

Clinical Quality Measures (2011)



Clinical Quality Measures (2011)

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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 SMARTText 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 "PQRltob".

* **0028b:** [Preventive Care and Screening Measure Pair: \(b\) Tobacco Cessation Intervention](#)

The shortcut code that has been created for this measure is "PQRlqui".

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

The shortcut code that has been created for this measure is "PQRlbmi."

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 "PQRlwei".

NQF 0038 (Alternate Core): [Childhood Immunization Status](#)

NQF 0041/PQRI 110 (Alternate Core): Preventative Care and Screening: Influenza Immunization for Patients \geq 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 "PQRlastAss".

NQF 0002/PQRI 66: Appropriate Testing for Children with Pharyngitis

The shortcut code that has been created for this measure is "PQRlpha".

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 "PQRlche".

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

The shortcut code that has been created for this measure is "PQRlpreHIV".

NQF 0014: Prenatal Care: Anti-D Immune Globulin

The shortcut code that has been created for this measure is "PQRlantD".

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 "PQRlchl".

NQF 0034/PQRI 113: Colorectal Cancer Screening

The shortcut code that has been created for this measure is "PQRlpreCol".

NQF 0036: Use of Appropriate Medications for Asthma

The shortcut code that has been created for this measure is "PQRlastThe".

NQF 0043/PQRI 111: [Pneumonia Vaccination Status for Older Adults](#)

The shortcut code that has been created for this measure is "PQRlpne".

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 "PQRllowBacl".

NQF 0055/PQRI 117: [Diabetes: Eye Exam](#)

The shortcut code that has been created for this measure is "PQRldmEye".

NQF 0056/PQRI 163: [Diabetes: Foot Exam](#)

The shortcut code that has been created for this measure is "PQRldmFoo".

NQF 0059/PQRI 1: [Diabetes: HbA1c Poor Control](#)

The shortcut code that has been created for this measure is "PQRldmA1c".

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 "PQRldmNep".

NQF 0064/PQRI 2: [Diabetes: LDL Management & Control](#)

The shortcut code that has been created for this measure is "PQRldmLDL".

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 "PQRlcadPla".

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 "PQRlivd".

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 "PQRlcadBB".

NQF 0073/PQRI 201: [Ischemic Vascular Disease \(IVD\): Blood Pressure Management](#)

The shortcut code that has been created for this measure is "PQRlivd".

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 "PQRlvd".

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 "PQRlhfACE".

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 "PQRlhfBB".

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

The shortcut code that has been created for this measure is "PQRlhfWar".

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 "PQRldmEye".

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 "PQRldepMed".

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 "PQRlcol".

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 "PQRlbreCan".

NQF 0389/PQRI 102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

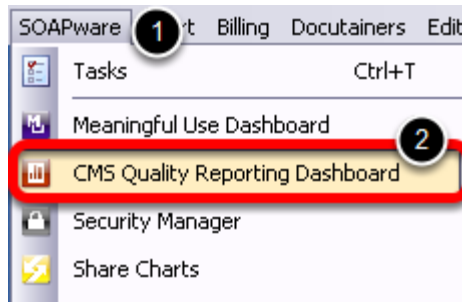
The shortcut code that has been created for this measure is "PQRlproBon".

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

How to Use the CMS Quality Reporting Dashboard

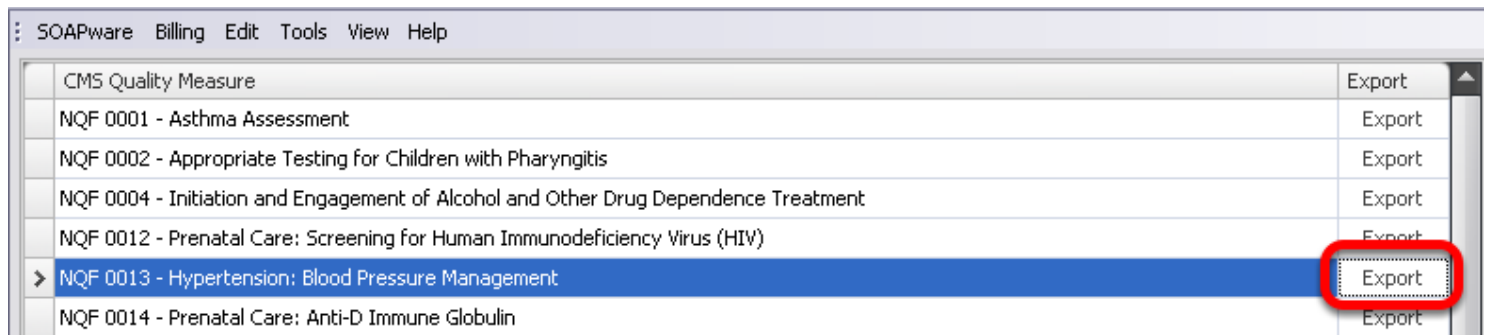
This lesson is designed to walk the user through the steps of exporting Quality Measures data for reporting.

CMS Quality Reporting Workspace



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

Clinical Quality Measures Export

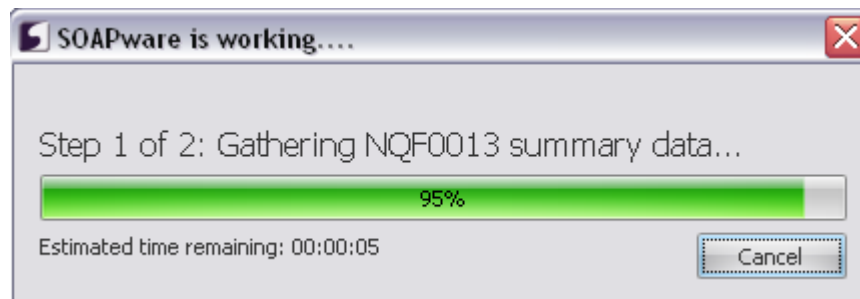


To export the data for a specific clinical quality measure, locate the quality measure to export and Click the Export button.

Select the Reporting Period

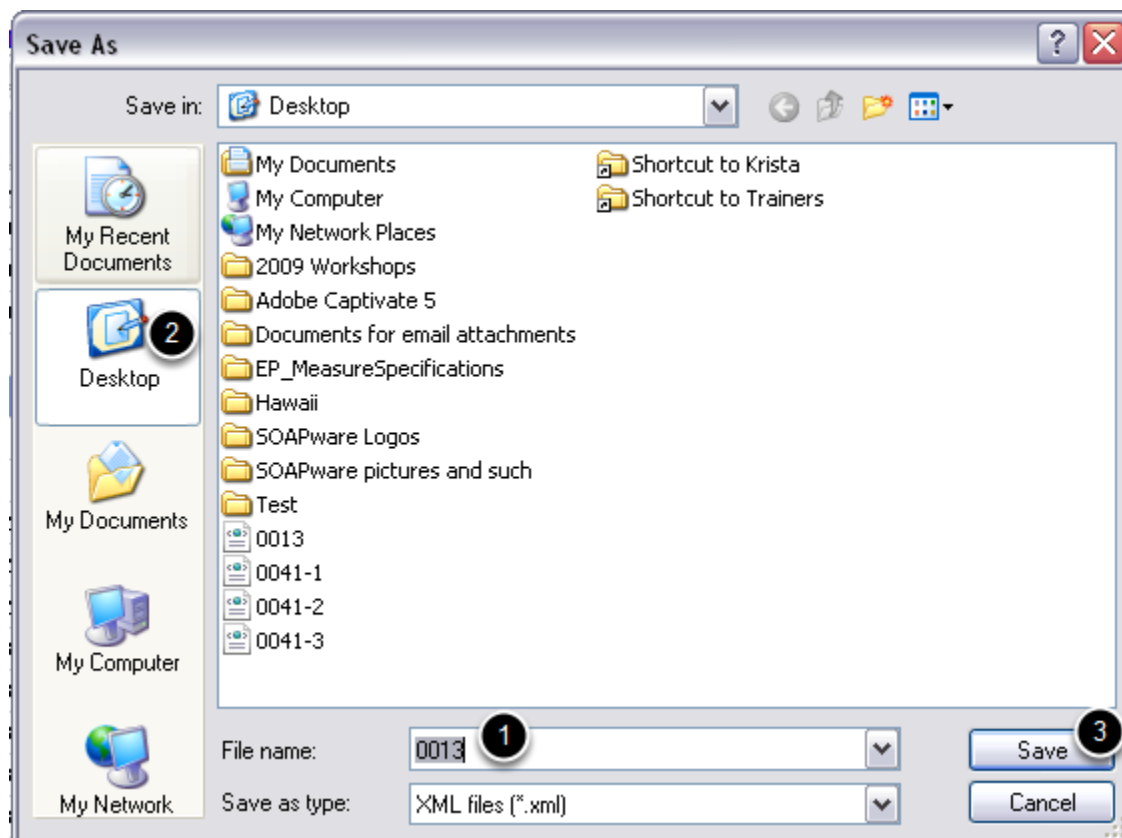


1. To select the reporting period for the export, choose the Custom option and enter the desired reporting period.
2. Click the Create button to begin the export.



