Sevocity® v.12
2018 Electronic Clinical Quality Measures
User Reference Guide

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About Sevocity v.12

Sevocity v.12 is ONC 2015 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable eligible certification criteria adopted by the Secretary of Health and Human Services.

ONC Certified HIT 2015 EDITION

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About Electronic Clinical Quality Measures (eCQMs)

eCQMs are designed to use data from electronic health records (EHR) or health information technology systems to measure health care quality and outcomes of patient care. The Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) use eCQMs in a variety of quality reporting and incentive programs. The information contained herein is based on the measure specifications as presented by the eCQI Resource Center and are subject to change.

Recommended Resources

eCQI Resource Center: The Electronic Clinical Quality Improvement (eCQI) Resource Center is a joint effort between CMS and the Office of the National Coordinator for Health IT (ONC) to bring together stakeholders from across the eCQI community and provide a centralized location for news, information, tools and standards related to eCQI and eCQMs.

USHIK: The United States Health Information Knowledgebase (USHIK) is an online, publicly accessible registry and repository of healthcare-related metadata, specifications, and standards. USHIK is funded and directed by the Agency for Healthcare Research and Quality (AHRQ).

Value Set Authority Center: The Value Set Authority Center (VSAC) provides downloadable access to all official versions of vocabulary value sets contained in the eCQMs.

Viewing or downloading value sets from USHIK or VSAC requires a free Unified Medical Language System® Metathesaurus License due to usage and licensing restrictions on certain codes included in the value sets.

About This Guide

The 2018 Electronic Clinical Quality Measures User Reference Guide has been developed to assist users with workflow requirements and guidelines for quality measures available in Sevocity. This guide is designed as a supplemental resource and is not a substitute for the program eligibility and requirements.

Terms and Definitions

Terminology used throughout this guide is specific to the language and function of Sevocity within the scope of the topic presented.

Active Diagnosis: An active diagnosis is an ICD-9 or ICD-10 code added in the Assessment tab of an encounter which has neither been resolved nor inactivated

Eligible Clinician/Eligible Provider (EC/EP): Sevocity user with an NPI and an Access Level of Full Chart Level

Measurement Period: For the 2018 performance year, the Measurement Period is defined as January 1, 2018 through December 31, 2018

Icons Used

- Recommended workflow
- System setup
- Workflow tip

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CMS 2v7: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period
Numerator	Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen
Denominator Exceptions	Patient Reason(s): Patient refuses to participate **OR** Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status **OR** Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
Denominator Exclusions	Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age is ≥ 12 years at the beginning of the Measurement Period
  AND
- Have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator
CPT: 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397

HCPCS: G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507

Denominator Exceptions

A patient will be counted as an exception for this measure if there is a medical reason they did not receive a depression screening or if the patient refused.

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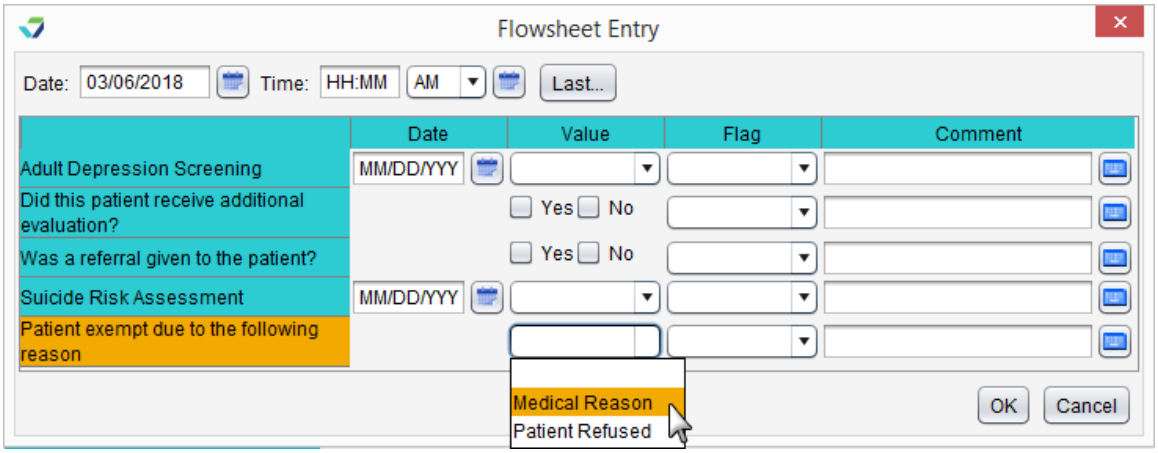
To document an exception from the Adult/Pediatric Depression Screening flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the appropriate **Depression Screening** flowsheet and click **Add**
3. Click **Add Column**
4. Select a value from the **Patient exempt due to the following reason** list
5. Click **OK** to save



Documenting a patient exception in the Depression Screening – Adult flowsheet

To document an exception from the PHQ-2 or PHQ-9 flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **PHQ-2** or **PHQ-9** flowsheet and click **Add**
3. Click **Add Column**
4. Select the checkbox for **Patient Declined Screening**
5. Click **OK** to save

Denominator Exclusions

Patients with an active diagnosis of depression or bipolar disorder will be excluded from the measure. Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible depression and bipolar disorder diagnosis codes can be located here.

Numerator

A patient will be counted in the numerator if they received a depression screening during the Measurement Period. If the result of the screening is **Positive**, the patient must receive a follow-up plan to be counted in the numerator.

Depression Screening

A depression screening can be documented from the following standard flowsheets: **Depression Screening Adult** or **Pediatric**, **PHQ-2,** or **PHQ-9.**

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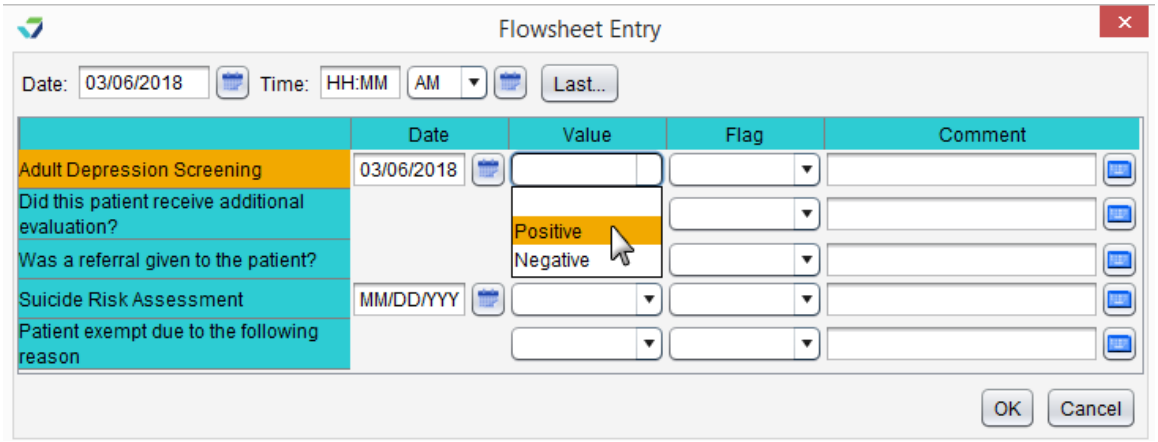
To document a screening from the Adult/Pediatric Depression Screening flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the appropriate **Depression Screening** flowsheet and click **Add**
    a. **Depression Screening – Pediatric** is for patients aged ≥ 12 years and < 18 years
    b. **Depression Screening – Adult** is for patients aged ≥ 18 years
3. Select a **Date** and **Value** for the screening
4. Click **OK** to save

To document a screening from the PHQ-2 or PHQ-9 flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **PHQ-2** or **PHQ-9** flowsheet and click **Add**
3. Select a **Value** for all questions in the PHQ screening
4. Click **OK** to save



Documenting an adult depression screening

Follow-Up Plan for a Positive Finding

If the result of the depression screening is **Positive**, additional evaluation for depression must be provided **OR** a suicide risk assessment must be performed **OR** the patient must be given a referral to a practitioner who is qualified to diagnose and treat depression **OR** the patient must be prescribed anti-depression medication.

A PHQ-2 score ≥ 3 will require a follow-up plan, and a PHQ-9 score ≥ 5 will require a follow-up plan.

Additional Evaluation Provided

From the **Adult/Pediatric Depression Screening** flowsheet, select **Yes** for the questions **Did this patient receive additional evaluation?**

Referral Provided

From the **Adult/Pediatric Depression Screening** flowsheet, select **Yes** for the question **Was a referral given to the patient?**

Suicide Risk Assessment Performed

From the **Adult/Pediatric Depression Screening** flowsheet, select a **Date** and a **Value** for the **Suicide Risk Assessment**

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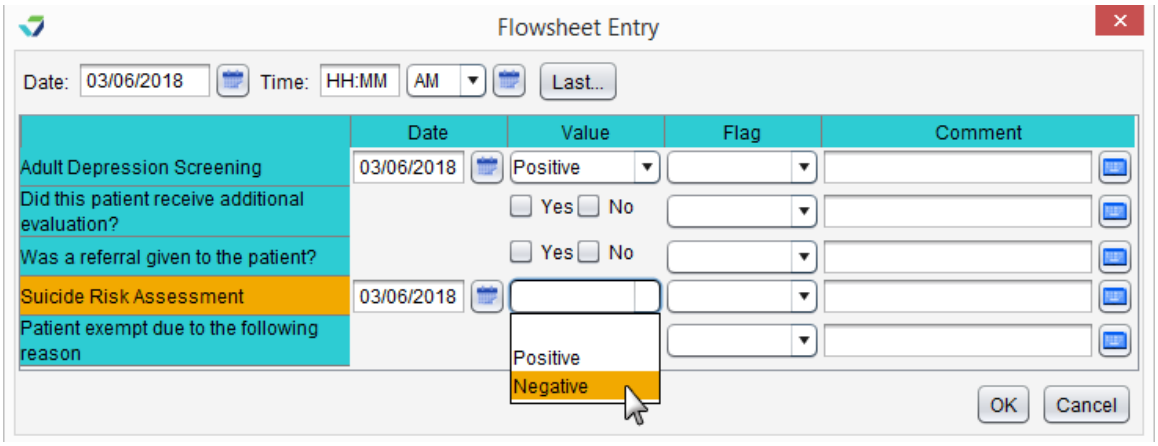

Documenting Suicide Risk Assessment performed

Anti-Depression Medication Prescribed

To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible anti-depression medications can be located here.

A combination of any of these interventions will also count toward the numerator; however, the intervention(s) must be performed on the same day as the depression screening or no later than the following day.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms002v7

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CMS 50v6: Closing the Referral Loop: Receipt of Specialist Report

Measure: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred		
Measure Type	**High Priority Measure**	**Scoring**
Process	Yes	A higher percentage indicates better quality

Denominator	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period
Numerator	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
Denominator Exceptions	None
Denominator Exclusions	Not Applicable

Denominator

Patients who meet the following criteria will be included in the denominator:

- Have at least one encounter during the Measurement Period finalized by EC/EP
  AND
- Have at least one referral created during the Measurement Period

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 92002, 92004, 92012, 92014, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99024, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Patient Referral

To document a referral from the patient chart or patient encounter:

1. From the **Referrals** tab in the chart or the **Orders/Referrals** tab in the encounter, click **Add**
2. Populate the following sections: **Date Requested** (chart level only), **Requested By**, **Refer To**, **Reason for Referral/Notes,** and **ICD Code** or **CPT/HCPCS**
   a. Requested By must be EC/EP
3. Click **Add**

Numerator

A patient will be counted in the numerator when the referral results are documented in the referral.

- Referral results must be documented at the chart level
- Documentation of results must occur after the referral has been created
- If a patient has multiple referrals during the Measurement Period, the **first** referral will be counted toward the numerator

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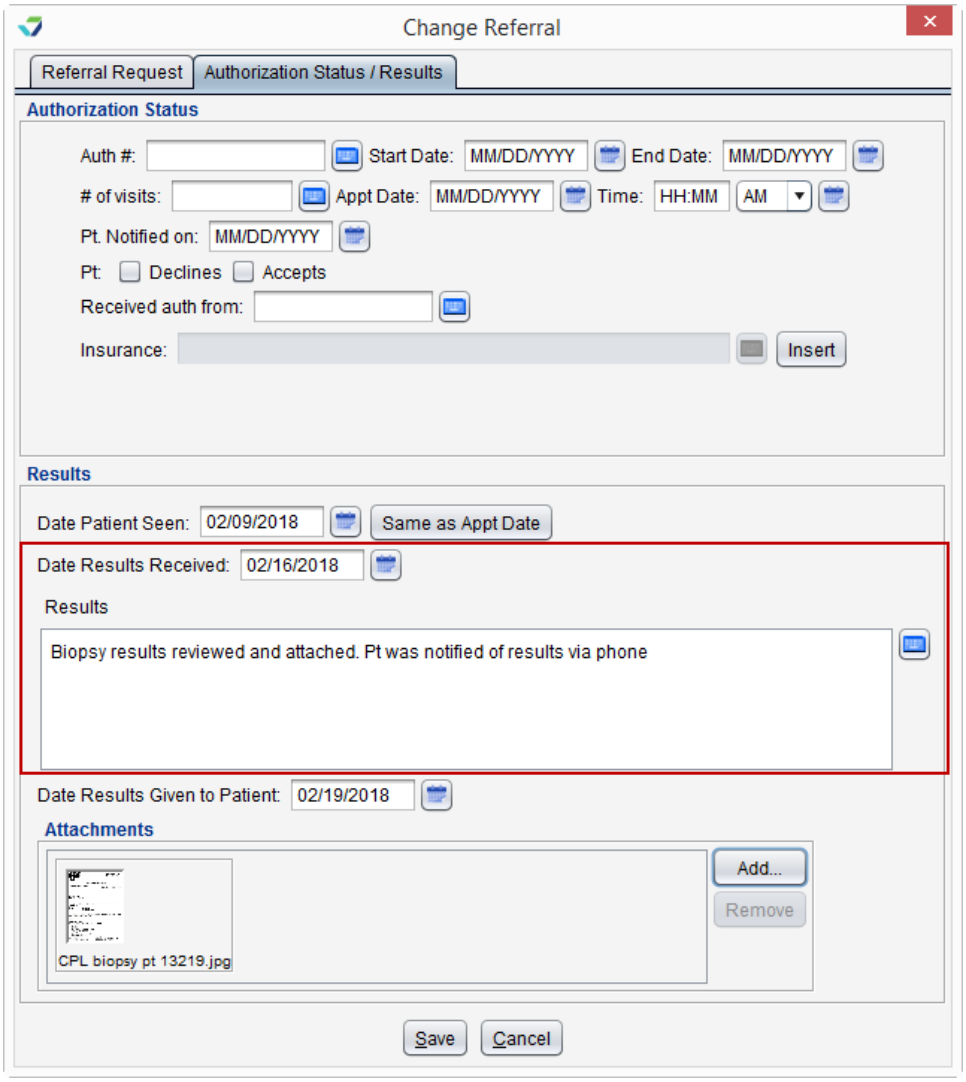
Documenting Referral Results

To document referral results:

1. From the **Referrals** tab, select the referral and click **Update**
2. From the **Authorization Status/Results** tab, populate **Date Results Received** and add information to **Results** field
    a. **Date Patient Seen**, **Date Results Given to Patient**, and **Attachments** can be populated but are optional
3. Click **Save**



Documenting referral results

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms050v6

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CMS 68v7: Documentation of Current Medications in the Medical Record

Measure: Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration		
Measure Type	**High Priority Measure**	**Scoring**
Process	Yes	A higher percentage indicates better quality

Denominator	All visits occurring during the 12 month measurement period for patients aged 18 years and older
Numerator	Eligible professional or eligible clinician attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration
Denominator Exceptions	Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
Denominator Exclusions	None

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years at the beginning of the Measurement Period
  AND
- Have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99024, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99281, 99282, 99283, 99284, 99285, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99495, 99496

HCPCS: G0101, G0108, G0270, G0402, G0438, G0439

Denominator Exceptions

A patient will be counted as an exception if a medication reconciliation was not performed due to an urgent medical situation.

To document an exception, go to **Encounter > Medications** and select the **Medication Reconciliation Not Performed Due to Urgent Medical Situation** checkbox.

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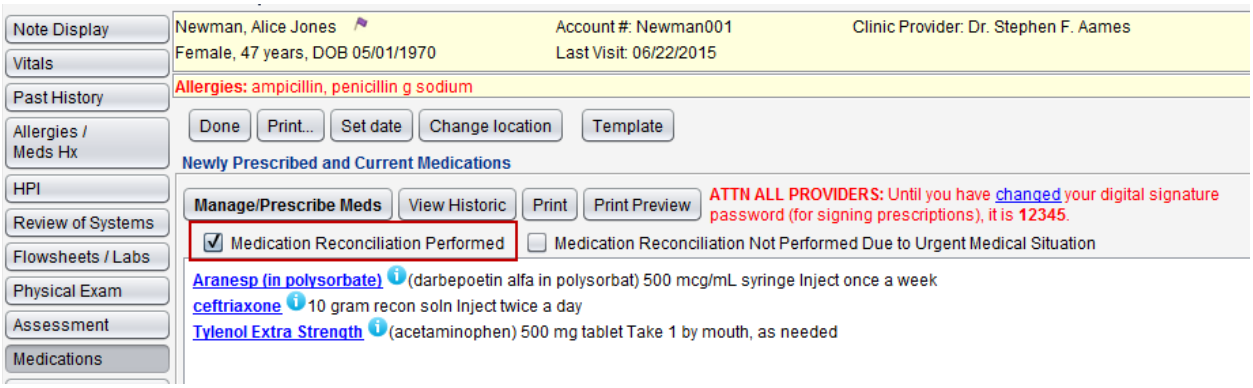
Numerator

A patient will be counted in the numerator if a medication reconciliation is performed at **every** eligible encounter during the Measurement Period.

