# Clinical Quality Measures (2011)


SOAPware, Inc.

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# Clinical Quality Measures (CQMs)

## Clinical Quality Measures

In SOAPware 2011+, many of the Meaningful Use Clinical Quality Measures (CQMs) now have pick lists available to assist users with the necessary structured data entry. Below, are all 44 Clinical Quality Measures sorted by those that are Core, Alternate Core and Additional measures. Each measure noted below includes a shortcut code for the SMARText item that will assist with the structured documentation. In addition, the steps also include a link to more detailed step-by-step instructions on the documentation that is required for reporting on each of the measures.

The shortcut codes and documentation steps will assist SOAPware users with reporting Clinical Quality Measures to CMS or States. For more information about this Meaningful Use Core requirement, please click the link below.

***REQUIRED FOR MEANINGFUL USE: CLICK HERE TO VIEW THE MEANINGFUL USE ROADMAP**
- Report Clinical Quality Measures (CQMs) to CMS/States

### Clinical Quality Measure Manual

Click here to view the full User Manual for Clinical Quality Measures.

### Core Clinical Quality Measures

**NQF 0013 (Core):** Hypertension: Blood Pressure Measurement

**NQF 0028 (Core):** Preventative Care and Screening Measure Pair *(includes 0028a & 0028b)*

*** 0028a:** Preventive Care and Screening Measure Pair: (a) Tobacco Use Assessment
The shortcut code that has been created for this measure is "PQRItob".

*** 0028b:** Preventive Care and Screening Measure Pair: (b) Tobacco Cessation Intervention
The shortcut code that has been created for this measure is "PQRIqui".

**NQF 0421/PQRI 128 (Core):** Adult Weight Screening and Follow Up
The shortcut code that has been created for this measure is "PQRIbmi."

### Alternate Core Clinical Quality Measures

**NQF 0024 (Alternate Core):** Weight Assessment and Counseling for Children and Adolescents
The shortcut code that has been created for this measure is "PQRIwei".

**NQF 0038 (Alternate Core):** Childhood Immunization Status

**NQF 0041/PQRI 110 (Alternate Core):** Preventative Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
The shortcut code that has been created for this measure is "InfQM".

## Additional Clinical Quality Measures

**NQF 0001/ PQRI 64:** Asthma Assessment
The shortcut code that has been created for this measure is "PQRIastAss".

**NQF 0002/PQRI 66:** Appropriate Testing for Children with Pharyngitis
The shortcut code that has been created for this measure is "PQRIpha".

**NQF 0004:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
The shortcut code that has been created for this measure is "PQRIche".

**NQF 0012:** Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
The shortcut code that has been created for this measure is "PQRIpreHIV".

**NQF 0014:** Prenatal Care: Anti-D Immune Globulin
The shortcut code that has been created for this measure is "PQRIantD".

**NQF 0018:** Controlling High Blood Pressure

**NQF 0027/PQRI 115:** Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies
The shortcut code that has been created for this measure is "TobQM".

**NQF 0031/PQRI 112:** Breast Cancer Screening
The shortcut code that has been created for this measure is "MamQm".

**NQF 0032:** Cervical Cancer Screening
The shortcut code that has been created for this measure is "CerCanQM".

**NQF 0033:** Chlamydia Screening for Women
The shortcut code that has been created for this measure is "PQRIchl".

**NQF 0034/PQRI 113:** Colorectal Cancer Screening
The shortcut code that has been created for this measure is "PQRIpreCol".

**NQF 0036:** Use of Appropriate Medications for Asthma
The shortcut code that has been created for this measure is "PQRIastThe".

**NQF 0043/PQRI 111:** Pneumonia Vaccination Status for Older Adults
The shortcut code that has been created for this measure is "PQRIpne".

**NQF 0047/ PQRI 53:** Asthma Pharmacologic Therapy
The shortcut code that has been created for this measure is "AstQm".

**NQF 0052:** Low Back Pain: Use of Imaging Studies
The shortcut code that has been created for this measure is "PQRIlowBacI".

**NQF 0055/PQRI 117:** Diabetes: Eye Exam
The shortcut code that has been created for this measure is "PQRIdmEye".

**NQF 0056/PQRI 163:** Diabetes: Foot Exam
The shortcut code that has been created for this measure is "PQRIdmFoo".

**NQF 0059/PQRI 1:** Diabetes: HbA1c Poor Control
The shortcut code that has been created for this measure is "PQRIdmA1c".

**NQF 0061/PQRI 3:** Diabetes: Blood Pressure Management

**NQF 0062/PQRI 119:** Diabetes: Urine Screening
The shortcut code that has been created for this measure is "PQRIdmNep".

**NQF 0064/PQRI 2:** Diabetes: LDL Management & Control
The shortcut code that has been created for this measure is "PQRIdmLDL".

**NQF 0067/PQRI 6:** Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
The shortcut code that has been created for this measure is "PQRIcadPla".

**NQF 0068/PQRI 204:** Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
The shortcut code that has been created for this measure is "PQRIivd".

**NQF 0070/PQRI 7:** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infraction (MI)
The shortcut code that has been created for this measure is "PQRIcadBB".

**NQF 0073/PQRI 201:** Ischemic Vascular Disease (IVD): Blood Pressure Management
The shortcut code that has been created for this measure is "PQRIivd".

**NQF 0074/PQRI 197:** Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

**NQF 0075:** Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
The shortcut code that has been created for this measure is "PQRIivd".

**NQF 0081/PQRI 5:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
The shortcut code that has been created for this measure is "PQRIhfACE".

**NQF 0083/PQRI 8:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
The shortcut code that has been created for this measure is "PQRIhfBB".

**NQF 0084/PQRI 200:** Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
The shortcut code that has been created for this measure is "PQRIhgWar".

**NQF 0086/PQRI 12:** Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
The shortcut code that has been created for this measure is "GlaQM".

**NQF 0088/PQRI 18:** Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
The shortcut code that has been created for this measure is "PQRIdmEye".

**NQF 0089/PQRI 19:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
The shortcut code that has been created for this measure is "DiaRetCom".

**NQF 0105/PQRI 9:** Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
The shortcut code that has been created for this measure is "PQRIdepMed".

**NQF 0385/PQRI 72:** Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
The shortcut code that has been created for this measure is "PQRIcol".

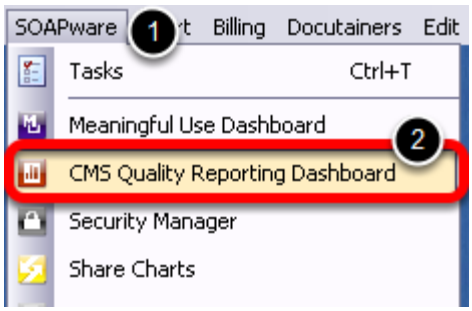
**NQF 0387/PQRI 71:** Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
The shortcut code that has been created for this measure is "PQRIbreCan".

**NQF 0389/PQRI 102:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
The shortcut code that has been created for this measure is "PQRIproBon".

**NQF 0575:** Diabetes: HbA1c Control (<8%)

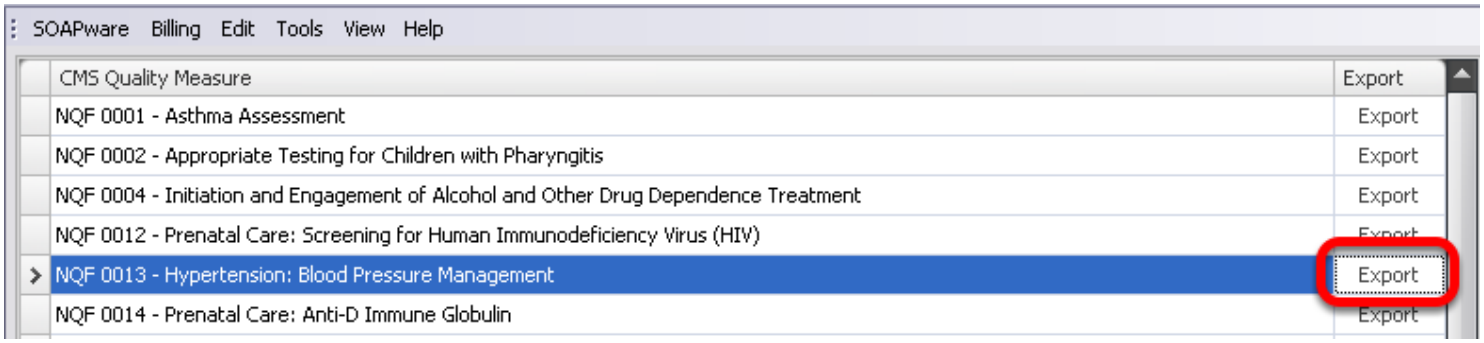
This lesson is designed to walk the user through the steps of exporting Quality Measures data for reporting.

## CMS Quality Reporting Workspace



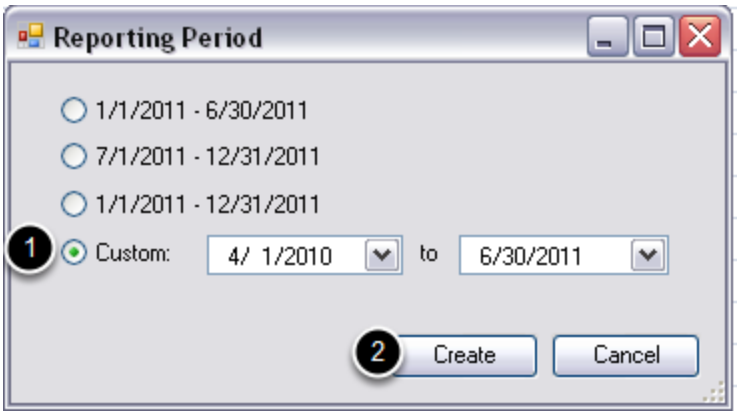

1. Click on the SOAPware Menu
2. Select the"CMS Quality Reporting Dashboard"

## Clinical Quality Measures Export

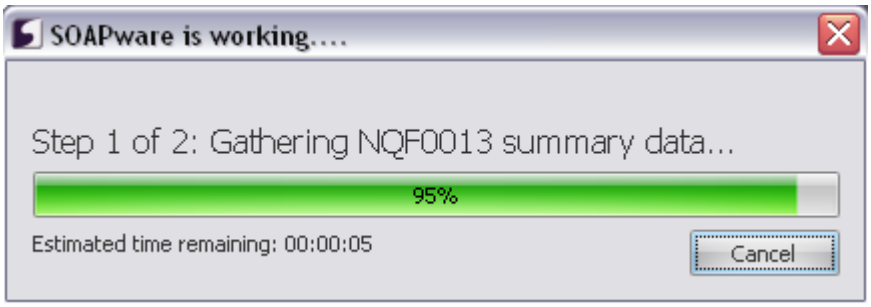



To export the data for a specific clinical quality measure, locate the quality measure to export and Click the Export button.

## Select the Reporting Period

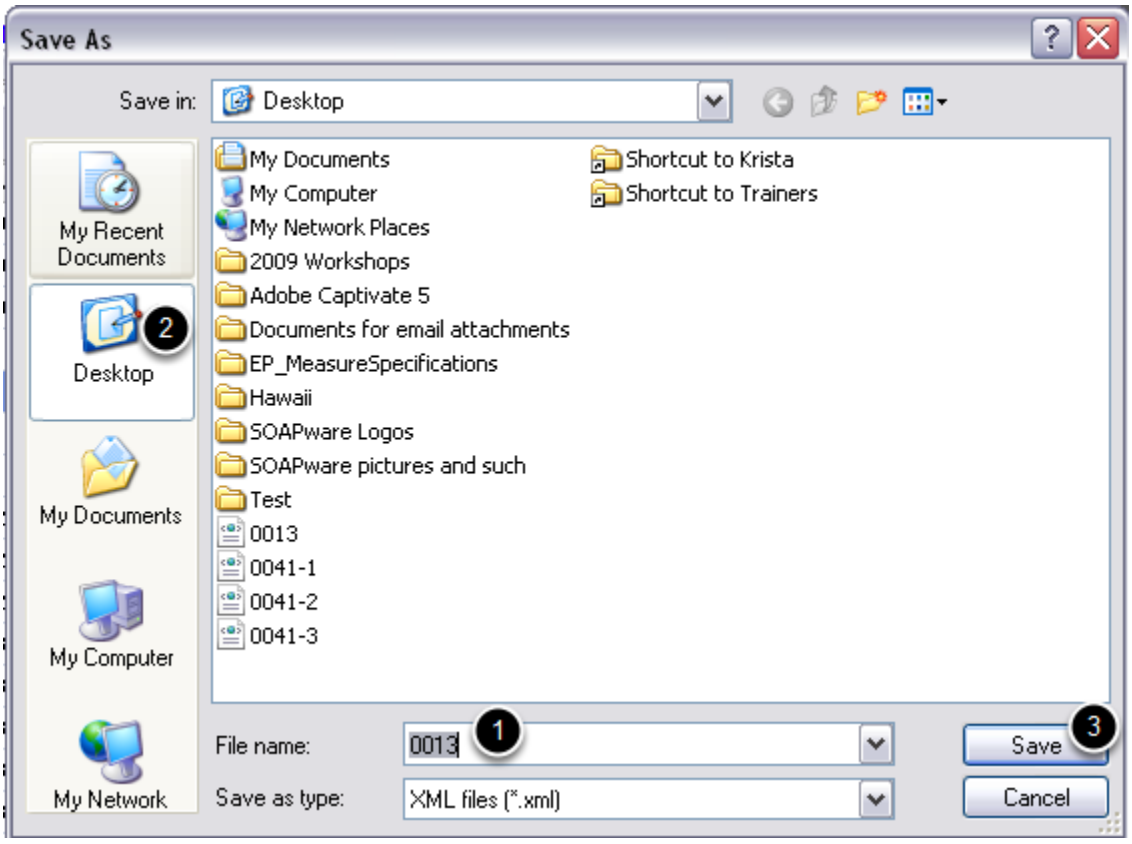



1. To select the reporting period for the export, choose the Custom option and enter the desired reporting period.
2. Click the Create button to begin the export.




While the report is running, the user will see a progress bar similar to the one shown above.

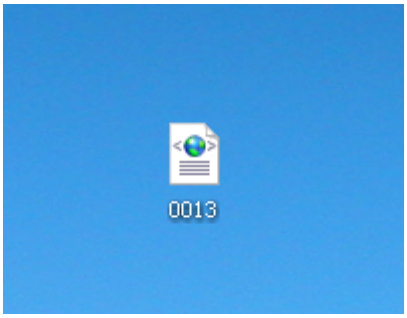
## Saving the Export Results




To save the export results:

1. Name the file.
2. Choose the desired destination.
3. Click the Save button.

## Viewing the Report




To view the clinical quality measure report, locate the file that was saved and simply double-click on the icon.

## Reading the XML File

```
<?xml version="1.0" encoding="UTF-8" ?>
- <submission type="PQRI-REGISTRY" version="3.0">
  - <file-audit-data>
      <create-date>06-29-2011</create-date>
      <create-time>11:23</create-time>
      <create-by>SOAPware</create-by>
      <version>1.0</version>
      <file-number>1</file-number>
      <number-of-files>1</number-of-files>
    </file-audit-data>
  - <registry>
      <registry-name>Test Registry</registry-name>
      <registry-id>01234</registry-id>
      <submission-method>B</submission-method>
    </registry>
  - <measure-group ID="X">
    - <provider>
        <npi>4567894561</npi>
        <encounter-from-date>01-01-2011</encounter-from-date>
        <encounter-to-date>06-30-2011</encounter-to-date>
      - <pqri-measure>
          <pqri-measure-number>NQF0013</pqri-measure-number>
          <eligible-instances>2</eligible-instances>
          <meets-performance-instances>1</meets-performance-instances>
          <performance-exclusion-instances>0</performance-exclusion-instances>
          <performance-not-met-instances>1</performance-not-met-instances>
          <reporting-rate>100</reporting-rate>
          <performance-rate>50</performance-rate>
        </pqri-measure>
      </provider>
    </measure-group>
  - <measure-group ID="X">
    - <provider>
        <npi>9876543210</npi>
        <encounter-from-date>01-01-2011</encounter-from-date>
        <encounter-to-date>06-30-2011</encounter-to-date>
      - <pqri-measure>
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          <meets-performance-instances>3</meets-performance-instances>
          <performance-exclusion-instances>0</performance-exclusion-instances>
          <performance-not-met-instances>0</performance-not-met-instances>
          <reporting-rate>100</reporting-rate>
          <performance-rate>100</performance-rate>
        </pqri-measure>
      </provider>
    </measure-group>
```

Providers NPI Number

Reporting Period Selected

Eligible Instances/ Denominator

Meets Performance Instances/ Numerator

Performance Rate/ Percentage

SOAPware exports the Clinical Quality Measure file in XML format. At this time, CMS does not require that the user upload the XML document during the attestation process. However, this may be a requirement in future Meaningful Use Stages.

The XML export contains the following information:

- Providers NPI Number
- Selected reporting period
- Clinical Quality Measure NQF or PQRI number
- Eligible Instances/Denominator
- Meets Performance Instances/Numerator
- Performance Exclusion Instances *(*Note: SOAPware does not report exclusions at this point in time. This number will always be 0)*
- Performance Not Met Instances
- Reporting Rate
- Performance Rate (the Numerator divided by the Denominator)

Please see the above screenshot for a visual explanation of how to read the XML document. The above screenshot can be resized for easier viewing (simply click on the picture to view a larger version).

# Core Measures (All 3 Required)

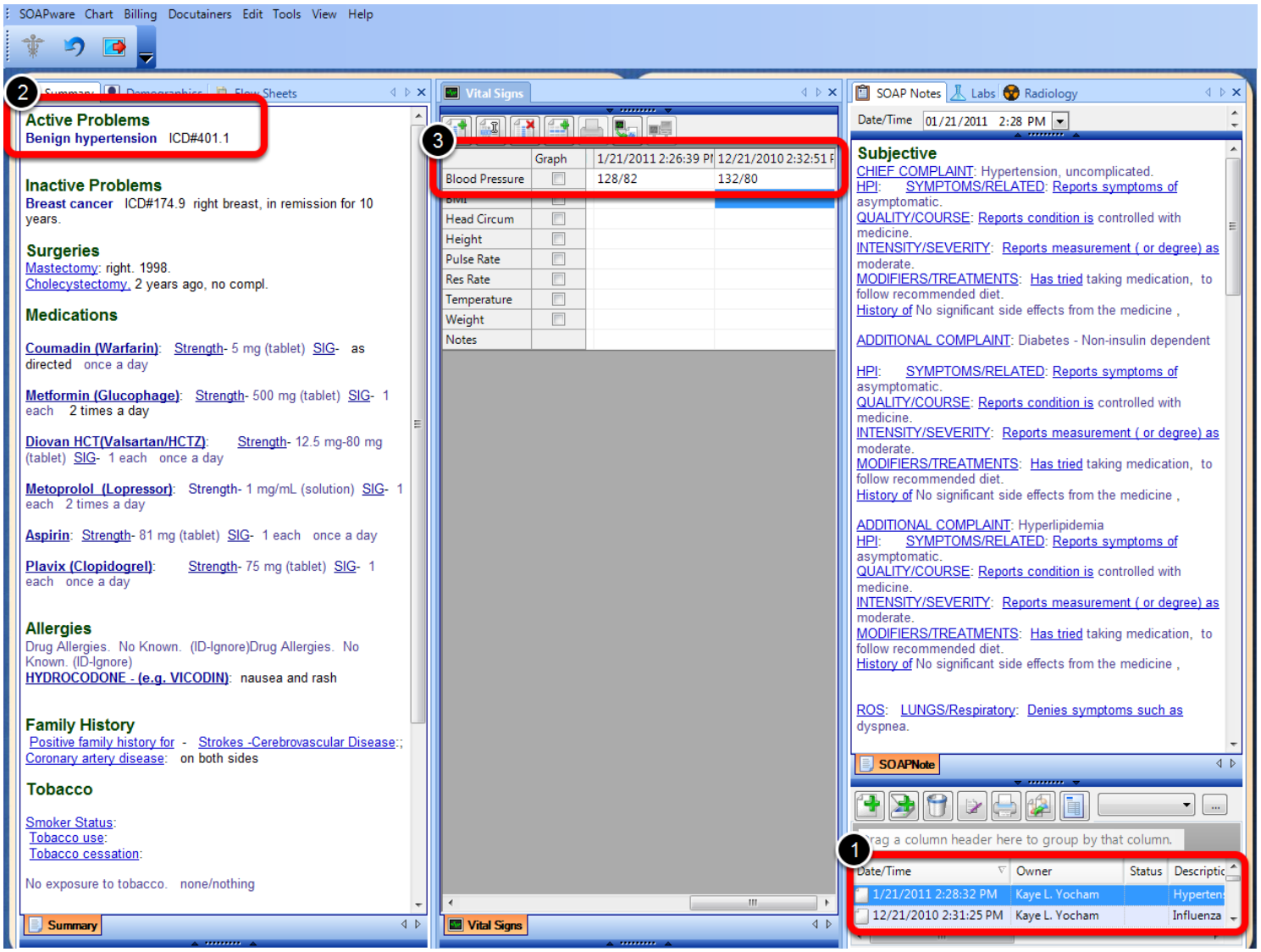
## NQF 0013 (Core): Hypertension: Blood Pressure Measurement

**Measure:** NQF 0013 (Core Measurement)

**Measure Title:** Hypertension: Blood Pressure Measurement

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

# Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be at least **18 years of age or older** at the start of the reporting period and have at least **two face-to-face encounters** with the provider during the reporting period.

2. Adiagnosis of **Hypertension** (recorded by using any of the ICD codes listed below) must be recorded in the patient's Summary **Active Problems** field **OR** encounter **Assessment** field. (401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93)

3. At least one **Blood Pressure reading** should be performed and documented during the reporting period in the Vital Signs chart section.

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient has a diagnosis of hypertension and has been seen for at least 2 office visits, with blood pressure (BP) recorded.*

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator who have at least one blood pressure reading performed and recorded in the Vital Signs chart section during the reporting period.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients who are age 18 years and older and have at least two face-to-face encounters with the provider during the reporting period;

2. And have a diagnosis of Hypertension in the Summary Active Problems field or encounter Assessment field:
(401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93)

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

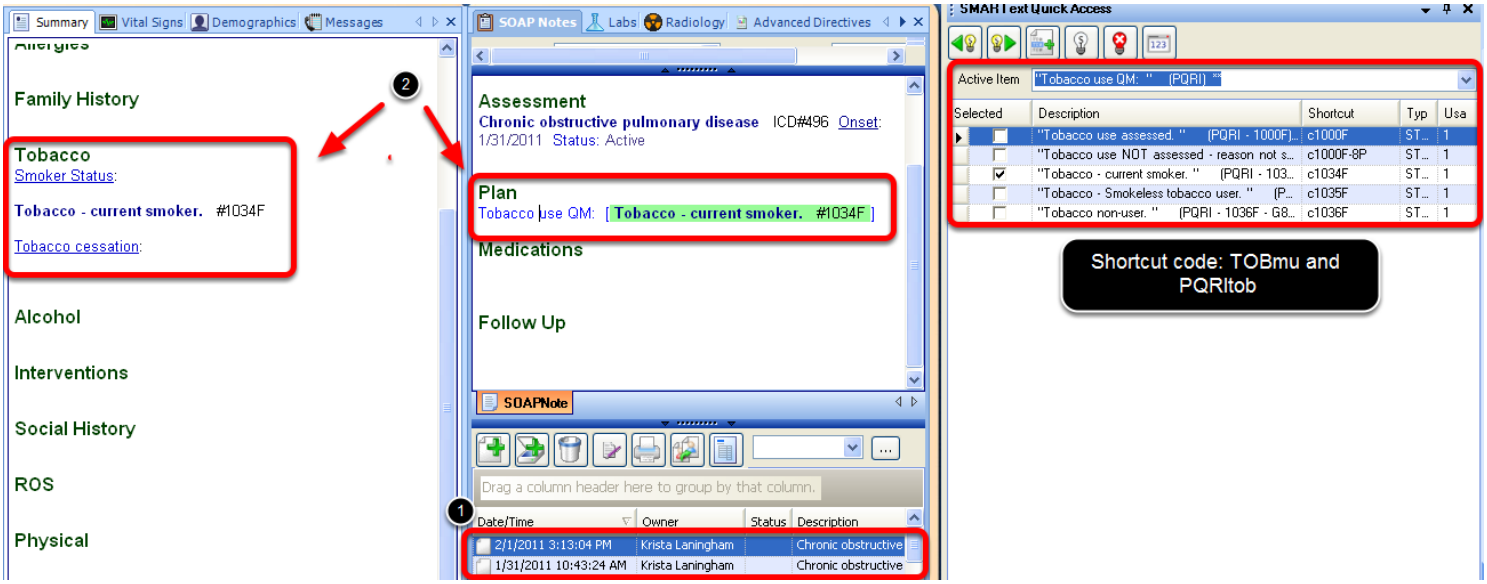
## NQF 0028a (Core): Preventative Care and Screening Measure Pair: a. Tobacco Use Assessment

**Measure:** NQF 0028a (Core Measurement)

**Measure Title:** Preventative Care and Screening Measure Pair: a. Tobacco Use Assessment

**Measure Description:** Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be at least 18 years old or older at the start of the reporting period and have at least two face-to-face encounters with the provider during the reporting period.

2. Documentation of tobacco use in the **Summary Tobacco** field **OR** the **encounter Plan** field must include any one of the CPT codes listed below:
(1000F, 1034F, G8455, 1035F, G8456, 1036F, G8457. ***Note:** 1000F-8P will not increase the numerator).

a. Inserting the shortcut code, "**TOBmu**" in the Summary Tobacco Field will insert three pick lists including the pick list for "Tobacco use" that will provide a list of criteria from which to document the above CPT codes.
b. Inserting the shortcut code, "**PQRItob**" in the encounter Plan Field will insert the pick list, "Tobacco use QM" that will provide a list of criteria from which to document the above CPT codes.

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient has been seen for at least 2 office visits and queried about tobacco use one or more times within 24 months.*

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator who have documentation of tobacco use in the Summary Tobacco field or SOAP Note Plan field using one of the following codes: 1000F, 1034F, G8455, 1035F, G8456, 1036F, G8457. (**Note:** 1000F-8P will not increase the numerator).