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

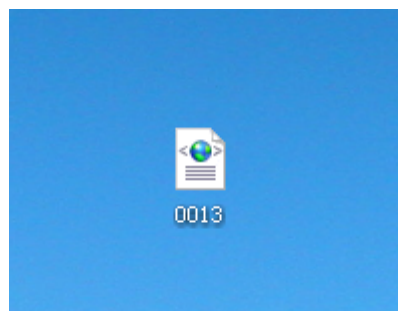
Saving the Export Results



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.

```

<?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>
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  <performance-rate>50</performance-rate>
</pqri-measure>
</provider>
</measure-group>
- <measure-group ID="X">
- <provider>
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  <encounter-to-date>06-30-2011</encounter-to-date>
- <pqri-measure>
  <pqri-measure-number>NQF0013</pqri-measure-number>
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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

2 **Active Problems**
Benign hypertension ICD#401.1

Inactive Problems
Breast cancer ICD#174.9 right breast, in remission for 10 years.
Surgeries
Mastectomy: right. 1998.
Cholecystectomy. 2 years ago, no compl.
Medications
Coumadin (Warfarin): Strength- 5 mg (tablet) SIG- as directed once a day
Metformin (Glucophage): Strength- 500 mg (tablet) SIG- 1 each 2 times a day
Diovan HCT (Valsartan/HCTZ): Strength- 12.5 mg-80 mg (tablet) SIG- 1 each once a day
Metoprolol (Lopressor): Strength- 1 mg/mL (solution) SIG- 1 each 2 times a day
Aspirin: Strength- 81 mg (tablet) SIG- 1 each once a day
Plavix (Clopidogrel): Strength- 75 mg (tablet) SIG- 1 each once a day
Allergies
Drug Allergies. No Known. (ID-Ignore) Drug Allergies. No Known. (ID-Ignore)
HYDROCODONE - (e.g. VICODIN): nausea and rash
Family History
Positive family history for - Strokes -Cerebrovascular Disease;; Coronary artery disease: on both sides
Tobacco
Smoker Status:
Tobacco use:
Tobacco cessation:
No exposure to tobacco. none/nothing

3

	Graph	1/21/2011 2:26:39 PM	12/21/2010 2:32:51 PM
Blood Pressure		128/82	132/80
BMI			
Head Circum			
Height			
Pulse Rate			
Res Rate			
Temperature			
Weight			
Notes			

1

Subjective
CHIEF COMPLAINT: Hypertension, uncomplicated.
HPI: SYMPTOMS/RELATED: Reports symptoms of asymptomatic.
QUALITY/COURSE: Reports condition is controlled with medicine.
INTENSITY/SEVERITY: Reports measurement (or degree) as moderate.
MODIFIERS/TREATMENTS: Has tried taking medication, to follow recommended diet.
History of No significant side effects from the medicine ,
ADDITIONAL COMPLAINT: Diabetes - Non-insulin dependent
HPI: SYMPTOMS/RELATED: Reports symptoms of asymptomatic.
QUALITY/COURSE: Reports condition is controlled with medicine.
INTENSITY/SEVERITY: Reports measurement (or degree) as moderate.
MODIFIERS/TREATMENTS: Has tried taking medication, to follow recommended diet.
History of No significant side effects from the medicine ,
ADDITIONAL COMPLAINT: Hyperlipidemia
HPI: SYMPTOMS/RELATED: Reports symptoms of asymptomatic.
QUALITY/COURSE: Reports condition is controlled with medicine.
INTENSITY/SEVERITY: Reports measurement (or degree) as moderate.
MODIFIERS/TREATMENTS: Has tried taking medication, to follow recommended diet.
History of No significant side effects from the medicine ,
ROS: LUNGS/Respiratory: Denies symptoms such as dyspnea.

Date/Time	Owner	Status	Description
1/21/2011 2:28:32 PM	Kaye L. Yocham		Hypertension
12/21/2010 2:31:25 PM	Kaye L. Yocham		Influenza

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. A diagnosis 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 SummaryActive 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

Family History

Tobacco
Smoker Status:
Tobacco - current smoker, #1034F
Tobacco cessation:

Alcohol

Interventions

Social History

ROS

Physical

Assessment
Chronic obstructive pulmonary disease ICD#496 Onset: 1/31/2011 Status: Active

Plan
Tobacco use QM: [Tobacco - current smoker, #1034F]

Medications

Follow Up

SOAP Note

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description
2/1/2011 3:13:04 PM	Krista Laningham	Chronic obstructive	
1/31/2011 10:43:24 AM	Krista Laningham	Chronic obstructive	

Active Item: Tobacco use QM: " (PQRI)

Selected	Description	Shortcut	Typ	Usa
<input type="checkbox"/>	"Tobacco use assessed, " (PQRI - 1000F),	c1000F	ST	1
<input type="checkbox"/>	"Tobacco use NOT assessed - reason not s...	c1000F-8P	ST	1
<input checked="" type="checkbox"/>	"Tobacco - current smoker, " (PQRI - 1034F)	c1034F	ST	1
<input type="checkbox"/>	"Tobacco - Smokeless tobacco user, " (P...	c1035F	ST	1
<input type="checkbox"/>	"Tobacco non-user, " (PQRI - 1036F - G8...	c1036F	ST	1

Shortcut code: TOBmu and PQRItob

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

Summary Demographics SOAP Notes Labs Radiology

Date/Time: 03/12/2011 11:03 AM Type: Face to Face

Objective

Assessment
Nicotine Dependence ICD#305.10

Plan
Tobacco cessation QM: Tobacco - current smoker. #1034F

Medications

SOAPNote

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Rel
3/12/2011 11:03:17 AM	Krista Laningham		Nicotine ...	Nico
3/12/2011 11:03:11 AM	Krista Laningham			

SMART Text Quick Access

Active Item: "Tobacco cessation QM. " (PQRI) "

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Tobacco - current smoker. " (PQRI - 1034F - G...	c1034F
<input type="checkbox"/>	"Tobacco - Smokeless tobacco user. " (PQRI ...	c1035F
<input type="checkbox"/>	"Tobacco non-user. " (PQRI - 1036F - G8457) "	c1036F
<input type="checkbox"/>	"Tobacco use cessation intervention, counseling. "	c4000F
<input type="checkbox"/>	"Tobacco use cessation interven, NOT counsel - r...	c4000F-8P
<input type="checkbox"/>	"Tobacco use cessation intervention, pharmacolog...	c4001F

Shortcut code: TOBmu & PQRIqui

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, "PQRlqui" 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

The screenshot displays the SOAPware clinical documentation interface. On the left, the Vital Signs chart shows BMI as 39.3. The central SOAP Note editor has the Plan section containing the text: "BMI Screening and F/U QM: BMI above normal and a follow-up plan is documented. #G8417". On the right, the SMARTText Quick Access panel shows a list of shortcuts, with "BMI above normal and a follow-up plan is documented. (PQRI... cG8417" highlighted. A black box displays the shortcut code "PQRlbmi".

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, **"PQRlbmi"** 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 PQRlbmi 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 SMARTText 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>111111111</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>
  <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>
- <measure-group ID="X">
- <provider>
  <npi>111111111</npi>
  <encounter-from-date>01-01-2011</encounter-from-date>
  <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>
  <reporting-rate>100</reporting-rate>
  <performance-rate>0</performance-rate>
</pqri-measure>
</provider>
```

Provider NPI Number
Reporting Period Selected
Population Criteria/ 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

The screenshot displays the SOAPware interface with the following components:

- Vital Signs Section:** A table showing patient data for "Test, Jessa". The BMI field is highlighted with a red box and a circled number 4.
- SOAP Note Section:** The Plan field is highlighted with a red box and a circled number 2. The text "Exercise class and/or counseling. #S9451" is highlighted with a red box and a circled number 3.
- SMART Text Quick Access Panel:** A list of shortcuts is shown. The "Weight counseling QM. " (PQRI - NQF24) is selected. A red box highlights the list, and a black box below it contains the text "Shortcut code: PQRIwei".
- Bottom Section:** A table with columns Date/Time, Owner, Status, and Description. The first row is highlighted with a red box and a circled number 1.