Documenting Medication Reconciliation

To document a medication reconciliation was performed for the patient, go to **Encounter > Medications** and select the **Medication Reconciliation Performed** checkbox.



Documenting medical reconciliation performed

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms068v7

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CMS 69v6: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Measure: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	All patients 18 and older on the date of the encounter with at least one eligible encounter during the measurement period
Numerator	Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter
Denominator Exceptions	Patients with a documented Medical Reason: • Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples: • Illness or physical disability • Mental illness, dementia, confusion • Nutritional deficiency, such as Vitamin/mineral deficiency • Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
Denominator Exclusions	• Patients who are pregnant • Patients receiving palliative care • Patients who refuse measurement of height and/or weight or refuse follow-up

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years on the date of the encounter
  AND
- Have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 90791, 90792, 90832, 90834, 90837, 96150, 96151, 96152, 97161, 97162, 97163, 97165, 97166, 97167, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99385, 99386, 99387, 99395, 99396, 99397

HCPCS: G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

Denominator Exceptions

A patient will be counted as an exception if there is a medical reason for not documenting their BMI or providing a BMI follow-up plan if BMI was out of normal range. The reason for exception must be documented on the day of the encounter or in the 12 months prior.

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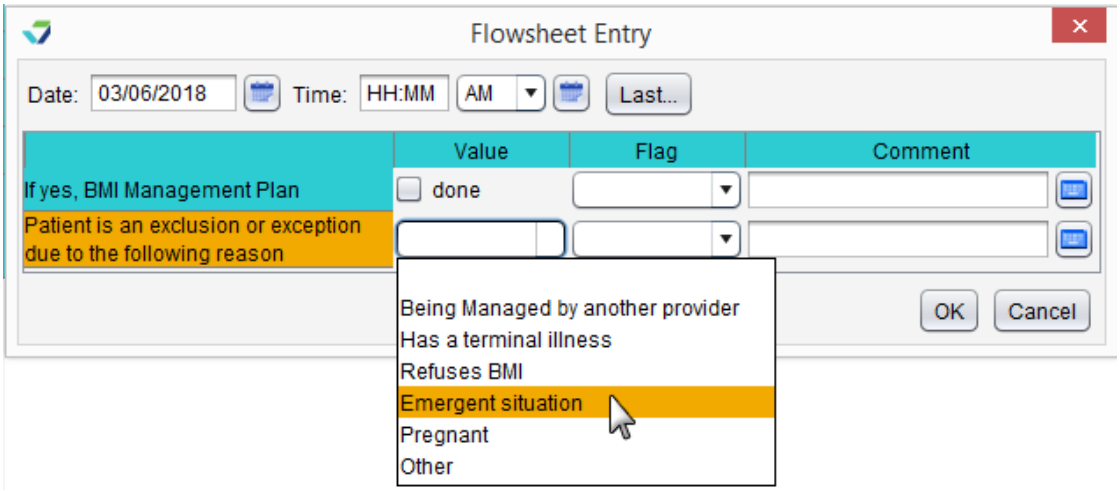
To document an exception:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets**
2. From the **BMI – Adult** flowsheet, click **Add Column**
3. Select **Emergent Situation** from the **Patient is an exclusion or exception due to the following reason** list
4. Click **OK** to save



Documenting exception from BMI – Adult flowsheet

Denominator Exclusions

A patient will be excluded from this measure if they meet any of the following conditions:

- Are receiving palliative care during the Measurement Period
- Have an active diagnosis of pregnancy during the Measurement Period
- Refuse to have their BMI documented or refuse a follow-up plan if BMI is our of normal range

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible pregnancy diagnosis codes can be located here.

To document an exclusion from the BMI – Adult flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets**
2. From the **BMI – Adult** flowsheet, click **Add Column**
3. Select **Has a terminal illness, Refuses BMI,** or **Pregnant** from the **Patient is an exclusion or exception due to the following reason** list
4. Click **OK** to save

Numerator

A patient will be counted in the numerator if their BMI was documented during the encounter or in the 12 months prior. If the patient's BMI is outside of the normal range (as defined by this measure), a BMI Management plan must be provided to be counted in the numerator.

If more than one BMI is documented during the Measurement Period, the most recent BMI will be used to determine if the measure performance has been met.

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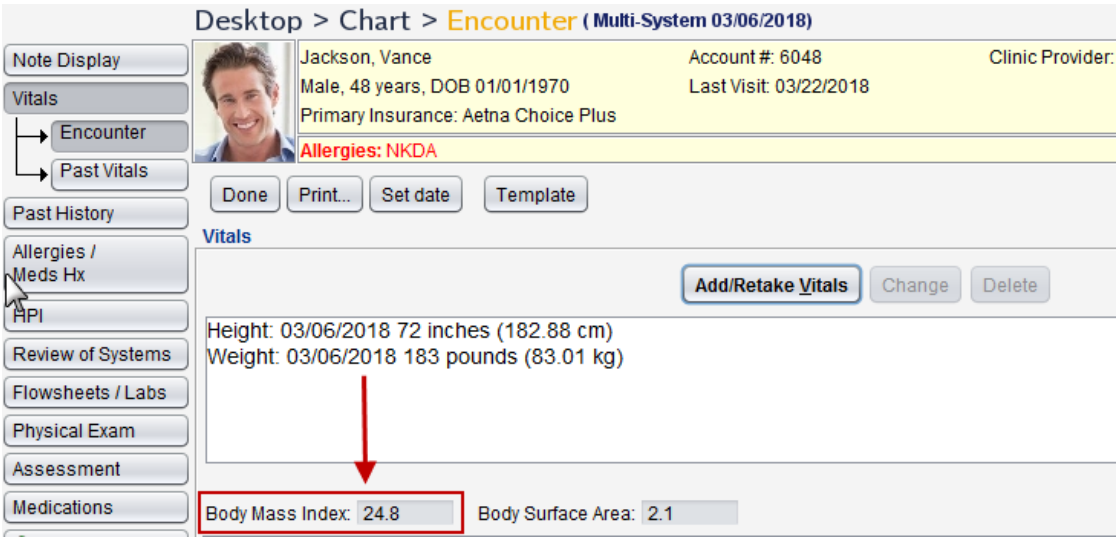
Documenting BMI

BMI is calculated based on the patient height and weight as entered in the **Vitals** tab of an encounter.

To document height and weight, go to **Encounter > Vitals >** click **Add/Retake Vitals**



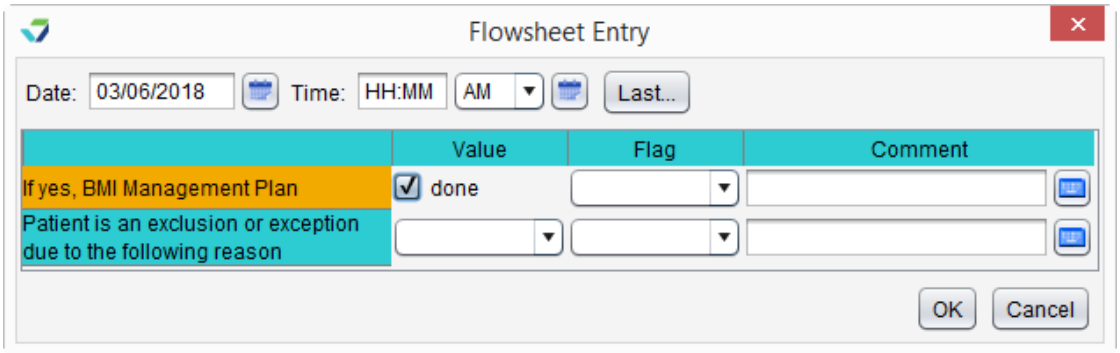
BMI calculated from patient Height and Weight

Documenting BMI Follow-Up Plan

For patients whose BMI falls outside of the normal range, a follow-up plan for BMI management must be provided. BMI management can be documented in the BMI – Adult flowsheet, as a diagnosis, as a procedure, or through the prescription of a medication.

To document a follow-up plan was provided in the BMI – Adult flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets**
2. From the **BMI – Adult** flowsheet, click **Add Column**
3. Select the **Done** checkbox for **BMI Management Plan**
4. Click **OK** to save



Documenting BMI Management Plan was performed in BMI – Adult flowsheet

Diagnosis

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for BMI management can be located here.

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Medication

To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible BMI management medications can be located here.

Procedure Codes

To document a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add an eligible code. Order Status must be marked as **Complete** in order to count toward the numerator. A comprehensive list of eligible procedure codes for BMI management can be located here.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms069v6

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CMS 75v6: Children Who Have Dental Decay or Cavities

Measure: Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Outcome	Yes	A lower percentage indicates better quality

Denominator	Children, age 0-20 years, with a visit during the measurement period
Numerator	Children who had cavities or decayed teeth
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 0 years and < 20 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator
CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they have an active diagnosis of dental caries during the Measurement Period. Diagnoses are documented in the **Assessment** tab of an encounter.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms075v6

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CMS 117v6: Childhood Immunization Status

Measure: 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); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period
Numerator	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 1 year before the start of the Measurement Period
  AND
- Age must = 2 years before the end of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator
CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99385, 99386, 99387, 99024, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

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SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they receive the following recommended vaccines **OR** have documented evidence of previously having the disease **OR** have documented evidence of having an allergic reaction to the vaccine by their 2nd birthday:

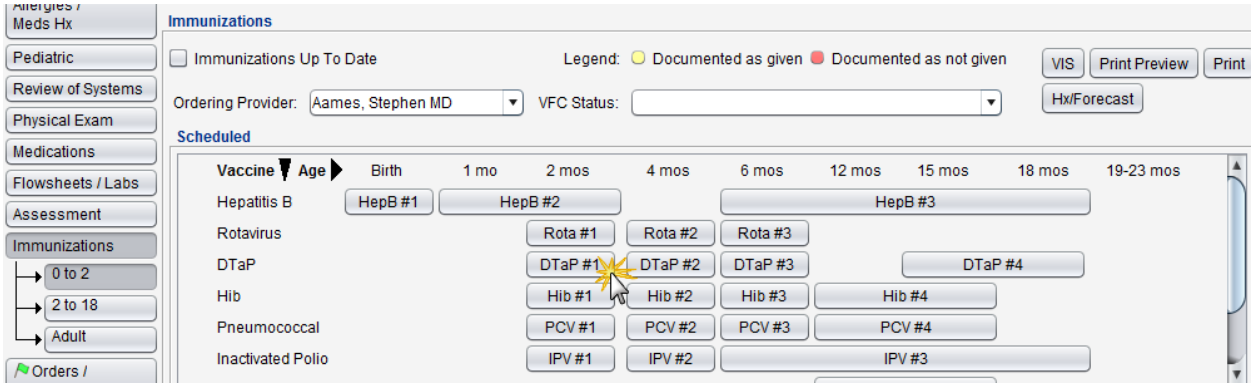
- 4 diphtheria, tetanus, acellular pertussis (DTap)
- 3 polio (IPV)
- 1 measles, mumps, rubella (MMR)
- 3 H influenza type B (HiB)
- 3 Hepatitis B (Hep B)
- 1 chicken pox (VZV)
- 4 pneumococcal conjugate (PCV)
- 1 hepatitis A (Hep A)
- 2 or 3 rotavirus (RV)
- 2 influenza (flu)

Immunizations Administered

The administration of vaccines is documented in the **Immunizations** tab of a patient encounter.

To document the administration of a vaccine:

1. Go to **Encounters > Immunizations > 0 to 2 tab**
2. Click the immunization name/dose button
    a. For **Influenza**, click the **Add** button
3. Complete the fields in the **Serum** section
4. Complete the applicable fields of the **Administration** section
5. Click **Save**



Vaccination schedule in Immunizations > 0 to 2 tab

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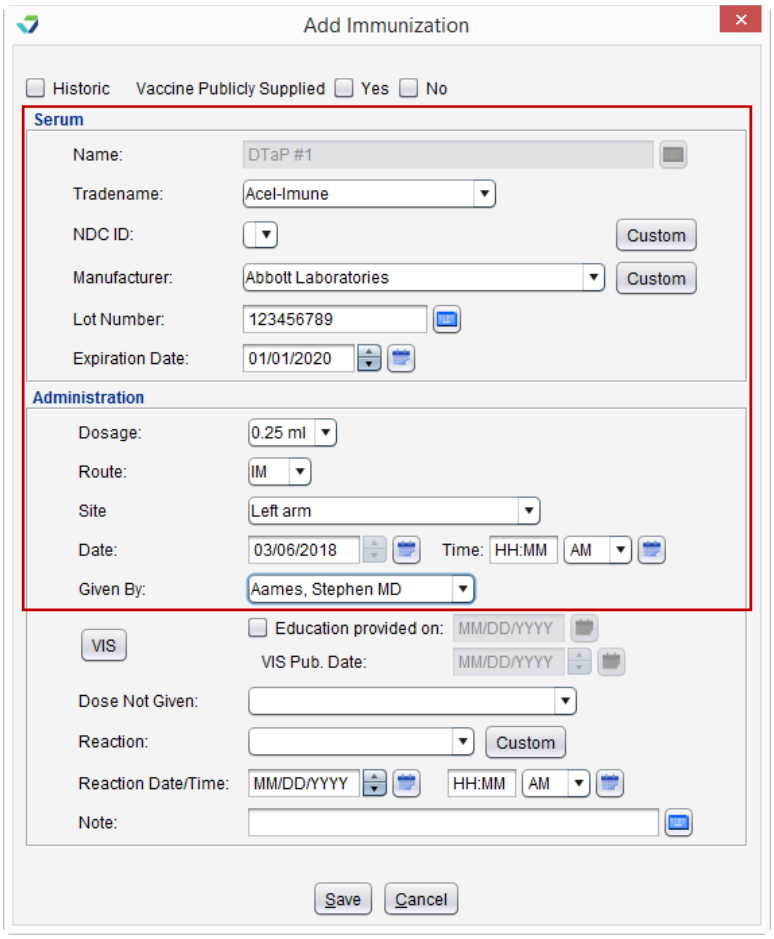

Documenting the administration of a vaccine in the Add Immunization window

Evidence of Having Disease or Allergic Reaction to Vaccine

A patient's history of the disease or allergic reaction to a vaccine can be documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for these conditions can be located here.

Eligible DTap Conditions
Diagnosis of Anaphylactic Reaction to DTaP Vaccine
Diagnosis of Encephalopathy due to Childhood Vaccination

Eligible IPV Conditions
Diagnosis of Anaphylactic Reaction to Inactivated Polio Vaccine (IPV)
Diagnosis of Anaphylactic Reaction to Streptomycin
Diagnosis of Anaphylactic Reaction to Polymyxin
Diagnosis of Anaphylactic Reaction to Neomycin

Eligible MMR Conditions
Diagnosis of Disorders of the Immune System
Diagnosis of HIV
Diagnosis of Malignant Neoplasm of Lymphatic and Hematopoietic Tissue
Diagnosis of Anaphylactic Reaction to Neomycin

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Diagnosis of Measles
Diagnosis of Mumps
Diagnosis of Rubella

Eligible HiB Conditions
Diagnosis of Anaphylactic Reaction to Hemophilus Influenza B (HiB) Vaccine

Eligible Hep B Conditions
Diagnosis of Anaphylactic Reaction to Hepatitis B Vaccine
Diagnosis of Anaphylactic Reaction to Common Baker's Yeast
Diagnosis of Hepatitis B

Eligible VZV Conditions
Diagnosis of Disorders of the Immune System
Diagnosis of HIV
Diagnosis of Malignant Neoplasm of Lymphatic and Hematopoietic Tissue
Diagnosis of Anaphylactic Reaction to Neomycin
Diagnosis of Varicella Zoster

Eligible PCV Conditions
Diagnosis of Anaphylactic Reaction to Pneumococcal Conjugate Vaccine

Eligible Hep A Conditions
Diagnosis of Anaphylactic Reaction to Hepatitis A Vaccine
Diagnosis of Hepatitis A

Eligible RV Conditions
Diagnosis of Anaphylactic Reaction to Rotavirus Vaccine
Diagnosis of Severe Combined Immunodeficiency
Diagnosis of Intussusception

Eligible Flu Conditions
Diagnosis of Anaphylactic Reaction to Influenza Vaccine
Diagnosis of Malignant Neoplasm of Lymphatic and Hematopoietic Tissue
Diagnosis of Anaphylactic Reaction to Neomycin
Diagnosis of HIV
Diagnosis of Disorders of the Immune System

The eligible diagnosis codes for conditions of **Diagnosis of Anaphylactic Reaction to [vaccine or ingredient]** are only available as SNOMED CT codes. SNOMED codes can be added in the Assessment tab by mapping the codes to an active ICD-10 using the **Map SNO** button.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms117v6

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CMS 122v6: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Measure: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Outcome	Yes	A lower percentage indicates better quality

Denominator	Patients 18-75 years of age with diabetes with a visit during the measurement period
Numerator	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

⚙ This eCQM requires a lab interface to be met. Customers interested in a lab interface should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years and < 75 years at the beginning of the Measurement Period
  AND
- Must have an active diagnosis of Type 1 or Type 2 diabetes during the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Diagnosis

The patient must have an active diagnosis of Type 1 or Type 2 diabetes during Measurement Period. Patients with a diagnosis of secondary diabetes due to another condition are not counted. Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diabetes diagnosis codes can be located here.

Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

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To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they have an e-Lab result with an HbA1c level of > 9% stored to their chart during the Measurement Period. If there are multiple HbA1c results within the Measurement Period, the most recent result will be counted toward the numerator.

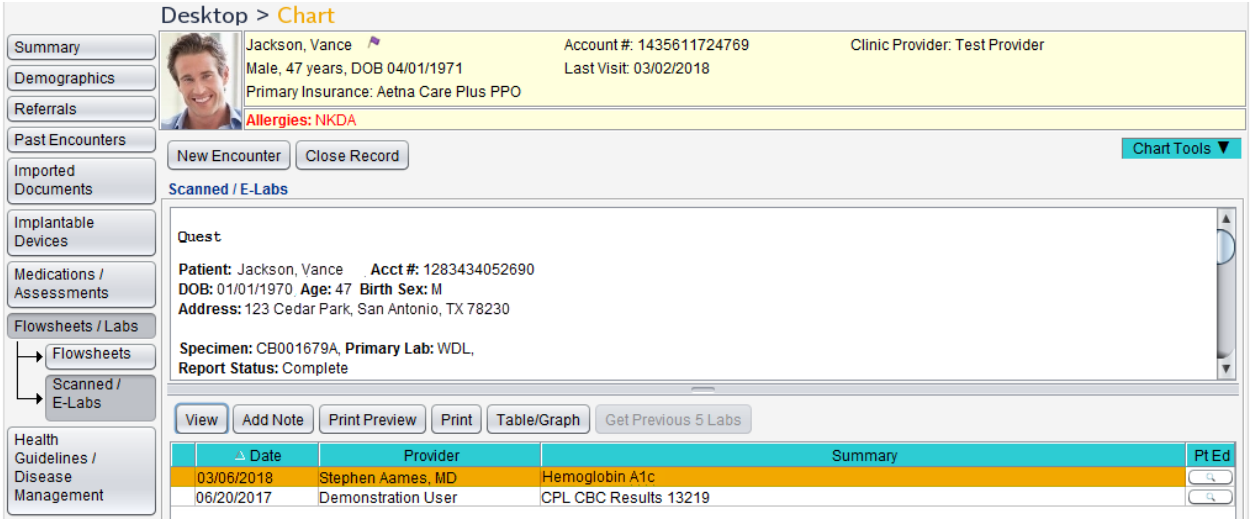
A patient will be included in the numerator if the most recent HbA1c result is missing or if there are no HbA1c tests performed and results documented during the Measurement Period.

Storing HbA1c e-Lab Results

To store an e-Lab result to the patient chart:

1. From the **Clinic Inbox**, select the lab result to be stored and click **View**
2. Click **Select** to search for and select a patient
3. Verify patient displayed matches the lab result and select the **I have verified the following lab results belong to the above patient** checkbox
4. Click **Sign/Route**
5. Select the **Sign** checkbox and click **OK**

e-Lab results stored to the patient chart can be viewed in the **Flowsheets/Labs > Scanned/E-Labs** tab.



HbA1c e-Lab result stored to patient chart

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms122v6

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CMS 123v6: Diabetes: Foot Exam

Measure: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 18-75 years of age with diabetes with a visit during the measurement period
Numerator	Patients who received visual, pulse and sensory foot examinations during the measurement period
Denominator Exceptions	None
Denominator Exclusions	• Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period • Patients who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years and < 75 years at the beginning of the Measurement Period
  AND
- Must have an active diagnosis of Type 1 or Type 2 diabetes during the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0438, G0439

Diagnosis

The patient must have an active diagnosis of Type 1 or Type 2 diabetes during Measurement Period. Patients with a diagnosis of secondary diabetes due to another condition are not counted. Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diabetes diagnosis codes can be located here.

Denominator Exclusions

Patients with an active diagnosis for a bilateral amputation above or below the knee or both a left and right amputation above or below the knee will be excluded from the measure. Diagnoses are documented in the **Assessment** tab of an encounter. If documenting both a left and right amputation,

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the **Anatomical Location Site** must be specified when adding the diagnosis codes. A comprehensive list of eligible amputation diagnosis codes can be located here.

Patients who were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

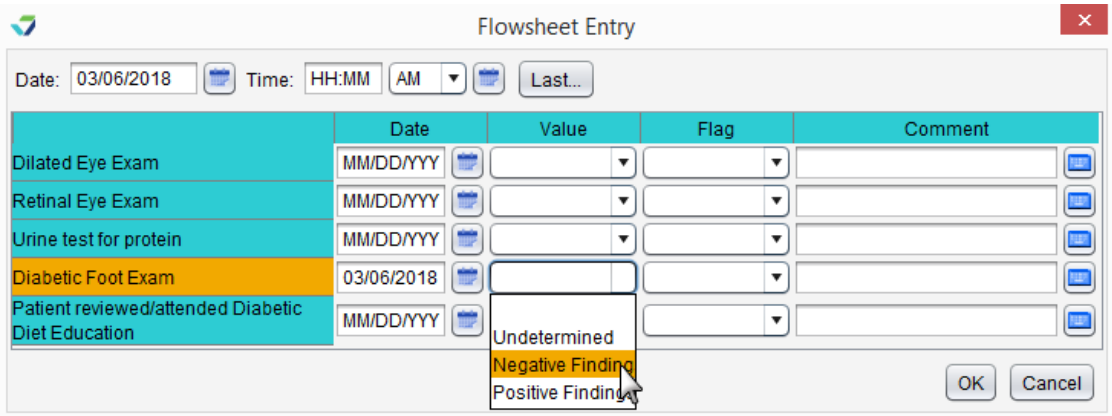
Numerator

A patient will be counted in the numerator if they received a diabetic foot exam during the Measurement Period.

Documenting a Diabetic Foot Exam

To document the performance of a diabetic foot exam:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Diabetes Care** flowsheet and click **Add**
3. Select a **Date** and a **Value** for **Diabetic Foot Exam**
4. Click **OK** to save



Documenting a diabetic foot exam

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms123v6

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CMS 124v6: Cervical Cancer Screening

Measure: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Women 23-64 years of age with a visit during the measurement period
Numerator	Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: • Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test • Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test
Denominator Exceptions	None
Denominator Exclusions	Women who: • Had a hysterectomy with no residual cervix • Were in hospice care during the measurement year

⚙ This eCQM requires a lab interface to be met. Customers interested in a lab interface should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Have a birth sex of female
  AND
- Age must be ≥ 23 years and < 64 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

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Denominator Exclusions

A patient will be excluded from the measure if they had a hysterectomy performed any time before the end of the Measurement Period.

To document the performance of a hysterectomy, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

CPT: 51925, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58951, 58953, 58954, 58956, 59135

Patients who were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they received at least one screening for cervical cancer. Appropriate screenings and timeframes for cervical cancer are defined as follows:

- At least one Pap test performed during the Measurement Period or in the 2 years prior
  OR
- For patients aged ≥30 years, one Pap test and one HPV test performed during the Measurement Period or in the 4 years prior
  - The patient must be 30 years or older at the time of the tests
  - The Pap test and HPV test must be performed on the same day or within 1 day of each other in order to count toward the numerator

Pap/HPV Test Performed

To document that a Pap test or Pap test and HPV test were performed, an e-Lab result for the test(s) must be stored to the patient chart.

To store an e-Lab result to the patient chart:

1. From the **Clinic Inbox**, select the lab result to be stored and click **View**
2. Click **Select** to search for and select a patient
3. Verify patient displayed matches the lab result and select the **I have verified the following lab results belong to the above patient** checkbox
4. Click **Sign/Route**
5. Select the **Sign** checkbox and click **OK**

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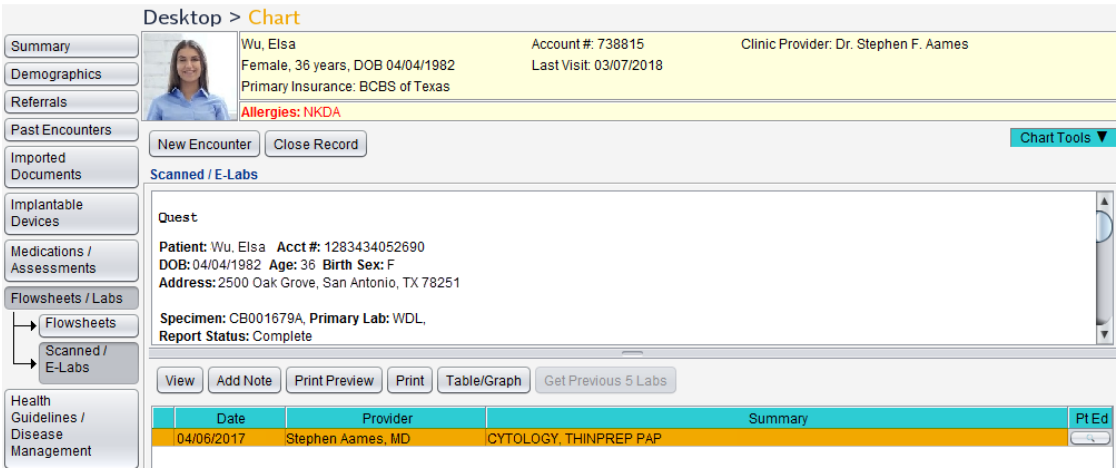
e-Lab results stored to the patient chart can be viewed in the **Flowsheets/Labs > Scanned/E-Labs** tab.



Pap test e-Lab result stored to patient chart

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms124v6

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CMS 125v6: Breast Cancer Screening

Measure: Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Women 51-74 years of age with a visit during the measurement period
Numerator	Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period
Denominator Exceptions	None
Denominator Exclusions	Women who: • Had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy. • Were in hospice care during the measurement year.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Have a birth sex of female
  AND
- Age must be ≥ 51 years and < 74 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Denominator Exclusions

A patient will be excluded from the measure if they meet any of the following conditions:

- Have an active diagnosis for two unilateral mastectomies
- Have an active diagnosis for history of bilateral mastectomy
- Have a documented history of a bilateral mastectomy or two unilateral mastectomies
- Had a bilateral mastectomy or two unilateral mastectomies

Diagnosis

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for bilateral and unilateral mastectomies can be located here. If documenting two

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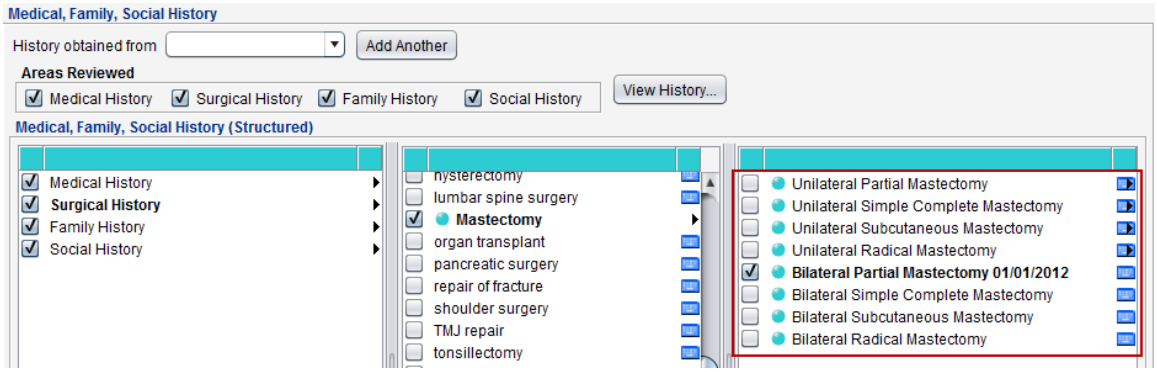
unilateral mastectomies, the **Anatomical Location Site** must be specified when adding each diagnosis code.

Documented History of Bilateral Mastectomy or Two Unilateral Mastectomies

To document a bilateral or two unilateral mastectomies in the patient history:

1. Go to **Encounter > Past History > Structured > Surgical History**
2. Select the hardcoded **Mastectomy** node
3. Select the appropriate bilateral or unilateral mastectomy type for the patient
    a. If selecting a unilateral mastectomy type, both **Right Breast** and **Left Breast** must be selected
4. Populate the **Date of Surgery** for the mastectomy
5. Click **OK** to save



Documenting history of bilateral mastectomy in Mastectomy node in Past History

Bilateral Mastectomy or Two Unilateral Mastectomies Performed

To document the performance of a bilateral mastectomy or two unilateral mastectomies in the Breast Cancer Screening flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Breast Cancer Screening** flowsheet and click **Add**
3. Select a **Value** for **Patient excluded due to the following reason**
4. Click **OK** to save

To document the performance of two unilateral mastectomies as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add any of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

CPT: 19180, 19307, 19306, 19305**,** 19304, 19303, 19240, 19220, 19200

Patients who were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

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SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

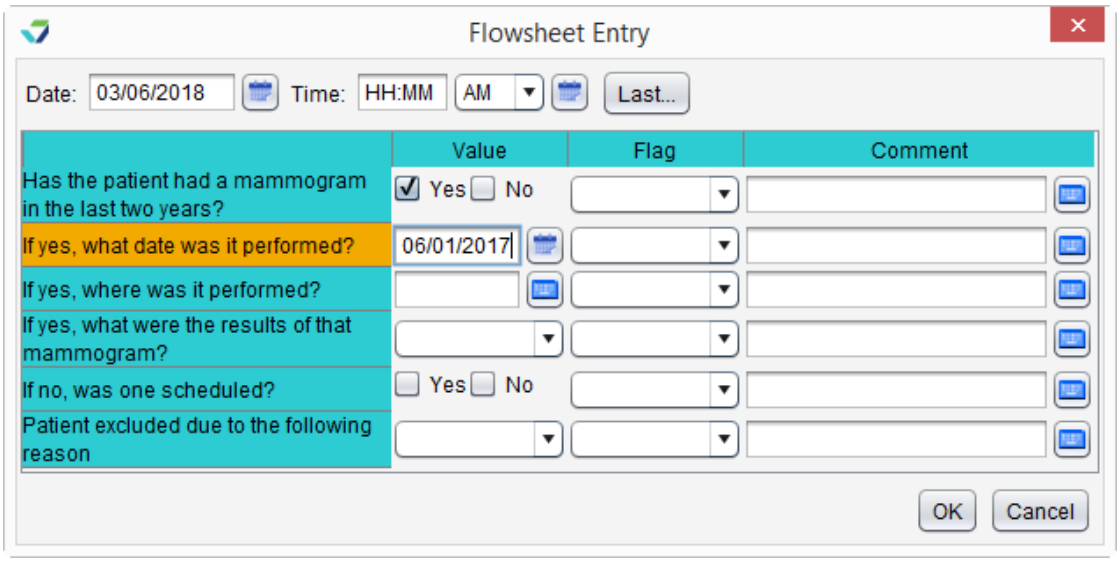
Numerator

A patient will be counted in the numerator if they received a mammogram during the Measurement Period or in the 15 months before the start of the Measurement Period.

Mammogram Performed

To document the performance of a mammogram in the Breast Cancer Screening flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Breast Cancer Screening** flowsheet and click **Add**
3. Select **Yes** for **Has the patient had a mammogram in the last two years?**
4. Populate a date for **If yes, what date was it performed?**
5. Click **OK** to save



Documenting mammogram performed in the Breast Cancer Screening flowsheet

To document the performance of a mammogram as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the numerator.

HCPCS: G0202, G0206, G0204

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms125v6

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CMS 127v6: Pneumococcal Vaccination Status for Older Adults

Measure: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 65 years of age and older with a visit during the measurement period
Numerator	Patients who have ever received a pneumococcal vaccination
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 65 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator
CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

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Numerator

A patient will be counted in the numerator if they receive a pneumococcal immunization before the end of the Measurement Period or if they report previously receiving a pneumococcal immunization.

Pneumococcal Vaccine Administered

To document the administration of a vaccine:

1. Go to **Encounters > Immunizations > Adult tab**
2. Click the **Add** button for **Pneumococcal**
3. Complete the fields in the **Serum** section
4. Complete the applicable fields of the **Administration** section
5. Click **Save**

To document the administration of a vaccine as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the numerator.

