date the measurement year ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD-9-CM)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	SYSTOLIC CODING SYSTEM	Type of coding system applicable for a systolic blood pressure measurement (SNOMED)
	SYSTOLIC CODE	Code used for systolic blood pressure
	SYSTOLIC DATE	Date systolic blood pressure was documented
	SYSTOLIC RESULT	Result of systolic blood pressure measurement (mm Hg)
	DIASTOLIC CODING SYSTEM	Type of coding system applicable for a diastolic blood pressure measurement (SNOMED)
	DIASTOLIC CODE	Code used for diastolic blood pressure
	DIASTOLIC DATE	Date diastolic blood pressure was documented
	DIASTOLIC RESULT	Result of diastolic blood pressure measurement (mm Hg)
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for insulin or oral hypoglycemics/antihyperglycemics drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
▲**Measure #5:** Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD-9-CM)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	EJEC FRAC CODING SYSTEM	Type of coding system applicable for an ejection fraction code (CPT, SNOMED)
	EJEC FRAC CODE	Code used for an ejection fraction
	EJEC FRAC DATE	Date ejection fraction was documented
	EJEC FRAC RESULT	Numeric result of ejection fraction percentage (%)
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for ACE inhibitor and ARB therapy drugs
	ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	PREGNANCY CODING SYSTEM	Type of coding system applicable for a pregnancy diagnosis code (ICD-9-CM)
	PREGNANCY CODE	Code used for pregnancy diagnosis
	PREGNANCY DATE	Date pregnancy diagnosis was documented
	ALLERGY CODING SYSTEM	Type of coding system applicable for an allergy diagnosis code (SNOMED)
	ALLERY CODE	Code used for an allergy diagnosis
	ALLERGY DATE	Date allergy diagnosis was documented
	PATIENT REASON CODING SYSTEM	Type of coding system used for patient reason for exclusion (CPT Category II)
	PATIENT REASON	Code used for patient reason for exclusion

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
▲**Measure #5:** Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		
	PATIENT REASON DATE	Date patient reason for exclusion was identified
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified
	SYSTEM REASON CODING SYSTEM	Type of coding system used for system reason for exclusion (CPT Category II)
	SYSTEM REASON	Code used for system reason for exclusion
	SYSTEM REASON DATE	Date system reason for exclusion was identified

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
▲**Measure #7:** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD-9-CM, CPT)
	DX CODE	Diagnosis and procedure codes used to identify the patients diagnosis
	DX DATE	Date of diagnosis
	MI DX CODING SYSTEM	Type of coding system applicable to the diagnosis code for myocardial infarction (ICD-9-CM)
	MI DX CODE	Myocardial infarction diagnosis code
	MI DX DATE	Date of myocardial infarction diagnosis
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for beta-blocker drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM, SNOMED)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	HEART RATE CODING SYSTEM	Type of coding system applicable for a heart rate code (SNOMED)
	HEART RATE CODE	Code used for heart rate
	HEART RATE DATE	Date heart rate measurement documented
	HEART RATE RESULT	Result of heart rate measurement (bpm)
	AV BLOCK CODING SYSTEM	Type of coding system applicable to the AV block diagnosis code (ICD-9-CM)
	AV BLOCK CODE	Diagnosis code used for AV block
	AV BLOCK DATE	Date AV block was documented
	PERM PACEMAKER CODING SYSTEM	Type of coding system applicable for a permanent pacemaker code (ICD-9-CM)
	PERM PACEMAKER CODE	Code used for a permanent pacemaker
	PERM PACEMAKER DATE	Date permanent pacemaker was documented
	PATIENT REASON CODING SYSTEM	Type of coding system used for patient reason for exclusion (CPT Category II)

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
▲**Measure #7:** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)		
	PATIENT REASON	Code used for patient reason for exclusion
	PATIENT REASON DATE	Date patient reason for exclusion was identified
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified
	SYSTEM REASON CODING SYSTEM	Type of coding system used for system reason for exclusion (CPT Category II)
	SYSTEM REASON	Code used for system reason for exclusion
	SYSTEM REASON DATE	Date system reason for exclusion was identified