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 "**PQRlwei**" 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.

SOAP Notes

Radiology

Labs

Date/Time

03/17/2011 11:50 AM

Type

Face to Face

Owner

Phineas A. Fogg

Assessment

Well child care - 3 year ICD#V20.2

Plan

DTAP VACCINE, < 7 YRS, IM. CPT 90700 [Related Dxs-](#)

POLIOVIRUS, IPV, SC/IM. CPT 90713 [Related Dxs-](#)

MMR VACCINE, SC. CPT 90707 [Related Dxs-](#)

HIB VACCINE, HBOC, IM. CPT 90645 [Related Dxs-](#)

CHICKEN POX VACCINE, SC. CPT 90716 [Related Dxs-](#)

HEPATITIS B IMMUNE GLOBULIN, IM. CPT 90371 [Related Dxs-](#)

HEP A VACC, PED/ADOL, 2 DOSE. CPT 90633 [Related Dxs-](#)

FLU VACCINE, 3 YRS, IM. CPT 90657 [Related Dxs-](#)

ROTOVIRUS VACC 3 DOSE, ORAL. CPT 90680 [Related Dxs-](#)

PNEUMOCOCCAL VACC, PED <5. CPT 90669 [Related Dxs-](#)

DTAP-HIB-IP VACCINE, IM. #90698 [Related Dxs-](#) [Modifiers-](#)

MMRV VACC, SC. CPT 90710 [Related Dxs-](#)

Medications

SOAPNote

+

+

+

+

+

+

+

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Related Dx	Type
3/17/2011 11:50:31 AM	Phineas A. Fogg				Face

Age-3 3/2/2008

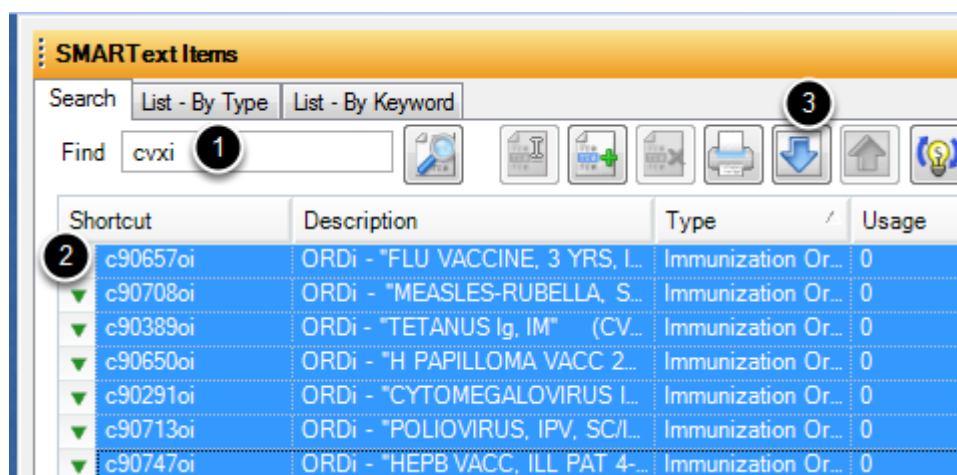
Catipillar, Wormie

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, Pneumonia**) 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 (pre 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 they 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 \geq 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

The screenshot displays the SOAPware interface. On the left, the 'Plan' field in the SOAP Note is highlighted with a red box and labeled with a circled '2'. It contains the text 'Influenza QM: [Administration of Influenza Virus Vaccine. #G0008]'. A red arrow points from this field to the 'SMART Text Quick Access' window on the right. This window has a search bar with 'Influenza QM: ' and a 'Shortcut code: InfQM' box. Below is a table of search results.

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Administration of Influenza Virus Vaccine" (G0008) **	cG0008
<input type="checkbox"/>	"FLU VACCINE NO PRESERV 3 & > " (INJECTION - Flu Vaccine (no pres...	c90656
<input type="checkbox"/>	"FLU VACCINE NO PRESERV 6-35M" (INJECTION - Flu Vaccine (no pres...	c90655
<input type="checkbox"/>	"FLU VACCINE, NASAL " (Intranasal Flu Vac - 90660) **	c90660
<input type="checkbox"/>	"IMMUNIZATION ADMIN" (INJECTION - Administer Immunization - 90471...	c90471
<input type="checkbox"/>	"FLU VACCINE, 3 YRS & >, IM" (INJECTION - Flu Vac, 36 Months & > IM...	c90658
<input type="checkbox"/>	"FLU VACCINE, 3 YRS, IM" (INJECTION - Flu Vac 6-35 Months, IM - 906...	c90657
<input type="checkbox"/>	"Influenza immunization administered" (G8482 - 4037F) **	cG8482
<input type="checkbox"/>	"Influenza immunization NOT administered - DOCUMENTED REASONS" ...	cG8483
<input type="checkbox"/>	"Influenza immunization NOT administered - REASONS NOT SPECIFIED" ...	cG8484

At the bottom of the SOAP Note, a table is highlighted with a red box and labeled with a circled '1'. It has columns for Date/Time, Owner, Status, Description, Related Dx, and Encounter Type. The first row shows data for 2/28/2011 10:43:15 AM, Krista Laningham, Face to Face.

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

NQF 0041 - Preventive Care and screening: Influenza Immunization for Patients >= 50 Years Old

Reporting Period

☐ 1/1/2011 - 6/30/2011

☐ 7/1/2011 - 12/31/2011

☐ 1/1/2011 - 12/31/2011

☒ Custom: 9/ 1/2010 to 2/28/2011

Example

Create Cancel

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

Active Problems
Extrinsic asthma w/o mention of status asthmaticus or acute exacerbation
ICD#493.00 Comment-

Inactive Problems

Surgeries

Medications

Allergies

Family History

Tobacco

Alcohol

Interventions

Objective

Assessment

Plan
Asthma assessment QM: [Asthma symptoms evaluation QM: Asthma night-time symptoms. Assessment of past history.]

SOAPNote

Drag a column header here to group by that column.

Date/Time	Owner	Status	Desc
3/2/2011 9:15:35 AM	Krista Laningham		
2/15/2011 9:15:26 AM	Krista Laningham		

SMART Text Quick Access

Active Item "Asthma assessment QM: " (PQRI) "

Shortcut code: PQRlastAss

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Asthma symptoms evaluation QM: " (PQRI) "	c1005F
<input type="checkbox"/>	"Asthma symptoms evaluation NOT performed - reasons other..."	1005F-8P

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. A diagnosis 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, **"PQRlastAss"**. 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 SummaryActive 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](#).

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

SOAP Notes | Labs | Radiology | New PT Paperwork

Date/Time: 03/03/2011 3:31 PM | Type: Face to Face

Subjective

Objective

Assessment
Antidepressant type abuse, unspecified ICD#305.80

Plan
Chemical dependency treatment QM: [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. #]

SOAPNote

Drag a column header here to group by that column.

Date/Time	Owner	Status	Description	Related Dx	Type
3/3/2011 3:31:49 PM	Krista Laningham	Antidepress...			Fac

SMAR Text Quick Access

Active Item: "Chemical dependency treatment QM: ' (PQR1)"

Select	Description	Shortcut	Type
<input checked="" type="checkbox"/>	"Chemical dependency with Tx in 14da...	c0004a	ST PL.
<input type="checkbox"/>	"Chemical dependency with NO Tx in 1...	c0004b	ST PL.

