

### Adoption/Use of Electronic Health Records (EHR)

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*This measure is to be reported at **each** visit occurring during the reporting period for all patients, regardless of age. This measure may be reported by clinicians who have adopted and are using certified/qualified health information technology.*

#### Measure 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 EHR. For the purpose of this measure, a certified/qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified<sup>1</sup>, the system must be capable of all of the following:

- Ability to manage a medication list
- Ability to manage a problem list
- Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
- Ability to meet basic privacy and security 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 EHR or other qualified non-CCHIT certified EHR (as described above)

#### What if the EHR was not used for this visit?

Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

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<sup>1</sup>If CCHIT certification is available (in primary care or a specialty) on or before August 1, 2008, the EHR in use must be CCHIT certified on or before August 1, 2011 or another CCHIT certified product must be in use for compliance after August 1, 2011.

# Health Information Technology (HIT)

## Adoption/Use of Electronic Health Records (EHR)

### 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?			Code Required on Claim Form
	Yes	No	
Any patient regardless of age.	<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. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
If <b>No</b> 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?			Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Patient Encounter Using an EHR	Yes	No	
Documented — CCHIT certified EHR used	<input type="checkbox"/>	<input type="checkbox"/>	G8447
Documented — Qualified(non-CCHIT certified) EHR <sup>1</sup> used	<input type="checkbox"/>	<input type="checkbox"/>	G8448

<sup>1</sup>The system must be capable of all of the following: managing a medication list; managing a problem list; manually entering or electronically receiving, storing and displaying laboratory results as discrete searchable data elements; meeting basic privacy and security elements.

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### 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.

All measure-specific coding should be reported ON THE SAME CLAIM.

#### 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),
- 92541, 92542, 92543, 92544, 92548 (vestibular function tests),
- 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92569, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588 (audiologic function tests with medical diagnostic evaluation),
- 92601, 92602, 92603, 92604 (diagnostic analysis of cochlear implant),
- 92620, 92621 (evaluation of central auditory function),
- 92625 (assessment of tinnitus),
- 92626, 92627 (evaluation of auditory rehabilitation status),
- 92640 (diagnostic analysis with programming of auditory brainstem implant),
- 95920 (intraoperative neurophysiology testing),
- 96150, 96151, 96152 (health behavior assessment/intervention),
- 97001, 97002 (physical therapy evaluation),
- 97003, 97004 (occupational therapy evaluation),
- 97750 (physical performance test or measurement),
- 97802, 97803, 97804 (medical nutrition therapy),
- 98940, 98941, 98942 (chiropractic manipulation),

OR

#### CPT E/M 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:

#### G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **G8447:** Patient encounter was documented using a CCHIT certified EHR
- **G8448:** Patient encounter was documented using a qualified (non-CCHIT certified) EHR