CPT: 90670, 90732

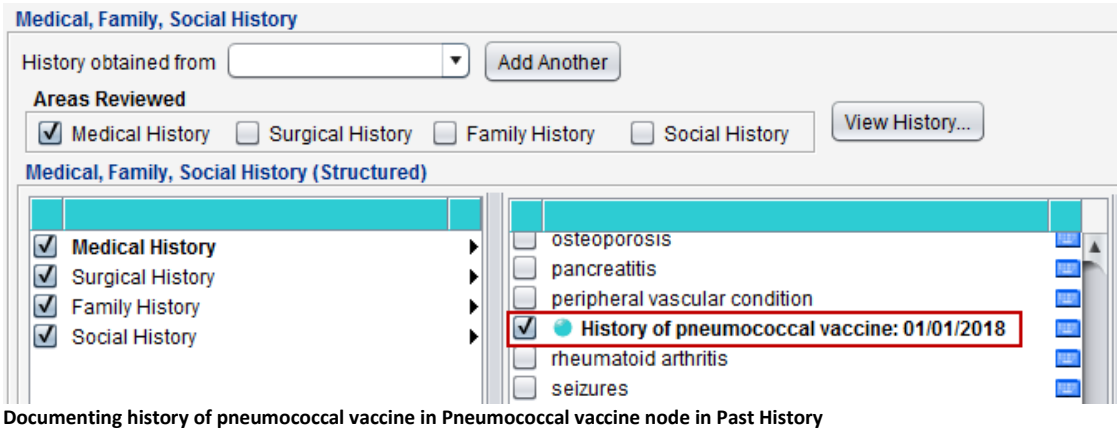
Previous Receipt of a Pneumococcal Immunization

To document a patient report of a previously received pneumococcal immunization in the Immunizations tab:

1. Go to **Encounter > Immunizations > Adult tab**
2. Click the **Add** button for **Pneumococcal**
3. Select the **Historic** checkbox
4. Document the date the immunization was given in the **Date** field of the Administration section
5. Click **Save**

To document previous receipt of a pneumococcal immunization in the patient history:

1. Go to **Encounter > Past History > Structured > Medical History**
2. Select the hardcoded **Pneumococcal vaccine** node
3. Populate the **Date Given** for the vaccine
4. Click **OK** to save



Documenting history of pneumococcal vaccine in Pneumococcal vaccine node in Past History

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms127v6

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CMS 128v6: Anti-depressant Medication Management

Measure: Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 18 years of age and older with a visit during the measurement period who were dispensed antidepressant medications in the time within 270 days (9 months) prior to the measurement period through the first 90 days (3 months) of the measurement period, and were diagnosed with major depression 60 days prior to, or 60 days after the dispensing event
Numerator	**Numerator 1:** Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date **Numerator 2:** Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who: • Were actively on an antidepressant medication in the 105 days prior to the Index Prescription Start Date • Were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years at the beginning of the Measurement Period
  AND
- Must have been prescribed antidepressant medication 9 months before the start of the Measurement Period or in the first 3 months of the Measurement Period
  AND
- Must have been diagnosed with major depression 60 days before they were prescribed antidepressant medication or 60 days after they were prescribed antidepressant medication
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223,

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99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 90791, 90792, 90832, 90834, 90837

HCPCS: G0402, G0438, G0439

Medication
The patient must have antidepressant medication prescribed 9 months before the start of the Measurement Period or in the first 3 months of the Measurement Period. A comprehensive list of eligible antidepressant medications can be located here.

Diagnosis
The patient must have an active diagnosis of major depression, diagnosed 60 days before they were prescribed antidepressant medication or in the 60 days after they were prescribed antidepressant medication.

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for major depression can be located here.

Denominator Exclusions

A patient will be excluded from the measure if they had an active prescription for antidepressant medication in the 105 days before being prescribed antidepressant medication.

Patients who were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

Numerator 1
A patient will be counted in Numerator 1 if they were on an antidepressant medication for 84 of the 114 days after the medication was prescribed.

Numerator 2
A patient will be counted in Numerator 2 if they were on an antidepressant medication for 180 of the 231 days after the medication was prescribed.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms128v6

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CMS 130v6: Colorectal Cancer Screening

Measure: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 50-75 years of age with a visit during the measurement period
Numerator	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: • Fecal occult blood test (FOBT) during the measurement period • Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period • Colonoscopy during the measurement period or the nine years prior to the measurement period • FIT-DNA during the measurement period or the two years prior to the measurement period • CT Colonography during the measurement period or the four years prior to the measurement period
Denominator Exceptions	None
Denominator Exclusions	Exclude patients: • With a diagnosis or past history of total colectomy or colorectal cancer • Who were in hospice care during the measurement year

⚙ A lab interface can be used to meet this eCQM but is not required. Customers interested in a lab interface should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 50 years and < 75 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

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Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

A patient will also be excluded from the measure if they have an active diagnosis of malignant neoplasm of colon or if they received a total colectomy.

Diagnosis

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for malignant neoplasm of colon can be located here.

Procedure Codes

To document a total colectomy procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

CPT: 44150, 44151, 44152, 44153, 44155, 44156, 44157, 44158, 44210, 44211, 44212

Numerator

A patient will be counted in the numerator if they received at least one of the following colon cancer screenings:

- FOBT during the Measurement Period
- Flexible sigmoidoscopy during the Measurement Period or the 4 years prior
- Colonoscopy during the Measurement Period or the 9 years prior
- FIT-DNA test during the Measurement Period or in the 2 years prior
- CT Colonography during the Measurement Period or in the 4 years prior

Colonoscopy, CT Colonography, Flexible Sigmoidoscopy, or FIT-DNA Performed

To document the performance of any of these procedures, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the numerator.

Colonoscopy

CPT: 44388, 44389, 44390, 44394, 44393, 44392, 44391, 45380, 45379, 45378, 45355, 44408, 44407, 44406, 44405, 44404, 44403, 44402, 44401, 44397, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45388, 45389, 45390, 45391, 45392, 45393, 45398
HCPCS: G0105, G0121

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CT Colonography
CPT: 74263

Flexible Sigmoidoscopy
CPT: 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45346, 45347, 45349, 45350
HCPCS: G0104

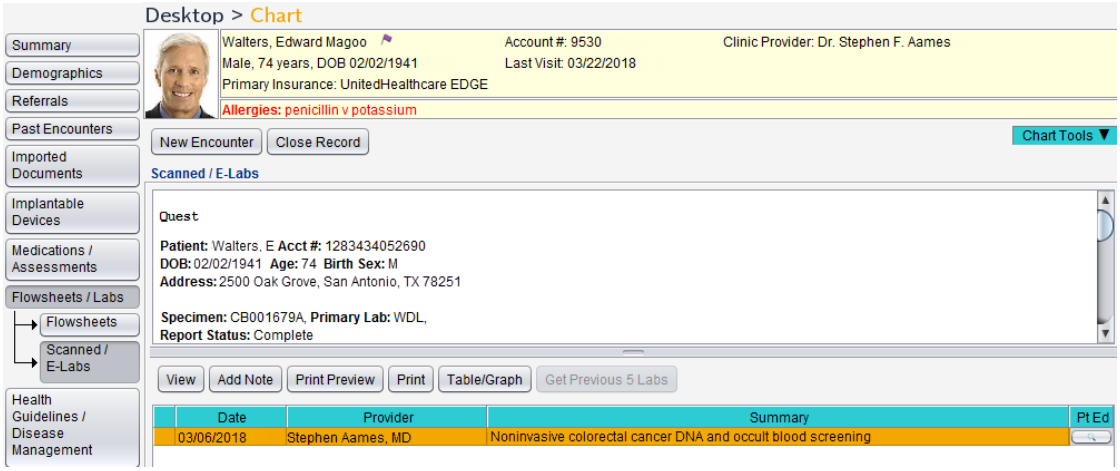
FIT-DNA
CPT: 81528
HCPCS: G0464

FOBT and FIT-DNA Test Results
To document that an FOBT test was performed, an e-Lab result for the test must be stored to the patient chart. FIT-DNA e-Lab results are also eligible for numerator inclusion.

To store an e-Lab result to the patient chart:

1. From the **Clinic Inbox**, select the lab result to be stored and click **View**
2. Click **Select** to search for and select a patient
3. Verify patient displayed matches the lab result and select the **I have verified the following lab results belong to the above patient** checkbox
4. Click **Sign/Route**
5. Select the **Sign** checkbox and click **OK**

e-Lab results stored to the patient chart can be viewed in the **Flowsheets/Labs > Scanned/E-Labs** tab.



FIT-DNA e-Lab result stored to patient chart

eCQI Reference
https://ecqi.healthit.gov/ecqm/measures/cms130v6

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CMS 131v6: Diabetes: Eye Exam

Measure: Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 18-75 years of age with diabetes with a visit during the measurement period
Numerator	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period **or** a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years and < 75 years at the beginning of the Measurement Period
  AND
- Must have an active diagnosis of Type 1 or Type 2 diabetes during the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 92002, 92004, 92012, 92014

HCPCS: G0402, G0438, G0439

Diagnosis

The patient must have an active diagnosis of Type 1 or Type 2 diabetes during Measurement Period. Patients with a diagnosis of secondary diabetes due to another condition are not counted. Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diabetes diagnosis codes can be located here.

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Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

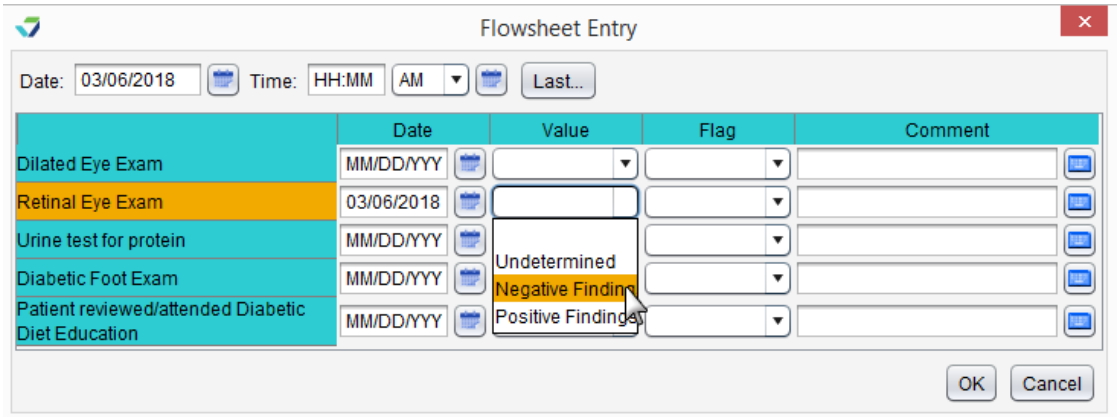
A patient will be counted in the numerator if they received a retinal eye exam or a dilated eye exam during the Measurement Period **OR** if they received a retinal or dilated eye exam with a **Negative** finding in the 12 months before the start of the Measurement Period.

The eye exam must be performed by an ophthalmologist or optometrist.

Documenting a Retinal/Dilated Eye Exam

To document a retinal or dilated eye exam:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Diabetes Care** flowsheet and click **Add**
3. Select a **Date** and a **Value** for **Dilated Eye Exam** or **Retinal Eye Exam**
4. Click **OK** to save



Documenting a retinal eye exam

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms134v6

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CMS 134v6: Diabetes: Medical Attention for Nephropathy

Measure: The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 18-75 years of age with diabetes with a visit during the measurement period
Numerator	Patients with a screening for nephropathy or evidence of nephropathy during the measurement period
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

⚙ A lab interface can be used to meet this eCQM but is not required. Customers interested in a lab interface should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years and < 75 years at the beginning of the Measurement Period
  AND
- Must have an active diagnosis of Type 1 or Type 2 diabetes during the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Diagnosis

The patient must have an active diagnosis of Type 1 or Type 2 diabetes during Measurement Period. Patients with a diagnosis of secondary diabetes due to another condition are not counted. Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diabetes diagnosis codes can be located here.

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Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

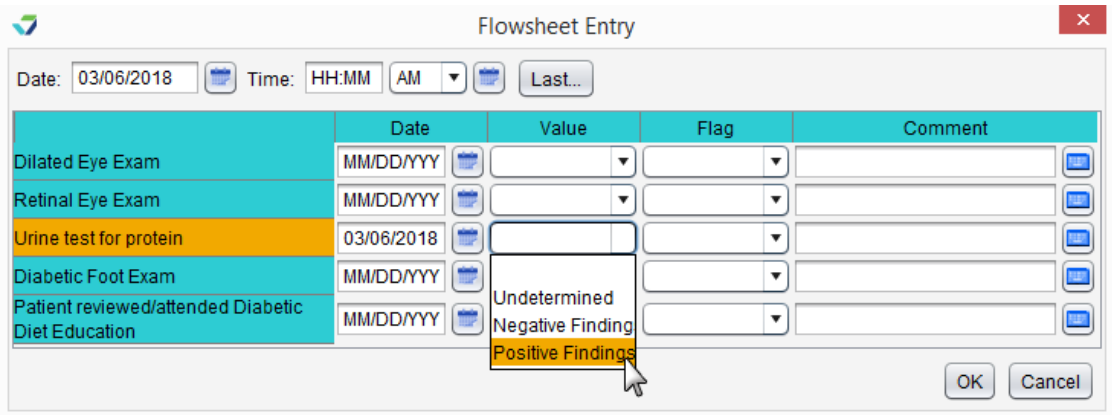
A patient will be counted in the numerator if they received a screening for urine protein during the Measurement Period **OR** have evidence of nephropathy during the Measurement Period. Evidence of nephropathy qualifies as one or more of the following:

- Active diagnosis of Hypertensive Chronic Kidney Disease, Kidney Failure, Glomerulonephritis and Nephrotic Syndrome, Diabetic Nephropathy, or Proteinuria
- Active prescription for an ACE inhibitor or angiotensin-receptor blocker (ARB)
- Kidney transplant, vascular access for dialysis, dialysis services, or end-stage renal disease (ESRD) monthly outpatient services performed

Documenting a Urine Protein Test

To document the performance of a urine protein test in the Diabetes Care flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Diabetes Care** flowsheet and click **Add**
3. Select a **Date** and a **Value** for **Urine test for protein**
4. Click **OK** to save



Documenting a urine protein test

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To document the performance of a urine protein test as an e-Lab result:

1. From the **Clinic Inbox**, select the lab result to be stored and click **View**
2. Click **Select** to search for and select a patient
3. Verify patient displayed matches the lab result and select the **I have verified the following lab results belong to the above patient** checkbox
4. Click **Sign/Route**
5. Select the **Sign** checkbox and click **OK**

Evidence of Nephropathy
Diagnosis
Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for evidence of nephropathy can be located here.

Medication
To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible ACE inhibitor and ARB medications can be located here.

Procedure Codes
To document a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the numerator.

Kidney Transplant
CPT: 50340, 50360, 50365, 50370, 50380
HCPCS: S2065

Vascular Access for Dialysis
CPT: 36147, 36148, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831, 36832, 36833

Dialysis Services
CPT: 90920, 90921, 90924, 90925, 90935, 90937, 90940, 90945, 90947
HCPCS: G0257

ESRD Monthly Outpatient Services
CPT: 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512

eCQI Reference
https://ecqi.healthit.gov/ecqm/measures/cms134v6

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CMS 136v7: Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Measure: Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported: **a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase** **b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended**		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	**Denominator 1:** Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period. **Denominator 2:** Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the Index Prescription Start Date (IPSD), and who had a visit during the measurement period.
Numerator	**Numerator 1:** Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD. **Numerator 2:** Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.
Denominator Exceptions	None
Denominator Exclusions	**Denominator 1 Exclusions** Exclude patients: • Diagnosed with narcolepsy at any point in their history or during the measurement period • Who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 30 days after the IPSD • Who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date • Who were in hospice care during the measurement year **Denominator 2 Exclusions** Exclude patients: • Diagnosed with narcolepsy at any point in their history or during the measurement period • Who had an acute inpatient stay with a principal diagnosis of mental health or

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	substance abuse during the 300 days after the IPSD • Who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date • Who were in hospice care during the measurement year

Denominator

Denominator 1

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 6 years and < 12 years at the beginning of the Measurement Period
  AND
- Must have been prescribed ADHD medication within the 60 days after the start of the Measurement Period or in the 90 days before the start of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator 1

CPT: 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99212, 99213, 99214, 99215, 99201, 99202, 99203, 99204, 99205, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Medication

The patient must have ADHD medication prescribed in the 90 days before the start of Measurement Period through 60 days after the start of the Measurement Period.

To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication**

Examples of ADHD medications include Adderall and Vyvanse. A comprehensive list of eligible ADHD medications can be located here.

Denominator 2

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 6 years and < 12 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP
  AND
- Must have been prescribed ADHD medication within the 60 days after the start of the Measurement Period or in the 90 days before the start of the Measurement Period
  AND
- Must remain on the ADHD medication for at least 210 of the 300 days following the initial prescription

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Encounter Codes Eligible for Denominator 2
CPT: 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99212, 99213, 99214, 99215, 99201, 99202, 99203, 99204, 99205, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Medication
The patient must have ADHD medication prescribed in the 90 days before the start of Measurement Period through 60 days after the start of the Measurement Period and must remain on the medication for at least 210 of the 300 days following the initial prescription.

To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication**

Examples of ADHD medications include Adderall and Vyvanse. A comprehensive list of eligible ADHD medications can be located here.

Denominator Exclusions

A patient will be excluded from **Denominator 1** and **Denominator 2** if they have an active diagnosis of narcolepsy **OR** were taking ADHD medication in the 120 days prior to the initial prescription **OR** were in hospice care during the Measurement Period.

Diagnosis
Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for narcolepsy can be located here.

Medication
To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible ADHD medications can be located here.

Hospice Care
To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

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Numerator

Numerator 1

A patient will be counted in Numerator 1 if they have at least one face-to-face encounter with a practitioner with prescribing authority in the 30 days after the initial prescription for ADHD medication.