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were at least 18 by the start of the reporting period and have had at least two face-to-face encounters with the physician during the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

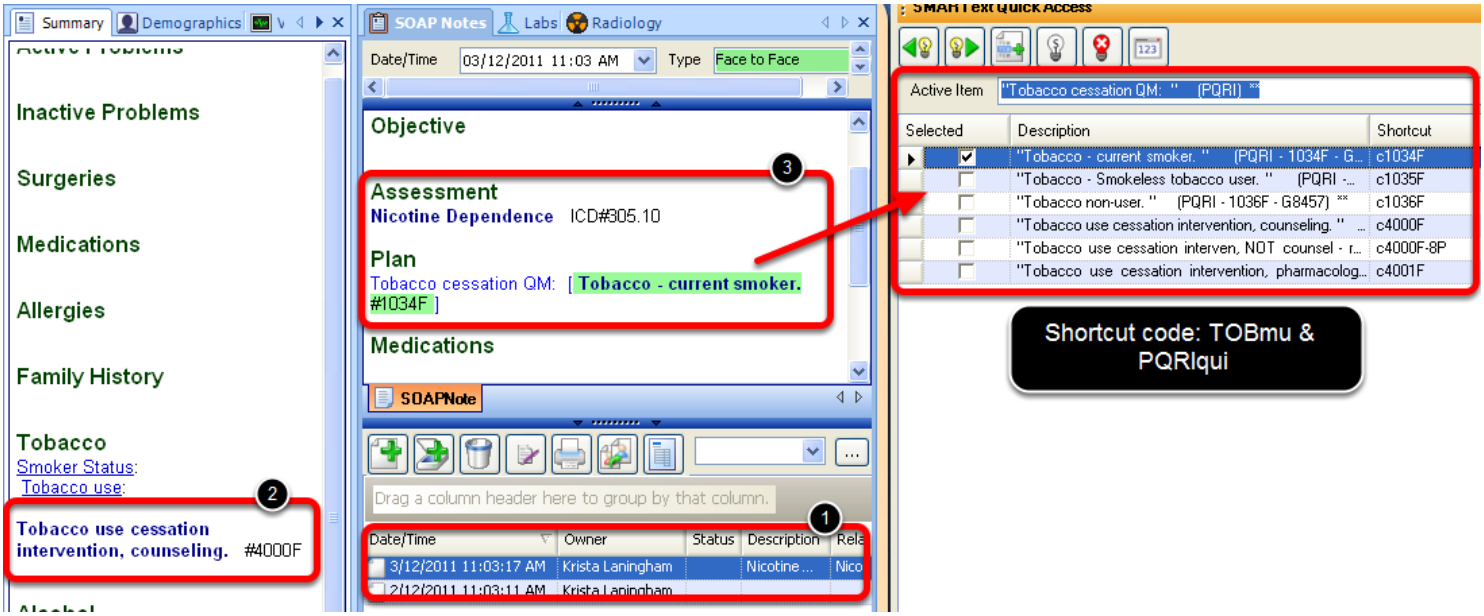
## NQF 0028b (Core): Preventive Care and Screening Measure Pair: b. Tobacco Cessation Intervention

**Measure:** NQF 0028b (Core Measure)

**Measure Title:** Preventative Care and Screening Measure Pair: b. Tobacco Cessation Intervention

**Measure Description:** Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months who received cessation intervention.

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be at least 18 years of age or older at the start of the reporting period have have at least two face-to-face encounters with the provider during the reporting period.

2. Documentation of tobacco cessation intervention in the **Summary Tobacco field**. Inserting the shortcut code, "**TOBmu**" will insert three pick lists including the pick list for **"Tobacco cessation"** that will provide a list of criteria from which to document tobacco cessation intervention **(CPT 4000F, 4001F. Note: 4000F-8P will not increase the numerator.)**

3. Documentation that the patient is a tobacco user. This can be done using one of the following methods:

a. Documentation in the **Summary Interventions** field **OR** the **encounter Plan** field must include

any one of the following CPT codes listed below:
**1034F or 1035F*.**
*Inserting the shortcut code, "**PQRIqui**" in the encounter Plan field or the Summary Interventions field will insert the pick list, **"Tobacco cessation QM"** that will provide a list of criteria from which to document the above CPT codes.

OR

b. Documentation by the presence of one of the following ICD9 codes in the **Summary Active Problems** field **OR encounter Assessment** field:
**305.1 OR 305.10.**

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator who have documentation of tobacco cessation intervention in the Summary Tobacco field using one of the following codes: **CPT 4000F or 4001F.** **(Note:** 4000F-8P (Tobacco use cessation interven, not counsel - reason NOS) will not increase the numerator.)

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were at least 18 by the start of the reporting period and have had at least two face-to-face encounters with the physician during the reporting period;

2. And has a confirmation of being a tobacco user, which can be accomplished by the presence of **ICD-9 305.1 or 305.10** in the Assessment or Active Problems fields; **OR** this can also be accomplished by the documentation of **CPT 1034F or 1035F** in the encounter Plan or Summary Interventions fields. **(Note:** CPT 1036F (Tobacco non-user) will not increase the denominator.)

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## NQF 0421/PQRI 128 (Core): Adult Weight Screening and Follow Up

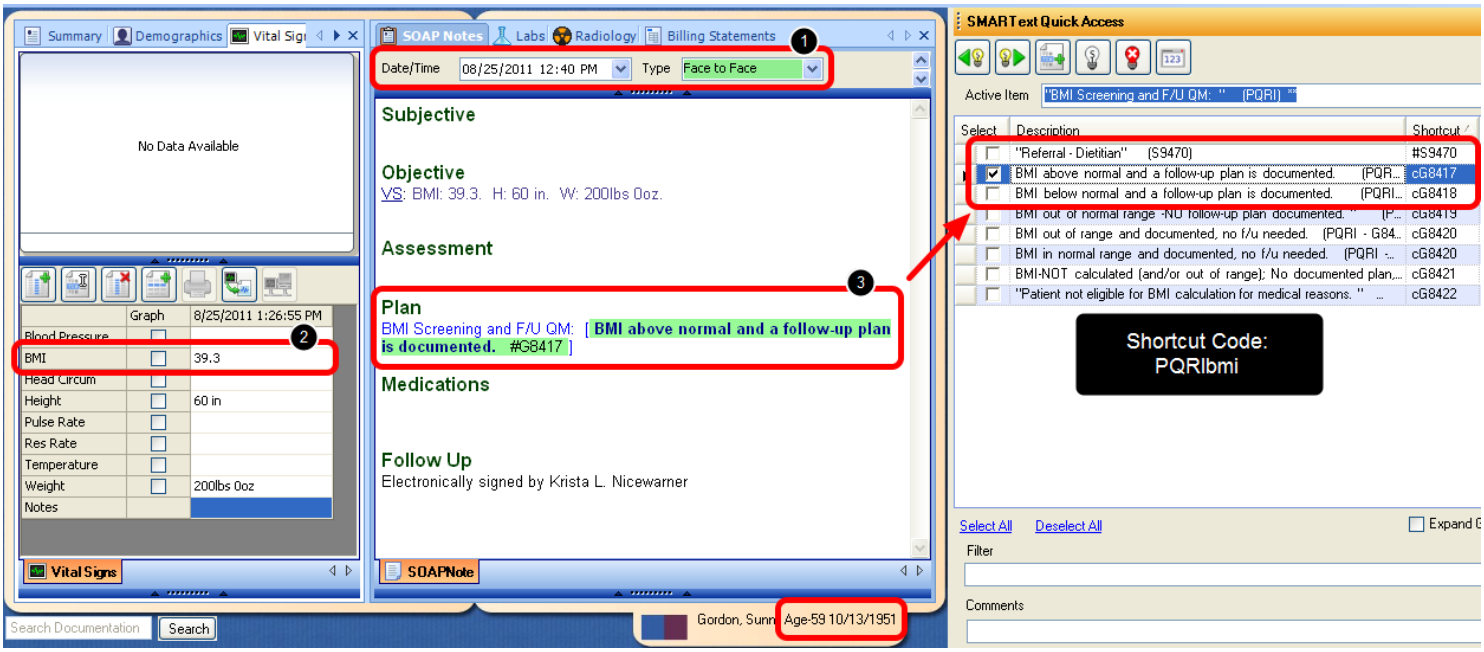
**Measure:** NQF 0421 (Core Measure)

**Measure Title:** Adult Weight Screening and Follow Up

**Measure Description:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

(Normal Parameters: age 65 and older BMI >=22 or <30; age 18-64 BMI >=18.5 or <25).

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be at least **18 years old or older** at the start of the reporting period and have at least one **face-to-face encounter** with the provider during the reporting period.

2. Patient must also have a **BMI recorded** in the **Vital Signs** chart section. The BMI must be recorded in the six months prior to the encounter date or during the reporting period.

3. In addition, if the patient has an abnormal BMI*, there should be documentation to record if an adult weight screening and follow-up plan was performed. Inserting the shortcut code, **"PQRIbmi"** in the **encounter Plan** field or **Summary Interventions** field will allow the user to

select from a group of specific SMARText CPT codes that can be used to document for this measure.

If the patient has an abnormal BMI*, the encounter Plan field or Summary Interventions field must include one of the following CPT codes:
(**G8417, G8418** and **S9470**. **Note: G8419, G8420, G8421 and G8422 will not increase the numerator*).

***Abnormal BMI:** Age 65 and older BMI >=30 or <22; age 18-64 BMI >=25 or <18.5.

***IMPORTANT NOTE:** The SMARText Items that are in the PQRIbmi pick list may need to be re-downloaded due to some updates that were added in April of 2011. To update your SMARText Items go to Docutainers > SMARText Items and click on the light bulb button to update your local SMARText Items. **DO NOT** update your SMARText Items during clinic hours (this will slow your SOAPware system down considerably). You should update SMARText Items overnight or through the weekend when the clinic is closed.

## Measure Calculation Details

Eligible Providers will be required to report two population criteria for this Clinical Quality Measure.

**Population Criteria #1: 65 Years and Older**

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator that have a normal BMI (BMI >= 22 or <30) OR an abnormal BMI (BMI >= 30 or <22) recorded in the Vital Signs chart section (BMI must be recorded in the six months prior to the encounter date or during the reporting period);

2. If the patient has an abnormal BMI, one of the following SMARText CPT codes must be documented in the Summary Interventions field or the SOAPnote Plan field:
- **G8417**: BMI above normal and a follow-up plan is documented
- **G8418**: BMI below normal and a follow-up plan is documented
- **S9470**: Referral - Dietitian

The following codes will not increase the numerator:
- G8419: BMI out of normal range - NO follow-up plan documented & BMI in normal range and documented, no f/u needed
- G8420: BMI out of range and documented, no f/u needed or BMI in normal range and documented, no f/u needed
- G8421: BMI-NOT calculated (and/or out of range); No documented plan, No reason specified

- G8422: Patient not eligible for BMI calculation for medical reasons

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were at least 65 years of age and older by the start of the reporting period and have at least one face-to-face encounter with the provider during the reporting period.

## Population Criteria #2: 18 Years to 64 Years Old

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator that have a normal BMI (BMI >=18.5 or <25) OR an abnormal BMI (BMI >=25 or <18.5) recorded in the Vital Signs chart section (BMI must be recorded in the six months prior to the encounter date or during the reporting period);

2. If the patient has an abnormal BMI, one of the following SMARText CPT codes must be documented in the Summary Interventions field or the SOAPnote Plan field:
- **G8417**: BMI above normal and a follow-up plan is documented
- **G8418**: BMI below normal and a follow-up plan is documented
- **S9470**: Referral - Dietitian

The following codes will not increase the numerator:
- G8419: BMI out of normal range - NO follow-up plan documented & BMI in normal range and documented, no f/u needed
- G8420: BMI out of range and documented, no f/u needed or BMI in normal range and documented, no f/u needed
- G8421: BMI-NOT calculated (and/or out of range); No documented plan, No reason specified
- G8422: Patient not eligible for BMI calculation for medical reasons

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were between the ages of 18 years and 64 years of age by the start of the reporting period and have at least one face-to-face encounter with the provider during the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## Reporting NQF 0421 with Two Population Criteria

```
- <provider>
    <npi>1111111111</npi>
    <encounter-from-date>01-01-2011</encounter-from-date>
    <encounter-to-date>12-31-2011</encounter-to-date>
  - <pqri-measure>
      <numerator>Numerator 1</numerator>
      <pqri-measure-number>NQF0421</pqri-measure-number>
      <eligible-instances>1</eligible-instances>
      <meets-performance-instances>1</meets-performance-instances>
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      <performance-not-met-instances>0</performance-not-met-instances>
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  </provider>
</measure-group>
- <measure-group ID="X">
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      <encounter-to-date>12-31-2011</encounter-to-date>
    - <pqri-measure>
        <numerator>Numerator 2</numerator>
        <pqri-measure-number>NQF0421</pqri-measure-number>
        <eligible-instances>0</eligible-instances>
        <meets-performance-instances>0</meets-performance-instances>
        <performance-exclusion-instances>0</performance-exclusion-instances>
        <performance-not-met-instances>0</performance-not-met-instances>
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        <performance-rate>0</performance-rate>
      </pqri-measure>
    </provider>
```

Provider NPI Number

Reporting Period Selected

Population Critera/ Numerator 1 or 2

Eligible Instances/ Denominator

Meets Performance Instances/ Numerator

Performance Rate/Percentage

When an Eligible Provider attests on NQF 0421 they will be required to report on two population criteria, which requires entering two sets of numerators and denominators.

SOAPware will export the Clinical Quality Measure report in XML format. The XML for NQF 0421

contains the following information:

Population Criteria 1

- Providers NPI Number for Numerator 1
- Selected Reporting Period
- CQM or PQRI number
- Eligible Instances/Denominator for Population Criteria 1
- Meets Performance Instances/Numerator for Population Criteria 1
- Reporting Rate
- Performance Rate for Population Criteria 1 (the Numerator 1 divided by the Denominator 1)

Population Criteria 2

- Providers NPI Number for Numerator 2
- Selected Reporting Period
- CQM or PQRI number
- Eligible Instances/Denominator for Population Criteria 2
- Meets Performance Instances/Numerator for Population Criteria 2
- Reporting Rate
- Performance Rate for Population Criteria 2 (the Numerator 2 divided by the Denominator 2)

Please see the above screenshot for a visual explanation of how to read the XML document. The above screenshot can be resized for easier viewing (simply click on the picture to view a larger version).

# Alternate Core Measures (Substitute Alternate for Core Measures if Necessary)

## *NQF 0024 (Alternate Core) Weight Assessment and Counseling for Children and Adolescents

**Measure:** NQF 0024 (Alternate Core)

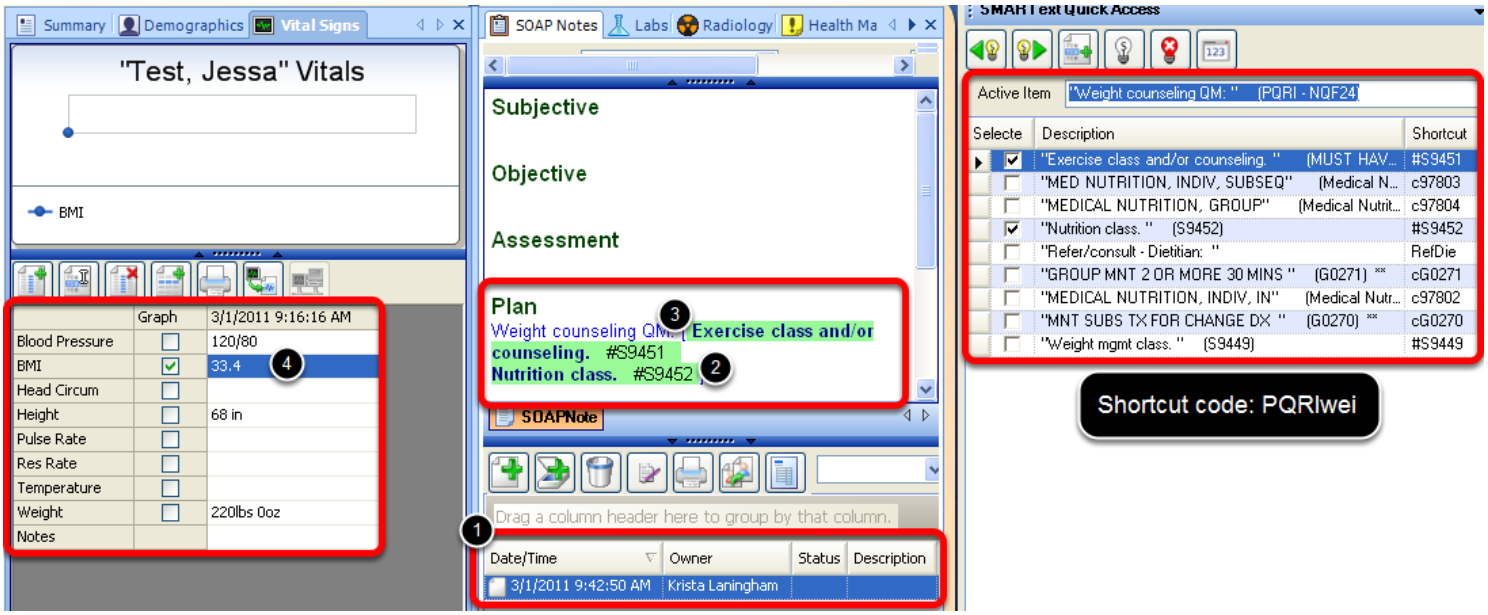
**Measure Title:** Weight Assessment and Counseling for Children and Adolescents

**Measurement Description:** The percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart.

1. The patient must be between the ages of 2-17 at the start of the reporting period and have at least one face-to-face encounter with the physician during the reporting period.

2. Documentation of weight counseling recorded during the reporting period. Inserting the shortcut code "**PQRIwei**" in the encounter **Plan field or Summary Interventions field** will insert a

pick list that will provide a list of criteria from which to document weight and nutrition counseling. To record that weight counseling has been performed, use the following CPT code: **S9451**.

3. Documentation of nutrition counseling recorded during the reporting period. Inserting the shortcut code "**PQRIwei**" in the encounter **Plan field or Summary Interventions field** will insert a pick list that will provide a list of criteria from which to document nutrition counseling. To record the nutrition counseling has been performed, use one of the following CPT codes: **G0270, GG0271, S9449, S9452, S9470, 97802, 97803, 97804**.

***IMPORTANT**: Exercise class and/or counseling (#S9451) MUST BE SELECTED, PLUS ONE ADDITIONAL CPT CODE FROM THE PICK LIST SUPPLIED MUST BE SELECTED TO DOCUMENT NUTRITION COUNSELING.

4. Documentation of patient's BMI recorded in the Vital Signs chart section during the reporting period.

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient aged 2-17 had an outpatient visit with a PCP or OB/GYN and had BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator who have documentation of weight counseling (CPT S9451) and nutrition counseling (CPT G0270, GG0271, S9449, S9452, S9470, 97802, 97803, or 97804) in the encounter Plan field during the reporting period;
2. And have a BMI reading in the VItal Signs chart section during the reporting period.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were between ages 2-17 at the start of the reporting period and have at least one face-to-face encounter with the provider during the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

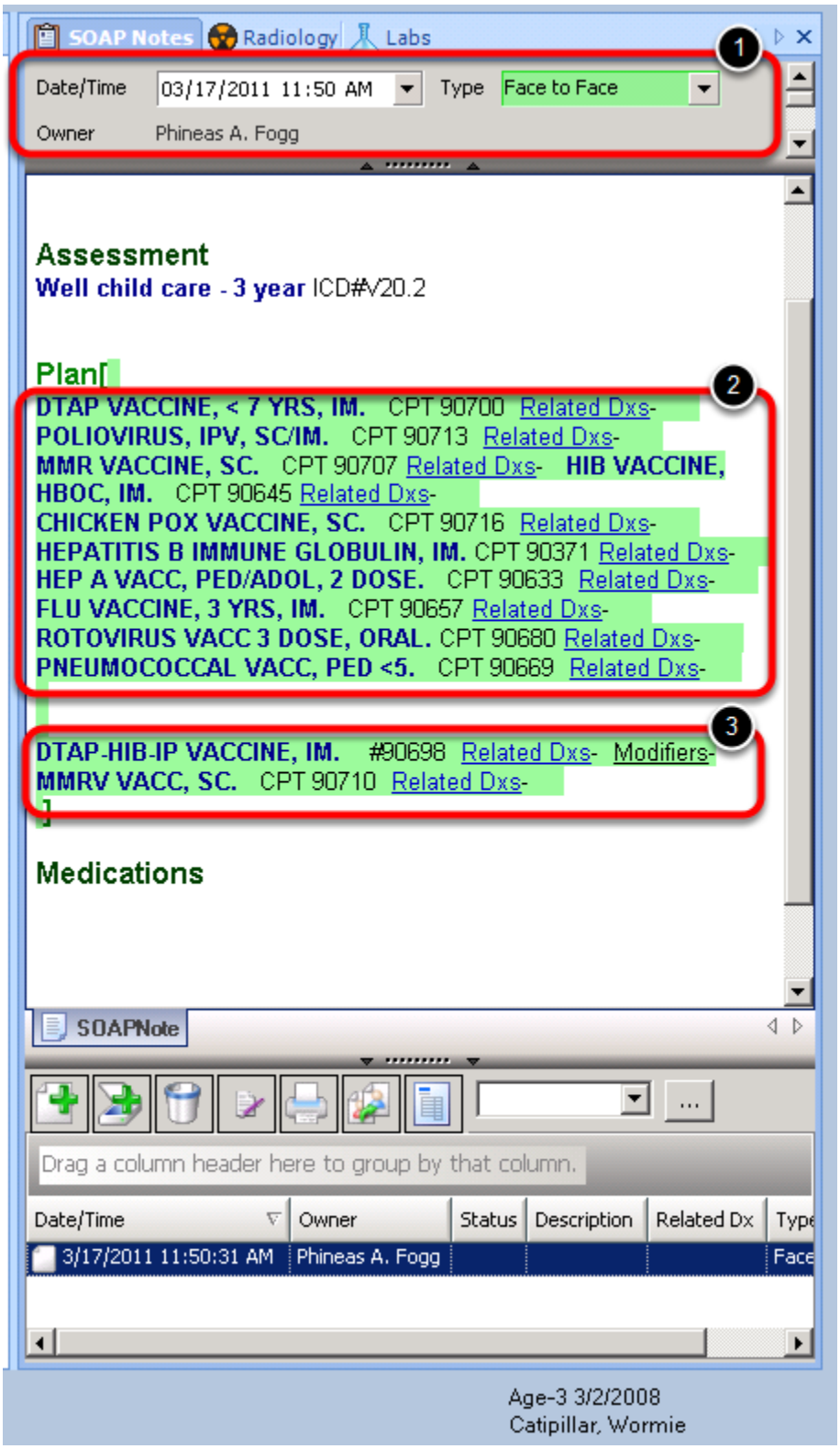
## NQF 0038 (Alternate Core) - Childhood Immunization Status

**Measure:** NQF 0038 (Alternate Core Measure)

**Measure Title:** Childhood Immunization Status

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

## Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

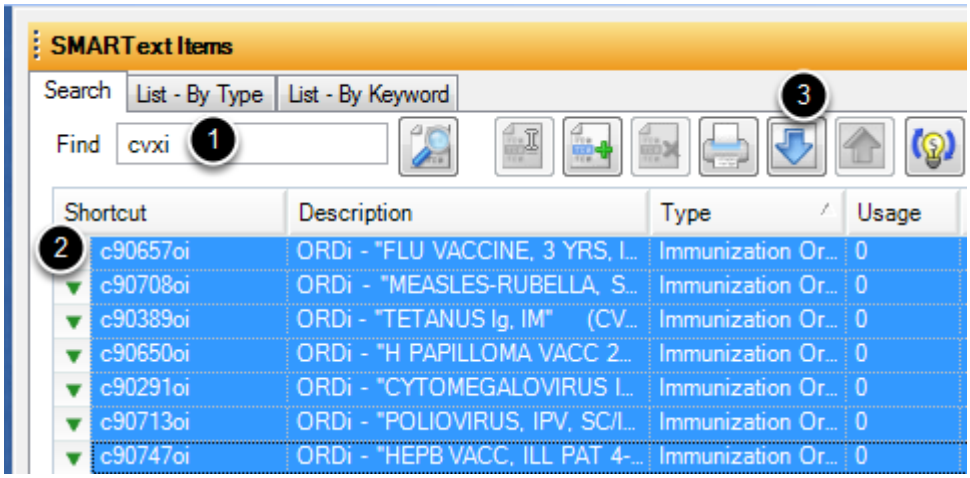
1. The patient must be at least 2 years of age at the start of the reporting period and have at least 1 face to face encounter during the reporting period.

2. Documentation of at least **10 readings related to the individual immunizations** (**Dtap, IPV, MMR, Hib, HepB, HepA, VZV, PCV, RV, Influenza**) documented in the encounter Plan field using Immunization Order Entry items in SOAPware Order Manager.

3. Documentation of at least **2 combined readings** (**Dtap, IPV, MMR, VZV, HepB**) and (**Dtap, IPV, MMR, VZV, HepB, Pnuemonia**) documented in the encounter Plan field.

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate the number of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.*

## Searching for Immunization items in SMARText




The Immunization item Types must be used to meet criteria requirements. These Items can be downloaded to a users local database using the following steps:

1. To find the SMARText Immunizations item types, type the keyword, "cvxi' into the search field of the SMARText Manager (pree F10 to access).

2. Press and hold the Shift key on the keyboard and then highlight the items to be used.

3. Click on the Download button to bring the items into the local database.

For more information on entering Immunization items using Order Manager, see: Immunization Order Items.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator who have at least 10 readings related to individual immunizations: (Dtap, IPV, MMR, Hib, HepB, HepA, VZV, PCV, RV, Influenza).

2. And have at least 2 combined readings (Dtap,IPV,MMR,VZV,HepB) and (Dtap,IPV,MMR,VZV,HepB,Pnuemonia).
*__IMPORTANT__: Patients will only be included in these numerators if the satisfy the criteria for each individual immunization listed.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients at least 2 years of age at the start of the reporting period and have at least 1 face to face encounter during the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

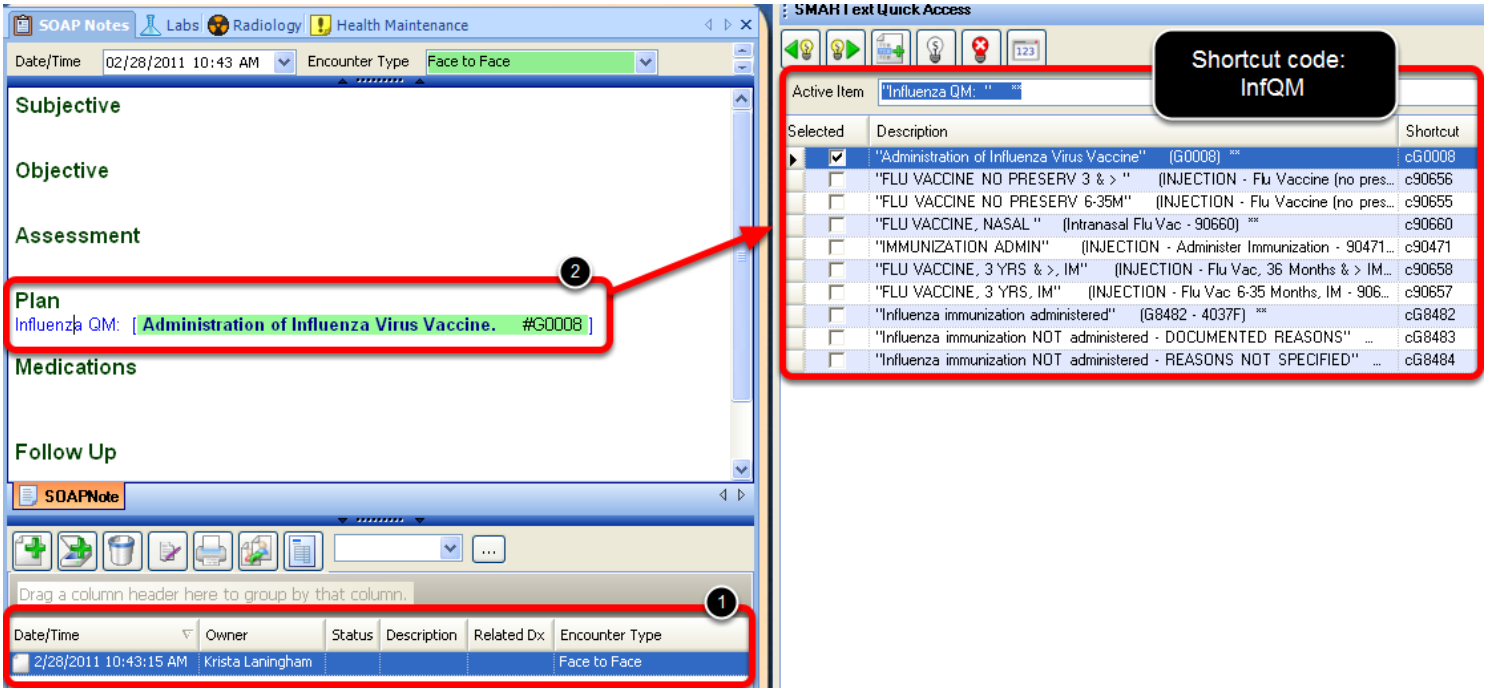
## NQF 0041 (Alternate Core) - Preventative Care and Screening: Influenza Immunization for Patients > 50 Years Old

**Measure:** NQF 0041 (Alternate Core Measure)

**Measure Title:** Preventative Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old

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

## Criteria

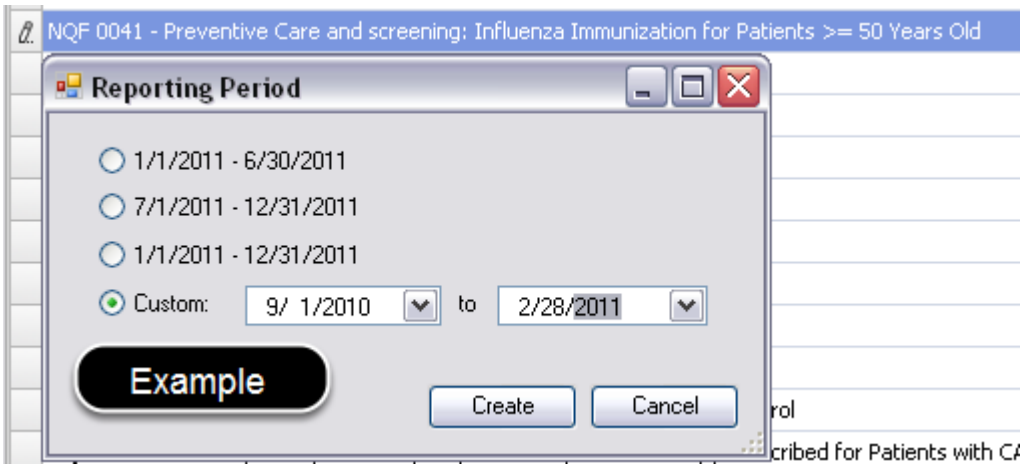



In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be age **50 years and older** at the start of the reporting period and have at least **one face to face encounter** with the provider during the reporting period.

