

Adoption/Use of Health Information Technology (Electronic Health Records)

*This measure is to be reported at **each** visit occurring during the reporting period for all patients aged 18 years and older. This measure may be reported by clinicians who have adopted and are using health information technology.*

Measure description

Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

What will you need to report for each visit for this measure?

If you select this measure for reporting, you will report:

- Whether or not the patient encounter was documented using either a CCHIT certified EMR or other qualified non-CCHIT certified EMR (as described above)

What if the EMR was not used for this visit?

There may be times when it is not possible to use a CCHIT certified EMR or other qualified non-CCHIT certified EMR, due to:

- System Reasons (eg, the system was inoperable at the time of the visit)

In these cases, you will need to indicate that the system reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

Health Information Technology (HIT)

Adoption/Use of Health Information Technology (Electronic Health Records)

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information

Billing Information

Step 1 Is patient eligible for this measure?			
	Yes	No	Code Required on Claim Form
Patient is aged 18 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
There is a CPT E/M Service Code, D-code, or G-code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes.
If No is checked for any of the above, STOP. Do not report a G-code.			
Step 2 Does patient meet or have an acceptable reason for not meeting the measure?			
Patient Encounter Using an EMR	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Documented — CCHIT certified EMR used	<input type="checkbox"/>	<input type="checkbox"/>	G8447
Documented — Non-CCHIT certified EMR ¹ used	<input type="checkbox"/>	<input type="checkbox"/>	G8448
Not documented for the following reason: • System (eg, system inoperable at the time of the visit)	<input type="checkbox"/>	<input type="checkbox"/>	G8449
Document reason here and in medical chart. _____ _____			

¹The system must be capable of all of the following: generating a medication list, generating a problem list, and entering laboratory tests as discrete searchable data elements.

Adoption/Use of Health Information Technology (Electronic Health Records)

Coding Specifications

Codes required to document a visit occurred:

A CPT service code, CPT E/M service code, HCPCS D-code or HCPCS G-code is required to identify patients to be included in this measure.

CPT service codes

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 92002, 92004 (ophthalmological services — new patient),
- 92012, 92014 (ophthalmological services — established patient),
- 96150, 96151 (health behavior assessment),
- 96152 (health and behavior intervention),
- 97001, 97002, 97003, 97004 (physical medicine and rehabilitation),
- 97750 (physical performance test or measurement),
- 97802, 97803, 97804 (medical nutrition therapy),
- 98940, 98941, 98942 (chiropractic manipulation)

OR

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult)

OR

HCPCS D-codes

- D7140, D7210 (oral and maxillofacial surgery)

OR

HCPCS G-codes

- G0101 (pelvic exam),
- G0108, G0109 (self-management training),
- G0270, G0271 (nutrition therapy)

Quality codes for this measure (one of the following for every eligible patient):

G-code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **G8447:** Patient encounter was documented using a CCHIT certified EMR
- **G8448:** Patient encounter was documented using a non-CCHIT certified EMR. To qualify, the system must be capable of all of the following:
 - Generating a medication list
 - Generating a problem list
 - Entering laboratory tests as discrete searchable data elements
- **G8449:** Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit. Use of this code implies that an EMR is in place and generally available