Encounter Codes Eligible for Numerator 1

CPT: 99201, 99202, 99203, 99204, 99205**,** 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99411, 99412, 96150, 96151, 96152, 96153, 96154, 98960, 98961, 98962, 99078, 99510, 99401, 99402, 99403, 99404, 90845, 90847, 90849, 90853, 90875, 90876, 99217, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394, 90791, 90792, 90832, 90834, 90837, 99221, 99222, 99223, 99231, 99232, 99233, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99384, 99385, 99386, 99387, 99024, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Numerator 2

A patient will be counted in Numerator 2 if they have at least one face-to-face encounter with a practitioner with prescribing authority in the 30 days after the initial prescription for ADHD medication **AND** have at least two follow-up encounters in the 31-300 days after the initial prescription.

One of the two follow-up encounters may be a telephone encounter.

Face-to-Face Encounter Codes Eligible for Numerator 2

CPT: 99201, 99202, 99203, 99204, 99205**,** 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99411, 99412, 96150, 96151, 96152, 96153, 96154, 98960, 98961, 98962, 99078, 99510, 99401, 99402, 99403, 99404, 90845, 90847, 90849, 90853, 90875, 90876, 99217, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394, 90791, 90792, 90832, 90834, 90837, 99221, 99222, 99223, 99231, 99232, 99233, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99384, 99385, 99386, 99387, 99024, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Telehealth Encounter Codes Eligible for Numerator 2

CPT: 99441, 99442, 99443, 99444, 98966, 98967, 98968, 98969, 98966, 98967, 98968

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms136v7

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CMS 138v6: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: **a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months** **b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention** **c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user**		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	**Denominator 1:** All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period **Denominator 2:** All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user **Denominator 3:** All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Numerator	**Numerator 1:** Patients who were screened for tobacco use at least once within 24 months **Numerator 2:** Patients who received tobacco cessation intervention **Numerator 3:** Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco use
Denominator Exceptions	**Denominator 1 Exceptions:** Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) **Denominator 2 Exceptions:** Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason) **Denominator 3 Exceptions:** Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)
Denominator Exclusions	None

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Denominator

Denominator 1

Patients who meet the following criteria will be included in the denominator:

- Age is ≥ 18 years at the beginning of the Measurement Period
  AND
- Have at least two encounters or at least one preventive care encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator 1

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 96152, 96150, 92002, 92004, 92012, 92014, 90791, 90792, 90832, 90834, 90837, 96151, 97165, 97166, 97167, 97168, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Preventive Care Encounter Codes Eligible for Denominator 1

CPT: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429

HCPCS: G0438, G0439

Denominator 2

Patients who meet the following criteria will be included in the denominator:

- Age is ≥ 18 years at the beginning of the Measurement Period
  AND
- Were screened for tobacco use and identified as a tobacco user
  AND
- Have at least two encounters or at least one preventive care encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator 2

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 96152, 96150, 92002, 92004, 92012, 92014, 90791, 90792, 90832, 90834, 90837, 96151, 97165, 97166, 97167, 97168, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Preventive Care Encounter Codes Eligible for Denominator 2

CPT: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429

HCPCS: G0438, G0439

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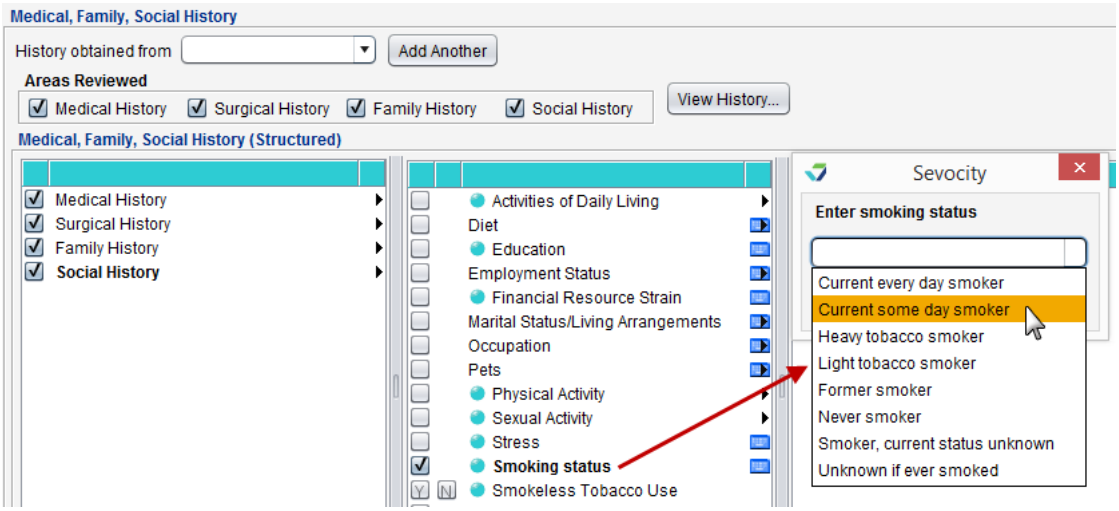
Screening and Identification as a Tobacco User
Screening for tobacco use is documented in the **Past History** tab of the patient encounter.

To document a tobacco screening in the patient history:

1. Go to **Encounter > Past History > Structured > Social History**
2. Select the hardcoded **Smoking status** node or the hardcoded **Smokeless Tobacco Use** node
3. Select the appropriate patient status from the **Smoking Status** list or select **Y** or **N** for **Smokeless Tobacco Use**
    a. If populating the **Smoking status** field, click **OK** to save



Selecting a status for patient Smoking status in Past History

- Selecting **Current every day smoker, Current some day smoker, Heavy tobacco smoker**, or **Light tobacco smoker** from **Smoking Status** identifies a patient as a tobacco user
- Selecting **Y** for **Smokeless Tobacco Use** identifies a patient as a tobacco user

Denominator 3
Patients who meet the following criteria will be included in the denominator:

- Age is ≥ 18 years at the beginning of the Measurement Period
  AND
- Have at least two encounters or at least one preventive care encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator 3
CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 96152, 96150, 92002, 92004, 92012, 92014, 90791, 90792, 90832, 90834, 90837, 96151, 97165, 97166, 97167, 97168, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

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Preventive Care Encounter Codes Eligible for Denominator 3
CPT: 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429

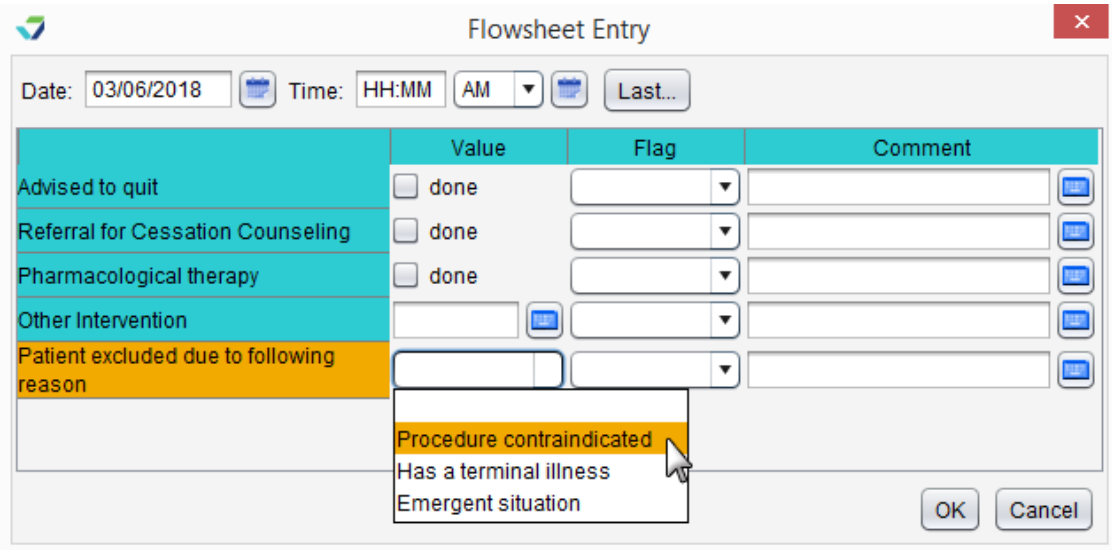
HCPCS: G0438, G0439

Denominator Exceptions

Denominator 1 Exception
A patient will be counted as an exception for Denominator 1 if there is documentation of a medical reason for not screening for tobacco use.

To document an exception from the Tobacco Cessation Intervention flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Tobacco Cessation Intervention** flowsheet and click **Add**
3. Click **Add Column**
4. Select a value from the **Patient excluded due to the following reason** list
5. Click **OK** to save



Documenting a patient exception in the Tobacco Cessation Intervention flowsheet

Denominator 2 Exception
A patient will be counted as an exception for Denominator 2 if there is documentation for not providing tobacco cessation intervention.

To document an exception from the Orders/Procedure tab:

1. Go to **Encounter > Orders/Procedure > Orders/Referrals**
2. Click **Add** to add one of the eligible codes listed below
3. Order **Status** must be **Not Performed**
4. **Not Performed Reason** must be **Medical contraindication, Procedure contraindication,** or **Treatment not tolerated**
5. Click **Add** to save

Procedure Codes Eligible for Denominator 2 Exception
CPT: 99406, 99407

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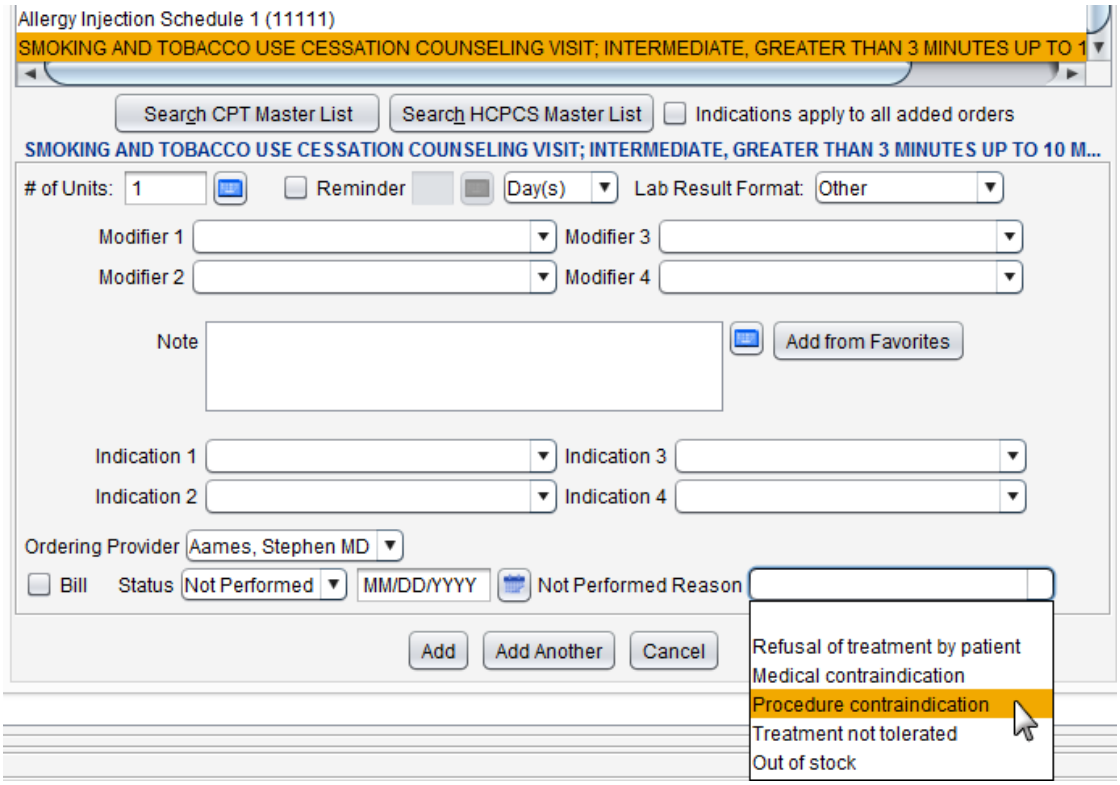

Documenting counseling not provided in the Add Order(s) window

Denominator 3 Exception

A patient will be counted as an exception for Denominator 3 if there is documentation for not screening for tobacco use **OR** for not providing tobacco cessation intervention for patients identified as tobacco users.

Exceptions for Denominator 3 can be performed using the steps outlined in **Denominator Exception 1** and **Denominator Exception 2**.

Numerator

Numerator 1

A patient will be counted in Numerator 1 if they were screened for tobacco use at least once during the Measurement Period or in the 12 months before the start of the Measurement Period. If a patient received multiple screenings, the most recent screening will be counted toward the numerator.

Tobacco Use Screening

To document a tobacco screening in the patient history:

1. Go to **Encounter > Past History > Structured > Social History**
2. Select the hardcoded **Smoking status** node or the hardcoded **Smokeless Tobacco Use** node
3. Select the appropriate patient status from the **Smoking Status** list or select **Y** or **N** for **Smokeless Tobacco Use**
    a. If populating the **Smoking status** field, click **OK** to save

Note: Selecting a Smoking Status of **Unknown if ever smoked** is equivalent to not performing a screening, and patients with this status will not be counted in the numerator

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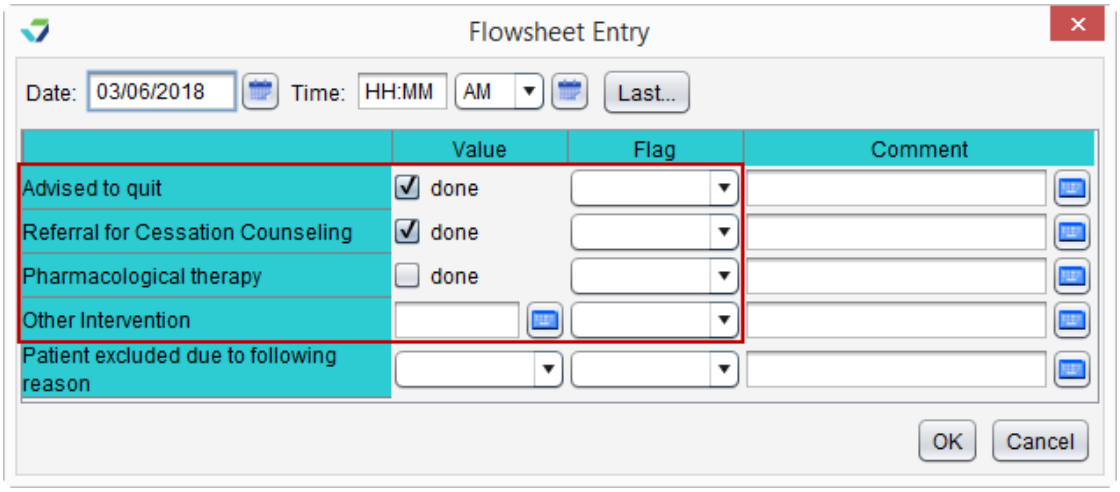
If a tobacco use screening was already documented during a previous visit, and there have been no changes to the patient's tobacco use status, selecting the **Social History** checkbox from **Areas Reviewed** in Past History will continue to count the patient toward the numerator on subsequent eligible encounters.

Numerator 2
A patient will be counted in Numerator 2 if they received tobacco cessation intervention on the day they were identified to be a tobacco user or any time before the end of the Measurement Period.

Documenting Tobacco Cessation Interventions
To document an intervention from the Tobacco Cessation Intervention flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Tobacco Cessation Intervention** flowsheet and click **Add**
3. Click **Add Column**
4. Select **Done** for **Advised to quit, Referral for Cessation Counseling,** or **Pharmacological therapy** OR populate a value for **Other Intervention**
5. Click **OK** to save



Interventions available in the Tobacco Cessation Intervention flowsheet

To document tobacco cessation counseling as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the numerator.

CPT: 99406, 99407

To prescribe a medication for pharmacological therapy, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible tobacco use cessation medications can be located here.

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Numerator 3
A patient will be counted in Numerator 3 if they were screened for tobacco use at least once during the Measurement Period or in the 12 months before the start of the Measurement Period **AND** if they received tobacco cessation intervention on the day they were identified to be a tobacco user or any time before the end of the Measurement Period if identified as a tobacco user.

Numerator 3 can be met by following the steps for **Tobacco Use Screening** outlined in **Numerator 1** and for **Documenting Tobacco Cessation Interventions** outlined in **Numerator 2.**

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms138v6

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CMS 139v6: Falls: Screening for Future Fall Risk

Measure: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Process	Yes	A higher percentage indicates better quality

Denominator	Patients aged 65 years and older with a visit during the measurement period
Numerator	Patients who were screened for future fall risk at least once within the measurement period
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who: • Were assessed to be non-ambulatory during the measurement period • Were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age is ≥ 65 years at the beginning of the Measurement Period
  AND
- Have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99393, 99397, 99401, 99402, 99403, 99404, 92540, 92541, 92542, 92548, 92002, 92004, 92012, 92014, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99394, 99396

HCPCS: G0402, G0438, G0439

Denominator Exclusions

A patient will be excluded from this measure if they were assessed to be non-ambulatory during the Measurement Period.