2. Patient must have documentation that an influenza vaccination was administered. Inserting the shortcut code, "**InfQM**" in the SOAPnote **Plan field** or **Summary Interventions field** will insert a pick list that will provide a list of criteria from which to document influenza administration. (CPT 90656, 90658, 90660, G0008, G8482, CVX 111, CVX 140. **Note:** CPT codes 90657, 90471, G8483, G8484, 90655 will not increase the numerator.)

## Exporting NQF 0041 for September through February




**IMPORTANT NOTE:** When the results for this measure are exported, the user must run the report for the appropriate dates of September through February (flu season) using the Custom date selection (see example above).

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator that have documentation of being given the influenza vaccine in the SOAPnote **Plan field** or Summary **Interventions** field. (CPT 90656, 90658, 90660, G0008, G8482, CVX 111, CVX 140. **Note:** CPT codes 90657, 90471, G8483, G8484, 90655 will not increase the numerator.)

**Denominator Calculation:**

The denominator for this measure is calculated based on the following:

1. The number of patients that were **50 years old or older** at the start of the reporting period and have at least **one face-to-face encounter** with the physician during the reporting period.

***IMPORTANT NOTE: When the results for this measure are exported, the user must run the report for the dates of September through February (flu season).***

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting Clinical Quality Measures, click here.

# Additional Measures (Choose 3 Additional Measures)

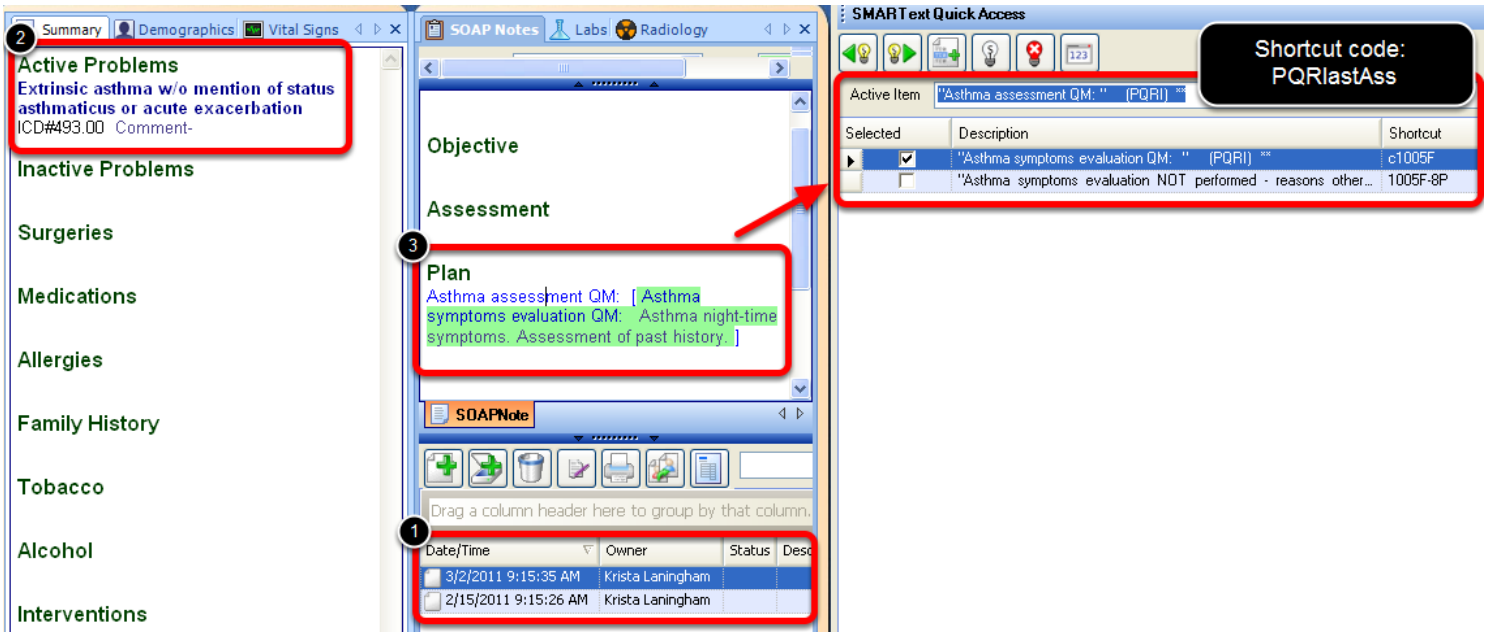
## NQF 0001 - (Additional) Asthma Assessment

**Measure:** NQF 0001 (Additional Measure)

**Measure Title:** Asthma Assessment

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

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be between the **ages of 5 and 40** and have at least **2 face-to-face SOAPnotes** during the reporting period.

2. Adiagnosis of **Asthma** (recorded by using any of the ICD9 codes listed below) in the **Summary Active Problems** field:
(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).

3. Documentation that the patient has been evaluated, during one of the office visits, for the frequency of daytime and nocturnal asthma symptoms. To do this, use the shortcut code, "**PQRIastAss**". This will insert the picklist header, "Asthma assessment QM: Asthma symptoms

evaluation QM", which will provide a list of criteria from which to document the frequency of daytime and nocturnal asthma symptoms. The **CPT code c1005F,** must display in the encounter **Plan field** of at least 1 of the encounters in order to document that the frequency of daytime and nocturnal asthma symptoms has been evaluated. ***Note****: CPT code 1005F-8P will not increase the numerator as it indicated that asthma symptoms evaluation was NOT performed.*

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient aged 5 through 40 years who has a diagnosis and has been seen for at least 2 office visits, has been evaluated once within 12 months for the frequency of daytime or nocturnal asthma symptoms.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator that have the appropriate CPT item in the SOAPnote Plan field: **1005f**.

**Denominator Calculation:**

The denominator for this measure is calculated based on the following:

1. The number of patients that were between the ages of 5 years to 40 years by the start of the reporting period and have had at least two face-to-face encounters with the provider during the reporting period;

2. And have a diagnosis in the Summary Active Problems field of Asthma. This can be accomplished by the documentation of one of the following ICD codes: 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.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

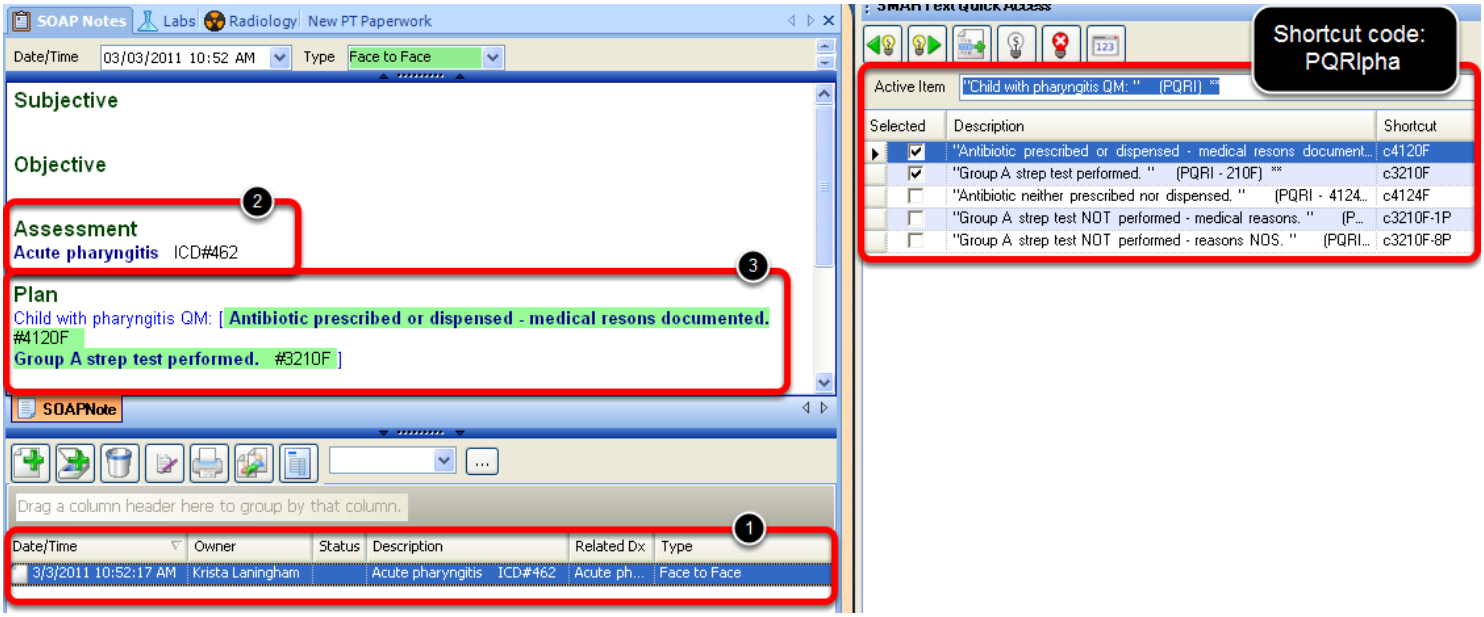
## NQF 0002 - (Additional) Appropriate Testing for Children with Pharyngitis

**Measure:** NQF 0002 (Additional Measure)

**Measure Title:** Appropriate Testing for Children with Pharyngitis

**Measure Description:** The percentage of children 2–18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group Astreptococcus (strep) test for the episode.

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient's must be between the **ages of 2 and 18** and have at least one **face-to-face encounter** with the provider during the reporting period.

2. Adiagnosis of **Pharyngitis** (recorded by using any of the ICD9 codes listed below) must be recorded in the SOAPnote **Assessment field** using one of the following ICD9 codes: (034.0, 462, 463).

3. Documentation that the patient was prescribed an antibiotic **AND** had received a group A streptococcus (strep) test for the episode. To document this, use the shortcut code "**PQRIpha**" in the SOAPnote **Plan field**. This will insert the picklist header, "Child with pharyngitisQM", which will provide a list of criteria from which to document that an antibiotic was prescribed an a group A

strep test was performed. The following CPT codes must be documented in the SOAPnote **Plan field: 4120F** and **3210F**. ***Note:*** *CPT codes 4124F, c3210F-1P, and c3210F-8P will not increase the numerator as they indicated that an antibiotic was not prescribed and group A strep test was not performed.*

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient who is between the ages of 2 and 18 and had a diagnosis of Pharyngitis during the reporting period, was prescribed an antibiotic and received a group A streptococcus test for the episode.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator that have the following CPT codes in the SOAPnote Plan field (in an encounter that is during the reporting period): 4120F and 3210F. ***Note:*** *CPT codes 4124F, c3210F-1P, and c3210F-8P will not increase the numerator as they indicated that an antibiotic was not prescribed and group A strep test was not performed.*

**Denominator Calculation:**

The denominator calculation for this measure is calculated based on the following:

1. The number of patients that were between the ages of 2-18 by the start of the reporting period and have at least one face to face encounter with the physician during the reporting period;
2. And have a diagnosis of Pharyngitis in the SOAPnote Assessment field using one of the following ICD9 codes: 034.0, 462, 463.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

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

**Measure:** NQF 0004 (Additional Measure)

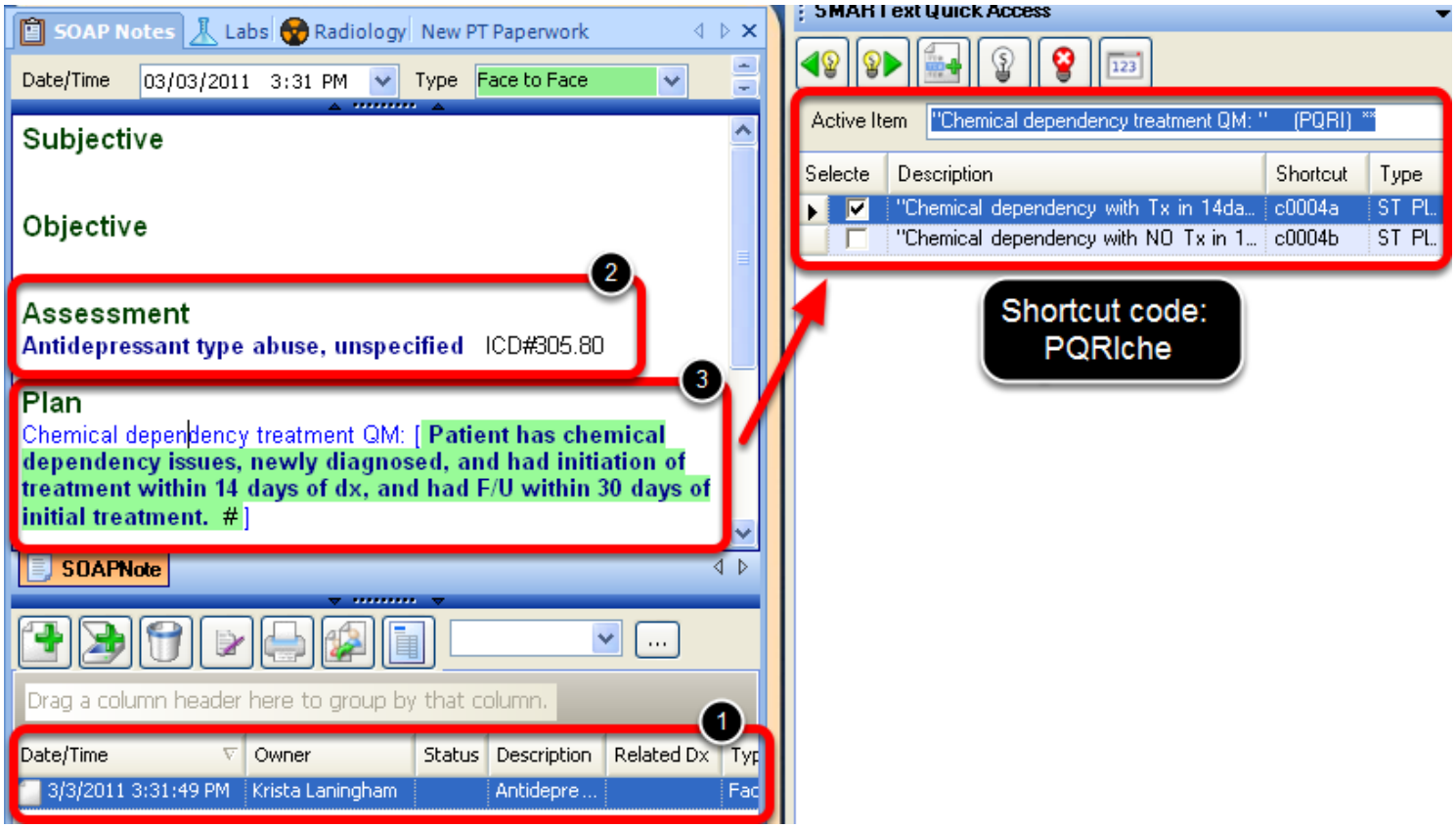
**Measure Title:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

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

***Note:**

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

## Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be **18 years or older** at the start of the reporting period and have at least **one face-to-face encounter** with the provider during the reporting period.

2. A **diagnosis of alcohol and other drug dependence** (recorded by using any of the ICD9 codes listed below) in the **SOAPnote Assessment field** or **Summary Active Problems Field**:
(291, 291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.89, 291.9, 292, 292.0, 292.1, 292.11, 292.12, 292.2, 292.8, 292.81, 292.82, 292.83, 292.84, 292.85, 292.89, 292.9, 303.00, 303.01, 303.02, 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92, 535.3, 535.30, 535.31, 571.1).

3. The patient must have documentation that confirms chemical dependency issues, newly diagnosed and had initiation of treatment within 14 days of diagnosis and had a follow up within

30 days of initial treatment. To document this, use the shortcut code, "**PQRIche**" in the encounter Plan field. This will insert the picklist header, "Chemical dependency treatment QM", which will provide a list of criteria from which to document. The following Custom code must be entered in the face-to-face encounter: **0004a** (Patient has chemical dependency issues, newly diagnosed, and had initiation of treatment within 14 days of dx, and had F/U within 30 days of initial treatment).
***Note:*** Custom code c0004b (Patient has chemical dependency issues, newly diagnosed, and did not have initiation treatment within 14 days of dx, or did not have F/U within 30 days of initial treatment) will not increase the numerator.

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient had a new episode of alcohol and other drug dependence and initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator who also have the appropriate custom code entered in the encounter Plan field: **0004a**.
***Note:*** *Custom code 0004b will not increase the numerator.*

**Denominator Calculation:**

The denominator for this measure is calculated based on the following:

1. The number of patients **18 years of age or older** with a **face to face encounter** during the reporting period;

2. And have a diagnosis recorded in the encounter Assessment field or Summary Active Problems field using one of the following ICD9 codes:
291, 291.0, 291.1, 291.2, 291.3, 291.4, 291.5, 291.8, 291.81, 291.82, 291.89, 291.9, 292, 292.0, 292.1, 292.11, 292.12, 292.2, 292.8, 292.81, 292.82, 292.83, 292.84, 292.85, 292.89, 292.9, 303.00, 303.01, 303.02, 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92, 535.3, 535.30, 535.31, 571.1.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

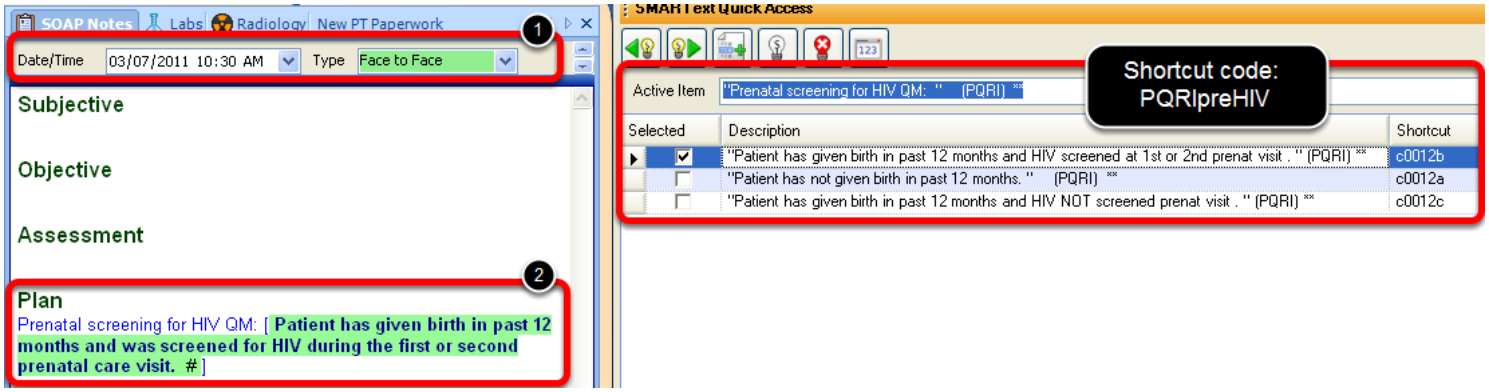
## NQF 0012 (Additional): Prenatal Care - Screening for Human Immunodeficiency Virus (HIV)

**Measure:** NQF 0012 (Additional Measure)

**Measure Title:** Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)

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

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must have at least **one face to face encounter** with the provider during the reporting period.

2. Patient must have given birth during a 12 month period and must have been screened for HIV infection during the first or second prenatal visit. To document this, use the shortcut code "**PQRIpreHIV**" in the encounter **Plan field**. This will insert the pick list header, "Prenatal screening for HIV QM", which will provide a list of criteria from which to document. The **custom code 0012b** must display in the **encounter Plan field.**
***Note**: Custom codes 0012a will not increase the numerator or denominator for this measure. Custom code 0012c will increase the denominator, but will not increase the numerator.*

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient gave birth during a 12-month period and was screened for HIV infection during the first or second prenatal visit.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator who also have the appropriate custom code entered in the encounter Plan field: **0012b**.
***Note:*** *Custom codes 0012a and 0012c will not increase the numerator.*

**Denominator Calculation:**

The denominator for this measure is calculated based on the following:

1. The number of patients with at least one **face to face encounter** during the reporting period (regarless of age);

2. And have a custom code entered in the encounter Plan field of either **0012b** or **0012c**.
***Note****: Custom code 0012a will not increase the denominator.*

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

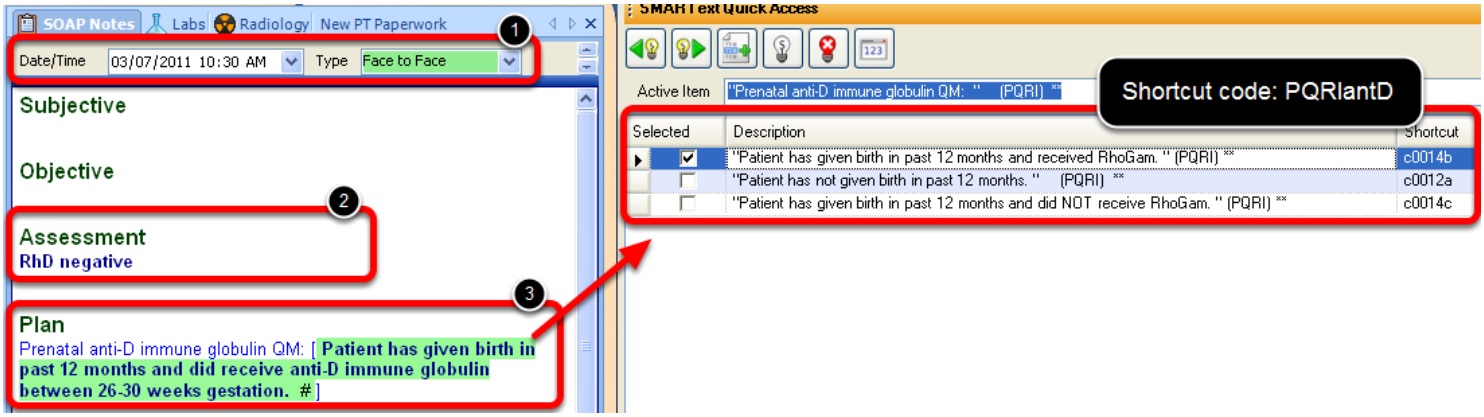
## NQF 0014 (Additional): Prenatal Care - Anti-D Immune Globulin

**Measure:** NQF 0014 (Additional Measure)

**Measure Title:** Prenatal Care: Anti-D Immune Globulin

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

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must have at least **one face to face encounter** with the provider during the reporting period.

2. Patient must have documentation of the following Diagnosis item in the **Summary Active Problems** field **or encounter Assessment field**: RhD negative (shortcut code: "**RhDneg**"; Snomed code sm165746003).

3. Patient must have given birth during a 12 month period and must have received anti-D immune globulin at 26-30 weeks gestation. To document this, use the shortcut code "**PQRIantD**" in the encounter **Plan field**. This will insert the pick list header, "Prenatal anti-D immune globulin QM", which will provide a list of criteria from which to document. The **custom code 0014b** must display in the **encounter Plan field**.
***Note**: Custom codes 0014a and 0012a will not increase the numerator or denominator for this measure.*

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient who gave birth during a 12-month period received anti-D immune globulin at 26-30 weeks gestation.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator that also have the appropriate custom code entered in the encounter Plan field: **0014b**. ***Note:*** *Custom codes 0014a and 0012c will not increase the numerator.*

**Denominator Calculation:**

The denominator for this measure is calculated based on the following:

1. The number of patients with at least one **face to face encounter** during the reporting period (regarless of age);

2. And has a diagnosis in the **Summary Active Problems** field or **encounter Assessment field** using shortcut code "**RhDneg**" for RhD negative (Snomed code sm165746003).

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

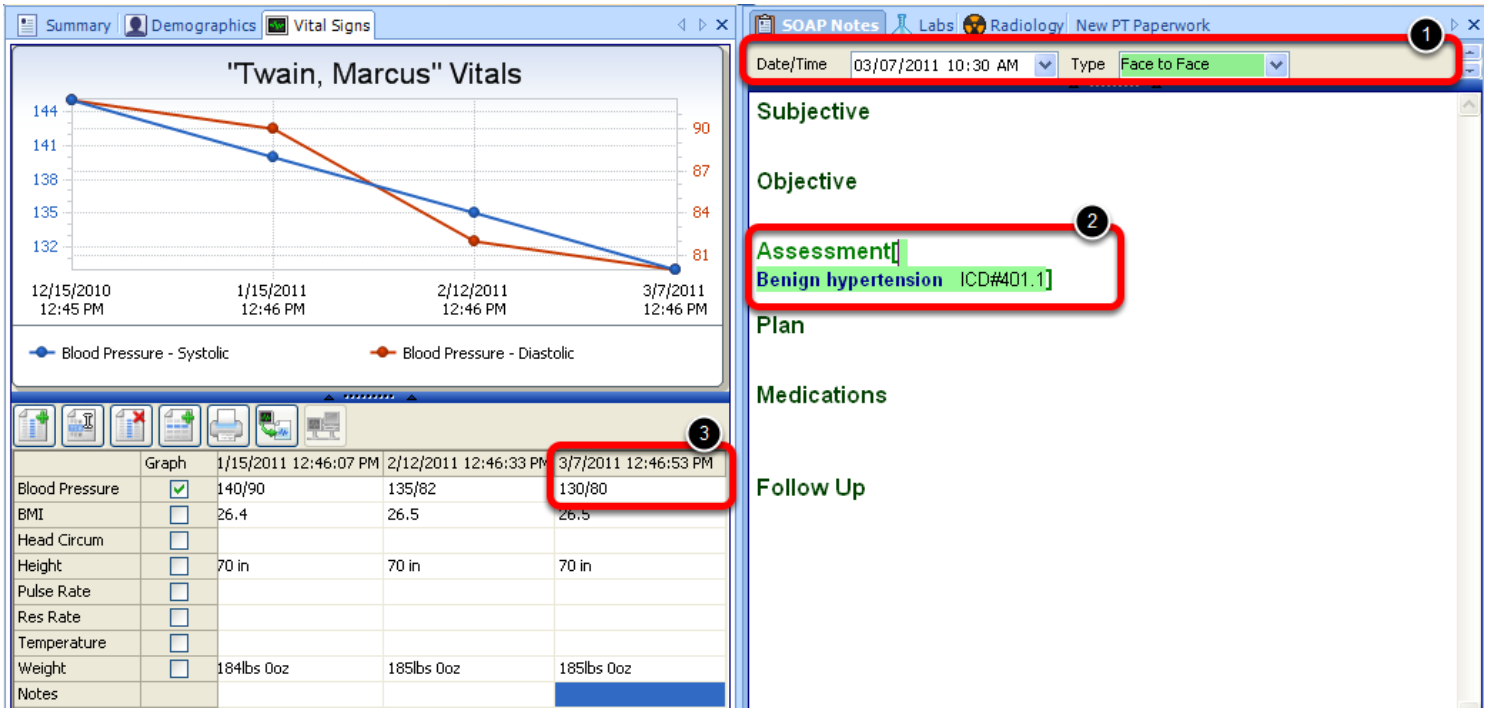
## NQF 0018 (Additional): Controlling High Blood Pressure

**Measure:** NQF 0018 (Additional Measure)

**Measure Title:** Controlling High Blood Pressure

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

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be between the ages of **18-85** at the start of the reporting period and have at least **one face to face encounter** with the provider during the reporting period.

