♠ Measure #124: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

2010 PQRI REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified EHR

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using certified/qualified health information technology.

Measure Reporting via Claims:
CPT codes, HCPCS (D- or G-) codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

Measure Reporting via Registry:
CPT codes and HCPCS (D-or G-) codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patient encounter documentation substantiates use of certified/qualified EHR

Definitions:
Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
Basic Privacy and Security Elements – Basic privacy and security elements include the following:

- Ability to audit the date/time and user of each time patient chart printed
- Ability to archive and retrieve health record information

CCHIT – The Certification Commission for Healthcare Information Technology – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.

Certified/Qualified Electronic Health Record – A certified/qualified EHR can be any of the following:

- Certification Commission for Healthcare Information Technology (CCHIT) certified EHR at the time of measurement
- If CCHIT certification is available (in primary care or a specialty) on or before August 1, 2008, but the system in use is not CCHIT certified, the EHR must meet the following criteria:
    - Ability to manage a medication list
    - Ability to manage a problem list
    - Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
    - Ability to meet basic privacy and security elements

    AND

    the EHR (above) must be CCHIT certified on or before August 1, 2011, or another CCHIT certified product must be in use for compliance after August 1, 2011
- If CCHIT certification is not available for a specialty on August 1, 2008, the EHR must have the following capabilities to be qualified:
    - Ability to manage a medication list
    - Ability to manage a problem list
    - Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
    - Ability to meet basic privacy and security elements

Note: *For providers having CCHIT certified EHR products available (according to specialty) on or before August 1, 2008, an extended time parameter has been placed in this measure of August 1, 2011 in order to allow for a period of time for providers to transition to a CCHIT certified product if necessary. After August 1, 2011, these providers will no longer meet the performance requirement of the measure without a CCHIT certified EHR in use.*

Manage a Medication List – Create, maintain and display a patient specific medication list
Manage a Problem List – Create, maintain and display a patient specific problem list
Discrete Searchable Data Elements – Laboratory data that can be recorded in predefined fields in predefined formats within the EHR that allow for reports to be generated, such as trends of a specific element over time. This cannot be easily done if data is entered via a free text format or by merely scanning a report into the EHR.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Encounter Documented Using Certified/Qualified EHR
G8447: Patient encounter was documented using a CCHIT certified EHR
OR
G8448: Patient encounter was documented using a qualified (non-CCHIT certified) EHR

DENOMINATOR:
All patient encounters

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544 92548, 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621, 92625, 92626, 92627, 92640, 95920, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0109, G0270, G0271

RATIONALE:
The need for clinical information systems to provide high-quality, safe care is a well recognized fact. This need was well publicized by Dr. Ed Wagner in his "Chronic Care Model" as one of the key elements to provide high-quality care. To quote from the Improving Chronic Care Web site, "Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders about needed services and summarized data to track and plan care. At the practice population level, they identify groups of patients needing additional care, as well as facilitate performance monitoring and quality improvement efforts." To be able to take advantage of many of the more advanced applications of health information technology, the facility must first implement an EMR and use it to document patient encounters.

Although some health plans and provider incentive programs do reward facilities for EMR adoption, our analysis did not reveal any established consensus-endorsed measure that measures adoption of technology and defines it in the way described above.

While it is preferable to encourage adoption of CCHIT certified EMRs, it became apparent during measure field testing that CCHIT certified EMRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. The following is an excerpt taken from the CCHIT website: *"The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of significance for specialties and domains not yet addressed by CCHIT Criteria."*