To document an exclusion from the Falls Risk Screening flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Falls Risk Screening** flowsheet and click **Add**
3. Click **Add Column**
4. Select **Bed-ridden**, **Unable to walk**, or **Wheelchair bound** for **Patient exempt due to following reason**
5. Click **OK** to save

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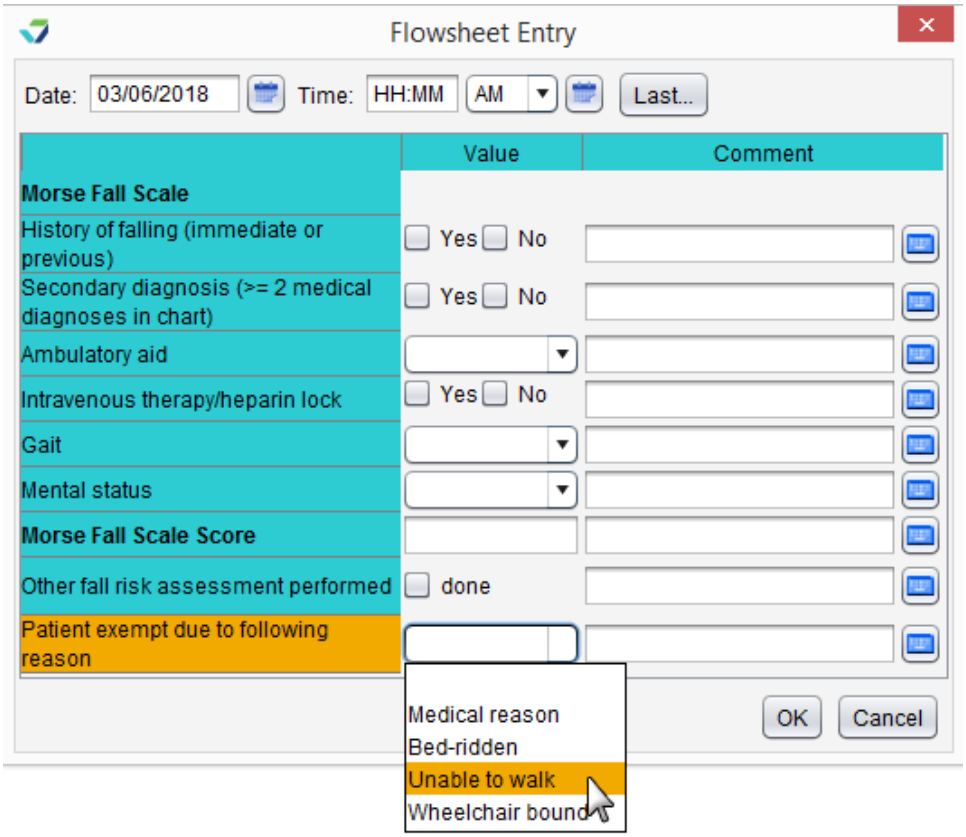

Documenting a patient exclusion in the Falls Risk Screening flowsheet

Patients who were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they received a fall risk screening with the Morse Fall Scale assessment or through another screening method during the Measurement Period.

Morse Fall Scale

To document a screening using the Morse Fall Scale:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Falls Risk Screening** flowsheet and click **Add**
3. Click **Add Column**
4. Select a **Value** for all questions in the screening
5. Click **OK** to save

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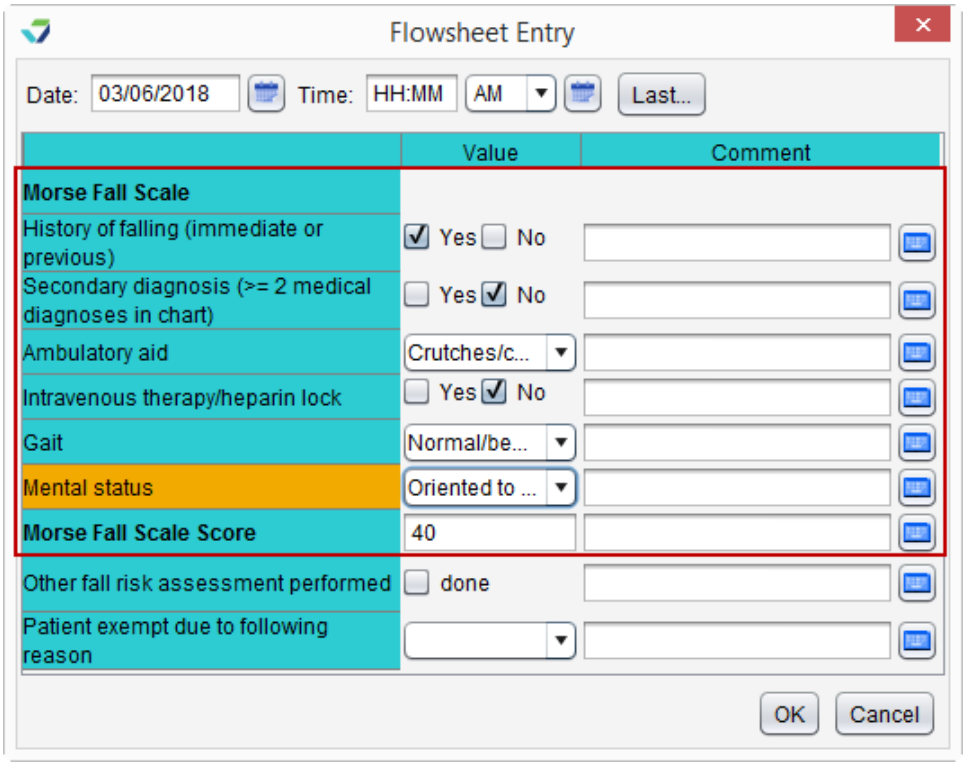

Completed Morse Fall Scale screening

Other Screening Methods

To document the performance of a fall risk screening with a different screening tool:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets > Add New Flowsheet**
2. Select the **Falls Risk Screening** flowsheet and click **Add**
3. Click **Add Column**
4. Select the **Done** checkbox for **Other fall risk assessment performed**
5. Click **OK** to save

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms139v6

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CMS 146v6: Appropriate Testing for Children with Pharyngitis

Measure: Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode		
Measure Type	**High Priority Measure**	**Scoring**
Process	Yes	A higher percentage indicates better quality

Denominator	Children 3-18 years of age who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit
Numerator	Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis
Denominator Exceptions	None
Denominator Exclusions	Children who: • Are taking antibiotics in the 30 days prior to the diagnosis of pharyngitis • Were in hospice care during the measurement year.

⚙ This eCQM requires a lab interface to be met. Customers interested in a lab interface should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 3 years and < 18 years at the beginning of the Measurement Period
  AND
- Must have an active diagnosis of pharyngitis or tonsillitis during the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP
  AND
- Must have an antibiotic prescribed on the day of their encounter or in the 3 days after the encounter

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456

Diagnosis

The patient must have an active diagnosis of pharyngitis or tonsillitis during the Measurement Period. Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for pharyngitis and tonsillitis can be located here.

Medication

To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible antibiotic medications for pharyngitis can be located here.

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Denominator Exclusions

A patient will be counted as an exclusion if:

- They have been prescribed an antibiotic in the 30 days before they were diagnosed with pharyngitis or tonsillitis
- Were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they received a group A strep test 3 days before their encounter, on the day of their encounter, or 3 days after their encounter.

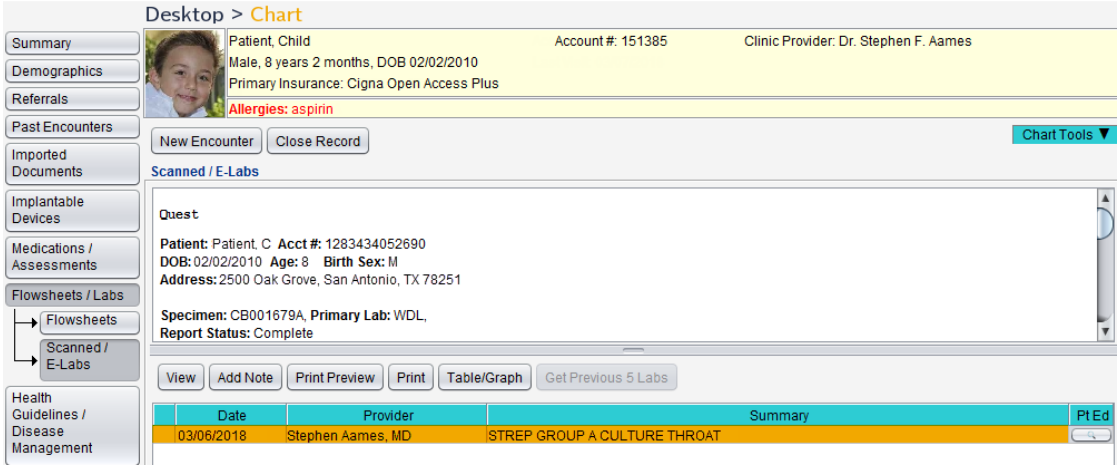
Group A Strep Test Performed

A positive result for group A strep must be stored as an e-Lab result in the patient chart to count toward the numerator.

To store an e-Lab result to the patient chart:

1. From the **Clinic Inbox**, select the lab result to be stored and click **View**
2. Click **Select** to search for and select a patient
3. Verify patient displayed matches the lab result and select the **I have verified the following lab results belong to the above patient** checkbox
4. Click **Sign/Route**
5. Select the **Sign** checkbox and click **OK**

e-Lab results stored to the patient chart can be viewed in the **Flowsheets/Labs > Scanned/E-Labs** tab.



Group A strep test e-Lab result stored to patient chart

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms146v6

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CMS 147v7: Preventive Care and Screening: Influenza Immunization

Measure: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	All patients aged 6 months and older seen for a visit during the measurement period and seen for a visit between October 1 and March 31
Numerator	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization
Denominator Exceptions	• Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reasons). • Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reasons). • Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reasons).
Denominator Exclusions	None

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 6 months at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP
  AND
- Must have been seen for an encounter between October 1 of the previous year through March 31 of the current year

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, , 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99315, 99316, 99221, 99222, 99223, 99231, 99232, 99233, 99281, 99282, 99283, 99284, 99285, 99251, 99252, 99253, 99254, 99255, 99024,

HCPCS: G0402, G0438, G0439

Procedure Codes Eligible for Denominator

Documentation of a procedure for Hemodialysis or Peritoneal Dialysis will also count toward an eligible visit.

To document a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the denominator

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Hemodialysis
CPT: 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 99512

Peritoneal Dialysis
CPT: 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970

Encounter Codes Eligible for Visit October 1 – March 31
CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429

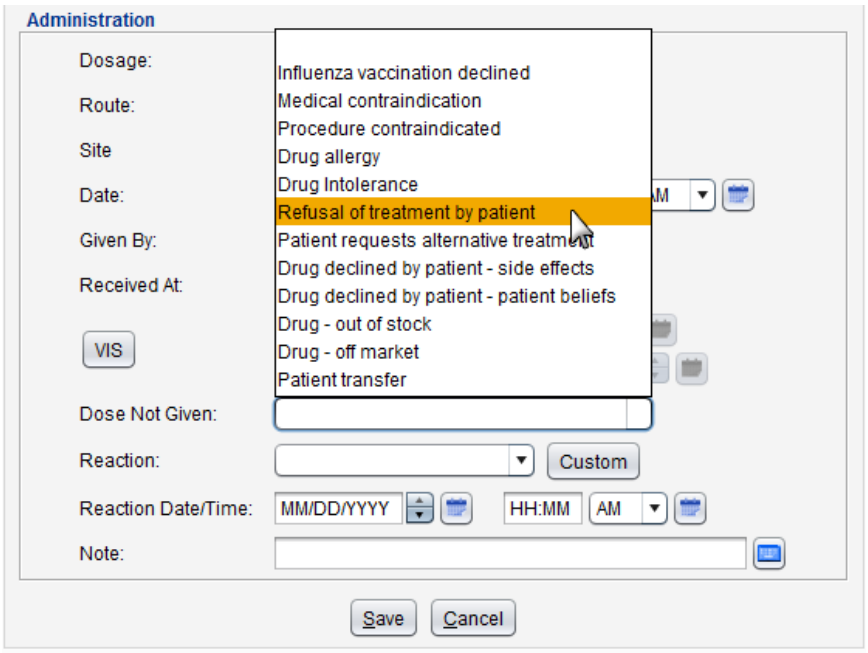
HCPCS: G0438, G0439

Denominator Exceptions

A patient will be counted as an exception for this measure if there is documentation of a medical, patient, or system reason for not receiving an influenza immunization.

To document an exception from the Immunizations tab:

1. Go to **Encounters > Immunizations > 0 to 2, 2 to 18,** or **Adult tab**
2. Click the **Add** button for **Influenza**
3. Select a reason from the **Dose Not Given** list
4. Click **Save**



Dose Not Given selection list in the Add Immunizations window

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Diagnosis Codes Eligible for Exception
An active diagnosis of allergy to eggs also qualifies as a patient exception. Diagnoses are documented in the **Assessment** tab of an encounter.

ICD-10: T78.08XA, T78.08XS, T78.08XD, Z91.012
ICD-9: 995.68, V15.03

Numerator

A patient will be counted in the numerator if they received an influenza immunization **OR** reported previously receiving an influenza immunization.

The immunization administration or date immunization was previously received must be within the 153 days prior to the start of the Measurement Period through the 89 days after the start of the Measurement Period.

Influenza Vaccine Administered

To document the administration of a vaccine from the Immunizations tab:

1. Go to **Encounters > Immunizations > 0 to 2, 2 to 18,** or **Adult tab**
2. Click the **Add** button for **Influenza**
3. Complete the fields in the **Serum** section
4. Complete the applicable fields of the **Administration** section
5. Click **Save**

To document the administration of a vaccine as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count toward the numerator.

CPT: 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90661, 90662, 90666, 90667, 90668, 90673, 90674, 90682, 90685, 90686, 90687, 90688
HCPCS: G0008, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039

Previous Receipt of an Influenza Immunization

To document a previously received influenza immunization:

1. Go to **Encounter > Immunizations > 0 to 2, 2 to 18,** or **Adult tab**
2. Click the **Add** button for **Influenza**
3. Select the **Historic** checkbox
4. Document the date the immunization was given in the **Date** field of the Administration section
    a. Optional: Populate the **Received At** field
5. Click **Save**

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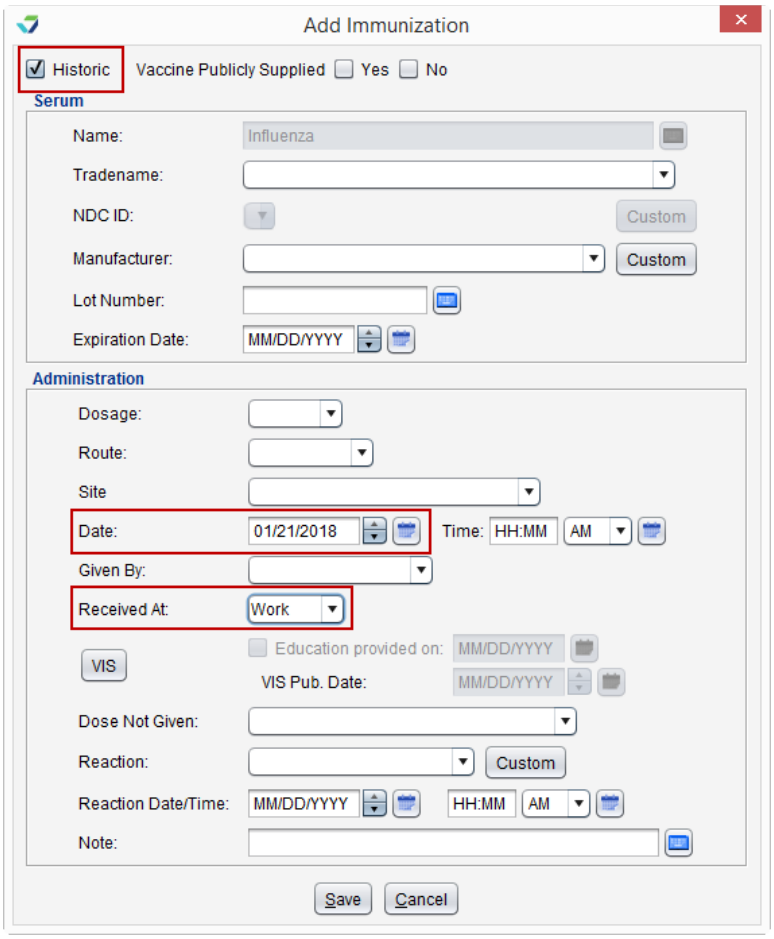

Documenting a previously received influenza immunization

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms147v7

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CMS 153v6: Chlamydia Screening for Women

Measure: Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period
Numerator	Women with at least one chlamydia test during the measurement period
Denominator Exceptions	None
Denominator Exclusions	Women who: • Are only eligible for the initial population due to a pregnancy test and who had an x-ray or an order for a specified medication within 7 days of the pregnancy test • Were in hospice care during the measurement year.

⚙ This eCQM requires a lab interface to be met. Customers interested in a lab interface should contact Sevocity Support to begin the process of a new interface setup. Interface setup requirements and fees vary per request.