2. Adiagnosis of Hypertension (recorded by using any of the ICD9 codes listed below) must be recorded in the patient's **Summary Active Problems** field OR encounter **Assessment field** using one of the following ICD9 codes: 401, 401.0, 401.1, or 401.9.

3. Patient must have documentation of a blood pressure reading that was adequately controlled during the measurement year. To document this, the patient's last blood pressure reading must be a **blood pressure reading < 140/90** recorded in the Vital Signs chart section.

** If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient who had a diagnosis of hypertension had a BP that was adequately controlled during the measurement year.*

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator whose last blood pressure reading was < 140/90 and was recorded in the Vital Signs chart section.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients ages 18-85 with at least one **face to face encounter** during the reporting period;

2. And has a diagnosis in the **Summary Active Problems** field or **encounter Assessment field** using one of the following ICD9 codes: 401, 401.0, 401.1, or 401.9.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## *NQF 0027 (Additional): Smoking and Tobacco Use Cessation, Medical Assistance

**Measure:** NQF 0027 (Additional Measure)

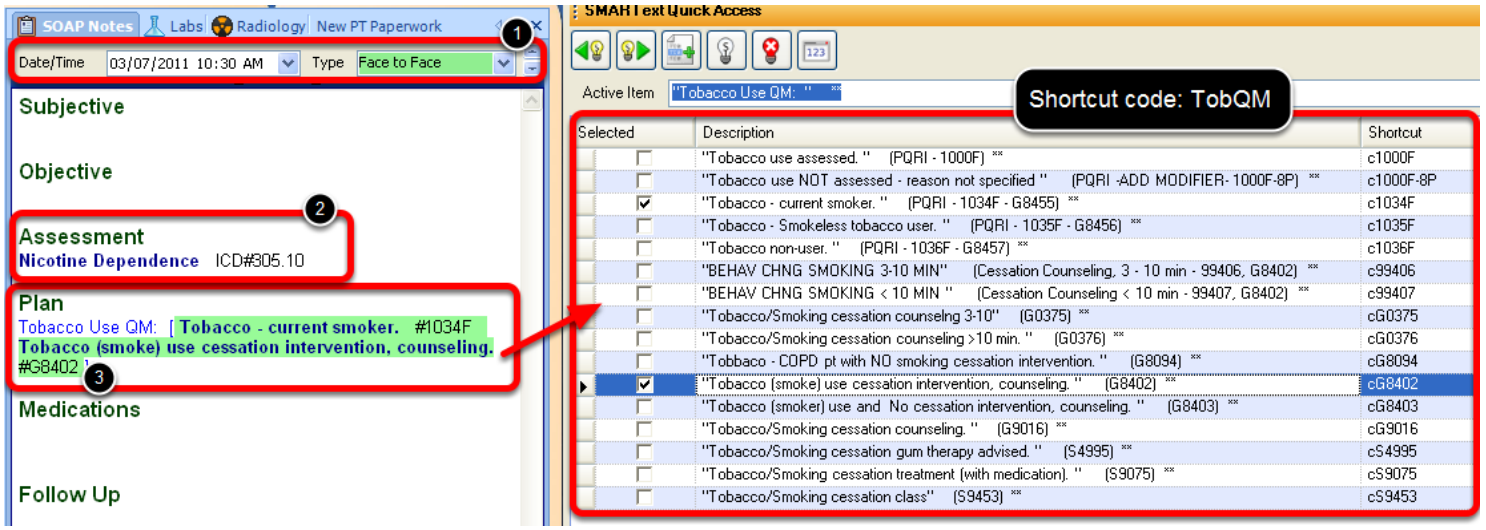
**Measure Title:** Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies

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

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be age **18 years old or older** at the start of the reporting period and have at least **one face to face encounter** with the provider during the reporting period.

2. Patient must have documentation that they are a current smoker or tobacco user . This can be

documented one of two ways:

(a) Use the shortcut code "**TobQM**". This will insert the pick list header, "Tobacco Use QM", which will provide a list of criteria from which to document. The CPT code **1034F or 1035F** must display in the **encounter Plan field or Summary Interventions field** in order to document that the patient is a tobacco user.
***Note:*** *1000F, 1000F-8P and 1036F will not increase the denominator.*

OR

(b) Patient must have one of the following diagnosis items entered in the **Summary Active Problems or encounter Assessment field**: **305.1 or 305.10.**

4. In addition, the patient must have documentation that they received advice to quit smoking or tobacco use or recommended or discussed smoking or tobacco use cessation medications, methods or strategies. To document this, use the shortcut code "**TobQM**" and select one of the following CPT codes to display in the **encounter Plan field or Summary Interventions field**: **G8402, S9075, S4995, G0376, S9453, G0375, G9016, 99406, 99407**.
***Note:*** *G8403 and G8094 will not increase the numerator.*

* *If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient, who was a current smoker or tobacco user, received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods, or strategies.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator that also have one of the following CPT code recorded in the **encounter Plan field or Summary Interventions field**: **G8402, S9075, S4995, G0376, S9453, G0375, G9016, 99406 or 99407.** ***Note:*** *G8403 and G8094 will not increase the numerator.*

**Denominator Calculation:**

The denominator for this measure is calculated based on the following:

1. The number of patients that are age **18 years old or older** at the start of the reporting period and have at least **one face to face encounter** with the provider during the reporting period;

2. And has a diagnosis entered in the **Summary Active Problems or encounter Assessment field** using one of the following ICD9 codes: **305.1 or 305.10** **OR** has one of the following CPT codes recorded in the encounter Plan field or Summary Interventions field: **1034F** or **1035F**. ***Note**: 1000F, 1000F-8P and 1036F will not increase the denominator.*

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## NQF 0031 (Additional): Breast Cancer Screening

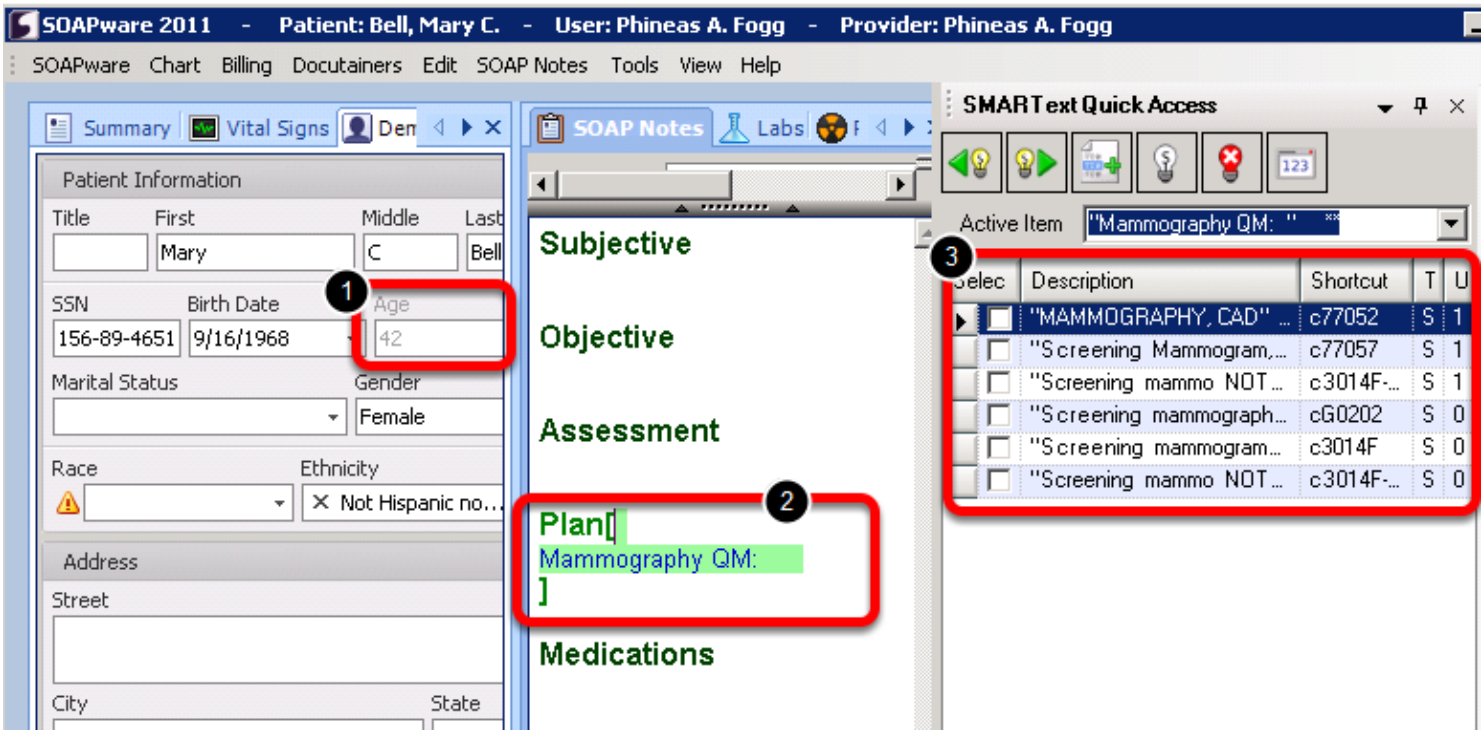
**Measure:** NQF 0031 (Additional Measure)

**Measure Title:** Breast Cancer Screening

**Measure Description:** Percentage of women 40-69 years of age whom had a mammogram to screen for breast cancer

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL CQM MEASURE:** **Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart.

1. The patient must be **female aged 40 - 69** at the start of the reporting period and have had **one face to face encounter** with the provider during the reporting period.

2. Documentation of Breast Cancer Screening in the **Plan Field**. Inserting the shortcut code, **"MamQM"** will insert the pick list header, **"Mammography QM:"** Clicking on the Mammography QM header will display a list of the CPT codes in the SMARText Quick Access that need to be present in the encounter Plan field.

3. Any of the these CPT codes need to be present in the **encounter Plan field**: **77055, 77056, 77057, G0202, G0204, G0206, 3014F, 77052.**

***Note:*** *CPT codes that indicate a mammogram* ***was not done*** *will not increase the numerator to meet the criteria.*

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator that have face to face encounter within the reporting period that has an appropriate CPT item the **SOAPnote Plan field**: **77055, 77056, 77057, G0202, G0204, G0206, 3014F, 77052.**

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of female patients aged 40-69 at the start of the study who have a face to face encounter within the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## NQF 0032 (Additional): Cervical Cancer Screening

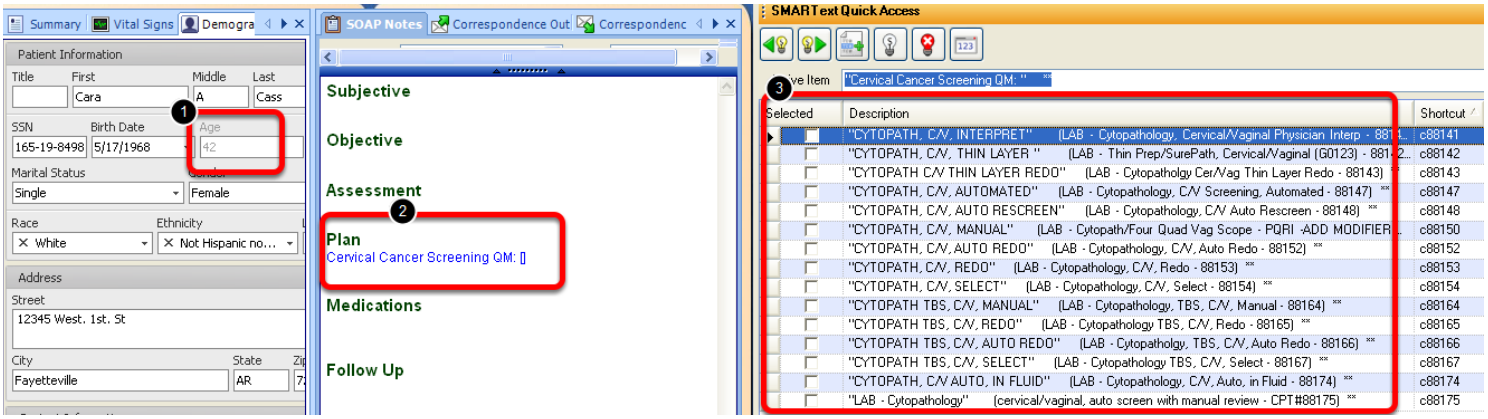
**Measure:** NQF 0032 (Additional Measure)

**Measure Title:** Cervical Cancer Screening

**Measure Description:** Percentage of women 21-64 years of age, whom received one or more Pap tests to screen for cervical cancer.

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL QM MEASURE: Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be **between the ages of 21 and 64** at the start of the reporting period AND have at least **one face-to-face encounter** with the provider during the reporting period and **received one or more PAP tests** to screen for cervical cancer within the reporting period.
2. Patient must have documentation that a PAP test has been performed. Inserting the shortcut code, "**CerCanQM**" in the SOAPnote Plan field will insert the pick list hearder, "Cervical Cancer Screening QM:"
3. Clicking on the header will display a list of items in SMARText Quick Access that meet the criteria. The encounter Plan field or the summary Interventions field **must contain one of the following CPT codes**: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator that have a **face-to-face encounter** within the reporting period that has the appropriate CPT item in the SOAPnote **Plan field**: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of female patients ages 21-64 and have at least **one face-to-face encounter** with the provider during the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here

For more information on reporting clinical quality measures, click here

## (DRAFT) *NQF 0033 (Additional): Chlamydia Screening for Women age 15-24

**Measure:** NQF 0033 (Additional Measure)

**Measure Title:** Chlamydia Screening for women

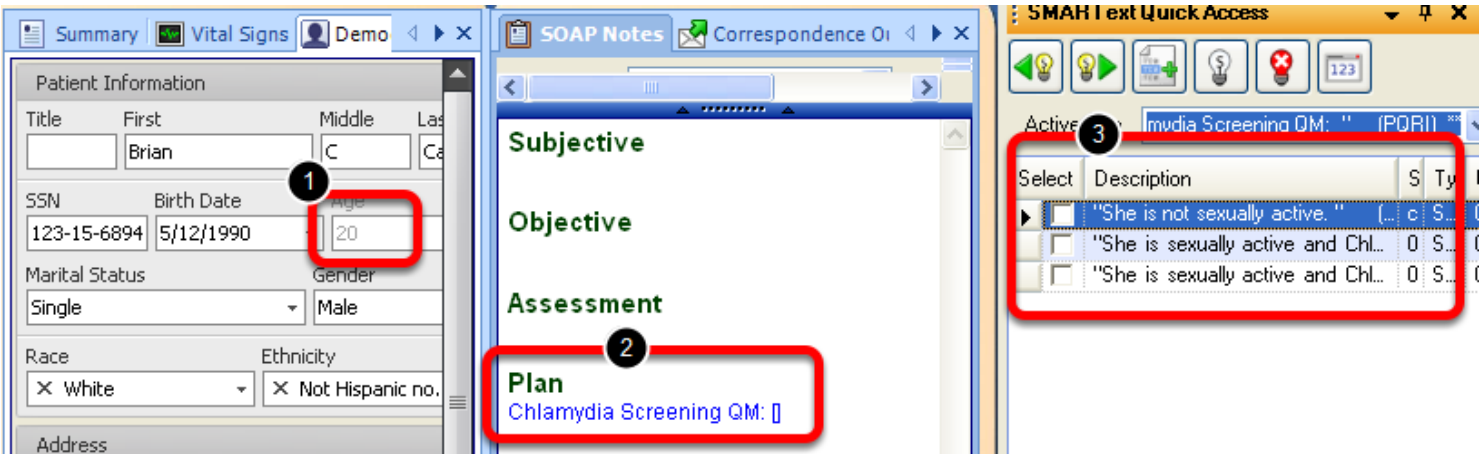
**Measure Description:** Percentage of women 15-24 years of age whom were identified as sexually active and whom had at least one test for chlamydia during the reporting period.

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL QM MEASURE: Click here to view Meaningful Use Criteria.**

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be between the ages of **15 and 24** years of age whom were identified as sexually active, have at least **one face-to-face encounter** and had at least **one test for Chlamydia** during the reporting period.
2. Documentation that the patient has received a Chlamydia test. Using the shortcut code, "**PQRIch**l" in the encounter Plan field will insert the pick list header, "Chlamydia Screening QM:"
3. Clicking on the header will display and list of items in SMARText Quick Access which need to be inserted into the Plan field to meet the criteria.

***Note:*** *The custom codes in the pick list above that indicate the patient is* ***not sexually active or is sexually active but has not been tested for Chlamydia within the reporting period will not meet the criteria.***

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator that have a **face-to-face encounter** with the reporting period that has the custom ID **"She is sexually active and Chlamydia testing performed with the past year"** inserted into the **Plan** field.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of female patients age **15-24** that have the custom ID **"She is sexually active and Chlamydia testing not performed within the past year"** inserted into the **Plan** field.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here

For more information on reporting clinical quality measures, click here

## NQF 0034 (Additional) Colorectal Cancer Screening

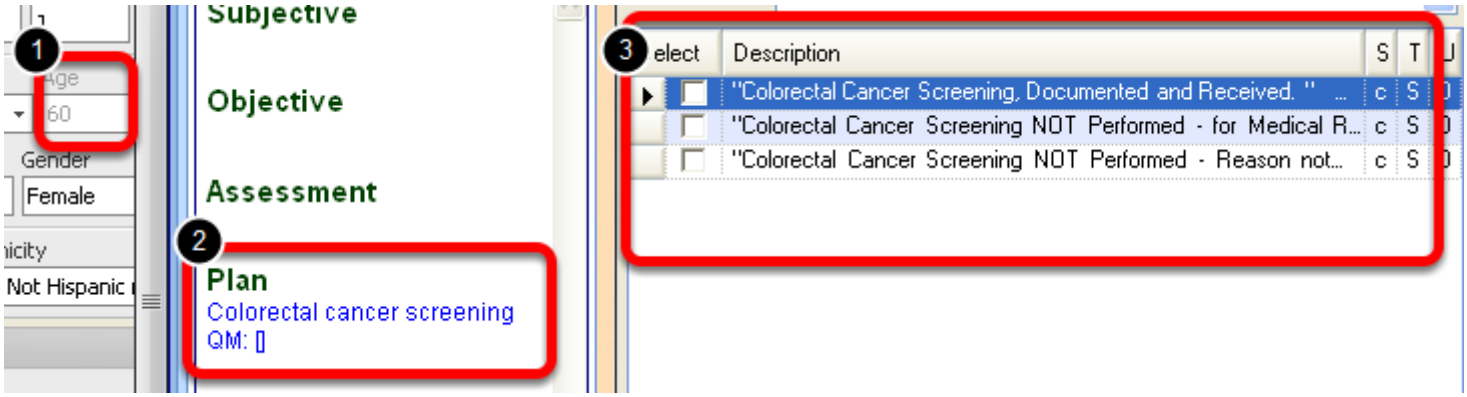
**Measure:** NQF 0034 (Additional Measure)

**Measure Title:** Colorectal Cancer Screening

**Measure Description:** Percentage of patient's 50-75 years of age whom had at least one face-to-encounter and appropriate screening for colorectal cancer.

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL QM MEASURE: Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart.

1. The patient needs to be between the ages of **50 and 75** AND seen by the physician with a **face-to-face encounter** during the reporting period.

2. Documentation for colorectal cancer screening. Using the shortcut code, "**PQRIpreCol**", will insert the pick list header, "Colorectal cancer screening QM:" Clicking on the header will display a list of items in SMARText Quick Access that will meet the needed criteria.The CPT Code, " 3017F" needs to be in the encounter **Plan** field **or** the summary **Interventions** field.
***Note:*** *The items in pick list that indicate Colorectal Cancer Screening* ***was not done*** *will not increase the numerator and meet the criteria.*

### Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. Patient's with the CPT code 3017F in the encounter Plan or summary Intervention field.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. Patient's age **50-75** with a **face-to-face** encounter during the reporting period.

## Report Clinical Quality Measure to CMS/State

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here

For more information on reporting clinical quality measures, click here

## (DRAFT) *NQF 0036 (Additional): Use of Appropriate Medications for Asthma

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

**Measure:** NQF 0036 (Additional Measure)

**Measure Title:** Use of Appropriate Medications for Asthma

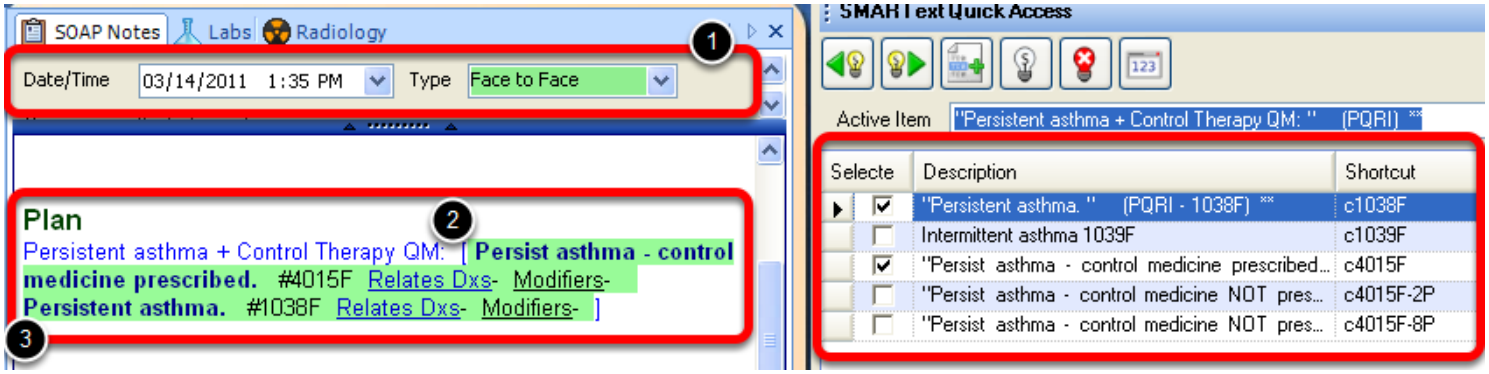
**Measure Description:** Percentage of patients 5 - 50 years of age whom were identified as having persistent asthma, had at least one face-to-face encounter and were appropriately prescribed medication during the reporting period. Report three age stratification's (5-11 years, 12-50 years, and total).

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL QM MEASURE: Click here to view Meaningful Use Criteria.**

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be between the **ages of 5-50** at the start of the reporting period and have at least **one face-to-face encounter** with the provider during the reporting period.

2. Documentation that thee patient was appropriately prescribed medication for persistent asthma during the measurement year. Using the shortcut code, "**PQRIastThe**" will insert the pick list that will display a list of items in SMARText Quick Access that meet the criteria. The encounter

**Plan field** or the **summary Interventions field** must contain the CPT codes, **4015F and 1038F.**
***Note:*** *Codes 4015F-2P and 4015F-8P will not increase the denominator because they will document that control medication was not prescribed.*

3. Documentation that thee patient has persistent asthma. Using the shortcut code "**PQRIastThe**" will insert the pick list header, "Persistent asthma + Control Therapy QM", which will provide a list of criteria from which to document. The CPT code **1038F** must display in the **encounter Plan field or Summary Interventions field** in order to document that the patient has persistent asthma and was prescribed medication during the measurement year.
***Note:*** *Code 1039F will not increase the numerator becasue it documents "Intermittent asthma".*

This measure reports three age stratification's (5-11 years, 12-50 years, and 5-50 years).

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator whose charts contain the CPT item **4015F** in the **encounter Plan field or the Summary Interventions** field and have had at least **one face-to-face encounter** within the reporting period.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. Patients between the ages of **5-50** with the CPT items **1038F and 4015F** in the encounter **Plan** field.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here

For more information on reporting clinical quality measures, click here

## NQF 0043 (Additional) - Pneumonia Vaccination Status for Older Adults

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

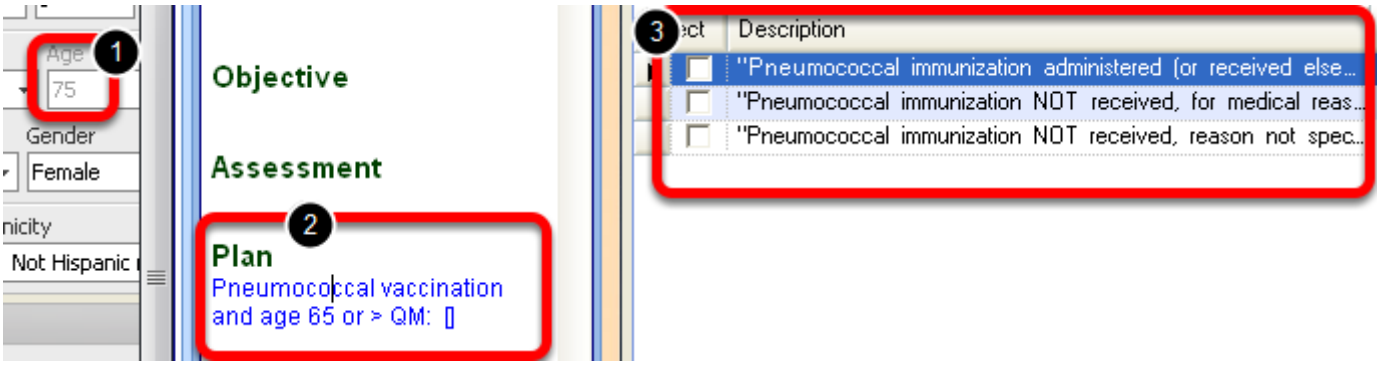
**Measure:** NQF 0043 (Additional Measure)

**Measure Title:** Pneumonia Vaccination Status for Older Adults

**Measure Description:** Percentage of patients 65 years of age and older whom have ever received a pneumococcal vaccine and have had at least one face-to-face encounter within the reporting period.