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
▲**Measure #110:** Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	INFLUENZA CODING SYSTEM	Coding system applicable to influenza vaccination (ICD-9-CM, CPT, CVX, HCPCS, SNOMED)
	INFLUENZA CODE	Code for influenza vaccination
	INFLUENZA DATE	Date of influenza vaccination
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	ALLERY CODING SYSTEM	Coding system applicable to the allergy reasons for exclusion (SNOMED)
	ALLERGY CODE	Allergy code used for exclusion
	ALLERGY DATE	Date allergy was documented
	ADVERSE EFFECT 1 CODING SYSTEM	Coding system applicable to adverse effects (ICD-9-CM)
	ADVERSE EFFECT 1 CODE	Code (1 of 2) used for adverse effects
	ADVERSE EFFECT 1 DATE	Date adverse effect (1 of 2) was documented
	ADVERSE EFFECT 2 CODING SYSTEM	Coding system applicable to adverse effects (ICD-9-CM E codes)
	ADVERSE EFFECT 2 CODE	Code (2 of 2) used for adverse effects
	ADVERSE EFFECT 2 DATE	Date adverse effect (2 of 2) was documented
	PATIENT REASON CODING SYSTEM	Type of coding system used for patient reason for exclusion (CPT Category II, SNOMED)
	PATIENT REASON	Code used for patient reason for exclusion
	PATIENT REASON DATE	Date patient reason for exclusion was identified
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II, SNOMED)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified
	SYSTEM REASON CODING SYSTEM	Type of coding system used for system reason for exclusion (CPT Category II)

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
▲**Measure #110:** Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old		
	SYSTEM REASON	Code used for system reason for exclusion
	SYSTEM REASON DATE	Date system reason for exclusion was identified

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	PNEUMO CODING SYSTEM	Coding system applicable to pneumococcal vaccination (ICD-9-CM, CPT, CVX, HCPCS, SNOMED)
	PNEUMO CODE	Code for pneumococcal vaccination
	PNEUMO DATE	Date of pneumococcal vaccination
	ALLERY CODING SYSTEM	Coding system applicable to the allergy reasons for exclusion (SNOMED)
	ALLERGY CODE	Allergy code used for exclusion
	ALLERGY DATE	Date allergy was documented
	ADVERSE EFFECT 1 CODING SYSTEM	Coding system applicable to adverse effects (ICD-9-CM)
	ADVERSE EFFECT 1 CODE	Code (1 of 2) used for adverse effects
	ADVERSE EFFECT 1 DATE	Date adverse effect (1 of 2) was documented
	ADVERSE EFFECT 2 CODING SYSTEM	Coding system applicable to adverse effects (ICD-9-CM E codes)
	ADVERSE EFFECT 2 CODE	Code (2 of 2) used for adverse effects
	ADVERSE EFFECT 2 DATE	Date adverse effect (2 of 2) was documented
	PATIENT REASON CODING SYSTEM	Type of coding system used for patient reason for exclusion (CPT Category II, SNOMED)
	PATIENT REASON	Code used for patient reason for exclusion
	PATIENT REASON DATE	Date patient reason for exclusion was identified
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II, SNOMED)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
♦**Measure #112:** Preventive Care and Screening: Screening Mammography		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	MAMMO CODING SYSTEM	Coding system applicable to mammography testing (ICD-9-CM, CPT, HCPCS, SNOMED)
	MAMMO CODE	Code used for mammography testing
	MAMMO DATE	Date mammography was performed
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (ICD-9-CM, CPT)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
♦**Measure #113:** Preventive Care and Screening: Colorectal Cancer Screening		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	FOBT CODING SYSTEM	Coding system applicable to fecal occult blood testing (LOINC, CPT, HCPCS, ICD-9-CM)
	FOBT CODE	Fecal occult blood testing code
	FOBT DATE	Date of fecal occult blood testing
	FLEX SIG CODING SYSTEM	Coding system applicable to flexible sigmoidoscopy (CPT, HCPCS, ICD-9-CM)
	FLEX SIG CODE	Flexible sigmoidoscopy code
	FLEX SIG DATE	Date of flexible sigmoidoscopy
	DCBE CODING SYSTEM	Coding system applicable to double contrast barium enema testing (CPT, HCPCS)
	DCBE CODE	Double contrast barium enema testing code
	DCBE DATE	Date of double contrast barium enema testing
	COLOSCOPE CODING SYSTEM	Coding system applicable to colonoscopy testing (CPT, HCPCS, ICD-9-CM)
	COLOSCOPE CODE	Colonoscopy code
	COLOSCOPE DATE	Date of colonoscopy
	COLOREC SCREEN CODING SYSTEM	Coding system applicable to colorectal screening (SNOMED)
	COLOREC SCREEN CODE	Colorectal screening code
	COLOREC SCREEN DATE	Date of colorectal screening
	EXCLUSION CODING SYSTEM	Type of coding system applicable to the medical exclusions (CPT, ICD-9-CM, SNOMED)
	EXCLUSION CODE	Code used for a medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified

APPENDIX A
EHR MEASURES WITH CORRESPONDING DATA ELEMENTS

2010 Measure	Data Element Short Name	Data Element Description
♠ **Measure #124:** Health Information Technology (HIT) - Adoption/Use of Electronic Health Records (EHR)		
	TOPIC TYPE	Topic that is being reported
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	EHR CODING SYSTEM	Type of coding system used to document use of electronic health record (EHR) system (HCPCS)
	EHR CODE	Code used for electronic health record (EHR) system
	EHR DATE	Date electronic health record (EHR) system was identified