Denominator

Patients who meet the following criteria will be included in the denominator:

- Have a birth sex of female
  AND
- Age must be ≥ 16 years and < 24 years at the beginning of the Measurement Period
  AND
- Must be identified as sexually active
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

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Characteristics of Sexual Activity
A patient can be identified as sexually active if they meet any of the following criteria during the Measurement Period:

- Has an active diagnosis of genital herpes, syphilis, chlamydia, HIV, inflammatory diseases of the female reproductive organs, gonococcal infection, venereal disease, or other female reproductive conditions
- Has an active diagnosis of complications of pregnancy, childbirth, and the puerperium
- Has a current prescription for contraceptive medication
- Received a prescription for contraceptive medication
- Has an order for a pregnancy test, pap test, or sexually transmitted infection test
- Has an order for a lab test or diagnostic study during pregnancy
- Has a completed procedure involving contraceptive devices or a procedure during pregnancy
- Has a completed procedure for a live delivery
- Responded **Yes** to having vaginal sex

Diagnosis
Diagnoses are documented in the Assessment tab of an encounter. A comprehensive list of eligible diagnosis codes for sexual activity characteristics can be located here.

Medication
To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible contraceptive medications can be located here.

Procedure Codes Eligible for Denominator
To document a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. The Order Status for procedures involving contraceptive devices, procedures during pregnancy, and delivery live births must be marked as Complete in order to count toward the denominator.

Pregnancy Test
CPT: 81025, 84702, 84703, 84704

Pap Test
CPT: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS: G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091

Sexually Transmitted Infection Test
CPT: 86592, 86593, 86631, 86632, 87110, 87164, 87166, 87270, 87320, 87490, 87491, 87492, 87590, 87591, 87592, 87620, 87621, 87622, 87660, 87800, 87801, 87808, 87810, 87850, 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175, 88235, 88267, 88269

Lab Test during Pregnancy
CPT: 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59200, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59610, 59612, 59614, 59618, 59620, 59622, 80055, 82105, 82106, 82143, 82731, 83632, 83661, 83662, 83663, 83664

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Diagnostic Study during Pregnancy
CPT: 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76827, 93325, 93976

Procedures Involving Contraceptive Devices
CPT: 11976, 58301, 58300
HCPCS: S4981

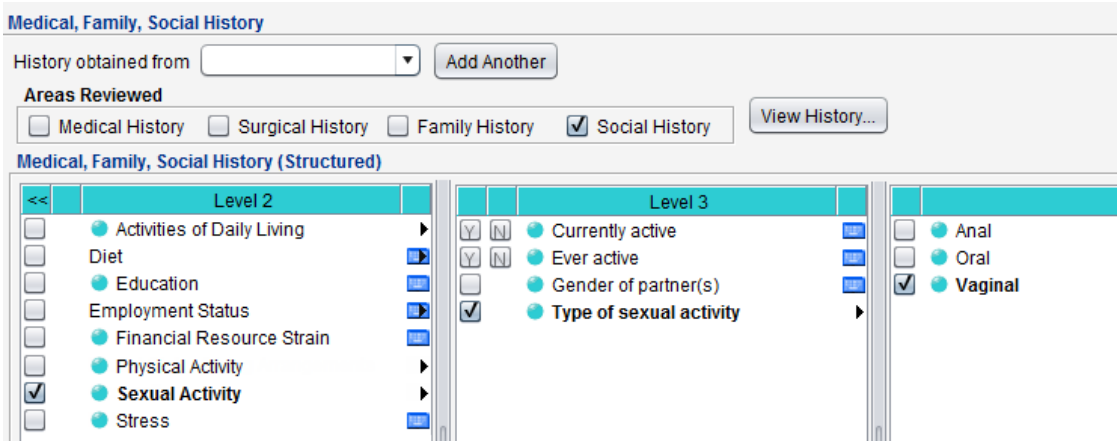
Procedures during Pregnancy
CPT: 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59412, 59414, 59430, 59525, 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, 59870, 59871, 59897, 59898, 59899

Delivery Live Births
CPT: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622

Affirmative Response to Sexual Activity – Vaginal Sex

To document an affirmative response to sexual activity - vaginal sex in the patient history:

1. Go to **Encounter > Past History > Structured > Social History**
2. Select the hardcoded **Sexual Activity** node
3. Select **Type of sexual activity** and **Vaginal**



Documenting sexual activity in Past History

Denominator Exclusions

A patient will be excluded from the measure if they were only included in the denominator due to a completed pregnancy test but received a prescription for isotretinoin or an x-ray study within 7 days of receiving the pregnancy test result. Patients who were in hospice care during the measurement year will also be excluded from the measure.

Medication

To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible isotretinoin medications can be located here.

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Procedure Codes Eligible for Denominator Exclusion

To document the order of an x-ray study, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below.

CPT: 79999

Hospice Care

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they received at least one chlamydia screening during the Measurement Period.

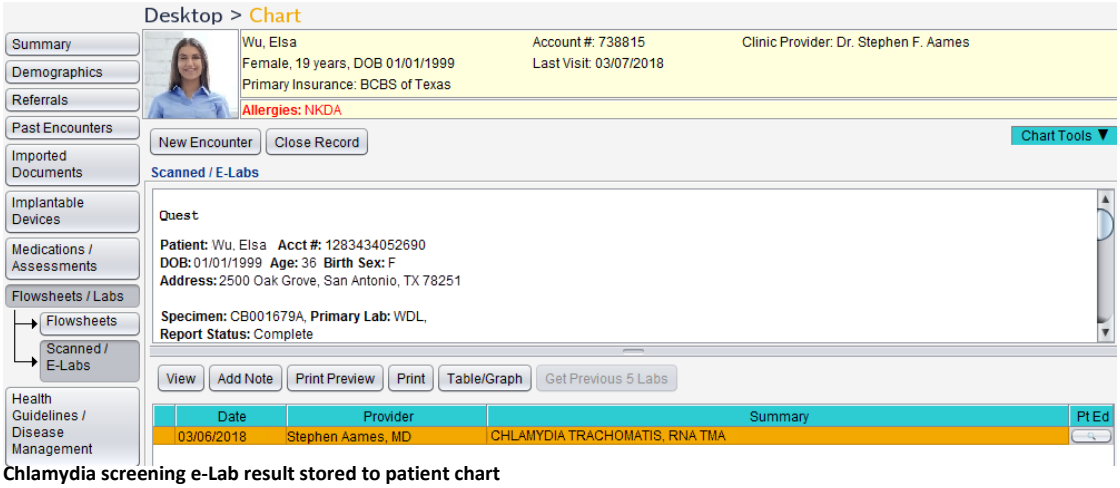
Chlamydia Screening Performed

To document that a chlamydia screening was performed, an e-Lab result for the test must be stored to the patient chart.

To store an e-Lab result to the patient chart:

1. From the **Clinic Inbox**, select the lab result to be stored and click **View**
2. Click **Select** to search for and select a patient
3. Verify patient displayed matches the lab result and select the **I have verified the following lab results belong to the above patient** checkbox
4. Click **Sign/Route**
5. Select the **Sign** checkbox and click **OK**

e-Lab results stored to the patient chart can be viewed in the **Flowsheets/Labs > Scanned/E-Labs** tab.



Chlamydia screening e-Lab result stored to patient chart

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms124v6

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CMS 155v6: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Measure: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported: • **Percentage of patients with height, weight, and body mass index (BMI) percentile documentation** • **Percentage of patients with counseling for nutrition** • **Percentage of patients with counseling for physical activity**		
Measure Type	**High Priority Measure**	**Scoring**
Process	No	A higher percentage indicates better quality

Denominator	Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period
Numerator	**Numerator 1:** Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period **Numerator 2:** Patients who had counseling for nutrition during a visit that occurs during the measurement period **Numerator 3:** Patients who had counseling for physical activity during a visit that occurs during the measurement period
Denominator Exceptions	None
Denominator Exclusions	Patients who: • Have a diagnosis of pregnancy during the measurement period • Were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 3 years and < 17 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP
  AND
- Encounter must be with a primary care physician or an obstetrician/gynecologist

Encounter Codes Eligible for Denominator

CPT: 99411, 99412, 99401, 99402, 99403, 99404, 99391, 99392, 99393, 99394, 99381, 99382, 99383, 99384, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99385, 99386, 99387, 99024, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

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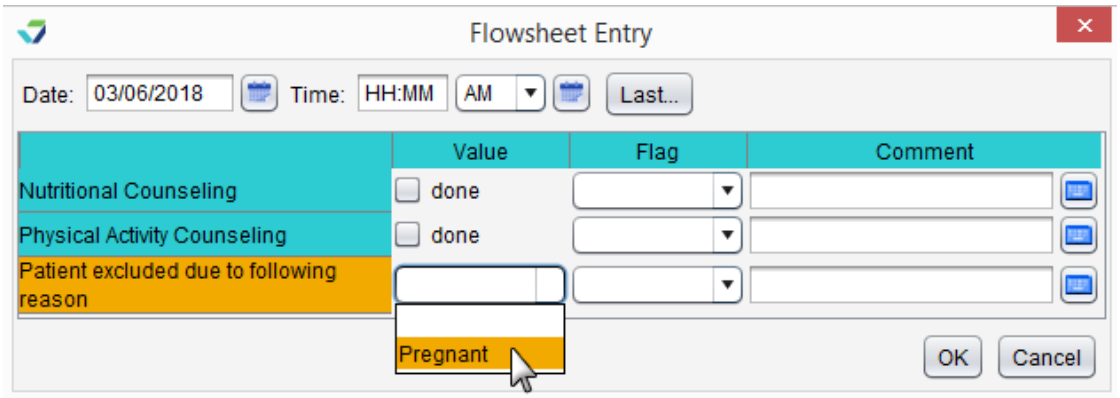
Denominator Exclusions

A patient will be excluded from the measure if they have an active diagnosis of pregnancy during the Measurement Period.

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for pregnancy can be located here. An exclusion can also be documented from the BMI – Pediatric flowsheet.

To document an exclusion from the BMI – Pediatric flowsheet:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets**
2. From the **BMI – Pediatric** flowsheet, click **Add Column**
3. Select **Pregnant** from the **Patient excluded due to following reason** list
4. Click **OK** to save



Documenting exclusion from BMI – Pediatric flowsheet

Patients who were in hospice care during the measurement year will also be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

Three separate actions are required for the numerator. A patient will be counted in the numerator if during the Measurement Period:

- Their height, weight, and BMI was documented
- They received counseling for nutrition
- They received counseling for physical activity

Numerator 1: Documenting Height, Weight, and BMI

BMI is calculated based on the patient height and weight as entered in the **Vitals** tab of an encounter.

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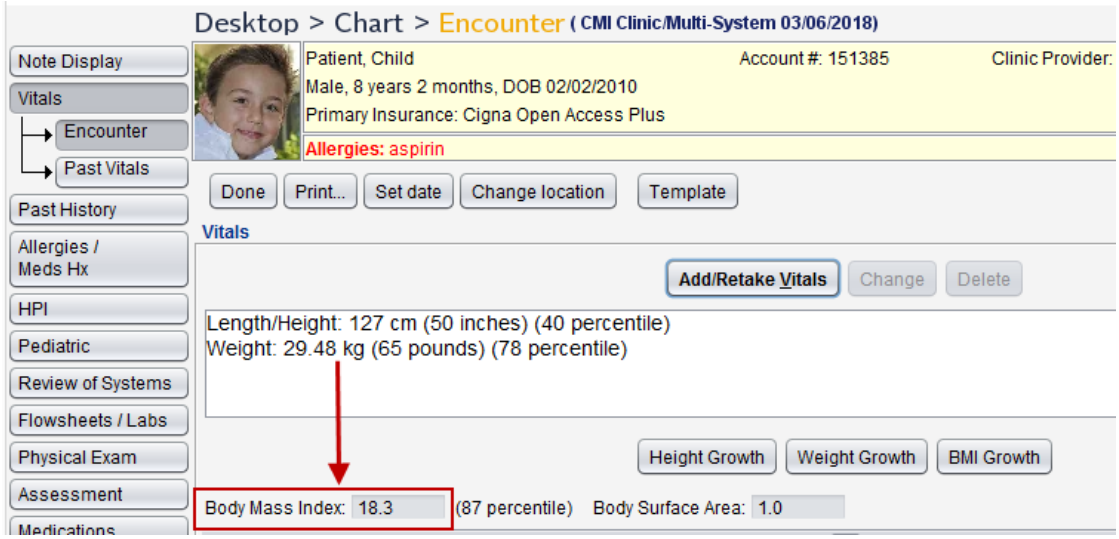
To document height and weight, go to **Encounter > Vitals >** click **Add/Retake Vitals**

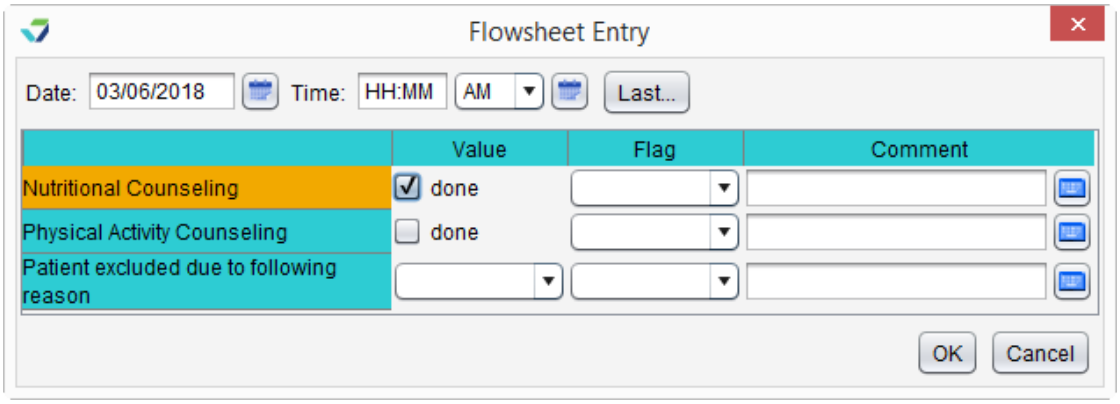


BMI calculated from patient Height and Weight

Numerator 2: Documenting Counseling for Nutrition

To document that nutrition counseling was provided:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets**
2. From the **BMI – Pediatric** flowsheet, click **Add Column**
3. Select the **Done** checkbox for **Nutrition Counseling**
4. Click **OK** to save



Documenting nutrition counseling was performed in BMI – Pediatric flowsheet

Numerator 3: Documenting Counseling for Physical Activity

To document that physical activity counseling was provided:

1. Go to **Encounter > Flowsheets/Labs > Standard Flowsheets**
2. From the **BMI – Pediatric** flowsheet, click **Add Column**
3. Select the **Done** checkbox for **Physical Activity Counseling**
4. Click **OK** to save

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms155v6

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CMS 156v6: Use of High-Risk Medications in the Elderly

Measure: Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported: a. Percentage of patients who were ordered at least one high-risk medication b. Percentage of patients who were ordered at least two of the same high-risk medications		
Measure Type	**High Priority Measure**	**Scoring**
Process	Yes	A lower percentage indicates better quality

Denominator	Patients 65 years and older who had a visit during the measurement period
Numerator	**Numerator 1:** Patients with an order for at least one high-risk medication during the measurement period **Numerator 2:** Patients with at least two orders for the same high-risk medication during the measurement period
Denominator Exceptions	None
Denominator Exclusions	Exclude patients who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 65 years at the beginning of the Measurement Period
  AND
- Must have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator
CPT: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

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SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in **Numerator 1** if at least one high-risk medication has been ordered for them during the Measurement Period. A patient will be counted in **Numerator 2** if at least two of the same high-risk medication have been ordered for them during the Measurement Period.

A high-risk medication is identified as: a prescription for medications classified as high-risk at any dose and for any duration; or as prescriptions for medications classified as high-risk at any dose with greater than a 90-day supply.

Examples of high-risk medications include muscle relaxants and certain antihistamines. A comprehensive list of eligible high-risk medications can be located here.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms156v6

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CMS 165v6: Controlling High Blood Pressure

Measure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period		
Measure Type	**High Priority Measure**	**Scoring**
Outcome	Yes	A higher percentage indicates better quality

Denominator	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period
Numerator	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
Denominator Exceptions	None
Denominator Exclusions	Exclude patients: • With evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period • With a diagnosis of pregnancy during the measurement period • Who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years and < 85 years at the beginning of the Measurement Period
  AND
- Have an existing diagnosis of essential hypertension or be diagnosed with essential hypertension within the first six months of the Measurement Period
  AND
- Have at least one encounter during the Measurement Period finalized by the EC/EP

Encounter Codes Eligible for Denominator
CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, 99221, 99222, 99223, 99231, 99232, 99233, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99305, 99306, 99307, 99308, 99309, 99310, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99024, 99391, 99392, 99393, 99394, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

HCPCS: G0402, G0438, G0439

Diagnosis Codes Eligible for Denominator
Diagnoses are documented in the **Assessment** tab of an encounter.

ICD-10: I10
ICD-9: 401.0, 401.1, 401.9

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Denominator Exclusions

A patient will be excluded from this measure if they meet any of the following conditions:

- Have an active diagnosis of pregnancy, end stage renal disease, or chronic kidney disease, stage 5 during the Measurement Period
- Received services related to kidney disease or a kidney transplant before or during the Measurement Period
- Were in hospice care during the measurement year

Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for this exclusion can be located here.