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL QM MEASURE:** **Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be **65 years or older** at the start of the reporting period.
2. Documentation that the patient has received a Pneumonia vaccine. Using the shortcut code, "**PQRIpne**" will insert the pick list header, "Pneumococcal vaccination and age 65 or > QM:". Clicking on the header will display a list of items in SMARText Quick Access that meet the needed criteria. Patient's will have had a Pneumococcal vaccine (**users must use the Immunization Order SMARText item**) with a CVX code of 100 or 133 **OR** a CPT code of 4040F recorded in the encounter **Plan** field or the summary **Interventions** field.
***Note:*** *The items indicating the patient has not received a pneumococcal immunization will not meet the criteria.*

## Measurement Calculation Details

**Numerator Calculation:**

The number for this measurement is calculated based on the following:

1. The number of patients in the denominator who are **65 and older** at the start of the reporting period with **a face to face encounter** within the reporting period.
2. AND have ever received a pneumococcal vaccine CVX code 100 or 133 **OR** CPT of 4040F in the encounter **Plan** or summary **Interventions** field.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients 65 and older at the start of the reporting period, with a face to face encounter within the reporting period.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here

For more information on reporting clinical quality measures, click here

# (DRAFT) NQF 0047 - (Additional) Asthma Pharmacologic Therapy

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

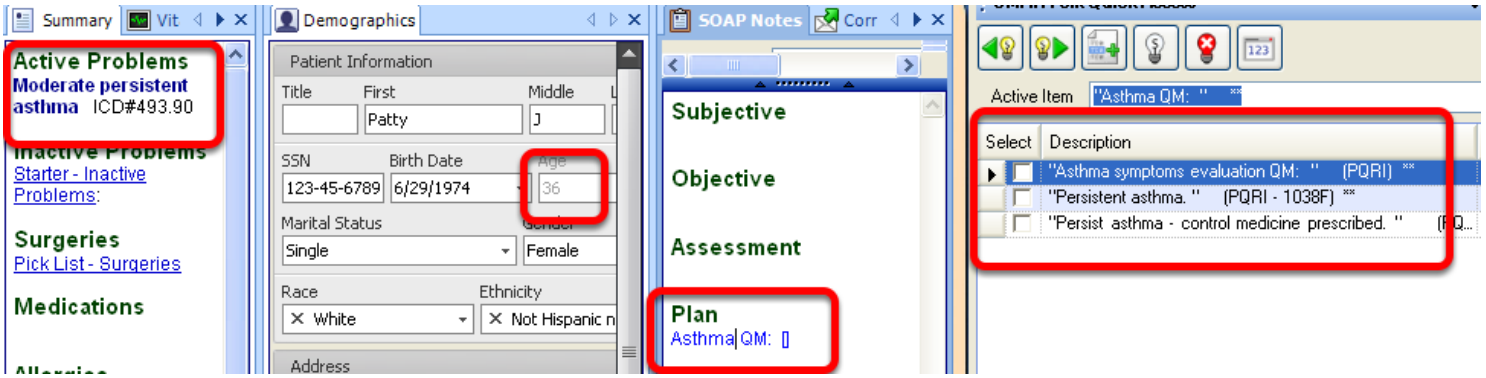
**Measure:** NQF 0047

**Measurement Title:** Asthma Pharmacologic Therapy

**Measure Description:** Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma whom were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment whom have had at least on face-to-face encounter within the reporting period.

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL QM MEASURE: Click here to view Meaningful Use Criteria.**

## Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patient's will have to be between the ages of **5 -40 years** with a diagnosis of Mild, Moderate, or Severe Persistent Asthma during the reporting period and had the preferred long-term control medication (inhaled corticosteroid) or acceptable alternative and has had at least one **face-to-face** encounter within the reporting period.
2. Using the shortcut code, "**AstQM**" in the encounter Plan field will insert the pick list header, "Asthma QM:". Clicking on the pick list header will display a list of items in SMARText Quick Access.The encounter **Plan** field must contain the CPT codes, 1038F and 4015F.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1 The number of Patient age **5-40** years  with a face to face encounter within the reporting period.
2. AND who's chart contains the CPT item 1038F in then encounter Plan Field

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of Patient between the ages of **5-40** years with a face to face encounter within the reporting period.
1. And whose chart contains the CPT item 4015F in the encounter **Plan** or summary **Intervention** field.

## Report Clinical Quality Measures to CMS/State

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here

For more information on reporting clinical quality measures, click here

## (DRAFT) NQF 0052 (Additonal) Low Back Pain: Use of Imaging Studies

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

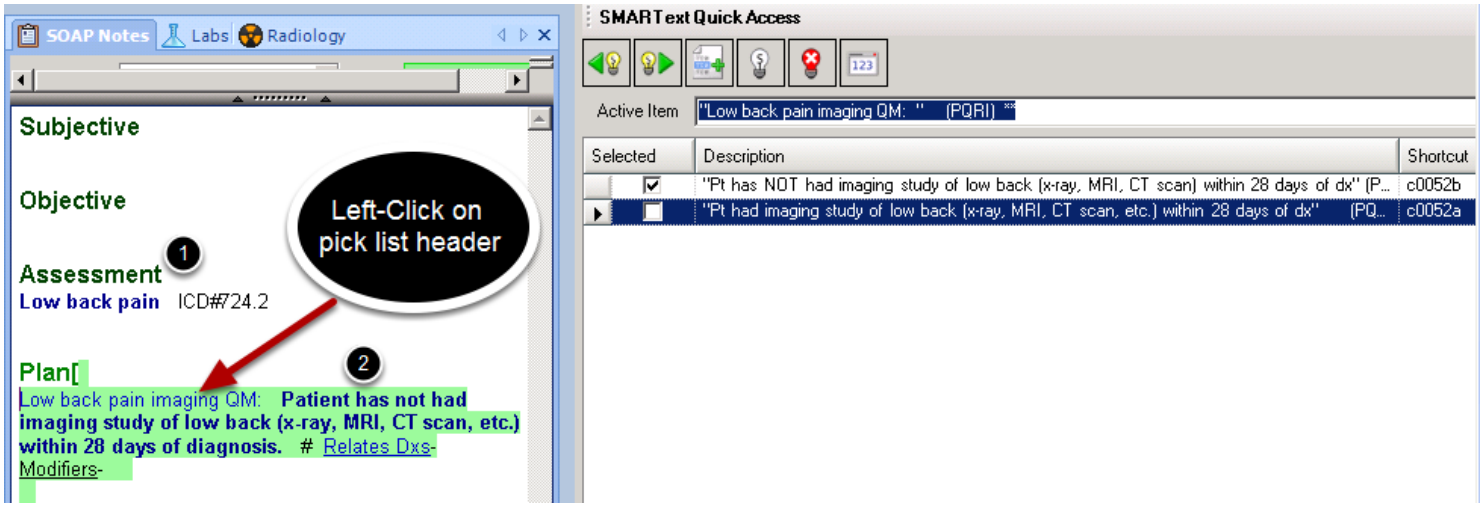
**Measure:** NQF 0052 (Additional Measure)

**Measure Title:** Low Back Pain: Use of Imaging Studies

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

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL CQM MEASURE: Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patient's must have a primary **diagnosis of Low Back Pain** in the Active Problems field of the Summary or the Face to Face encounter Assessment field using one of the following ICD codes: **724.2, 724.5.**
2. This measure calcualates patient's who **did not** have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis during the reporting period. To enter documentation, use the shortcut code "**PQRIlowBacI**". This will insert the pick list header, "**Low back pain imaging QM**". Left-Click on the pick list header to display a list of items in SMARText Quick Access that meet the criteria. See the screen shot that displays the appropriate selection. The Custom ID 0052b (**Patient has not had imaging study of low back (x-ray, MRI, CT scan, etc.) within 28 days of**

**diagnosis.** # Relates Dxs- Modifiers-) must display in the encounter Plan field.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients with a face to face encoutner within the reporting period:
2. **AND** the number of patients that have not had an imaging study of the low back within 28 days of the diagnosis using custom ID code **0052b** in the Plan field of an encounter.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients with a face to face encounter withing the reporting period;
2. **AND** have a **diagnosis of Low Back Pain** in the Active Problems field in the Summary or the Assessment field in the Face to Face encounter. This can be accomplished by documenting one of the following ICD codes: **724.2, 724.5**

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## (DRAFT) NQF 0055 (Additional) Diabetes: Eye Exam

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

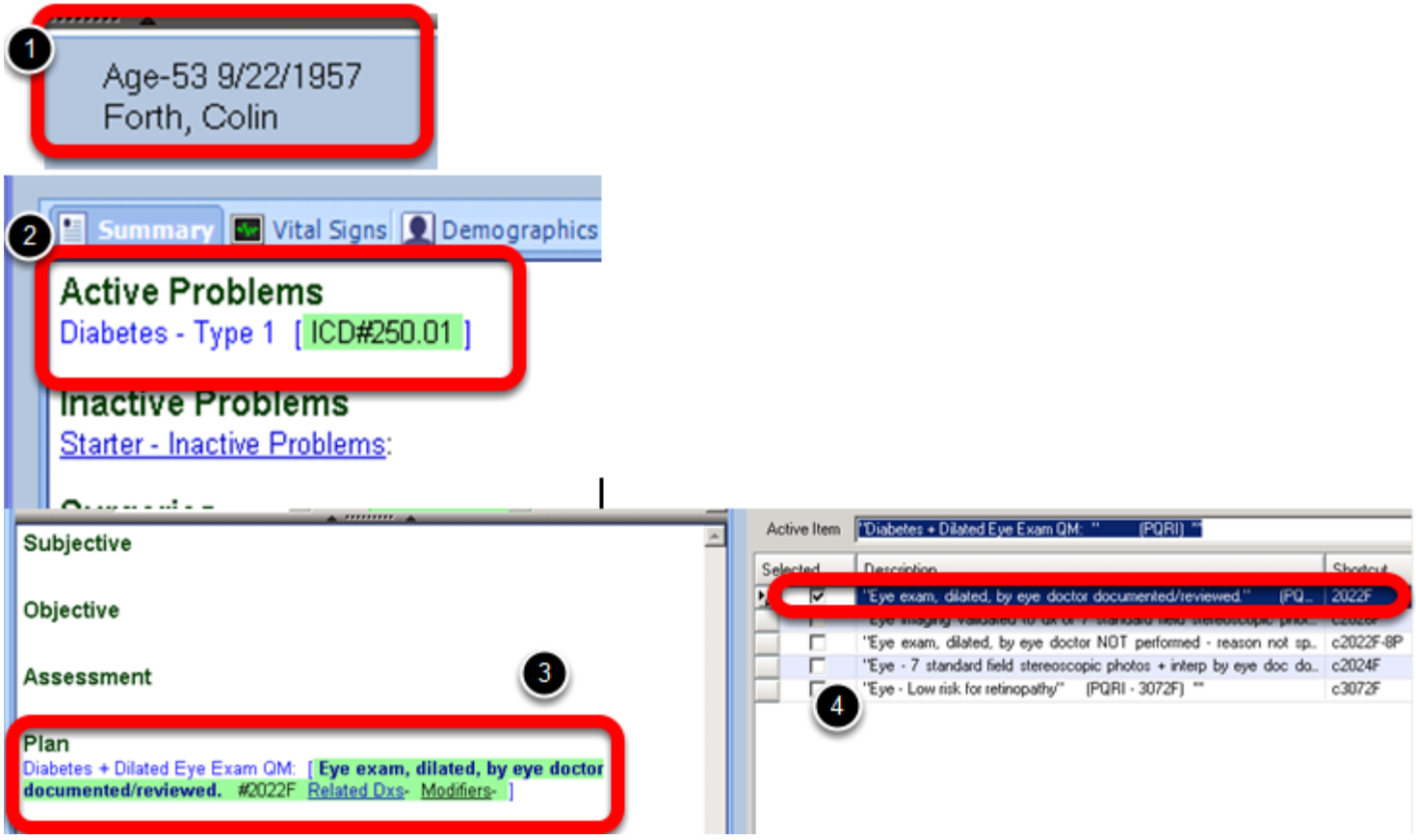
**Measure:** NQF 0055 (Additional Measure)

**Measure Title:** Diabetes: Eye Exam

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

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL MEASURE: Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be between the **18 and 75 years of age** and have at least one Face to Face

encounter during the reporting period.
2. Patients must have a **diagnosis of Diabetes Type 1 or Type 2** in the Summary Active Problems field with one of the following **ICD codes:** 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04
3. Patients must have had a **retinal or dilated eye exam** or a **negative retinal exam (no evidence of retinopathy)** by an eye care professional during the reporting period.
4. To accomplish this, use the shortcut code **"PQRIdmEye"** in the encounter Plan field to insert the pick list header ("Diabetes + Dilated Eye Exam QM:" ) Left-Clicking on the pick list header will display a list of items in SMARText Quick Access that contains one of the following **CPT codes:** 2022F,2024F,2026F,3072F. The following **CPT codes** need to be inserted using the Shift + F11 search method: 67028, 67030, 67031, 67036, 67038, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260,S0620, S0621, S0625, S3000.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients that have a Face to Face encounter within the reporting period that has the appropriate CPT code: 67028, 67030, 67031, 67036, 67038, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260,S0620, S0621, S0625, S3000,2022F,2024F,2026F,3072,2022F,2024F,2026F,3072

2. And have had a retinal or dilated eye exam or negative retinal exam (no evidence of retinopathy) by an eye care professional during the reporting period.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were between the ages of 18 and 75 years of age by the start of the reporting period and a face to face encounter during the reporting period.

2. And have a diagnosis of Diabetes (Type 1 or Type 2) in the Summary Active Problems field during the reporting period. This can be accomplished by the documentation of one of the following ICD codes: 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## (DRAFT) NQF 0056 (Additional) Diabetes: Foot Exam

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE

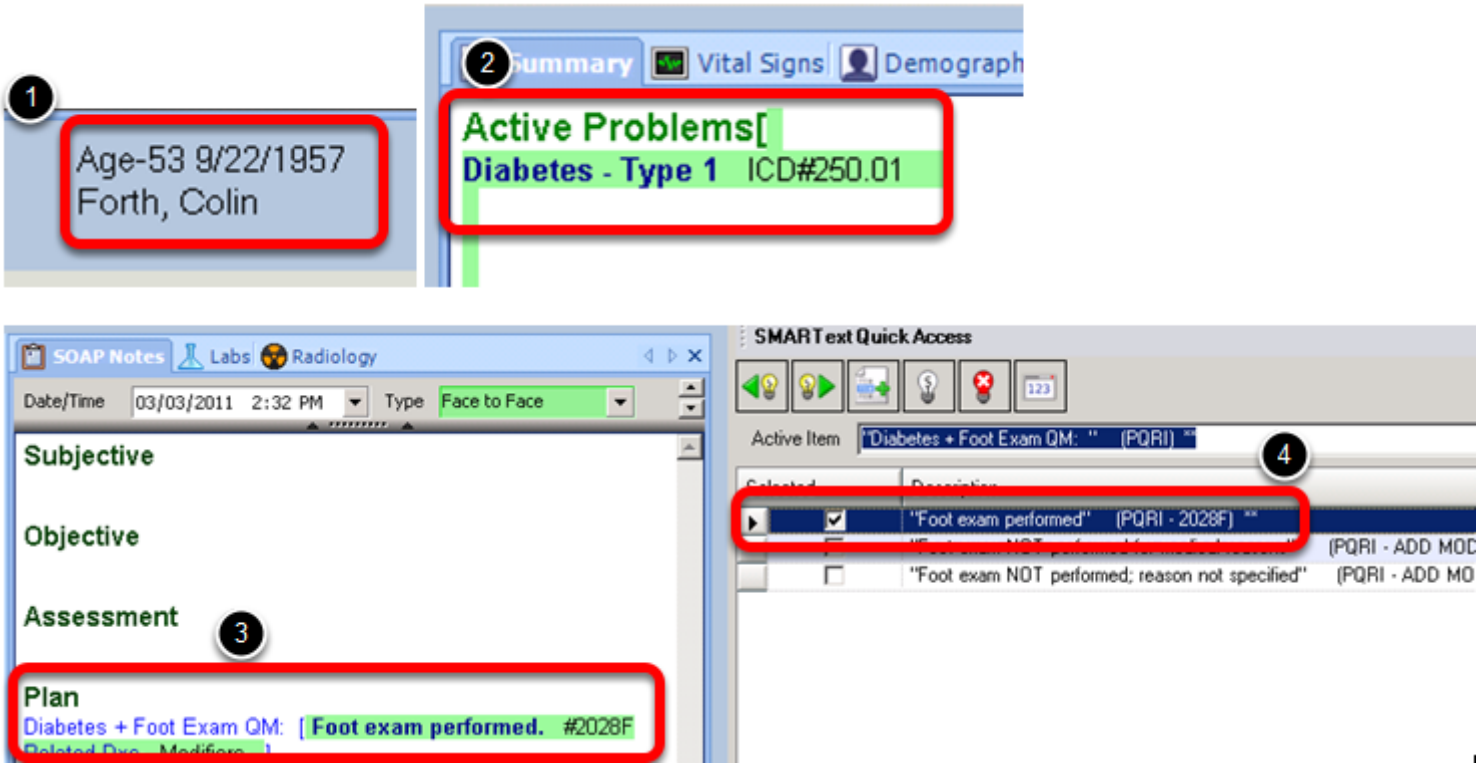
**Measure:** NQF 0056 (Additional Measure)

**Measure Title:** Diabetes: Foot Exam

**Measure Description:** The percentage of patients aged 18 - 75 years with diabetes (Type 1 or Type 2) whom had a foot exam (visual inspection, sensory exam with mono filament, or pulse exam).

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL MEASURE: Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be between the ages of 18 and 75 with the **diagnosis of Diabetes (Type 1 or Type 2)** during the reporting period.
2. The Summary Active Problems field or Encounter Assessment Field **must contain** one of the following **ICD codes**: 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

3. The Face to Face encounter must show documentation in the Plan field or the Summary Interventions field that the patient had a foot exam (visual inspection, sensory exam with mono filament, or pulse exam) during the reporting period. It must contain the **CPT code:** 2028F.

4. To accomplish this, use the shortcut code **"PQRIdmFoo"** in the encounter Plan field. This will insert the pick list header, "Diabetes + Foot Exam QM:" Left-Click on the pick list header to display a list of items in SMARText Quick Access that meet the criteria. See the screen shot that displays the appropriate selection.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients age 18 to 75 with at least 1 Face to Face encounter within the reporting period.
2. AND have had a foot exam (visual inspection, sensory exam with mono filament, or pulse exam) during the reporting period. **CPT** item in the SOAPnote Plan field: 2028F

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were between 18 and 75 years of age by the start of the reporting period.

2. AND have a diagnosis in the Summary Active Problems field or Encounter Assessment field for Diabetes (Type or Type 2) during the reporting period. This can be accomplished with the documentation of one of the following **ICD codes:** 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## (DRAFT) NQF 0059/PQRI 1 (Additional) - Diabetes: Hemoglobin A1c Poor Control

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

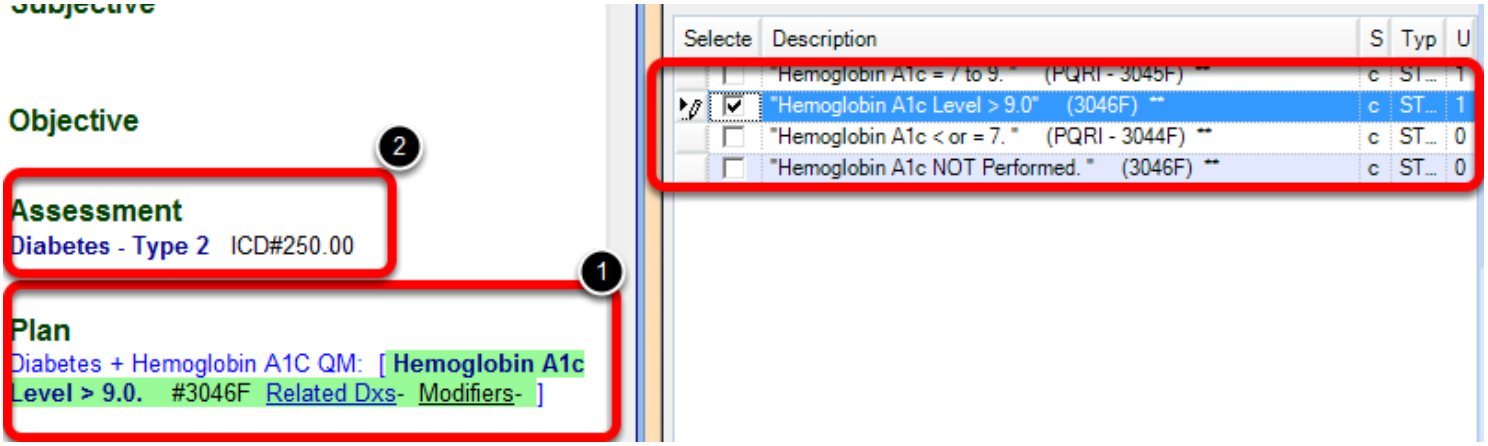
**Measure:** NQF 0059 (Additional Measurement)

**Measure**: Diabetes: HbA1c Poor Control

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

***REQUIRED FOR MEANINGFUL USE (MU) CORE REQUIREMENT - Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




1. Using the shortcut, "**PQRIdmA1c**" will insert the pick list header, "**Diabetes + Hemoglobin A1C QM** ". Clicking on the header will display a list of data that meet the criteria. The CPT of 3046f will need to be present in the enounter Plan field or the summary Interventions field that indicates the patient whose latest Hemoglobin A1c reading is above 9%.

2. Patient's during the reporting period must have a diagnosis of Diabetes. ICD's that can be used include: 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

Patient's must be between the ages of 17 and 74 at the start of the measurement period.

## Measurement Calculation Details

**Numerator Calculation**:

The numerator for this measurement is calculated based on the following:

1. The number of patients whose latest A1c reading is above 9%
2. OR have the SMARText CPT code, **3046f** documented in the either the Encounter Plan field or the Summary Interventions field.

**Denominator Calculaiton**:

The denominator for this measurement is calculated based on the following:

1. The number of patients between the ages of 17 and 74 at the start of the measurement period
2. And have a diagnosis of Diabetes. ICD's that can be used include: 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## (DRAFT) NQF 0061/PQRI 3 (Additional)- Diabetes: Blood Pressure Management

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

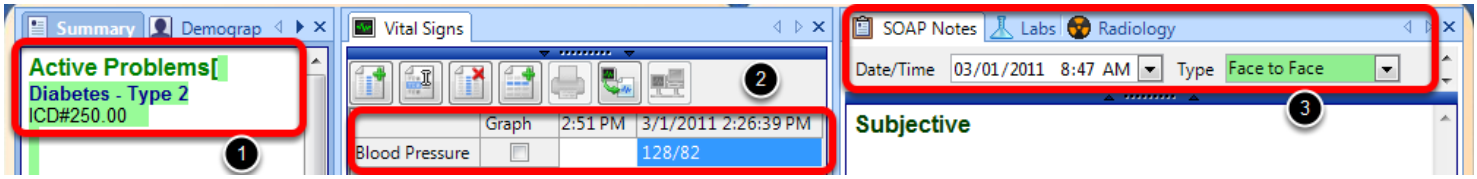
**Measure:** NQF 0061 (Additonal Measurement)

**Measure Title**: Diabetes: Blood Pressure Management

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

***REQUIRED FOR MEANINGFUL USE (MU) CORE REQUIREMENT:** **Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




1. Patients in the reporting period last blood pressure reading must be <140/90 during the reporting period.

2. And have a diagnosis of Diabetes (Type 1 or Type 2) Acceptable ICD codes: 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

3. **AND** have been seen by the provider (Face to Face encounter)

Patient's must be between the ages of 18 and 75 years at the start of the measurement period

### Measurement Calcuation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based onthe following:

1. The number of patients whose last blood pressure was < 140/90

**Denominator Calculation:**

The denominator for the measurement is calculated based on the following:

1. The number of patients that were between the ages of 18 and 75
2. And had been seen by the provider during the reporting period
3. And had a diagnoisis of Diabetes recorded in the Summary Active Problems or Encounter Assessment field. Acceptable ICD codes: 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

## Report ClinicalQuality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## (DRAFT) NQF 0062 (Additional): Diabetes Urine Screening

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE**

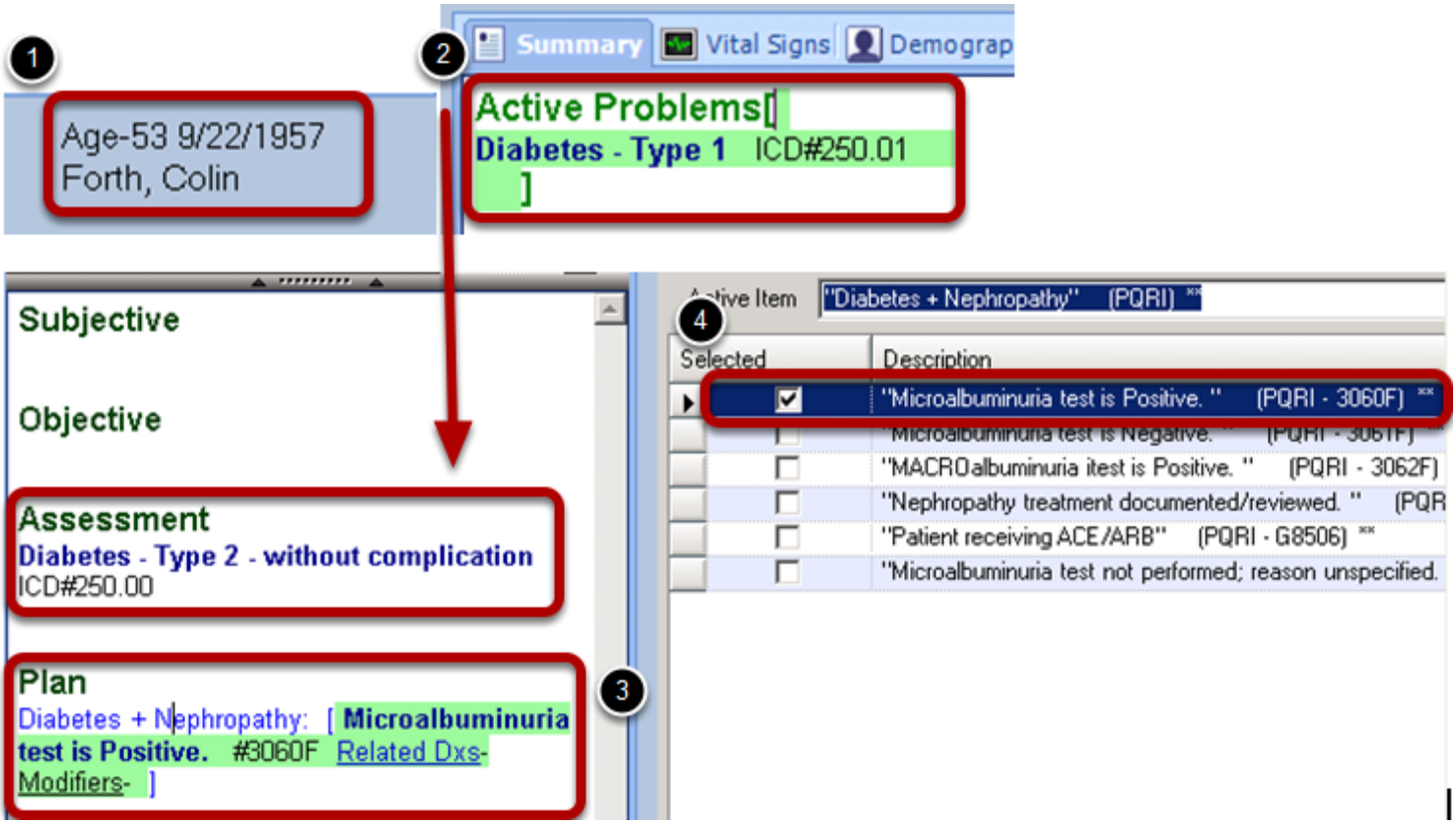
**Measure:** NQF 0062 (Additional Measure)

**Measure Title:** Diabetes Urine Screening

**Measure Description:** Percentage of patients 18 - 75 years of age with Diabetes (Type 1 or Type 2) who had a nephropathy screening test or evidence of nephropathy.

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL MEASURE:** **Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be between the ages of 18 - 75 years of age with Diabetes (Type 1 or Type 2) during the reporting period.