Shortcut code: PQR1che

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

The screenshot displays the SOAPware interface. On the left, the SOAP Note window shows the 'Plan' field with the text: 'Prenatal screening for HIV QM: [Patient has given birth in past 12 months and was screened for HIV during the first or second prenatal care visit. #]'. On the right, the SMART Text Quick Access window is open, showing a list of criteria. A callout box indicates the shortcut code: PQRipreHIV. The list of criteria includes:

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Patient has given birth in past 12 months and HIV screened at 1st or 2nd prenatal visit." (PQRI) **	c0012b
<input type="checkbox"/>	"Patient has not given birth in past 12 months." (PQRI) **	c0012a
<input type="checkbox"/>	"Patient has given birth in past 12 months and HIV NOT screened prenatal visit." (PQRI) **	c0012c

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 (regardless 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

SOAP Notes | Labs | Radiology | New PT Paperwork

Date/Time: 03/07/2011 10:30 AM | Type: Face to Face

Subjective

Objective

Assessment
RhD negative

Plan
Prenatal anti-D immune globulin QM: [Patient has given birth in past 12 months and did receive anti-D immune globulin between 26-30 weeks gestation. #]

SMARText Quick Access

Active Item: "Prenatal anti-D immune globulin QM: '' (PQRI) "

Shortcut code: PQRIantD

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Patient has given birth in past 12 months and received RhoGam. " (PQRI) "	c0014b
<input type="checkbox"/>	"Patient has not given birth in past 12 months. " (PQRI) "	c0012a
<input type="checkbox"/>	"Patient has given birth in past 12 months and did NOT receive RhoGam. " (PQRI) "	c0014c

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 (regardless 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](#).

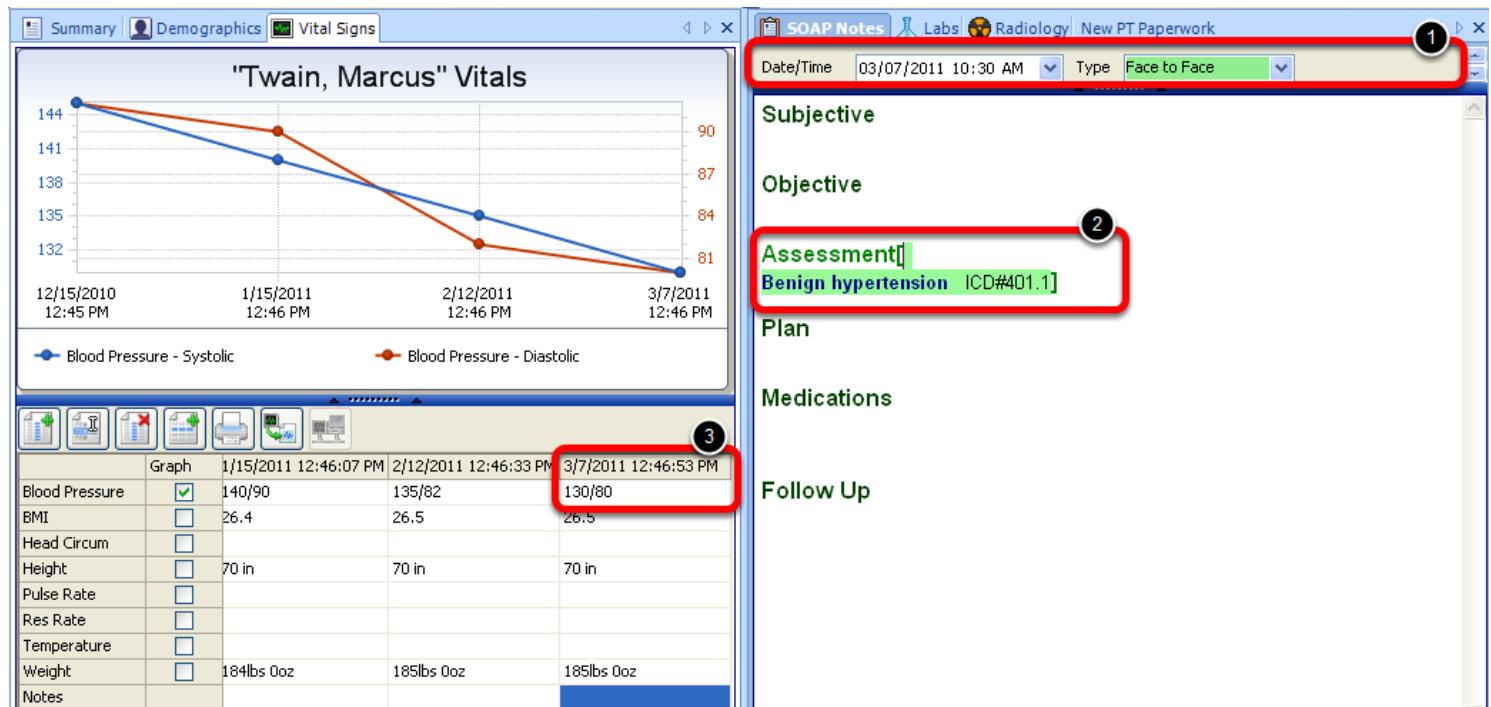
NQF 0018 (Additional): Controlling High Blood Pressure

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. A diagnosis 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

Selected	Description	Shortcut
<input type="checkbox"/>	"Tobacco use assessed." (PQRI - 1000F) **	c1000F
<input type="checkbox"/>	"Tobacco use NOT assessed - reason not specified " (PQRI -ADD MODIFIER- 1000F-8P) **	c1000F-8P
<input checked="" type="checkbox"/>	"Tobacco - current smoker." (PQRI - 1034F - G8455) **	c1034F
<input type="checkbox"/>	"Tobacco - Smokeless tobacco user." (PQRI - 1035F - G8456) **	c1035F
<input type="checkbox"/>	"Tobacco non-user." (PQRI - 1036F - G8457) **	c1036F
<input type="checkbox"/>	"BEHAV CHNG SMOKING 3-10 MIN" (Cessation Counseling, 3 - 10 min - 99406, G8402) **	c99406
<input type="checkbox"/>	"BEHAV CHNG SMOKING < 10 MIN " (Cessation Counseling < 10 min - 99407, G8402) **	c99407
<input type="checkbox"/>	"Tobacco/Smoking cessation counseling 3-10" (G0375) **	cG0375
<input type="checkbox"/>	"Tobacco/Smoking cessation counseling >10 min." (G0376) **	cG0376
<input type="checkbox"/>	"Tobacco - COPD pt with NO smoking cessation intervention." (G8094) **	cG8094
<input checked="" type="checkbox"/>	"Tobacco (smoke) use cessation intervention, counseling." (G8402) **	cG8402
<input type="checkbox"/>	"Tobacco (smoker) use and No cessation intervention, counseling." (G8403) **	cG8403
<input type="checkbox"/>	"Tobacco/Smoking cessation counseling." (G9016) **	cG9016
<input type="checkbox"/>	"Tobacco/Smoking cessation gum therapy advised." (S4995) **	cS4995
<input type="checkbox"/>	"Tobacco/Smoking cessation treatment (with medication)." (S9075) **	cS9075
<input type="checkbox"/>	"Tobacco/Smoking cessation class" (S9453) **	cS9453

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

The screenshot shows the SOAPware 2011 interface. The top bar displays 'SOAPware 2011 - Patient: Bell, Mary C. - User: Phineas A. Fogg - Provider: Phineas A. Fogg'. The main window is divided into three panes. The left pane shows 'Patient Information' with fields for Title, First, Middle, Last, SSN, Birth Date, Age, Marital Status, Gender, Race, Ethnicity, and Address. The 'Age' field is highlighted with a red box and a circled '1'. The middle pane shows 'SOAP Notes' with sections for Subjective, Objective, Assessment, Plan, and Medications. The 'Plan' section is highlighted with a red box and a circled '2'. The right pane shows 'SMART Text Quick Access' with a table of CPT codes. The table has columns for 'Select', 'Description', 'Shortcut', 'T', and 'U'. The first row is highlighted with a red box and a circled '3'.