Encounter Codes Eligible for Denominator Exclusion
CPT: 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 90997, 90999, 99512

Procedure Codes Eligible for Denominator Exclusion
To document the performance of a services received related to kidney disease or a kidney transplant, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

Dialysis Services
CPT: 90920, 90947, 90945, 90940, 90937, 90935, 90925, 90924, 90921
HCPCS: G0257

Vascular Access for Dialysis
CPT: 36147, 36833, 36832, 36831, 36821, 36820, 36819, 36818, 36815, 36810, 36800, 36148

Kidney Transplant
CPT: 50340, 50380, 50370, 50365, 50360
HCPCS: S2065

Hospice Care
To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

Numerator

A patient will be counted in the numerator if they have a documented blood pressure reading of < 140/90 during their most recent encounter during the Measurement Period. If no blood pressure is recorded during the Measurement Period, the patient's blood pressure is assumed not controlled.

If there are multiple blood pressure readings on the same day, the lowest reading will be counted toward the numerator.

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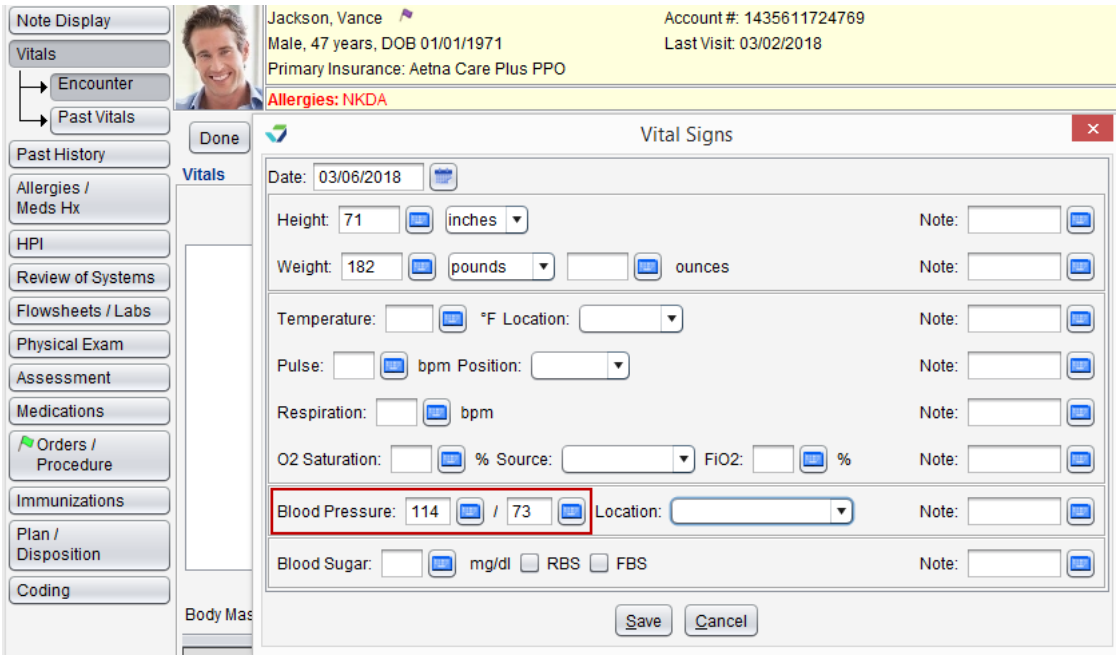
Documenting Blood Pressure
Blood pressure is documented in the **Vitals** tab of an encounter.

To document blood pressure, go to **Encounter > Vitals >** click **Add/Retake Vitals**



Blood pressure documented in Vitals

eCQI Reference
https://ecqi.healthit.gov/ecqm/measures/cms165v6

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CMS 166v7: Use of Imaging Studies for Low Back Pain

Measure: Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis ***This measure is for use in the Medicaid EHR Incentive Program for Eligible Professionals only***		
Measure Type	**High Priority Measure**	**Scoring**
Process	Yes	A higher percentage indicates better quality

Denominator	Patients 18-50 years of age with a diagnosis of uncomplicated low back pain during a visit
Numerator	Patients without an imaging study conducted on the index episode start date or in the 28 days following the index episode start date
Denominator Exceptions	None
Denominator Exclusions	Exclude patients: • With a diagnosis of uncomplicated low back pain during the 180 days (6 months) prior to the index episode start date • With neurologic impairment, spinal infection, or diagnosis of IV drug abuse any time during the 12 months prior to the index episode start date through 28 days after the index episode start date • With trauma any time during the 90 days prior to the index episode start date through 28 days after the index episode start date • With a diagnosis of HIV or cancer any time in the patient's history through 28 days after the index episode start date • Who had a major organ transplant any time in the patient's history through 28 days after the index episode start date • Who had prolonged use of corticosteroids (at least 90 consecutive days) any time in the 12 months prior to the index episode start date • Who were in hospice care during the measurement year

Denominator

Patients who meet the following criteria will be included in the denominator:

- Age must be ≥ 18 years and < 50 years at the beginning of the Measurement Period
  AND
- Must have an encounter finalized by the EP within the first 337 days of the Measurement Period during which they received a diagnosis for uncomplicated low back pain

Encounter Codes Eligible for Denominator

CPT: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 98966, 98967, 98968, 98969, 99441, 99442, 99443, 99444, 98925, 98926, 98927, 98928, 98929, 98940, 98941, 98942, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99024, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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HCPCS: G0402, G0438, G0439

Diagnosis
The patient must have a diagnosis of uncomplicated low back pain. A comprehensive list of eligible diagnosis codes for uncomplicated low back pain can be located here.

Denominator Exclusions

Patients who were in hospice care during the measurement year will be excluded from the measure.

To document hospice care services as a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add one of the eligible codes listed below. Order Status must be marked as **Complete** in order to count as an exclusion.

SNOMED CT: 385763009, 385765002

SNOMED CT codes must be added as a **Favorite** in **Preferences > Form Data > Orders** prior to being added in the **Orders/Referrals** tab.

A patient will also be excluded from this measure if they meet any of the following criteria:

- Had a diagnosis of HIV or cancer prior to or in the 28 days after the encounter in which they were diagnosed with uncomplicated low back pain
- Was diagnosed with uncomplicated low back pain in the 180 days before the encounter in which they were diagnosed with uncomplicated low back pain
- Had a major organ transplant performed prior to or in the 28 days after the encounter in which they were diagnosed with uncomplicated low back pain
- Had an active diagnosis of trauma in the 90 days prior to or in the 28 days after the encounter in which they were diagnosed with uncomplicated low back pain
- Had an active diagnosis of IV drug abuse, neurologic impairment, or spinal infection in the 12 months prior to or in the 28 days after the encounter in which they were diagnosed with uncomplicated low back pain
- Had an active prescription for corticosteroids for at least 90 days in the 12 months prior to the encounter in which they were diagnosed with uncomplicated low back pain

Diagnosis
Diagnoses are documented in the **Assessment** tab of an encounter. A comprehensive list of eligible diagnosis codes for these exclusions can be located here.

Medication
To prescribe a medication, go to **Encounter > Medications > Manage/Prescribe Meds > Prescribe a Medication.** A comprehensive list of eligible corticosteroids can be located here.

Procedure Codes
To document a procedure, go to **Encounter > Orders/Procedure > Orders/Referrals** and click **Add** to add an eligible code. Order Status must be marked as **Complete** in order to count toward an exclusion. A comprehensive list of eligible procedure codes for major organ transplant can be located here.

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Numerator

A patient will be counted in the numerator if they **did not** receive an imaging study on the day of the encounter in which they were diagnosed with uncomplicated low back pain or in the 28 days after the encounter in which they were diagnosed with uncomplicated low back pain.

The imaging studies for uncomplicated low back pain counted for this measure are: MRI of the lower spine, CT scan of the lower spine, and X-ray of the lower spine.

eCQI Reference

https://ecqi.healthit.gov/ecqm/measures/cms166v7

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eCQM Reports

Sevocity's eCQM report allows users to query their patient data to assess performance on quality measures. These reports can be run on demand and exported as a PDF or QRDA file.

2018 eCQMs	P = Process Measures	O = Outcome Measure	↑ = High Priority Measure
EP/EC eCQMs			
(P)	CMS 2v7 Preventive Care and Screening: Screening for Depression and Follow-Up		
(P,↑)	CMS 50v6 Closing the Referral Loop: Receipt of Specialist Report		
(P,↑)	CMS 68v7 Documentation of Current Medications in the Medical Record		
(P)	CMS 69v6 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan		
(O,↑)	CMS 75v6 Children Who Have Dental Decay or Cavities		
(P)	CMS 117v6 Childhood Immunization Status		
(O,↑)	CMS 122v6 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)		
(P)	CMS 123v6 Diabetes: Foot Exam		
(P)	CMS 124v6 Cervical Cancer Screening		
(P)	CMS 125v6 Breast Cancer Screening		
(P)	CMS 127v6 Pneumococcal Vaccination Status for Older Adults		
(P)	CMS 128v6 Anti-depressant Medication Management		
(P)	CMS 130v6 Colorectal Cancer Screening		
(P)	CMS 131v6 Diabetes: Eye Exam		
(P)	CMS 134v6 Diabetes: Medical Attention for Nephropathy		
(P)	CMS 136v7 Follow-Up Care for Children Prescribed ADHD Medication (ADD)		
(P)	CMS 138v6 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		
(P,↑)	CMS 139v6 Falls: Screening for Future Fall Risk		
(P,↑)	CMS 146v6 Appropriate Testing for Children with Pharyngitis		
(P)	CMS 147v7 Preventive Care and Screening: Influenza Immunization		
(P)	CMS 153v6 Chlamydia Screening for Women		
(P)	CMS 155v6 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents		
(P,↑)	CMS 156v6 Use of High-Risk Medications in the Elderly		
(O,↑)	CMS 165v6 Controlling High Blood Pressure		
Medicaid EP Only eCQM			
(P,↑)	CMS 166v7 Use of Imaging Studies for Low Back Pain		
	eCQM Reference Guide (PDF)		
	Consolidated QRDA Export		

2018 eCQM reports

Running a Report

From the Reporting Tool, go to **Reports > eCQMs > 2018** and click the name of the measure to be reported on.

To run the report:

1. Select a **Provider**: Individual (EC/EP) or Group (listed by TIN)
2. Select the **Reporting Period** for the eCQM data. The report can be run by the following date ranges:
    a. Calendar Year: will report data for the current year to date listed on the report
    b. 90 Days: will report data for a continuous 90 day period, calculated based on the **From** date
    c. Custom date range: will report data based on a specific date range
3. Click **Generate Report** to process the data for the report parameters selected

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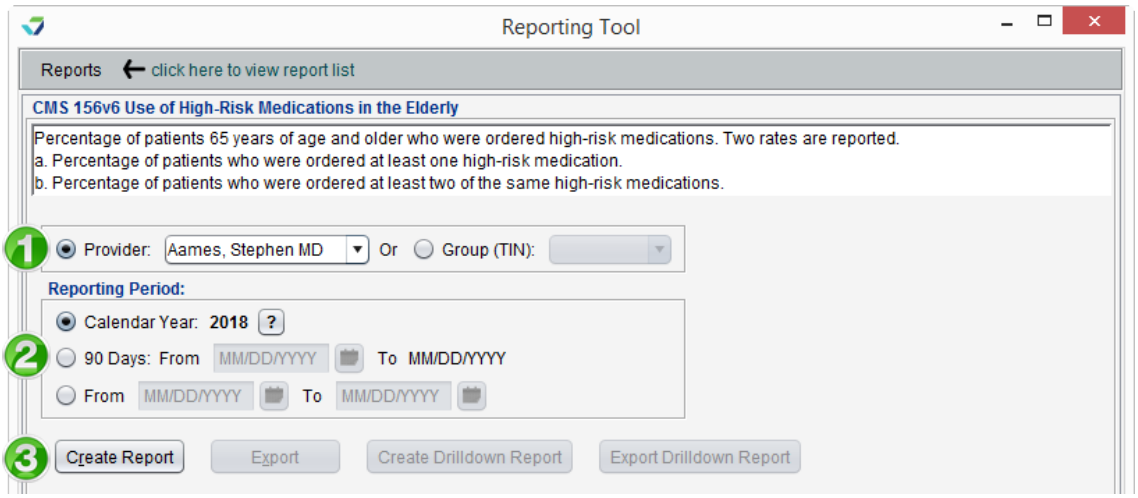

Running eCQM report for an individual provider

The generated report will display the Population, Denominator, Exclusions, Exceptions, Numerator, and Percentage at which the measure is met:

CMS 2v7 Preventive Care and Screening: Screening for Depression and Follow-Up
CMI Clinic
03/31/2018 02:10 PM

User: Aames, Stephen MD
Date From: 01/01/2018
Date To: 03/31/2018

Population	Denominator	Exclusions	Exceptions	Numerator	Percentage (%)
100	100	0	0	62	62

The generated report will display in a PDF format. Once generated, the following actions can be performed for the report:

- **Export:** allows the user to save the eCQM report in PDF format to their local machine
- **Create Drilldown Report:** generates a report in PDF format that lists the patients included in the measure
- **Export Drilldown Report:** allows the user to save the drilldown report in PDF format to their local machine

Exporting a QRDA

QRDA is a formatting standard that enables quality measure data to be reported electronically. QRDA files are used for data submission to EHR incentive and regulatory programs and are accepted by most Healthcare IT systems, such as registries.

There are two types of QRDA formats, both of which are available in Sevocity:

- **QRDA Category I:** contains data on an individual patient for the selected measure
- **QRDA Category III:** aggregates data for all patients included in the selected measure

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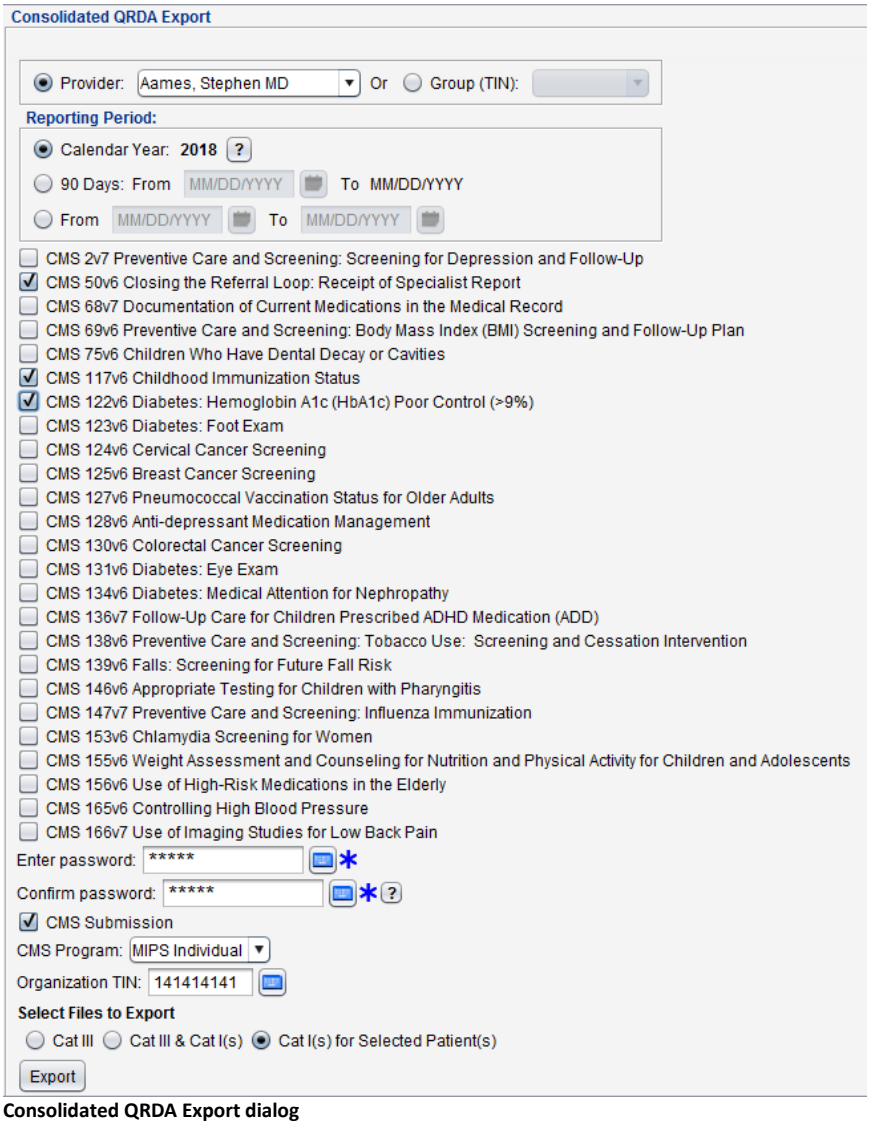
To export one or more eCQM reports in QRDA format:

1. Go to **Reports > eCQMs > 2018** and click **Consolidated QRDA Export**
2. Select a **Provider**: Individual (EC/EP) or Group (listed by TIN)
3. Select the **Reporting Period** for the eCQM data
4. Select one or more measures for the export
5. Create and verify a password by populating the **Enter password** and **Confirm password** fields
    a. Password must be alphanumeric with a minimum of 5 characters
    b. Password is used to encrypt the data export and will be required to open the file
6. If submitting the file(s) for MIPS reporting, select the **CMS Submission** checkbox and select **MIPS Individual** or **MIPS Group** from the **CMS Program** field
    a. The **Organization TIN** field will auto-populate based on the CMS Program field selection
7. Select the QRDA file type to export
    a. Selecting **Cat I(s) for Selected Patient(s)** will require the user to select the patient for this export
8. Click **Export**
9. Save the QRDA file to a local machine



Consolidated QRDA Export dialog

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