2. The Summary Active Problems field or the Face to Face encounter Assessment field, must contain one of the following **ICD codes:** 250.4, 250.40, 250.41, 250.42, 250.43, 403, 403.0, 403.00, 403.01, 403.1, 403.10, 403.11, 403.9, 403.90, 403.91, 404, 404.0, 404.00, 404.01, 404.02, 404.03, 404.1, 404.10, 404.11, 404.12, 404.13, 404.9, 404.90, 404.91, 404.92, 404.93, 405.01, 405.11, 405.91, 580, 580.0, 580.4, 580.8, 580.81, 580.89, 580.9, 581, 581.0, 581.1, 581.2, 581.3, 581.8, 581.81, 581.89, 581.9, 582, 582.0, 582.1, 582.2, 582.4, 582.8, 582.81, 582.89, 582.9, 583, 583.0, 583.1, 583.2, 583.4, 583.6, 583.7, 583.8, 583.81, 583.89, 583.9, 584, 584.5, 584.6, 584.7, 584.8, 584.9, 585, 585.1, 585.2, 585.3, 585.4, 585.5, 585.6, 585.9, 586, 587, 588, 588.0, 588.1, 588.8, 588.81, 588.89, 588.9, 753.0, 753.1, 753.10, 753.11, 753.12, 753.13, 753.14, 753.15, 753.16, 753.17, 753.19, 791.0, V42.0, V45.1, V45.11, V45.12, V56, V56.0, V56.1, V56.2, V56.3, V56.31, V56.32, V56.8

3. The Face to Face encounter Plan field or the Summary Interventions field must show documentation that the patient had a nephropathy screening test or evidence of nephropathy during the reporting period. It must contain one of the following **CPT codes:** 82042, 82043, 82044, 84156,3060F, 3061F, 3062F, 3066F, G8506

4. To accomplish this, use the shortcut code, **"PQRIdmNep"** in the Face to Face encounter Plan field to insert the pick list header "Diabetes + Nephropathy:" Left-Click on the pick list header to display a list of items in SMARText Quick Access that meet the criteria. **CPT codes**: 82042, 82043, 82044, 84156 are not included in the pick list but can be entered by doing a Shift + F11 or F11 search.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients that have a Face to Face encounter within the reporting period that has one of the appropriate **CPT** item in the SOAPnote Plan field: 82042, 82043, 82044, 84156,3060F, 3061F, 3062F, 3066F, G8506

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were between 18 and 75 years of age by the start of reporting period, with a Face to Face Encounter during the reporting period;
2. And have a diagnosis for Diabetes (Type 1 or Type 2) in the Summary Active Problems or Encounter Assessment field. This can be accomplished with the documentation of one of the following **ICD codes:** 250.4, 250.40, 250.41, 250.42, 250.43, 403, 403.0, 403.00, 403.01, 403.1, 403.10, 403.11, 403.9, 403.90, 403.91, 404, 404.0, 404.00, 404.01, 404.02, 404.03, 404.1, 404.10,

404.11, 404.12, 404.13, 404.9, 404.90, 404.91, 404.92, 404.93, 405.01, 405.11, 405.91, 580, 580.0, 580.4, 580.8, 580.81, 580.89, 580.9, 581, 581.0, 581.1, 581.2, 581.3, 581.8, 581.81, 581.89, 581.9, 582, 582.0, 582.1, 582.2, 582.4, 582.8, 582.81, 582.89, 582.9, 583, 583.0, 583.1, 583.2, 583.4, 583.6, 583.7, 583.8, 583.81, 583.89, 583.9, 584, 584.5, 584.6, 584.7, 584.8, 584.9, 585, 585.1, 585.2, 585.3, 585.4, 585.5, 585.6, 585.9, 586, 587, 588, 588.0, 588.1, 588.8, 588.81, 588.89, 588.9, 753.0, 753.1, 753.10, 753.11, 753.12, 753.13, 753.14, 753.15, 753.16, 753.17, 753.19, 791.0, V42.0, V45.1, V45.11, V45.12, V56, V56.0, V56.1, V56.2, V56.3, V56.31, V56.32, V56.8

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## *NQF 0064 (Additional) - Diabetes: Low Density Lipoprotein (LDL) Management and Control

**Measure**: NQF 0064 (Additional Measure)

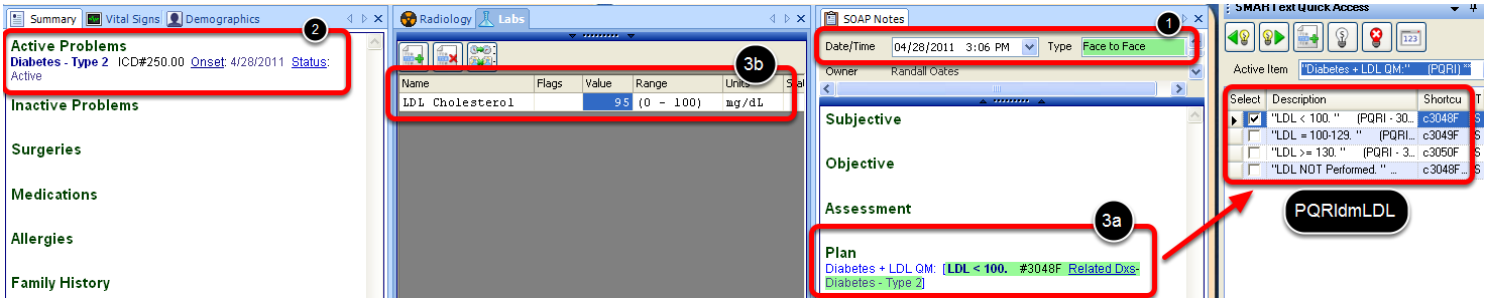
**Measure Title**: Diabetes: Low Density Lipoprotein (LDL) Management and Control

**Measure Description:** The percentage of patients 18-75 years of age with Diabetes (Type 1 or Type 2) who had LDL-Cholesterol < 100 mg/dL.

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patient's must be **between age 18-75 years of age** at the start of the reporting period and have at least **one face-to-face encounter** with the provider during the reporting period.

2. Patients must have a **diagnosis of Diabetes (Type 1 or Type 2)** documented in the **Summary Active Problems or the Assessment field** of the encounter using one of the following **ICD codes:** 250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.

3. Two documentation options:

(a) Documentation that LDL-Cholesterol was < 100 mg/dL. Inserting the shortcut code "**PQRIdmLDL**" in the **encounter Plan** field or **Summary Interventions** field will allow the user to select from a group of specific SMARText CPT codes that can be used to document for this measure. The encounter Plan field or Summary Interventions field must inlcude any on of the **CPT codes** listed below: (**3048F,** *__Note__: 3049F, 3050F and 3048F-8P will not increase the numerator).

**OR**

(b) Documentation in the Lab chart section using a Lab Test that is named one of the following: "**LDL-C, LDL Cholesterol, LDL-Calculated, LDL Cholesterol, LDL Calculated, or LDL**"* with a structured result < 100 on the last LDL.
***Note:** It is very important that the name of the lab test exactly matches one of the items listed above. To edit your lab test names in SOAPware, go to Tools > Lab Tests.*

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator who have one of the following documented during the reporting period:

(a) The following SMARText CPT code is documented in the Summary Interventions for or the encounter Plan field:
(CPT **3048F**, *__Note__: 3049F, 3050F and 3048F-8P will not increase the numerator)

**OR**

(b) Have a structured LDL Cholesterol reading of <100 during the reporting period using one of the following lab test names: "**LDL-C, LDL Cholesterol, LDL-Calculated, LDL Cholesterol, LDL Calculated, or LDL**"*.
***Note:** It is very important that the name of the lab test exactly matches one of the items listed above. To edit your lab test names in SOAPware, go to Tools > Lab Tests.*

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients who were between the ages of 18 and 75 at the start of the reporting period and have at least one face-to-face encounter with the provider during the reporting period;

2. And have a diagnosis of Diabetes (Type 1 or Type 2) in the Summary Active Problems field or encounter Assessment field:
(250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04)

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## (DRAFT) NQF 0067 (Additional) Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

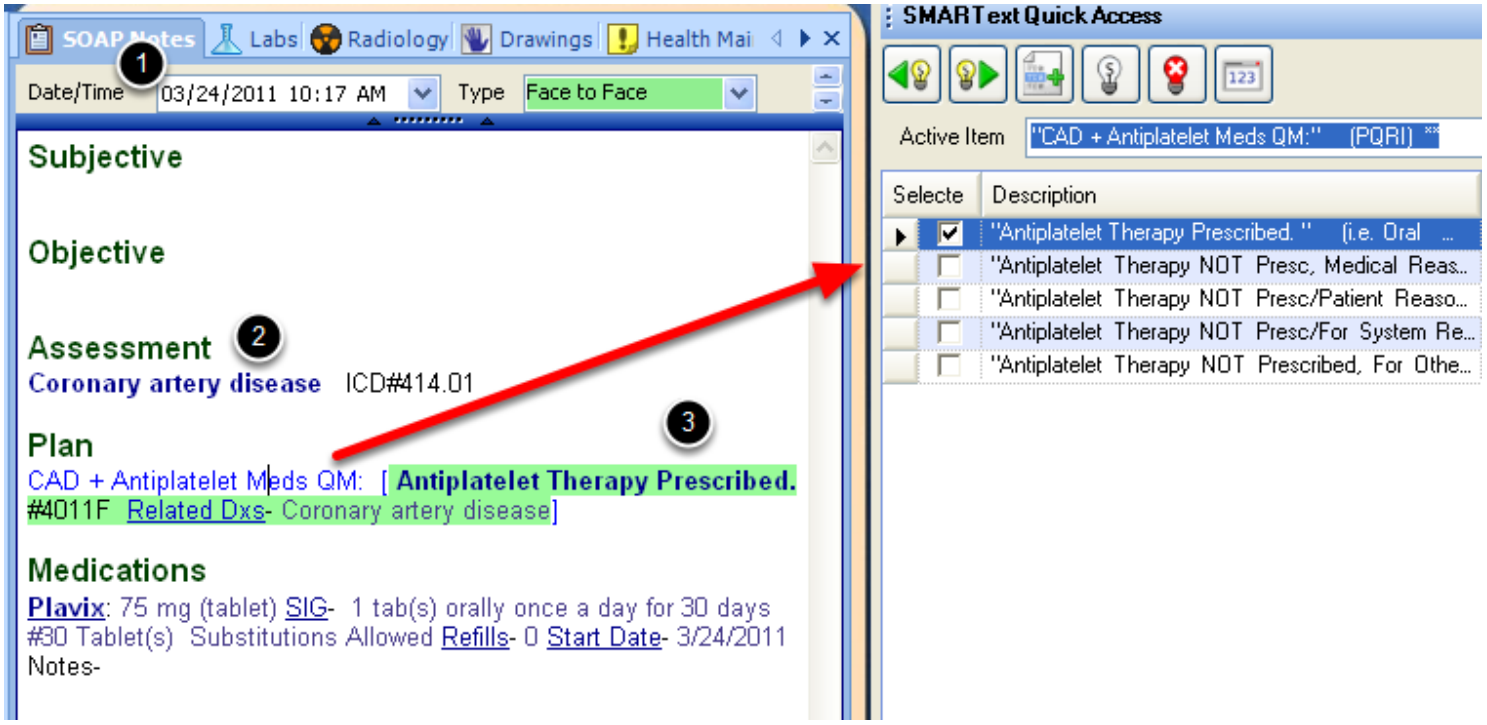
**Measure:** NQF 0067

**Measure Title:** Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

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

***REQUIRED FOR MEANINGFUL USE (MU) ADDITIONAL CQM MEASURE: Click here to view Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart.

1. Patient's must be **18 years of age or older and** have at least one face-to-face encounter with the provider during the reporting period.

2. The Assessment field of the face-to-face encounter or the Summary Active Problems field must have the the **diagnosis of Coronary Artery Disease (CAD)** using one of the following **ICD codes:** 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, 411.0, 411.1, 411.81, 411.89, 412, 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

3. Patients must have one of the following antiplatelet therapy medications prescribed by documenting a SMARText medication in the SOAPnote Medications field or Summary Medications field: **Plavix, Ticlid, Aspirin.**
**OR:** A pick list has been created that can be used to document that Antiplatelet Therapy has been prescribed. Enter the pick list using the shortcut code "**PQRIcadPla**" and select CPT code **4011F** (Note: 4011F-1P, 4011F-2P, 4011F-3P and 4011F-8P will not increase the numerator because they indicate that antiplatelet therapy was not prescribed).

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients that have a Face to Face encounter with a physician within the reporting period;

2. And have had one of the following antiplatelet therapy SMARText structured Medications prescribed during the reporting period: **Plavix, Ticlid, Aspirin.** These structured SMARText items will contain the Multum codes in the background. **OR**, has the appropriate **CPT** item in the Face to Face encounter Plan field: **4011F**.

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients that were **18 years of age** or older during the reporting period;

2. And have had at least one Face to Face encounter with the physician during the reporting period;

3. And have a **diagnosis of Coronary Artery Disease (CAD)** in the Summary Active Problems field or the Assessment field of the Face to Face encounter using one of the **ICD codes:** 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, 411.0, 411.1, 411.81, 411.89, 412, 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

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## (DRAFT) NQF 0068 (Additiona) - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.**

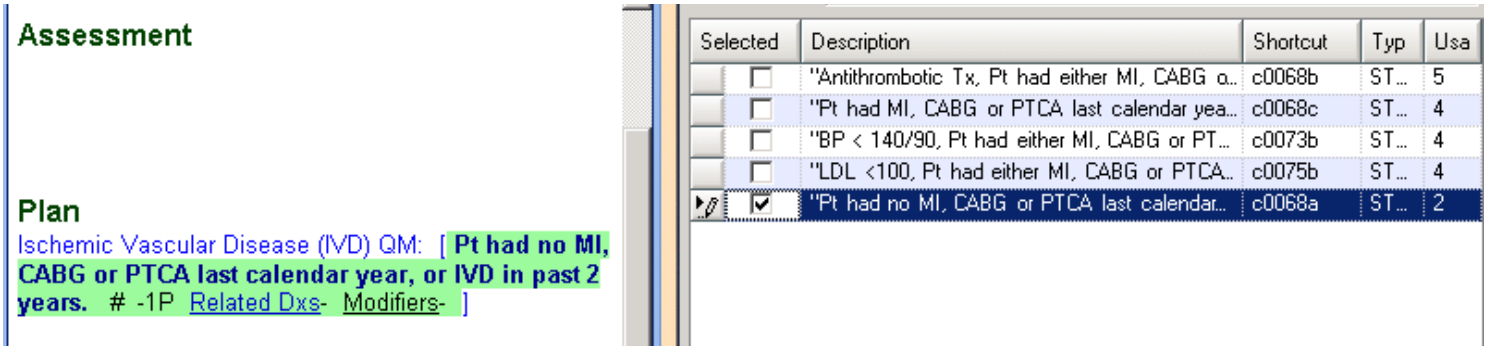
**Measure:** NQF 0068 (Additional Measure)

**Measure Title:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

**Measure Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.

***REQUIRED FOR MEANINGFUL USE (MU): Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be **18 years of age and older** and have documentation in the Face to Face encounter showing that they were discharged alive for **Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA)** from January 1 November 1 of the year prior to the measurement year.

2. OR, Patients must have had a **diagnosis of Ischemic Vascular Disease (IVD)** during the measurement year and the year prior to the measurement year AND who had documentation of use of aspirin or another antithrombotic during the measurement year .

3. The Face to Face encounter Medications field or the Summary Medications field must contain one of the following SMARText Medications item with the appropriate Multum codes in the background when using the : Plavix - d04258, Ticlid - d00514, Aspirin - d00170

4. Or, by using the shortcut code, **"PQRIivd"** in the Face to Face encounter Plan field will insert the pick list header "Ischemic Vascular Disease (IVD) QM:" Click on the pick list header to display a list of items in SMARText Quick Access that will meet the criteria using one of the following **Custom codes**: 0068a, 0068b, 0068c

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1. The number of patients that have a Face to Face encounter within the reporting period that has the appropriate **Custom code** in the Plan field: 0068b;

2. Or, entering a SMARText Medication item into the Face to Face encounter field or Summary Medications field that contains the appropriate Multum codes in the background: Plavix - d04258, Ticlid - d00514, Aspirin - d00170;

3. Or, the number of patients that have a Face to Face encounter within the reporting period with the **Custom code** in the Plan field: 0068c;

4. And has one of the following SMARText Medicatiions entered into the Medications field of the Face to Face encounter or Summary Medications field: Plavix - d04258, Ticlid - d00514, Aspirin - d00170

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1. The number of patients 18 years of age and older who were discharged alive for **Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA)** from January 1 November 1 of the year prior to the measurement year;

2. AND patients with the **diagnosis of Ischemic Vascular Disease (IVD)** documented in the Face to Face enounter Plan field during the reporting period using one of the **Custom codes:** 0068b,

0068c

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, Click here.

For more information on reporting clinical quality measures, Click here.

## *NQF 0070 (Additional) - Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

**Measure:** NQF 0070 (Additional Measure)

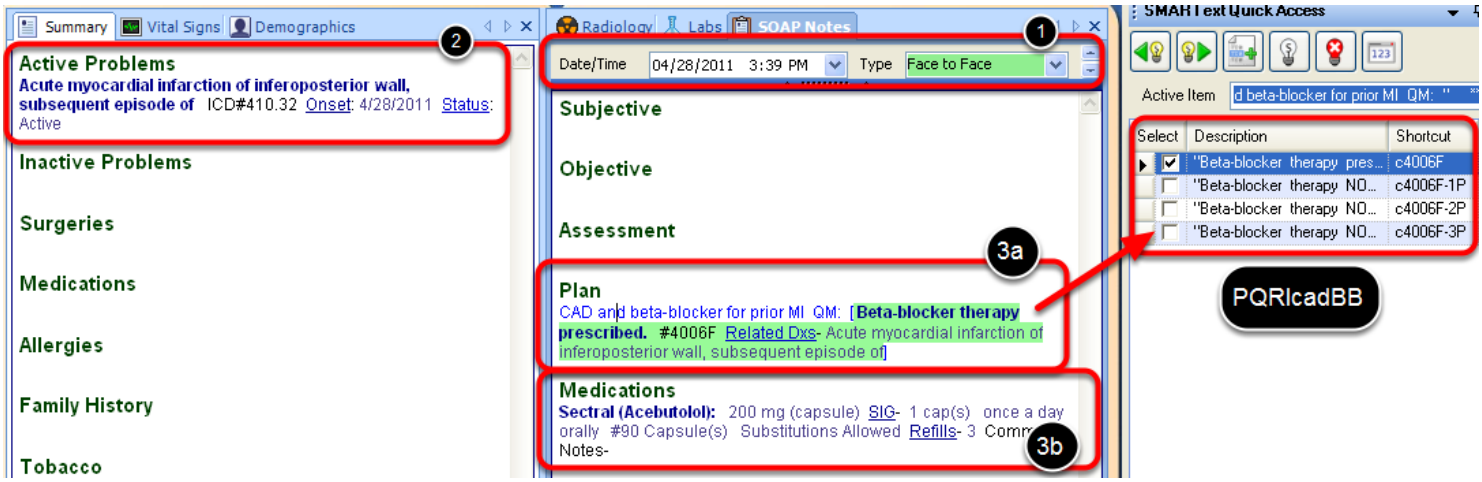
**Measure Title:** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

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

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patient's must be **18 years old or older** at the start of the reporting period have have at least **one face-to-face encounter** with the provider during the reporting period.

2. Patients must have an **appropriate diagnosis** documented in the **Summary Active Problems** or the encounter **Assessment field** using one of the following ICD codes: (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).

3. Two documentation options:

(a) Documentation that beta blocker therapy was prescribed. Inserting the shortcut code "**PQRIcadBB**" in the **encounter Plan** field or **Summary Interventions** field will allow the user to select from a group of specific SMARText codes that can be used to document for this measure. The encounter Plan field or Summary Interventions field must include any one of the CPT codes listed below: (**4006F**, ***Note**: 4006F-1P, 4006F-2P, and 4006F-3P will not increase the numerator).

**OR**

(b) Documentation that beta blocker therapy was prescribed by entering one of the following medications in the encounter Medications or Summary Medications field:
(Atenolol, Betapace, Betaxolol, Coreg, Propranolol, Inderide, Labetalol/Normodyne, Metoprolol, Nadolol, Pindolol, Acebutolol, Tenoretic, Bisoprolol).

## Measure Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based on the following:

1.The number of patients in the denominator who have one of the following items documented:

(a) The following SMARText CPT code is documented in the Summary Interventions field or the encounter Plan field:
**(4006F, *Note:** 4006F-1P, 4006F-2P, and 4006F-3P will not increase the numerator).

OR

(b) Abeta blocker medication entered into the Summary Medications of encounter Medications field:

Beta Blocker Meds - Multum Code
Atenolol - d00004
Betapace - d00371
Betaxolol - d00176
Coreg - d03847
Propranolol - d00032
Inderide - d03261
Labetalol/Normodyne - d00016
Metoprolol - d00134
Nadolol - d00018

Pindolol - d00137
Acebutolol - d00128
Tenoretic - d03258
Bisoprolol - d00709

**Denominator Calculation:**

The denominator for this measurement is calculated based on the following:

1.The number of patients 18 or older at the start of the reporting period and have at least one face-to-face encounter with the provider during the reporting period;

2. And have an appropriate diagnosis in the Summary Active Problems field or encounter Assessment field:
(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)

## Report Clinical Quality Measures to CMS/States

All of the items in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For more information on how to export the numerator, denominator, and percentage for each Clinical Quality measure, Click Here.

For more information on reporting clinical quality measures, Click Here.

## NQF 0073 (Additional): Ischemic Vascular Disease (IVD): Blood Pressure Management

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.**

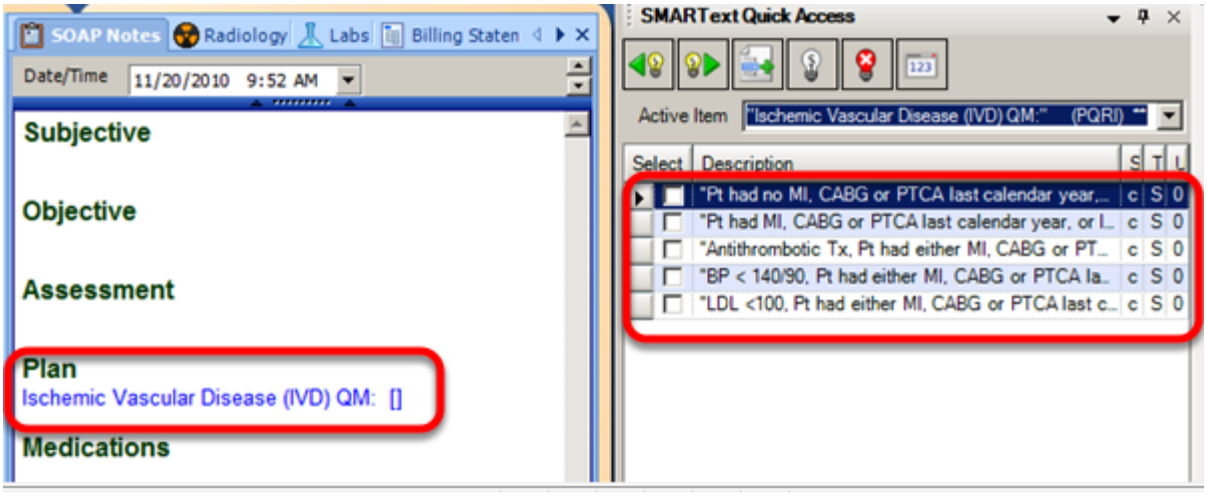
**Measure:** NQF 0073 (Additional Measure)

**Measure Title:** Ischemic Vascular Disease (IVD): Blood Pressure Management

**Measure Description:** The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

### Criteria




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be **18 years of age and older** who were **discharged alive** for **Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG)** or **Percutaneous Transluminal Coronary Angioplasty (PTCA)** from January 1 November 1 of the **year prior to the measurement year**.

2. Patients must have documentation of a **diagnosis of Ischemic Vascular Disease (IVD)** during the measurement year and the year prior to the measurement year AND whose most recent **blood pressure is in control (<140/90 mmHg).** Inserting the shortcut code, **"PQRIivd"** in the encounter

Plan field will allow the user to select froma group of specific SMARText custom codes that can be used to document for this measure. Patients must have the custom SMARText code of **0073b** entered in the **encounter Plan field** to document for this measure.

## Measurement Calculation Details

**Numerator Calculation:**
The Numerator for this measurement is calculated based on the following:

1. The number of patients that have a face-to-face encounter within the reporting period and have the following SMARText custom code in the encounter Plan field:
**0073b** (Note: 0068c, 0075b, 0075a, 0068a, and 0068b will not increase the numerator or denominator for this measure).

**Denominator Calculation:**
The Denominator for this measurement is calculated based on the following:

1. The number of patients that have a face-to-face encounter within the reporting period and have the following SMARText custom code in the encounter Plan field:
**0073b** (Note: 0068c, 0075b, 0075a, 0068a, and 0068b will not increase the numerator or denominator for this measure).

## Report Clinical Quality Measures to CMS/States

All of the items in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For more information on how to export the numerator, denominator, and percentage for each Clinical Quality measure, Click Here.

For more information on reporting clinical quality measures, Click Here.

## (DRAFT) NQF 0074 (Additional): Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

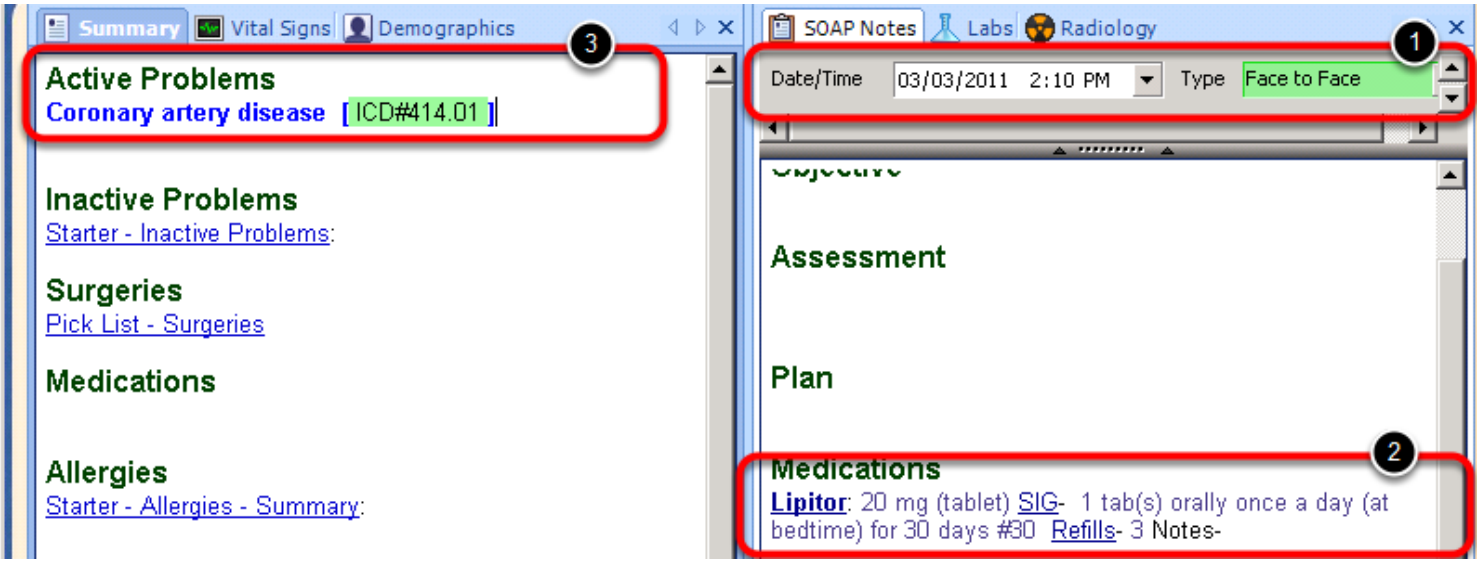
**Measure:** NQF 0074 (Additional Measure)

**Measure Title:** Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

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

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be **18 years of age or older** with a **diagnosis of CAD** AND had had a face to face encounter during the reporting period.