Select	Description	Shortcut	T	U
<input checked="" type="checkbox"/>	"MAMMOGRAPHY, CAD" ...	c77052	S	1
<input type="checkbox"/>	"Screening Mammogram,..."	c77057	S	1
<input type="checkbox"/>	"Screening mammo NOT..."	c3014F...	S	1
<input type="checkbox"/>	"Screening mammograph..."	cG0202	S	0
<input type="checkbox"/>	"Screening mammogram..."	c3014F	S	0
<input type="checkbox"/>	"Screening mammo NOT..."	c3014F...	S	0

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 SMART Text 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

The screenshot displays the SOAPware interface with three main sections:

- Patient Information:** Fields for Title, First, Middle, Last, SSN, Birth Date, Age (highlighted with a red box and number 1), Marital Status, Race, Ethnicity, and Address.
- SOAP Notes:** Fields for Subjective, Objective, Assessment, Plan (highlighted with a red box and number 2), Medications, and Follow Up. The Plan field contains the text "Cervical Cancer Screening QM: []".
- SMART Text Quick Access:** A list of CPT codes and descriptions (highlighted with a red box and number 3). The list includes codes 88141 through 88175, with descriptions such as "CYTOPATH, C/V, INTERPRET", "CYTOPATH, C/V, THIN LAYER", "CYTOPATH, C/V, THIN LAYER REDO", "CYTOPATH, C/V, AUTOMATED", "CYTOPATH, C/V, AUTO RESCREEN", "CYTOPATH, C/V, MANUAL", "CYTOPATH, C/V, AUTO REDO", "CYTOPATH, C/V, REDO", "CYTOPATH, C/V, SELECT", "CYTOPATH TBS, C/V, MANUAL", "CYTOPATH TBS, C/V, REDO", "CYTOPATH TBS, C/V, AUTO REDO", "CYTOPATH TBS, C/V, SELECT", "CYTOPATH, C/V, AUTO, IN FLUID", and "LAB - Cytopathology".

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 header, "Cervical Cancer Screening QM:"
3. Clicking on the header will display a list of items in SMART Text 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

The screenshot displays the SOAPware interface with three main panels. The left panel, titled 'Patient Information', shows fields for Title, First, Middle, Last, SSN, Birth Date, Age (highlighted with a red box and a circled '1'), Marital Status, Gender, Race, and Ethnicity. The middle panel, titled 'SOAP Notes', shows the 'Plan' section (highlighted with a red box and a circled '2') with the text 'Chlamydia Screening QM:'. The right panel, titled 'SMART Text Quick Access', shows a list of items (highlighted with a red box and a circled '3') including 'Chlamydia Screening QM: (PDR)' and 'She is not sexually active.'.

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, "**PQRichl**" 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 SMART Text 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

1 Age 60 Gender Female

2 Plan
Colorectal cancer screening
QM: []

3 select Description S T U
[] "Colorectal Cancer Screening, Documented and Received. " ... c S 0
[] "Colorectal Cancer Screening NOT Performed - for Medical R... c S 0
[] "Colorectal Cancer Screening NOT Performed - Reason not... c S 0

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, "**PQRlpreCol**", will insert the pick list header, "Colorectal cancer screening QM:" Clicking on the header will display a list of items in SMARTText 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](#)

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

The screenshot shows the SOAPware interface. On the left, the 'SOAP Notes' window is open, showing a 'Plan' section with the text: 'Persistent asthma + Control Therapy QM: [Persist asthma - control medicine prescribed. #4015F Relates Dxs- Modifiers- Persistent asthma. #1038F Relates Dxs- Modifiers-]'. On the right, the 'SMART Text Quick Access' window is open, showing a list of items with checkboxes, descriptions, and shortcuts. The items are: 'Persistent asthma. ' (PQRI - 1038F) ** (c1038F), 'Intermittent asthma 1039F' (c1039F), 'Persist asthma - control medicine prescribed...' (c4015F), 'Persist asthma - control medicine NOT pres...' (c4015F-2P), and 'Persist asthma - control medicine NOT pres...' (c4015F-8P). The 'Active Item' is 'Persistent asthma + Control Therapy QM: ' (PQRI) **'. The workflow is indicated by numbered circles: 1 points to the 'Date/Time' and 'Type' fields in the SOAP Notes window, 2 points to the 'Plan' section, and 3 points to the 'SMART Text Quick Access' window.

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 the 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 SMART Text 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 the patient has persistent asthma. Using the shortcut code "PQRlastThe" 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 because it documents "Intermittent asthma".

This measure reports three age stratifications (5-11 years, 12-50 years, and 51-64 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

The screenshot displays a patient record interface. On the left, a form contains fields for 'Age' (75), 'Gender' (Female), and 'Ethnicity' (Not Hispanic). A red box labeled '1' highlights the 'Age' field. In the center, a section titled 'Objective' and 'Assessment' is visible. Below it, a red box labeled '2' highlights the 'Plan' field, which contains the text 'Pneumococcal vaccination and age 65 or > QM:'. On the right, a table with columns 'Object' and 'Description' is shown. A red box labeled '3' highlights the table content, which lists three immunization options: 'Pneumococcal immunization administered (or received else...', 'Pneumococcal immunization NOT received, for medical reas...', and 'Pneumococcal immunization NOT received, reason not spec...'.

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, **"PQRlpne"** 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](#)

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

The screenshot displays a medical chart interface with several panels. On the left, the 'Active Problems' panel lists 'Moderate persistent asthma' with ICD#493.90. The 'Demographics' panel shows patient information for 'Patty J', including SSN 123-45-6789, Birth Date 6/29/1974, Age 36, Marital Status Single, Gender Female, Race White, and Ethnicity Not Hispanic. The 'SOAP Notes' panel shows a 'Plan' section with the text 'Asthma|QM:'. On the right, a pick list for 'Asthma QM:' is open, showing three items: 'Asthma symptoms evaluation QM: " (PQRI) **', 'Persistent asthma. " (PQRI - 1038F) **', and 'Persist asthma - control medicine prescribed. " (PQ...'. The 'Age' field in the demographics panel and the pick list are highlighted with red boxes.

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](#)

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

SOAP Notes | Labs | Radiology

Subjective

Objective

Assessment
Low back pain ICD#724.2

Plan
Low back pain imaging QM: Patient has not had imaging study of low back (x-ray, MRI, CT scan, etc.) within 28 days of diagnosis. # Relates Dx-Modifiers-

SMARTText Quick Access

Active Item: "Low back pain imaging QM: " (PQRI) ...

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Pt has NOT had imaging study of low back (x-ray, MRI, CT scan) within 28 days of dx" (P...	c0052b
<input type="checkbox"/>	"Pt had imaging study of low back (x-ray, MRI, CT scan, etc.) within 28 days of dx" (PQ...	c0052a

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 calculates 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 "**PQRllowBacI**". 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 SMARTText 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 encounter 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 within 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](#).

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

1 Age-53 9/22/1957
Forth, Colin

2 Summary Vital Signs Demographics

Active Problems
Diabetes - Type 1 [ICD#250.01]

Inactive Problems
[Starter - Inactive Problems:](#)

3

Subjective

Objective

Assessment

Plan
Diabetes + Dilated Eye Exam QM: [Eye exam, dilated, by eye doctor documented/reviewed, #2022F Related Dx- Modifiers-]

4

Active Item "Diabetes + Dilated Eye Exam QM: " (PQRI) "

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Eye exam, dilated, by eye doctor documented/reviewed." (PQRI)	c2022F
<input type="checkbox"/>	"Eye imaging validated to dx of 7 standard field stereoscopic photo..."	c2022F-8P
<input type="checkbox"/>	"Eye exam, dilated, by eye doctor NOT performed - reason not sp..."	c2024F
<input type="checkbox"/>	"Eye - 7 standard field stereoscopic photos + interp by eye doc do..."	c3072F

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 SummaryActive 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 **“PQRldmEye”** 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 SummaryActive 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

The diagram illustrates the documentation workflow for the Diabetes: Foot Exam measure. It consists of four numbered steps:

- 1** Patient Demographics: Age-53, 9/22/1957, Forth, Colin.
- 2** Active Problems: Diabetes - Type 1, ICD#250.01.
- 3** Plan: Diabetes + Foot Exam QM: Foot exam performed. #2028F.
- 4** SMART Text Quick Access: Foot exam performed (PQRI - 2028F).