2. Patients must have been prescribed **a lipid-lowing therapy medication** during the reporting period (based on current ACC/AHA guidelines). The encounter Medication field or the summary Medication field must contain one of the following medications: **Lipitor - d04105, Crestor - d04851, Lofibra - d04286, Lovastatin - d00280, Lovasa - d00497, Pravastatin - d00348, Questran - d00193, Simvastatin - d00746, Tricor - d04286, Vytorin -d05348, Welchol - d04695,**

**Zetia - d04824**

3. The summary Active Problems field must contain one of the following ICD codes: **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, 411.0, 411.1, 411.81, 411.89, 412, 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**

## Measurement Calculation Details

**Numerator Calculation:**
The Numerator for this measurement is calculated based on the following:

1. The number of Patients that were **age 18 years or older** with a **face-to-face encounter** during the reporting period;
2. AND were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines) documented in the Summary Medications or the Encounter Medications. This can be accomplished by documentation of one of the following Medication Items:

**Lipitor - d04105**
**Crestor - d04851**
**Lofibra - d04286**
**Lovastatin - d00280**
**Lovasa - d00497**
**Pravastatin - d00348**
**Questran - d00193**
**Simvastatin - d00746**
**Tricor - d04286**
**Vytorin - d05348**
**Welchol - d04695**
**Zetia - d04824**

**Denominator:**
The Denominator for this measurement is calculated based on the following:

1. The number of Patients that were **age 18 years or older** with a **face-to-face encounter** during the reporting period;
2. AND have a **diagnosis of Coronary Artery Disease** documented in the Summary Active problems or the Encounter Assessments. This can be accomplished by documentation of one of the following ICD codes: **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, 411.0, 411.1, 411.81, 411.89, 412, 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**

## Report Clinical Quality Measures to CMS/States

All of the items in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For more information on how to export the numerator, denominator, and percentage for each Clinical Quality measure, Click Here.

For more information on reporting clinical quality measures, Click Here.

## *NQF 0075 (Additional): Ischemic Vascular Disease ( IVD): Complete Lipid Panel and LDL Control

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

**Measure:** NQF 0075 (Additional Measure)

**Measure Title:** Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

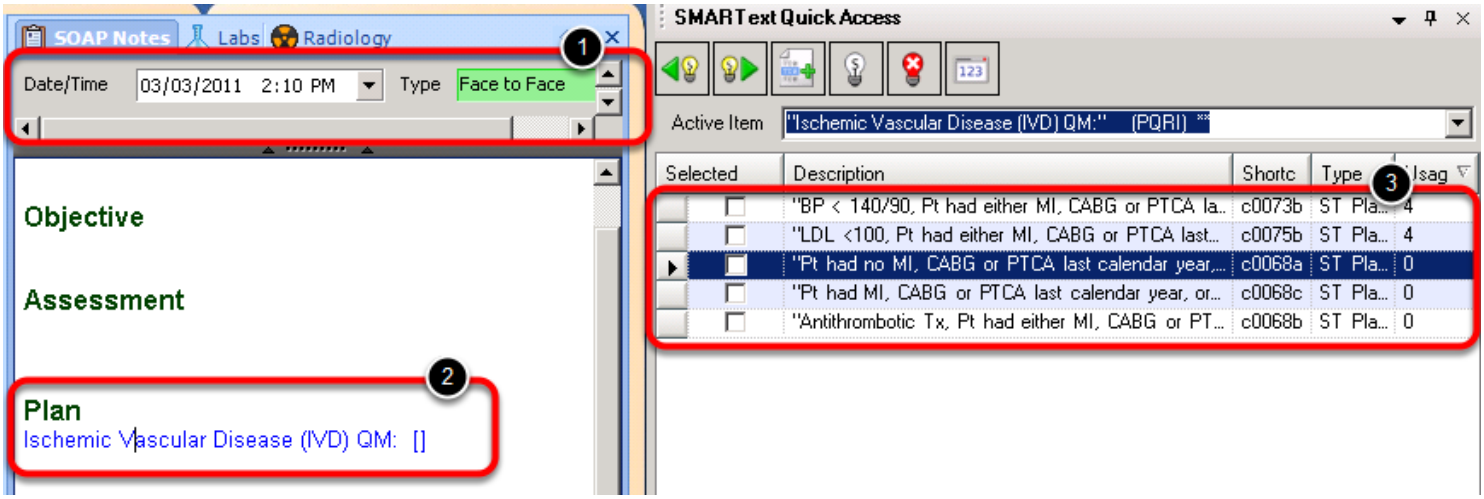
**Measurement Description:** The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be **18 years of age or older** and have at least **one face-to-face encounter** with

the provider during the reporting period.

2. Patients must have documentation of a diagnosis of Ischemic Vascular Disease (IVD) during the measurement year and the year prior to the measurement year. Inserting the shortcut code **"PQRIivd"** in the encounter Plan field will allow the user to select from a group of specific SMARText custom codes that can be used to document for this measure. Patients must have the custom SMARText code of **0068b or 0068c** entered into the **encounter Plan field** to document *"Patient had MI, CABG or PTCA last calendar year, or IVD in past 2 years".*

3. Patients must also have documentation that they have had a complete lipid profile performed during the measurement year and the following code should be used for those who have an LDL-C <100 mg/dL. Inserting the shortcut code **"PQRIivd"** in the encounter Plan field will allow the user to select from a group of specific SMARText custom codes that can be used to document for this measure. Patients must have the custom SMARText code of **0075b** entered into the **encounter Plan field** to document *"LDL <100 (or lipid goals reached), had either MI, CABG or PTCA last calendar year or IVD past 2 years".*

## Measurement Calculation Details

**Numerator Calculation:**
The Numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator that have the appropriate Custom ID item in the plan field:

- **0075b:** *LDL <100 (or lipid goals reached), had either MI, CABG, or PTCA last calendar year or IVD past 2 years*

The following codes **will not** increase the numerator:

- 0068a: *Pt had no MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- 0068b: *Antithrombotic Tx, Pt had either MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- 0068c: *PT had MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- 0073b: *BP <140/90, Pt had either MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- 0075a: *LDL<100 (or lipid goals reached), had either MI, CABG or PTCA last calendar year or IVD past 2 years*

**Denominator:**
The Denominator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with at least one **face-to-face encounter** within the reporting period;

2. AND have one of the following SMARText custom codes in the encounter Plan field:

- **0075b:** *LDL <100 (or lipid goals reached), had either MI, CABG, or PTCA last calendar year or IVD past 2 years*
- **0068b:** *Antithrombotic Tx, Pt had either MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- **0068c:** *Pt had MI, CABG or PTCA last calendar year, or IVD in past 2 years*

The following codes **will not** increase the denominator:

- 0068a: *Pt had no MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- 0073b: *BP <140/90, Pt had either MI, CABG or PTCA last calendar year, or IVD in past 2 years*
- 0075a: *LDL<100 (or lipid goals reached), had either MI, CABG or PTCA last calendar year or IVD past 2 years*

## Report Clinical Quality Measures to CMS/States

All of the items in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For more information on how to export the numerator, denominator, and percentage for each Clinical Quality measure, Click Here.

For more information on reporting clinical quality measures, Click Here.

# (DRAFT) NQF 0081/PQRI 5 (Additional) - Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

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**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.**

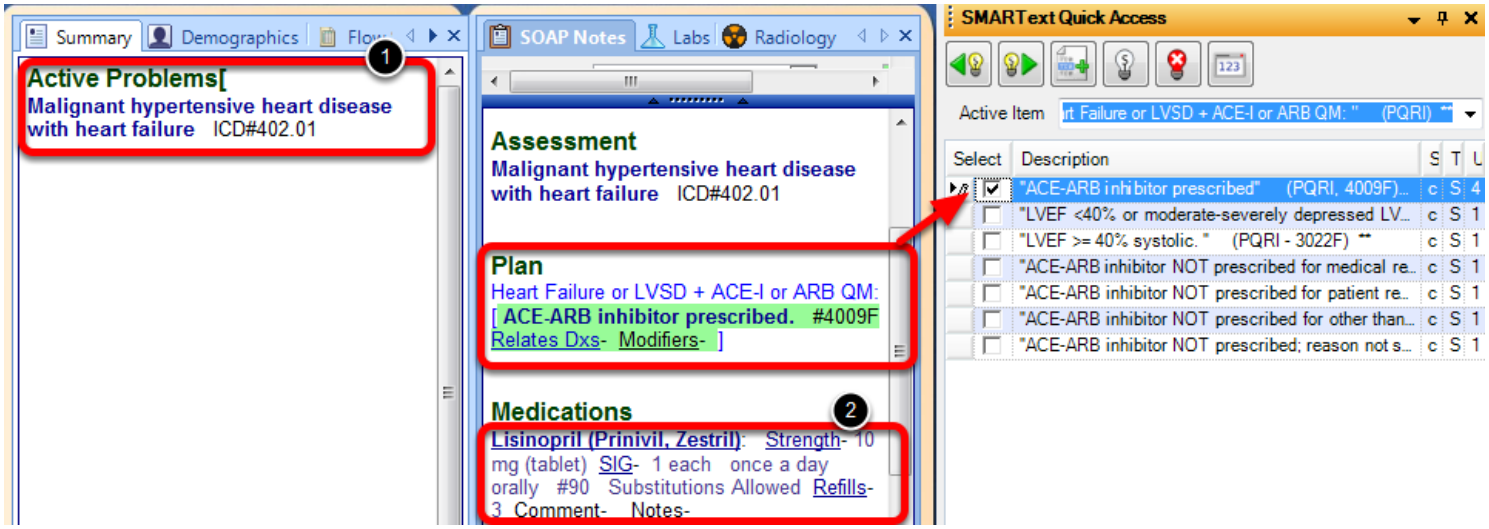
**Measure**: NQF 0081 (Additional Measurement)

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

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

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

## Quality Measure Documentation Workflow




1. Patients need to be 18 years of age or older the reporting period AND must have a diagnosis of Heart Failure AND LVSD (LVEF < 40%).
Diagnosis ICD codes that meet the criteria: 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

2. Patients during the reporting period must have been prescribed an ACE inhibitor or ARB therapy. Medications that meet the criteria: Micardis - d04364, Cozaar/Losartan - d03821, Diovan - d04113, Accuretic - d04509, Accupril - d00365, Altace - d00728, Captopril - d00006, Captozide - d03566, Lisinopril - d00732, Lotensin/Benzepril - d00730, Lotensin-HCT - d03265, Monopril/Fosinopril - d00242, Monopril-HCT - d04539, Zestoretic - d03266 ( "d" codes are the Multum identifier codes).

**OR** Using the shortcut code, **'PQRIhfACE"** in the encounter Plan field will insert the pick list header, "Heart Failure or LVSD + ACE-1 or ARB QM". Clicking on the header will display a list of the needed structured data that meet the criteria. The CPT code, "4009f" must be present in either the Encounter Plan Field or the Summary Interventions field.

## Measurement Calculation Details

**Numerator Calculation**:

The numerator for this measurement is calculated based on the following:

1. The number of patient whose were prescribed an ACE inhibitor or ARB therapy. Medications that meet the criteria: Micardis - d04364, Cozaar/Losartan - d03821, Diovan - d04113, Accuretic - d04509, Accupril - d00365, Altace - d00728, Captopril - d00006, Captozide - d03566, Lisinopril - d00732, Lotensin/Benzepril - d00730, Lotensin-HCT - d03265, Monopril/Fosinopril - d00242, Monopril-HCT - d04539, Zestoretic - d03266 ( "d" codes are the Multum identifier codes)
2. OR have the SMARText CPT code, 4009F documented in the either the SOAP Note Plan field or the Summary Interventions field.

**Denominator Calculaiton**:

The denominator for this measurement is calculated based on the following:

1. The number of patients 18 years of age or older at the start of the measurement period
2. And have a diagnosis of of Heart Failure. Diagnosis ICD codes that meet the criteria: 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

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## (DRAFT) NQF 0083 (Additional) Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

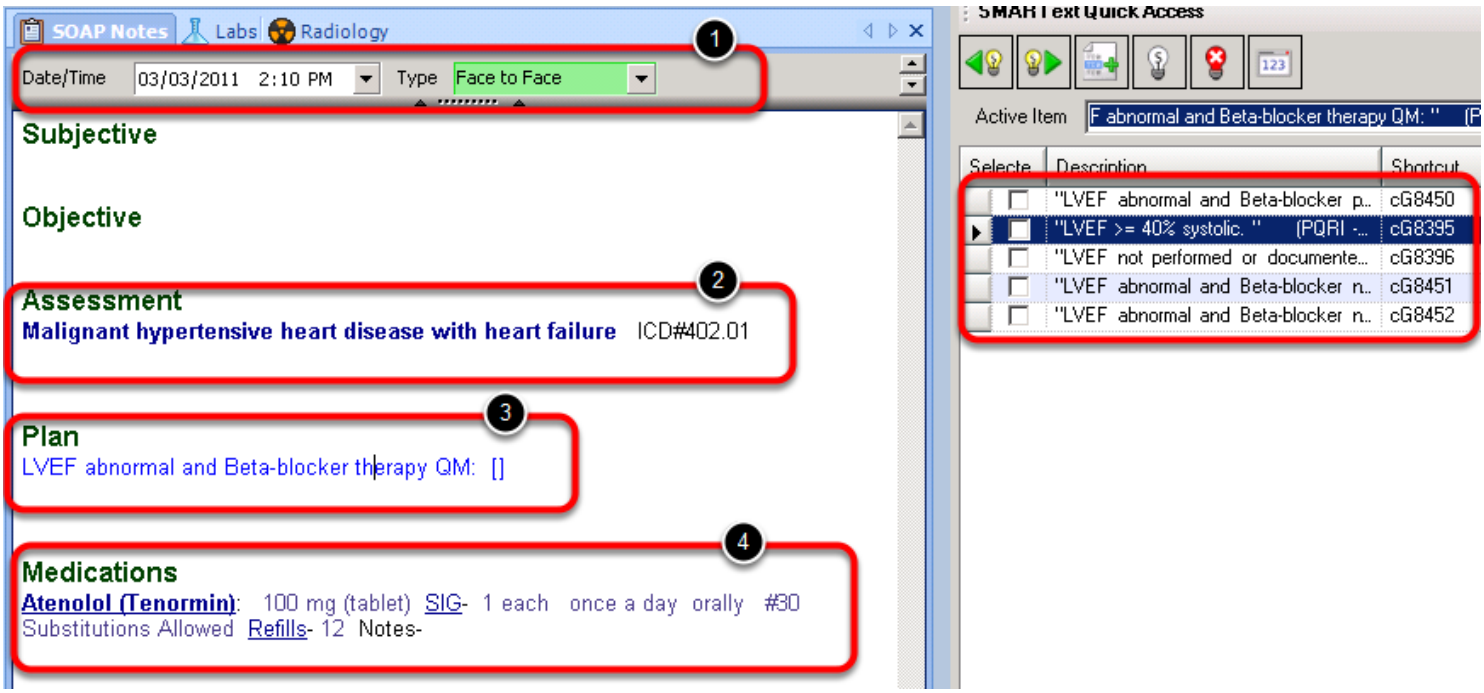
**Measure:** NQF 0083 (Additional Measure)

**Measure Title:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

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

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patient's must be 18 years of age or older and have a face to face encounter during the reporting period.

2. Patients must have a **diagnosis of heart failure** AND also have **Left Ventricular Systolic Dysfunction-LVSD** (LVEF < 40%). This can be accomplished by entering one of the following

**diagnosis codes in the Summary Active Problems or Encounter Assessments**: **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.;**

3. The patient must have been **prescribed in the encounter Medications field,** or have **recorded in the summary Medications field**, any one of these **beta blocker therapy medications** during the reporting period: **Atenolol - d00004, Betapace - d00371, Betaxolol - d00176, Coreg - d03847, Propranolol - d00032, Inderide - d03261, Labetalol/Normodyne - d00016, Metoprolol - d00134, Nadolol - d00018, Pindolol - d00137, Acebutolol - d00128, Tenoretic - d03258, Bisoprolol - d00709.**

4. The patient must have any one of the following CPT codes entered in either the **Encounter Plan field** or the **Summary Interventions field**: **G8395, G8396, G8450, G8451, G8452.** This can be accomplished be using the shortcut code, **"PQRIhfBB"** in the encounter Plan field and then clicking on the header, **"LVEF abnormal and Beta-Blocker therapy QM"** will display a list of items in SMARText Quick Access that meet the criteria.

## Measurement Calculation Details

**Numerator Calculation:**
The Numerator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with **a face-to-face encounter** within the reporting period;
2. The number of patients that have been prescribed a Beta blocker, documented in the Summary Medications field or encounter medications:
**Atenolol - d00004**
**Betapace - d00371**
**Betaxolol - d00176**
**Coreg - d03847**
**Propranolol - d00032**
**Inderide - d03261**
**Labetalol/Normodyne - d00016**
**Metoprolol - d00134**
**Nadolol - d00018**
**Pindolol - d00137**
**Acebutolol - d00128**
**Tenoretic - d03258**
**Bisoprolol - d00709**
3. OR The number of patients with a **specific CPT code** documented in the **Encounter Plan** field or **Summary Interventions** Field: **G8395, G8396, G8450, G8451, and G8452**

**Denominator:**
The Denominator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with **a face-to-face encounter** within the reporting period;
2. AND have **a diagnosis of Heart Failure** AND **have LVSD** (LVEF < 40%). This can be accomplished by thr documentation of one of the following ICD 9 Codes in the Summary Active Problems or Encounter Assessments: **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**

## Report Clinical Quality Measures to CMS/States

All of the items in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For more information on how to export the numerator, denominator, and percentage for each Clinical Quality measure, Click Here.

For more information on reporting clinical quality measures, Click Here.

# (DRAFT) NQF 0084 (Additional): Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

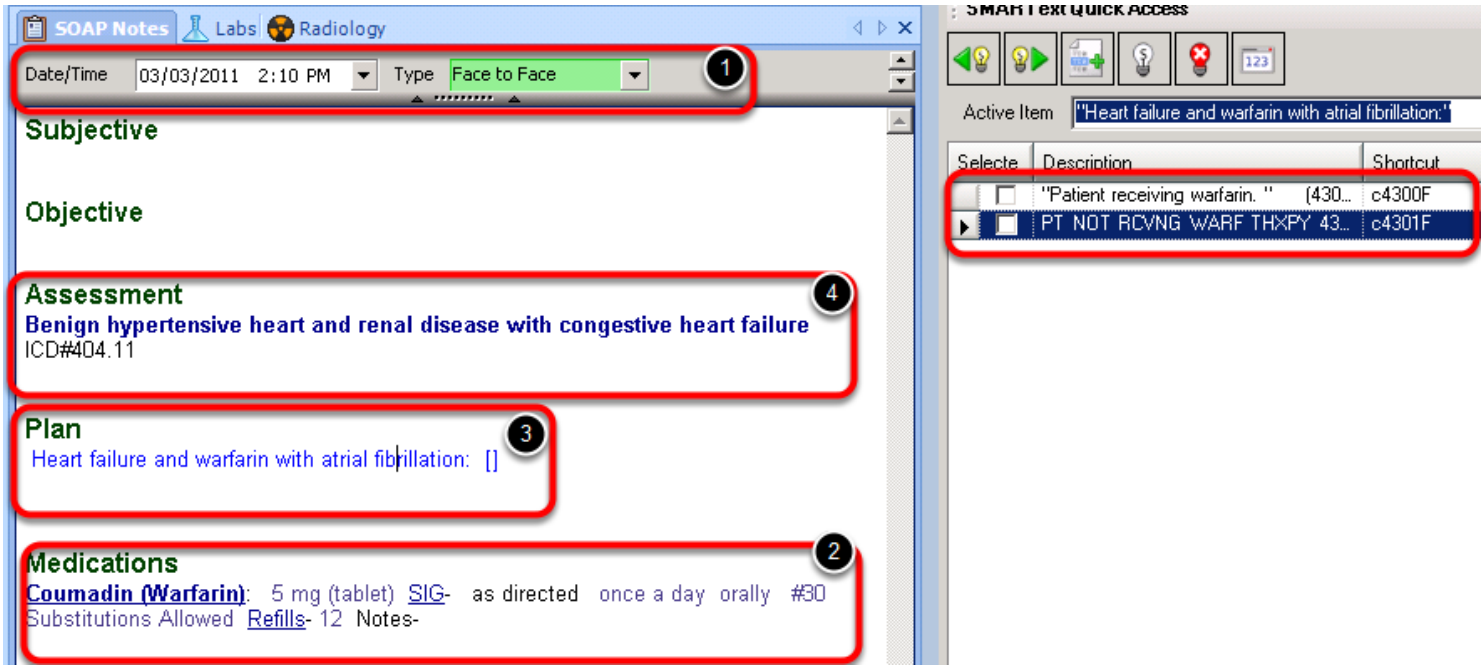
**Measure**: NQF 0084 (Additional Measurement)

**Measure Title**: Heart Failure (HF) : Warfarin Therapy Patients with Atrial Fibrillation

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

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

## Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be 18 years of age and older with a face to face encounter within the reporting period.

2. Patients had to have been prescribed **warfarin therapy**. This can be accomplished by documenting in the **Encounter Medication field** or the **Summary Medication** the active drug **Coumadin.**

3. The SOAPnote Plan field or the Summary Interventions field must contain the CPT code 4301F.

4. The Summary Active Problems field or the SOAPnote Assessment field must have **a diagnosis of Heart Failure AND paroxysmal or chronic Atrial Fibrillation** with of the following ICD codes: **427.31,402.01, 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** This can be accomplished by using the shortcut code, **"PQRIhfWar"** in the encounter Plan field will insert the pick list header, "Heart failure and warfarin with atrial fibrillation:" Clicking on the header will display a list of items in SMARText Quick Access that meet the criteria. The screen shot will display the appropriate selection.

## Measurement Calculation Details

**Numerator Calculation**:

The numerator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with a **face to face encounter** during the reporting period;
2. AND have been prescribed **Coumadin (warfarin)**. This may be accomplished by documenting the drug coumdin/warfarin with the drug ID od d00022 in the Summary Medications field or the Encounter Medications Field.
3. OR have the **CPT code of 4300F** in the **Plan or Interventions Field**. This can be accomplished by using the pick list **"pqrihfwar"**.

**Denominator Calculaiton**:

The denominator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with a **face to face encounter** during the reporting period;
2.AND have a diagnosis of Heart Failure documented in the Summary Active problems or Encounter Assessments. ICD of **427.31,402.01, 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**

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## (DRAFT) NQF 0086 - (Additional) Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

**THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.**

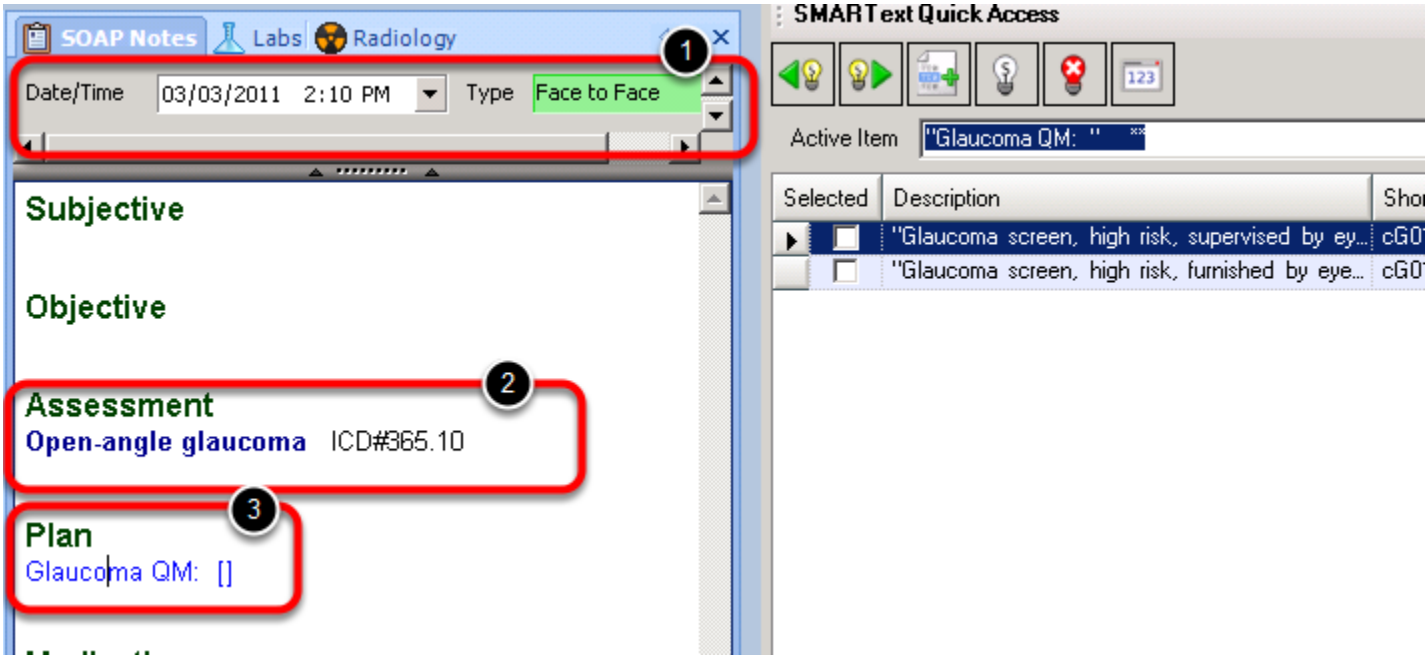
**Measure**: NQF 0086 (Additional Measurement)

**Measure Title**: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

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

***REQUIRED FOR MEANINGFUL USE (MU): Click here to view the Meaningful Use Criteria.**

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patient's must be 18 years of age or older with at least 2 face to face encounters within the reporting period.

2. Patients must have a diagnosis of POAG. This can be accomplished by entering one of the following ICD codes in the summary Active Problems field: **365.10, 365.11, 365.12, 365.15**.

3. Patient's must have had an optic nerve head evaluation during one or more office visits within 12 months. An Optic nerve evaluation must be recorded in the encounter Plan field during the start date of the reporting period minus 12 months and end date. This can be documented using the shortcut code, **"GlaQM"** in the encounter Plan field will inser the picklist header, "Gaucoma QM:" Clicking on this header will display a list of items in SMARText Quick Access that meet the criteria.