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 SummaryActive 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 SummaryActive 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](#).

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

Subjective

Objective

Assessment
Diabetes - Type 2 ICD#250.00

Plan
Diabetes + Hemoglobin A1C QM: [Hemoglobin A1c Level > 9.0. #3046F Related Dx- Modifiers-]

Selecte	Description	S	Typ	U
<input type="checkbox"/>	"Hemoglobin A1c = / to 9." (PQRI - 3045F) **	c	ST...	1
<input checked="" type="checkbox"/>	"Hemoglobin A1c Level > 9.0" (3046F) **	c	ST...	1
<input type="checkbox"/>	"Hemoglobin A1c < or = 7." (PQRI - 3044F) **	c	ST...	0
<input type="checkbox"/>	"Hemoglobin A1c NOT Performed." (3046F) **	c	ST...	0

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 encounter 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 SMARTText CPT code, **3046f** documented in the either the Encounter Plan field or the Summary Interventions field.

Denominator Calculation:

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](#).

THIS LESSON IS CURRENTLY A DRAFT AND IS NOT YET COMPLETE

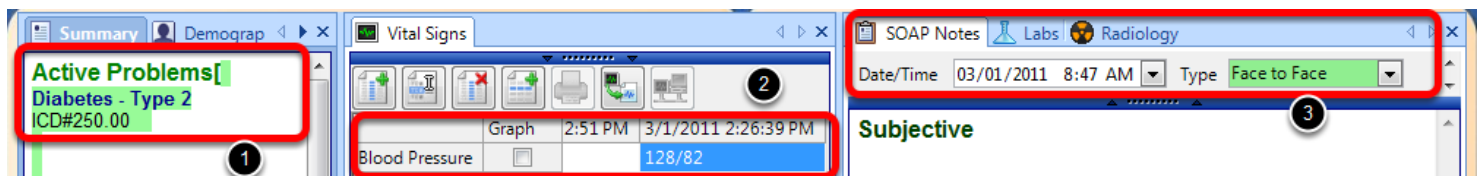
Measure: NQF 0061 (Additonal Measurement)

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 Calculation Details

Numerator Calculation:

The numerator for this measurement is calculated based on the 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 diagnosis of Diabetes recorded in the SummaryActive 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

The diagram illustrates the workflow for documenting a patient's condition for NQF 0062. It shows a patient's chart with the following sections:

- 1. Patient Information:** Age-53 9/22/1957, Forth, Colin.
- 2. Active Problems:** Diabetes - Type 1 ICD#250.01.
- 3. Assessment:** Diabetes - Type 2 - without complication ICD#250.00.
- 4. Plan:** Diabetes + Nephropathy: [Microalbuminuria test is Positive. #3060F Related Dx-Modifiers-]

A red arrow points from the 'Active Problems' section to the 'Plan' section, indicating the flow of documentation. The 'Plan' section also includes a table of selected items:

Selected	Description
<input checked="" type="checkbox"/>	"Microalbuminuria test is Positive. " (PQRI - 3060F) **
<input type="checkbox"/>	"Microalbuminuria test is Negative. " (PQRI - 3061F)
<input type="checkbox"/>	"MACROalbuminuria itest is Positive. " (PQRI - 3062F)
<input type="checkbox"/>	"Nephropathy treatment documented/reviewed. " (PQR
<input type="checkbox"/>	"Patient receiving ACE/ARB" (PQRI - G8506) **
<input type="checkbox"/>	"Microalbuminuria test not performed; reason unspecified.

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 SummaryActive 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 SummaryActive 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

The screenshot displays the SOAPware interface for documenting a quality measure. The 'Summary' tab is active, showing 'Active Problems' with 'Diabetes - Type 2' selected. The 'Diagnosis' field in the SOAP Note is populated with 'Diabetes + LDL QM: LDL < 100. #3048F Related Dx: Diabetes - Type 2'. The 'Plan' field is also populated with 'Diabetes + LDL QM: LDL < 100. #3048F Related Dx: Diabetes - Type 2'. The 'SOAP Notes' window shows a 'Face to Face' encounter on 04/28/2011. The 'SMARText Quick Access' window shows a list of quality measures, with 'Diabetes + LDL QM' selected. A red box highlights the 'Diagnosis' field in the SOAP Note, and another red box highlights the 'Plan' field. A red arrow points from the 'Plan' field to the 'Diagnosis' field. A red box also highlights the 'Diagnosis' field in the 'Active Problems' list.

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 "PQRldmLDL" in the **encounter Plan** field or **Summary Interventions** field will allow the user to select from a group of specific SMARTText CPT 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: **(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 SMARTText 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 SummaryActive Problems field or encounterAssessment 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

The screenshot illustrates the documentation workflow for the CAD measure. The interface shows the SOAP Notes section with the Plan section highlighted. The Plan section contains the text 'CAD + Antiplatelet Meds QM: [Antiplatelet Therapy Prescribed. #4011F Related Dx- Coronary artery disease]'. A red arrow points from this text to the SMARTText Quick Access panel on the right. The SMARTText panel shows a list of items with checkboxes, where the first item, 'Antiplatelet Therapy Prescribed. (i.e. Oral ...', is selected. The Active Item field shows 'CAD + Antiplatelet Meds QM: (PQRI)'.

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 SummaryActive 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 SummaryActive 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 (Additional) - 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

Assessment

Plan
Ischemic Vascular Disease (IVD) QM: [Pt had no MI, CABG or PTCA last calendar year, or IVD in past 2 years. # -1P [Related DxS-](#) [Modifiers-](#)]

Selected	Description	Shortcut	Typ	Usa
<input type="checkbox"/>	"Antithrombotic Tx, Pt had either MI, CABG o...	c0068b	ST...	5
<input type="checkbox"/>	"Pt had MI, CABG or PTCA last calendar yea...	c0068c	ST...	4
<input type="checkbox"/>	"BP < 140/90, Pt had either MI, CABG or PT...	c0073b	ST...	4
<input type="checkbox"/>	"LDL <100, Pt had either MI, CABG or PTCA...	c0075b	ST...	4
<input checked="" type="checkbox"/>	"Pt had no MI, CABG or PTCA last calendar...	c0068a	ST...	2

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, **“PQRlvd”** 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 Medications 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 encounter Plan field during the reporting period using one of the **Custom codes: 0068b**,

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](#).

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 SMARTText 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 SMARTText 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) A beta 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 SummaryActive 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.

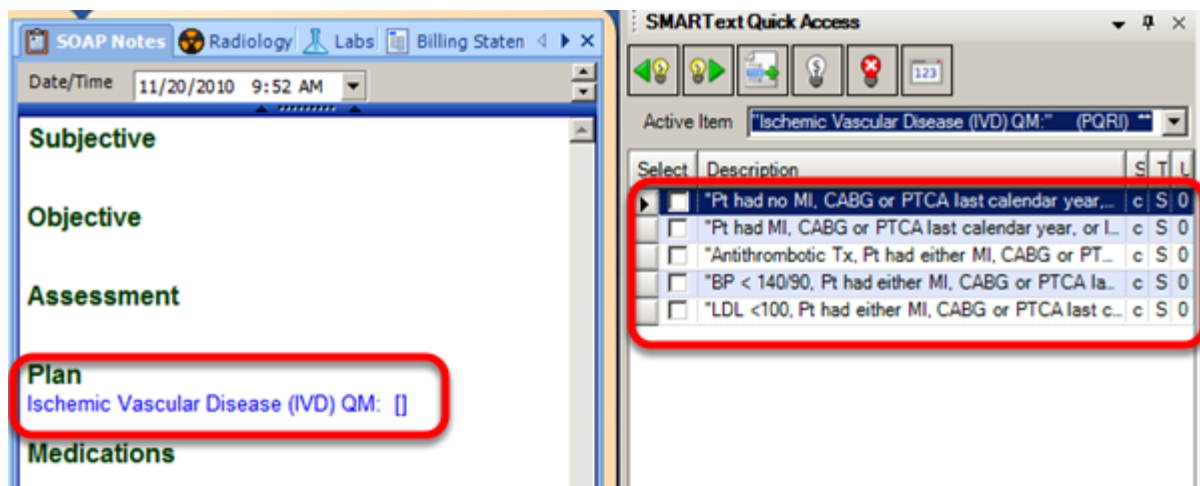
Measure: NQF 0073 (Additional Measure)

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, **"PQRlvd"** in the encounter

Plan field will allow the user to select from a group of specific SMARTText custom codes that can be used to document for this measure. Patients must have the custom SMARTText 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 SMARTText 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 SMARTText 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

The screenshot shows a medical chart interface with several tabs: Summary, Vital Signs, Demographics, SOAP Notes, Labs, and Radiology. The 'Summary' tab is active. On the left sidebar, under 'Active Problems', 'Coronary artery disease' is listed with ICD#414.01. Below this are sections for 'Inactive Problems', 'Surgeries', 'Medications', and 'Allergies'. The 'SOAP Notes' tab is also visible, showing a date/time of 03/03/2011 2:10 PM and a type of 'Face to Face'. The 'Medications' section in the SOAP Notes is highlighted with a red box and a circled '2'. The 'Active Problems' section in the Summary tab is highlighted with a red box and a circled '3'. The 'Medications' section in the SOAP Notes is highlighted with a red box and a circled '2'.