## Measurement Calculation Details

**Numerator Calculation**:

The numerator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with at **least 2 face to face encounters** during the reporting period;
2. AND have documentation of Optic never Evaluated in the Plan Field

**Denominator Calculaiton**:

The denominator for this measurement is calculated based on the following:

1. The number of patients **18 years of age or older** with a **face to face encounter** during the reporting period;
2. AND have a a diagnosis of POAG. This can be accomplished by documenting in the Summarfy Active Problems or Encounter Assessments one of the following ICD's; **365.10, 365.11, 365.12, 365.15**

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

# (DRAFT) NQF 0088 - (Additional) Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

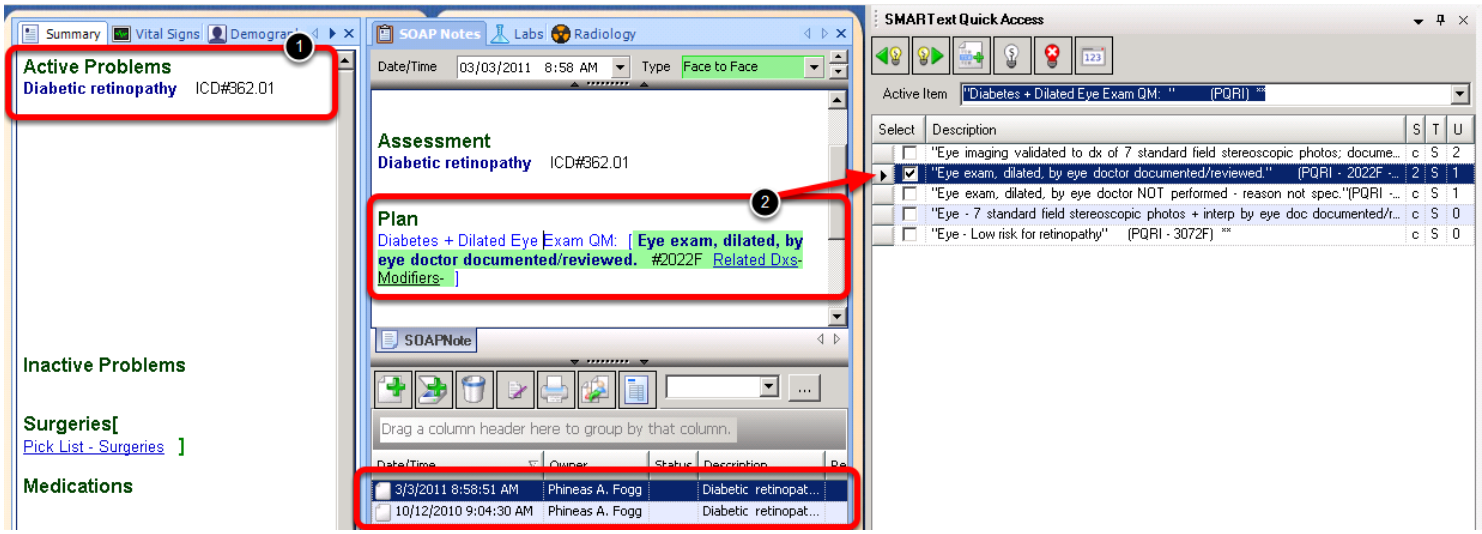
**Measure:** NQF 0088 (Alternate Core Measurement)

**Measure Title**: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

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

***REQUIRED FOR MEANINGFUL USE (MU): Click here to view the Meaningful Use Criteria.**

## Quality Measure Documentation Workflow




1. Patient's must be 18 years of age or older with a diagnosis of Diabetic Retinopathy AND had had one or more **face-to-face** office visits within a 12 period. The diagnosis codes that meet the criteria: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

2. Patient's must have had a dilated macular or fundus exam [performed which included documentation of the elvel of severithy of the Retinopathy and the presence or absence of macular edema). Using the shortcut code, **"PQRIdmEye"**, in the encounter Plan field will insert the pick list header, "**Diabetes + Dilated Exam QM**:" Clicking on the header will display a list of items in SMARText Quick Access that meet the documentation criteria.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based onthe following:

1. The number of patient's that have documentation in the Encounter Plan field that indicates a dilated macular or fundus exam was performed AND includes docmentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits with in a 12 month period.
2. The Encounter Plan field must contain a structured SMARText IT that contains the SNOMED code, 410455004

**Denominator Calculation:**

The denominator for the measurement is calculated based on the following:

1. The number of patients 18 years of age or older seen by a provider with a diagnosis of Diabeteic Retinopathy: The diagnosis codes that meet the criteria: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
2. AND had one or more **face-to-face** office visits within a 12 month period.

## Report Clinical Quality Measures to CMS/State

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

# (DRAFT) NQF 0089 - (Additional) Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

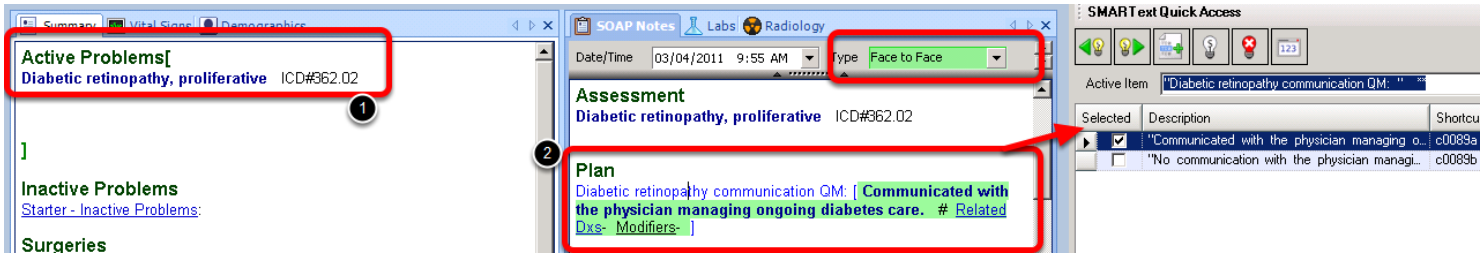
**Measure:** NQF 0089 (Additional Measurement)

**Measure**: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

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

***REQUIRED FOR MEANINGFUL USE (MU):** **Click here to view the Meaningful Use Criteria.**

## Quality Measure Documentation Workflow




1. Patient's must be 18 years of age or older with a diagnosis of Diabetic Retinopathy and Diabetes Mellitus **AND** had had one or more office visits within a 12 period. Patient's must have had a dilated macular or fundus exam [performed which included documented communication to the physician who manages the ongoing care of the patient's diabetes regarding the findings of the macular or fundus exam AT LEAST ONCE within 12 months. The diagnosis codes that meet the criteria: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

2. Using the shortcut code, "**DiaRetCom**", in the encounter Plan field will insert the pick list header, "**Diabetic retinopathy communication QM**::" Clicking on the header will display a list of items in SMARText Quick Access that meet the documentation criteria.

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based onthe following:

1. Number of patients that have the custom ID code 0089a (communicated with the physician managing ongoing diabetes care.) documented in the Encounter Plan field or the Summary Interventions field.

**Denominator Calculation:**

The denominator for the measurement is calculated based on the following:

1. The number of patients 18 years of age or older and has had a Face-to-Face encounter with the provider within the reporting period
2. AND had a diagnosis of Diabetic Retinopathy. ICD codes that meet the criteria: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

## (DRAFT) *NQF 0105 - (Additional) Anti-depressant medication management: (a) Effective Acute Phase Treatment,(b)Effective Continuation Phase Treatment

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE.

**Measure:** NQF 0105 (Additional Measurement)

**Measure**: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b)Effective Continuation Phase Treatment

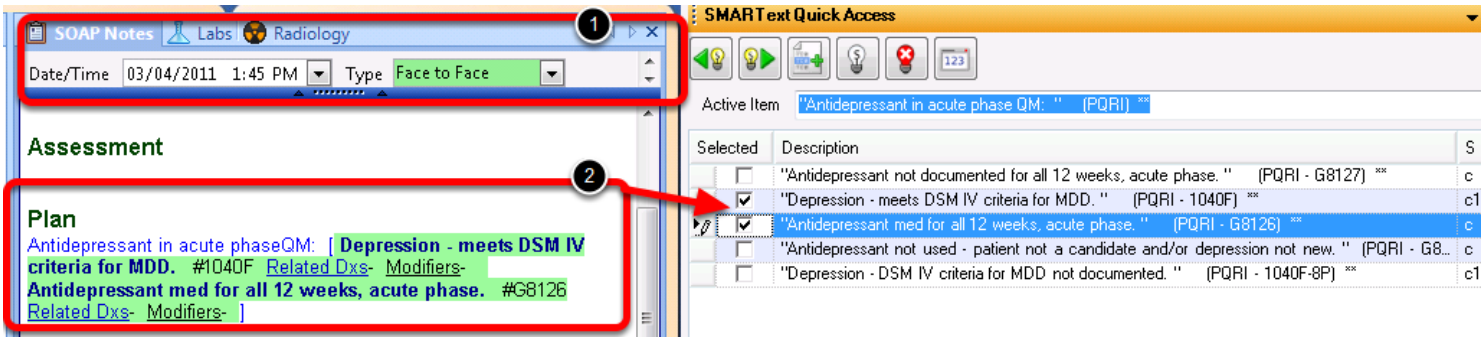
**Measure Description**: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

***REQUIRED FOR MEANINGFUL USE (MU): Click here to view the Meaningful Use Criteria.**

### *Note:

**At this time, we do not suggest that SOAPware users select this particular quality measure. We are in the process of adjusting the work flow and reporting in order to be more consistent with the reporting requirements.**

### Quality Measure Documentation Workflow




1. Patient's must be 18 years of age or older, diagnosed witha new episode of Major Depression during the reporitng period and had a Face-to-Face enounter with the provider. Patien'ts must have been treated with antidepressant medication AND who remained on an antidepressant medication treatment.
2. CPT codes, 1040F or G8126 must display in either the Encounter Plan field or the Summary Interventions field. Using the shortcut code, "**PQRIdepMed**" will insert the pick list header, "**Antidepressant in acute phaseQM**:" Clicking on the header will display a list of items in SMARText Quick Access that meet the criteria. Click to check, "Antidepresseants med for all 12 weeks, acute phase, " (PQRI - G8126) AND "Depression - meets DSM IV criteria for MDD" (PQRI - 1040F)

## Measurement Calculation Details

**Numerator Calculation:**

The numerator for this measurement is calculated based onthe following:

1. Number of patients that have documentation of the CPT code G8126 in the Encounter Plan field or the Summary Interventions field during the reportin period.

**Denominator Calculation:**

The denominator for the measurement is calculated based on the following:

1. The number of patients 18 years of age or older and has had a Face-to-Face encounter with the provider within the reporting period
2. AND have documentation of the CPT code 1040F in the Encounter Plan Field or the Summary Interventions field.

## Report Clinical Quality Measures to CMS/States

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

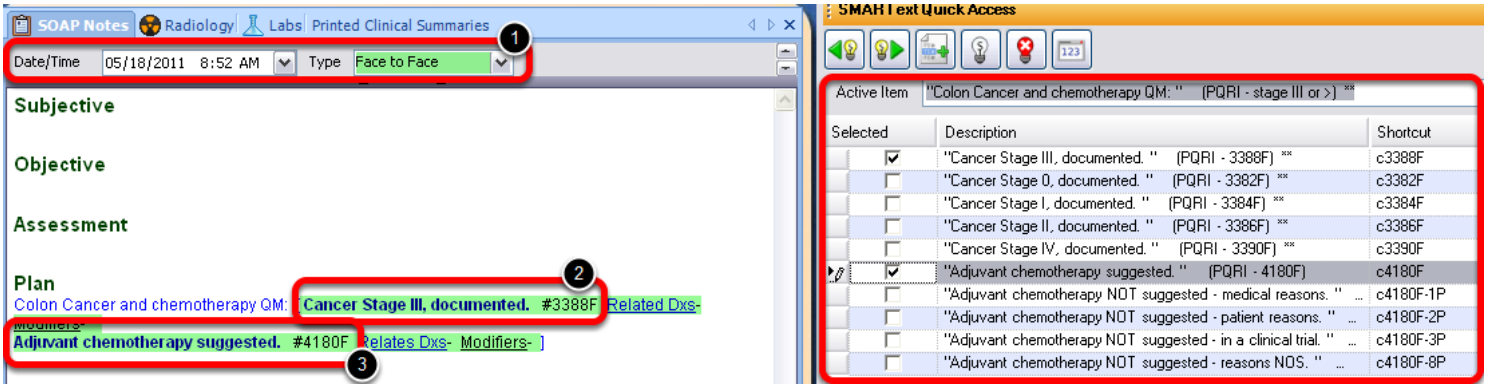
## NQF 0385 (Additional): Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

**Measure**: NQF 0385 (Additional Measurement)

**Measure Title**: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

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

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be at least **18 years or older** at the start of the reporting period and have at least one **face-to-face encounter** with the provider during the reporting period.

2. Documentation that the patient has Stage IIIAthrough IIIC colon cancer. Inserting the shortcut code "**PQRIcol**" in the **encounter Plan** or **Summary Interventions** field will allow the user to select from a group of specific SMARText codes that can be used to document for this measure. The encounter Plan or Summary Interventions field must include the following code to document Stage IIIAthrough IIIC colon cancer: **3388F**. ***Note**: 3382F, 3384F, 3386F and 3390F will not increase the denominator.

3. Documentation that the patient was referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy , or has previously received adjuvant chemo therapy within the 12 month reporting period. Inserting the shortcut code "**PQRIcol**" in the **encounter Plan** or **Summary Interventions** field will allow the user to select from a group of specfic SMARText codes that can be used to document for this measure. The encounter Plan or Summary Interventions field must include the following code to document that adjuvant chemotherapy has been suggested: **4180F**. ***Note:**

4180F-1P, 4180F-2P, 4180F-3P and 4180F-8P will not increase the numerator.

**If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient is 18 years or older with stage IIIA through IIIC colon cancer during the 12 month reporting period, have been referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or has previously received adjuvant chemotherapy within the 12 month reporting period.*

## Measure Calculation Details

**Numerator Calculation**:

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator for whom adjuvant chemotherapy has been suggested and document by using SMARText code **4180F** in the encounter Plan or Summary Interventions field. The pick list "PQRIcol" can be used to document this.
***Note:** 4180F-1P, 4180F-2P, 4180F-3P and 4180F-8P will not increase the numerator.

**Denominator Calculation**:

The denominator for this measure is calculated based on the following:

1. The number of patients that were at least 18 at the start of the reporting period and have at least one face-to-face encounter with the provider during the reporting period;

2. And have documentation of Stage III Colon Cancer by using SMARText code **3388F** in the encounter Plan Field or Summary Interventions field. The pick list "PQRIcol" can be used to document this.
***Note**: 3382F, 3384F, 3386F and 3390F will not increase the denominator.

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

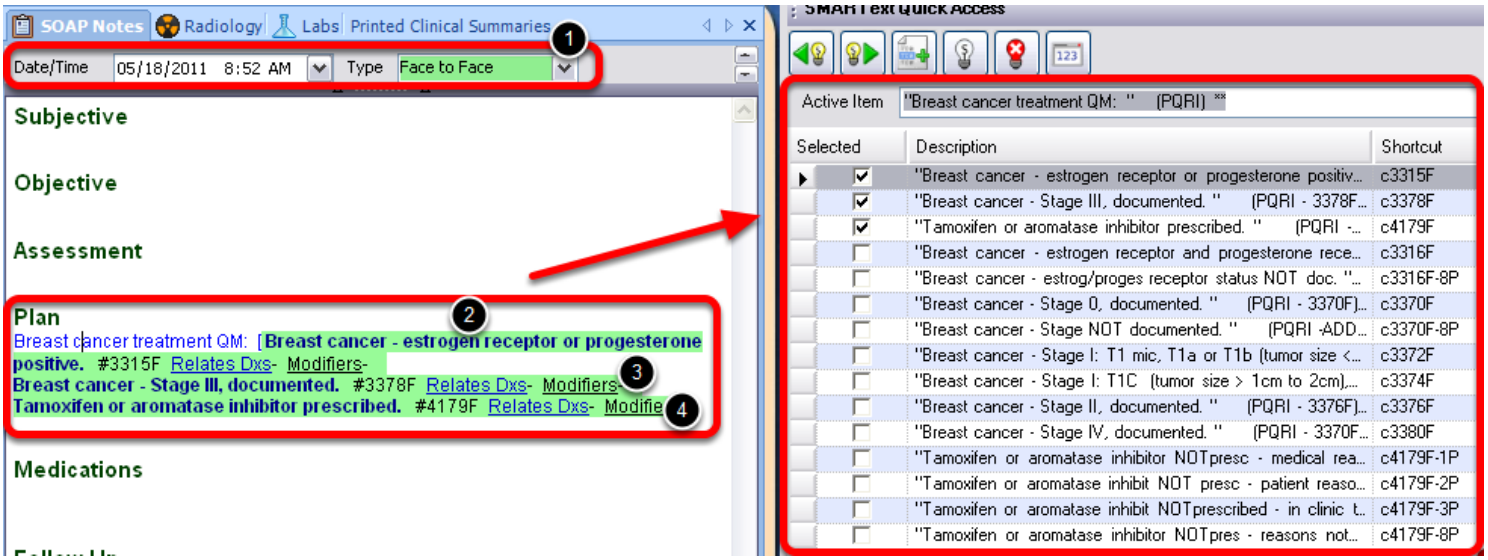
## NQF 0387 - (Additional) Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen

**Measure**: NQF 0387 (Additional Measurement)

**Measure Title**: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen

**Measure Description**: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. The patient must be at least **18 years or older** at the start of the reporting period and have at least one **face-to-face encounter** with the provider during the reporting period.

2. Documentation that the patient has stage IC-IIIC estrogen receptor/progesterone receptor positive breast cancer. Inserting the shortcut code "**PQRIbreCan**" in the **encounter Plan** field will allow the user to select from a group of specific SMARText codes that can be used to document for this measure. The encounter Plan field must include the following codes to document estrogen receptor or progesterone recptor positive breast cancer: **3315F**. ***Note**: 3316F and 3316F-8P will not increase the denominator.

3. Documentation that patient has stage IC-IIIC breast cancer. Inserting the shortcut code "**PQRIbreCan**" in the **encounter Plan** field will allow the user to select from a group of specific SMARText codes that can be used to document for this measure. The encounter Plan field must

include one of the following codes to document breast cancer: **3370F, 3372F, 3374F, 3376F or 3380F**. ***Note**: 3370F-8P will not increase the denominator.

4. Documentation that the patient was prescribed tamoxifen or aromatase inhibitor. Inserting the shortcut code "**PQRIbreCan**" in the **encounter Plan** field will allow the user to select from a group of specfic SMARText codes that can be used to document for this measure. The encounter Plan field must include the following code to document that tamoxifen or aromatase inhibitor was prescribed: **4179F**. ***Note:** 4179F-1P, 4179F-2P, 4179F-3P and 4179F-8P will not increase the numerator.

**If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient is over the age of 18, has been seen at least once in the reporting period, has a diagnosis of Breast Cancer and Tamoxifen or aromatase inhibitor was not prescribed.*

## Measure Calculation Details

**Numerator Calculation**:

The numerator for this measure is calculated based on the following:

1. The number of patients in the denominator who have documentation that the patient was prescribed tamoxifen or aromatase inhibitor using the SMARText code **4179F** in the encounter Plan field. ***Note:** 4179F-1P, 4179F-2P, 4179F-3P and 4179F-8P will not increase the numerator.

**Denominator Calculation**:

The denominator for this measure is calculated based on the following:

1. The number of patients who are age 18 and older and have at least one face-to-face encounter with the provider during the reporting period;

2 And have a documentation of breast cancer estrogen receptor or progesterone positive using SMARText code **3315F** in the encounter Plan field; ***Note**: 3316F and 3316F-8P will not increase the denominator.

3. And have documentation of Stage IC-IIIC breast cancer using one of the following SMARText codes in the encounter Plan field: **3370F, 3372F, 3374F, 3376F or 3380F**. ***Note**: 3370F-8P will not increase the denominator.

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

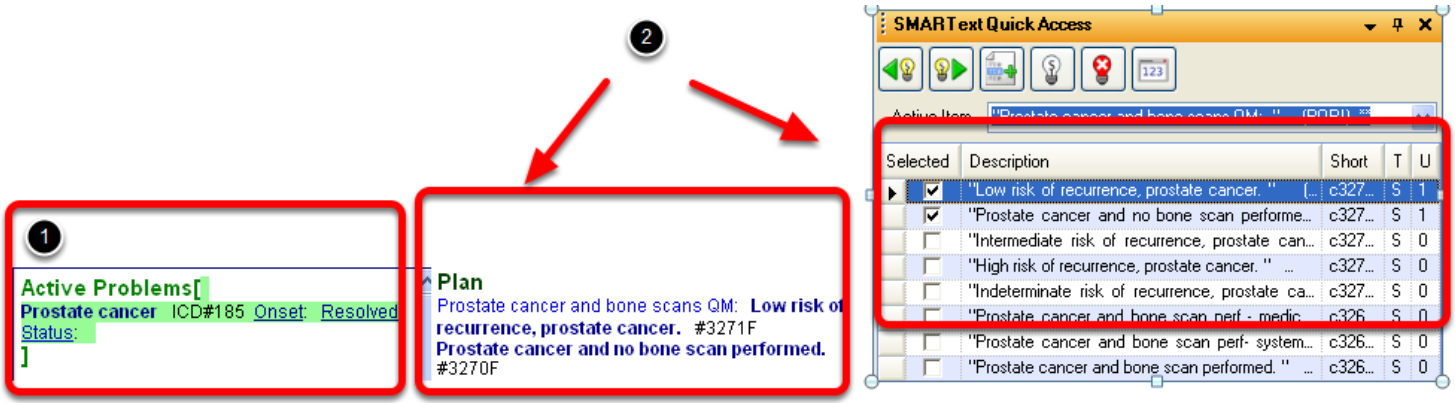
## NQF 0389 (Additional): Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

**Measure**: NQF 0389 (Additional Measurement)

**Measure Title**: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

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

### Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Percentage of patient's, regardless of age, **with a diagnosis of prostate cancer** at low risk of recurrence, receiving interstitial prostate brachytherapy, Or external beam radiotherapy to the prostate, Or radical prostatectomy, Or cryotherapy whom did not have a bone scan performed at any time since diagnosis of prostate cancer.
2. The CPT codes **3270F** and **3271F** **must display in the encounter Plan field**. This can be documented by using the shortcut code, "PQRIproBon" in the encounter Plan field will insert the pick list header, "Prostate cancer and bone scans QM:" Clicking on the pick list header will display a list of items in SMARText Quick Access that meet the criteria. See the screen shot that displays the appropriate selections.

**If the above is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient has a diagnosis prostate cancer at low risk, has been seen as least once during the reporting period and receiving interstitial prostate brachytherapy,*

*OR external beam radiotherapy to the prostate, Or radical prostatectomy, Or cryotherapy whom did not have a bone scan performed at any time since diagnosis of prostate cancer.*

## Measurement Calculation Details

**Numerator Calculation**:

The numerator for this measurement is calculated based on the following:

1. The number of patients with a **diagnosis of prostate cancer** with **a face to face encounter** within the reporting period
2. Whom have not had a bone scan performed documented by placing CPT code **3270F** in the **Plan field.**

**Denominator Calculation**:

The denominator for this measurement is calculated based on the following:

1. The number of Patients with a **face to face encounter** within the reporting period;
2. AND have a diagnosis of **Prostate Cancer at low risk of recurrence receiving interstitial prostate brachytherapy.**

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.

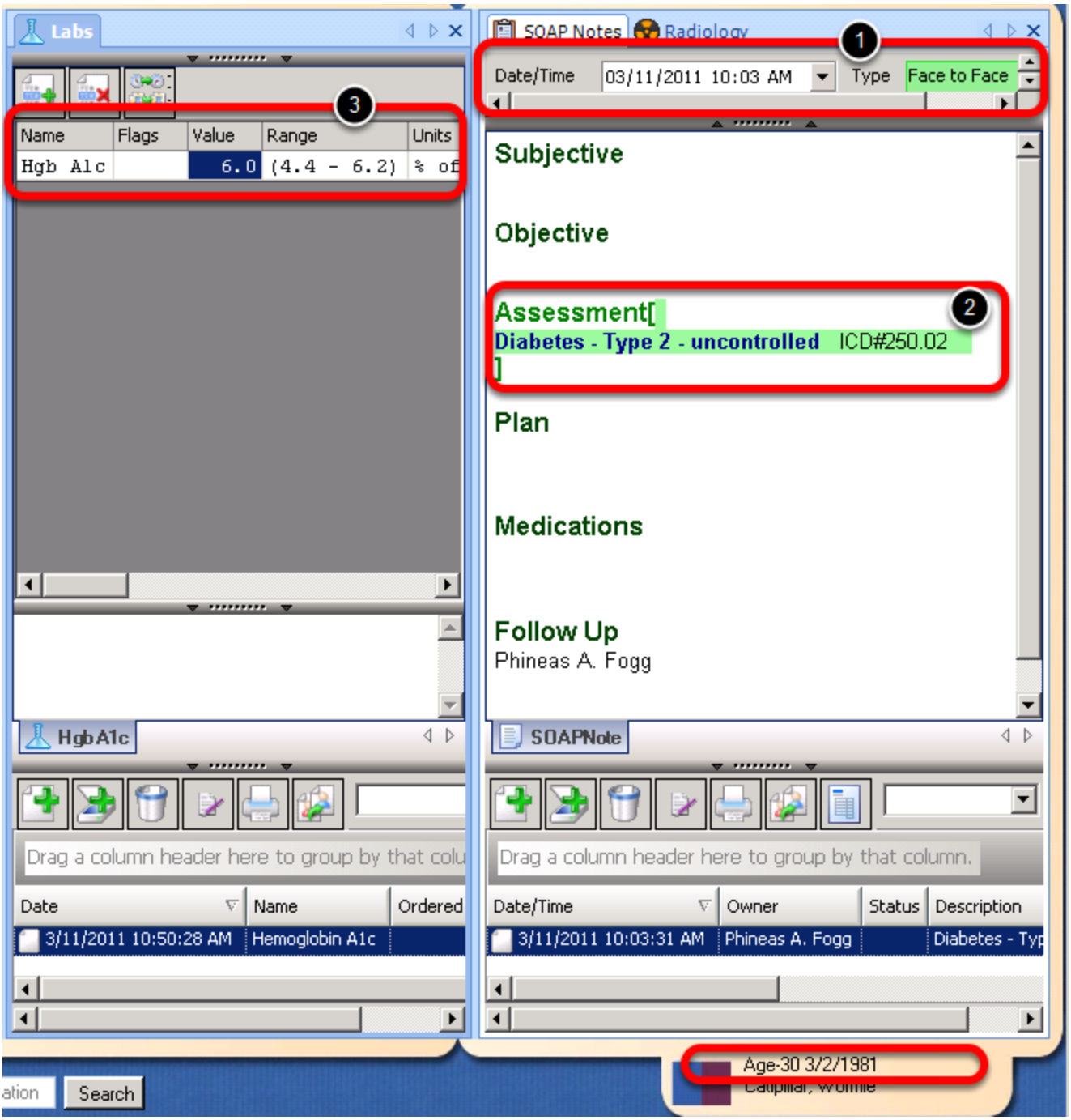
## NQF 0575 (Additional): Diabetes: Hemoglobin A1c Control (<8.0%)

**Measure**: NQF 00575 (Additional Measurement)

**Measure Title**: Diabetes: HbA1c Control (<8%)

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

## Quality Measure Documentation Workflow




In Order for the Clinical Quality Measure report to generate, the following must be documented in the relevant patient's chart:

1. Patients must be between the ages of **18 and 75** with a face to face encounter within the reporting period.

2. Patient must have a diagnosis of **Diabetes Type I or Type 2.** The summary Active Problems field or the encounter Assessment field must contain on of the following **ICD** codes: **250, 250.0,**

**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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04**

2. Patients must have the most recent **Hemoglobin A1c** value of **less than 8.0.** ***Note: Lab test name must be exactly "Hgb A1c" in order for the quality measure report to calculate it in the numerator (this include HL7 lab test names).***

****It is recommended that users add a lab item to the chart if the test was performed at a different facility.**

**If the above measure is documented appropriately, this should increase the numerator and denominator for this measure to indicate that the patient has a diagnosis of Diabetes Type 1 or Type 2, has been since at least once in the reporting period, and the most recent documented Hemoglobin A1c is less than 8.0.*

## Measurement Calculation Details

**Numerator Calculation**:

The numerator for this measurement is calculated based on the following:

1. The number of patients in the denominator with a most recent **Hemoglobin A1C that was less than 8%**. (The name of the specific lab test must read exactly "**Hgb A1c**" om prder for them to be included in the numerator)

**Denominator Calculation**:

The denominator for this measurement is calculated based on the following:

1. The number of patients **between the ages of 18 and 75** during the reporting period with **a face to face encounter**;

2. AND Have one or more of the following **ICD codes** in the Summary Active Problems or Encounter Assessments Field: **250, 250.0, 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, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04**

## Report Clinical Quality Measures to CMS/Status

All of the items listed in the above steps need to be documented as structured data (as detailed above) in order to allow the user to capture the numerator, denominator and percentage for this quality measure.

For information on how to export the numerator, denominator and percentage for each Clinical Quality Measure, click here.

For more information on reporting clinical quality measures, click here.