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-lowering 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 summaryActive 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 SummaryActive 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

Selected	Description	Shortc	Type	Isag
<input type="checkbox"/>	"BP < 140/90, Pt had either MI, CABG or PTCA la...	c0073b	ST Pla...	4
<input type="checkbox"/>	"LDL <100, Pt had either MI, CABG or PTCA last...	c0075b	ST Pla...	4
<input checked="" type="checkbox"/>	"Pt had no MI, CABG or PTCA last calendar year,...	c0068a	ST Pla...	0
<input type="checkbox"/>	"Pt had MI, CABG or PTCA last calendar year, or...	c0068c	ST Pla...	0
<input type="checkbox"/>	"Antithrombotic Tx, Pt had either MI, CABG or PT...	c0068b	ST Pla...	0

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 **"PQRlivd"** in the encounter Plan field will allow the user to select from a group of specific SMARTText custom codes that can be used to document for this measure. Patients must have the custom SMARTText 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 **"PQRlivd"** in the encounter Plan field will allow the user to select from a group of specific SMARTText custom codes that can be used to document for this measure. Patients must have the custom SMARTText 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 SMARTText 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)

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

The screenshot displays a medical software interface with the following components:

- Summary Tab:** Shows 'Active Problems' with 'Malignant hypertensive heart disease with heart failure ICD#402.01' highlighted by a red box and labeled with a circled '1'.
- SOAP Notes Tab:** Contains an 'Assessment' section with 'Malignant hypertensive heart disease with heart failure ICD#402.01' and a 'Plan' section with 'Heart Failure or LVSD + ACE-I or ARB QM: [ACE-ARB inhibitor prescribed. #4009F]'. The Plan section is highlighted by a red box. Below it, the 'Medications' section lists 'Lisinopril (Prinivil, Zestril)' with a strength of 10 mg (tablet) and a SIG of 1 each once a day orally. This section is also highlighted by a red box and labeled with a circled '2'.
- SMARTText Quick Access Panel:** A dropdown menu shows 'Active Item: Heart Failure or LVSD + ACE-I or ARB QM: (PQRI)'. Below it, a table lists various items with checkboxes. The first item, 'ACE-ARB inhibitor prescribed' (PQRI, 4009F), is checked and highlighted by a red box. A red arrow points from the Plan section to this item.

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/Benzepiril - d00730, Lotensin-HCT - d03265, Monopril/Fosinopril - d00242, Monopril-HCT - d04539, Zestoretic - d03266 ("d" codes are the Multum identifier codes).

OR Using the shortcut code, "PQRlhfACE" 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, Captopride - d03566, Lisinopril - d00732, Lotensin/Benzepiril - 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

The screenshot displays a medical software interface with a SOAP note on the left and a list of quality measures on the right. The SOAP note is divided into sections: Subjective, Objective, Assessment, Plan, and Medications. The Assessment section contains the text "Malignant hypertensive heart disease with heart failure ICD#402.01". The Plan section contains the text "LVEF abnormal and Beta-blocker therapy QM: []". The Medications section contains the text "Atenolol (Tenormin): 100 mg (tablet) SIG- 1 each once a day orally #30 Substitutions Allowed Refills- 12 Notes-". The list of quality measures on the right includes several items, with the second item, "LVEF >= 40% systolic. " (PQRI ...", highlighted in blue. This item is associated with the shortcut "cG8395".

SOAP Notes | Labs | Radiology

Date/Time: 03/03/2011 2:10 PM | Type: Face to Face

Subjective

Objective

Assessment
Malignant hypertensive heart disease with heart failure ICD#402.01

Plan
LVEF abnormal and Beta-blocker therapy QM: []

Medications
Atenolol (Tenormin): 100 mg (tablet) SIG- 1 each once a day orally #30
Substitutions Allowed Refills- 12 Notes-

SMH Text Quick Access

Active Item: F abnormal and Beta-blocker therapy QM: " (P

Select	Description	Shortcut
<input type="checkbox"/>	"LVEF abnormal and Beta-blocker p...	cG8450
<input checked="" type="checkbox"/>	"LVEF >= 40% systolic. " (PQRI ...	cG8395
<input type="checkbox"/>	"LVEF not performed or documente...	cG8396
<input type="checkbox"/>	"LVEF abnormal and Beta-blocker n...	cG8451
<input type="checkbox"/>	"LVEF abnormal and Beta-blocker n...	cG8452

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 by using the shortcut code, **“PQRlhFBB”** 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 the 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

The screenshot displays the SOAPware interface for documenting a patient encounter. The SOAP Notes window is open, showing the following fields:

- Date/Time:** 03/03/2011 2:10 PM
- Type:** Face to Face (highlighted with a red box and a circled '1')
- Subjective:**
- Objective:**
- Assessment:** Benign hypertensive heart and renal disease with congestive heart failure (ICD#404.11) (highlighted with a red box and a circled '4')
- Plan:** Heart failure and warfarin with atrial fibrillation: [] (highlighted with a red box and a circled '3')
- Medications:** Coumadin (Warfarin): 5 mg (tablet) SIG- as directed once a day orally #30 (highlighted with a red box and a circled '2')

The SMART Text Quick Access window is also visible, showing a list of active items:

Select	Description	Shortcut
<input type="checkbox"/>	"Patient receiving warfarin. " (430...	c4300F
<input checked="" type="checkbox"/>	PT NOT RCYNG WARF THXPY 43...	c4301F

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 SummaryActive 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, “**PQRlhfWar**” 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 SummaryActive 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

SOAP Notes Labs Radiology

Date/Time 03/03/2011 2:10 PM Type Face to Face

Subjective

Objective

Assessment
Open-angle glaucoma ICD#365.10

Plan
Glaucoma QM: []

SMARText Quick Access

Active Item "Glaucoma QM: "

Selected	Description	Sho
<input type="checkbox"/>	"Glaucoma screen, high risk, supervised by ey...	cG0
<input type="checkbox"/>	"Glaucoma screen, high risk, furnished by eye...	cG0

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 summaryActive 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 insert 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 Calculation:

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 POAG. This can be accomplished by documenting in the SummaryActive 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

The screenshot displays the SOAPware interface for documenting a patient's condition. On the left, the 'Active Problems' section lists 'Diabetic retinopathy' with ICD code 362.01. The main window shows the 'SOAP Notes' tab, with the 'Assessment' section containing 'Diabetic retinopathy' (ICD#362.01) and the 'Plan' section containing 'Diabetes + Dilated Eye Exam QM: [Eye exam, dilated, by eye doctor documented/reviewed. #2022F Related Dx: Modifiers:]'. A red box highlights the 'Plan' section. The 'SMARTText Quick Access' window is open, showing a list of documentation items. A red box highlights the 'Active Item' dropdown menu, which is set to 'Diabetes + Dilated Eye Exam QM: (PQRI)'. The list of items includes: 'Eye imaging validated to dx of 7 standard field stereoscopic photos; docume...', 'Eye exam, dilated, by eye doctor documented/reviewed.' (PQRI - 2022F - ...), 'Eye exam, dilated, by eye doctor NOT performed - reason not spec.' (PQRI - ...), 'Eye - 7 standard field stereoscopic photos + interp by eye doc documented/r...', and 'Eye - Low risk for retinopathy' (PQRI - 3072F) **.

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 SMARTText Quick Access that meet the documentation criteria.

Measurement Calculation Details

Numerator Calculation:

The numerator for this measurement is calculated based on the 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 documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within a 12 month period.
2. The Encounter Plan field must contain a structured SMARTText 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 Diabetic 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.

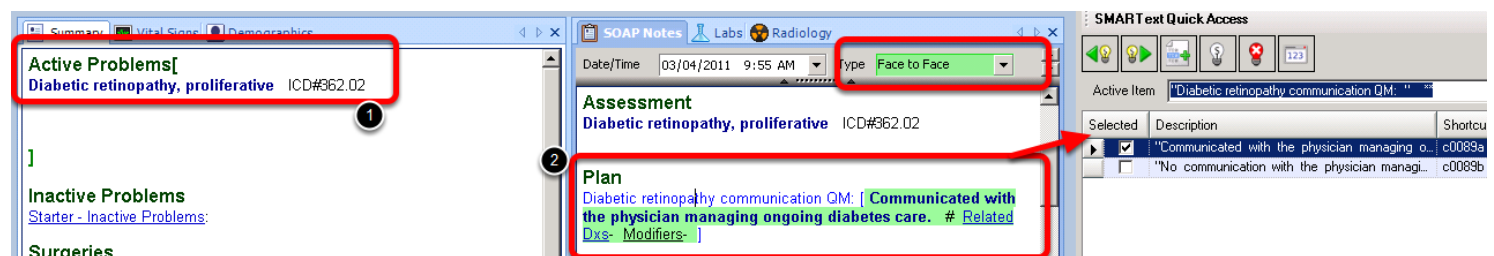
Measure: NQF 0089 (Additional Measurement)

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 SMART Text Quick Access that meet the documentation criteria.

Measurement Calculation Details

Numerator Calculation:

The numerator for this measurement is calculated based on the 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 with a new episode of Major Depression during the reporting period and had a Face-to-Face encounter with the provider. Patient's 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, "Antidepressants 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 on the 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 reporting 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 IIIA through 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

The screenshot displays the SOAPware interface. On the left, the 'SOAP Notes' window shows the 'Plan' section with the following text: 'Colon Cancer and chemotherapy QM: Cancer Stage III, documented, #3388F Related Dx's: Adjuvant chemotherapy suggested, #4180F Related Dx's: Modifiers:'. Red boxes and numbers highlight specific elements: 1. The 'Date/Time' (05/18/2011 8:52 AM) and 'Type' (Face to Face) fields in the SOAP Notes header. 2. The 'Cancer Stage III, documented, #3388F' code in the Plan section. 3. The 'Adjuvant chemotherapy suggested, #4180F' code in the Plan section. On the right, the 'SMART Text Quick Access' window shows a list of codes with their descriptions and shortcuts. The list includes codes for 'Cancer Stage III, documented' (PQRI - 3388F), 'Cancer Stage I, documented' (PQRI - 3384F), 'Cancer Stage II, documented' (PQRI - 3386F), 'Cancer Stage IV, documented' (PQRI - 3390F), 'Adjuvant chemotherapy suggested' (PQRI - 4180F), and 'Adjuvant chemotherapy NOT suggested' (PQRI - 4180F-1P, 4180F-2P, 4180F-3P, 4180F-8P).

Selected	Description	Shortcut
<input checked="" type="checkbox"/>	"Cancer Stage III, documented. " (PQRI - 3388F) **	c3388F
<input type="checkbox"/>	"Cancer Stage I, documented. " (PQRI - 3384F) **	c3384F
<input type="checkbox"/>	"Cancer Stage II, documented. " (PQRI - 3386F) **	c3386F
<input type="checkbox"/>	"Cancer Stage IV, documented. " (PQRI - 3390F) **	c3390F
<input checked="" type="checkbox"/>	"Adjuvant chemotherapy suggested. " (PQRI - 4180F) **	c4180F
<input type="checkbox"/>	"Adjuvant chemotherapy NOT suggested - medical reasons. " ...	c4180F-1P
<input type="checkbox"/>	"Adjuvant chemotherapy NOT suggested - patient reasons. " ...	c4180F-2P
<input type="checkbox"/>	"Adjuvant chemotherapy NOT suggested - in a clinical trial. " ...	c4180F-3P
<input type="checkbox"/>	"Adjuvant chemotherapy NOT suggested - reasons NOS. " ...	c4180F-8P

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 IIIA through 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 SMART text 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 IIIA through 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 chemotherapy 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 specific SMART text 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 "PQRlcol" 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 "PQRlcol" 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 SMARTText 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 receptor 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 SMARTText 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 specific SMARTText 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 SMARTText 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 SMARTText 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 SMARTText 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](#).

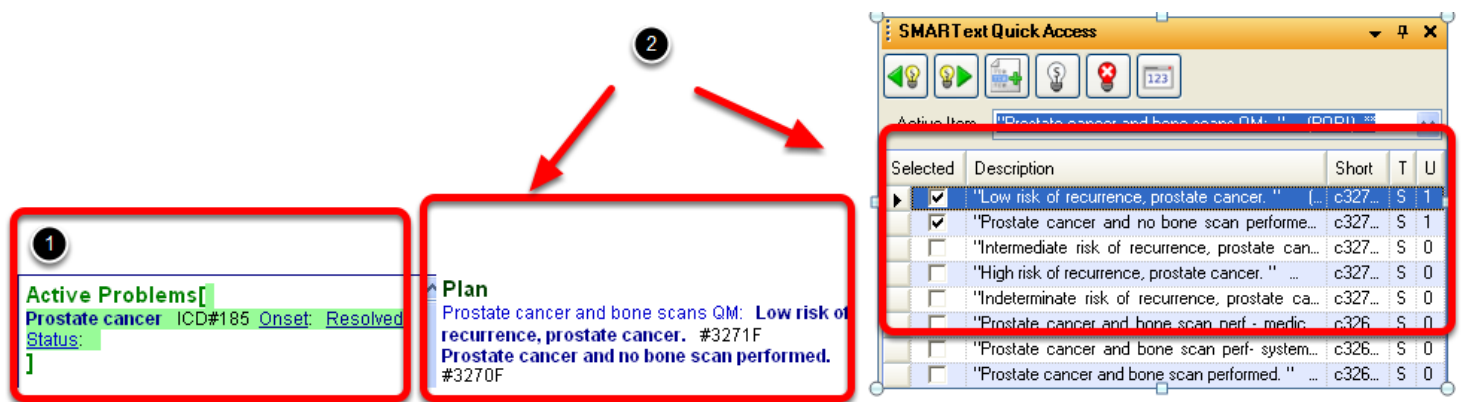
NQF 0389 (Additional): Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

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, "PQRlproBon" 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 SMARTText 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%.

The screenshot displays a medical software interface with two main panels. The left panel, titled 'Labs', contains a table of laboratory results. The right panel, titled 'SOAP Notes', contains a form for documenting patient encounters. Three red boxes with numbered circles highlight specific areas:

- Box 1:** Located in the top right of the 'SOAP Notes' panel, it highlights the 'Date/Time' field (03/11/2011 10:03 AM) and the 'Type' field (Face to Face).
- Box 2:** Located in the middle of the 'SOAP Notes' panel, it highlights the 'Assessment' field, which contains the text 'Diabetes - Type 2 - uncontrolled' and the ICD code 'ICD#250.02'.
- Box 3:** Located in the top left of the 'Labs' panel, it highlights a table of laboratory results.

The 'Labs' table has the following data:

Name	Flags	Value	Range	Units
Hgb A1c		6.0	(4.4 - 6.2)	% of

The 'SOAP Notes' form has the following sections:

- Subjective**
- Objective**
- Assessment** (highlighted by Box 2)
- Plan**
- Medications**
- Follow Up** (Phineas A. Fogg)

The bottom of the interface shows a 'Search' button and a patient information bar with the text 'Age-30 3/2/1981' and 'Caucasian, female'.

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 summaryActive Problems field or the encounterAssessment 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

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 SummaryActive Problems or EncounterAssessments 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**

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