

Updated DOQ-IT Measure Specifications for Potential 2008 CMS EHR Programs

♦ **Effective January 1, 2008:** Possibly replacing a subset of the existing DOQ-IT measure specifications

Version 1.0

- ♦ **Disclaimer:** No decision has been made at this time on the continuation of the current DOQ-IT (Doctor's Office Quality – Information Technology) Project or the availability of an EHR-based data submission mechanism for PQRI (Physician Quality Reporting Initiative) in 2008. Therefore, it should not be assumed or concluded based on this posting that either DOQ-IT or PQRI EHR data submission mechanism(s) will be available in 2008. However, insofar as these five measures would be used in either DOQ-IT or for EHR reporting for PQRI for 2008, these are the final updated measure and technical specifications for 2008, subject only to minor technical corrections. See accompanying Vendor Notification.

2008 EHR Measure Specifications

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Measure Number Crosswalk for potential 2008 CMS EHR Programs	
<u>PQRI Measure</u>	<u>DOQ-IT Measure</u> <i>(for the QIO Outpatient Clinical Warehouse)</i>
#1	DM-2
#2	DM-5
#3	DM-3
#5	HF-7
#7	CAD-3

Measure Owner Designation
♣ AMA/PCPI is the measure owner
■ NCQA is the measure owner

♦ **Disclaimer:** See page 1.

Note: CPT Category II codes will be included in these five overlapping 2008 EHR Measure Specifications only when other standard coding systems are not available (e.g. medical, patient, system reasons for not performing the recommended care) as determined appropriate by the measure owners.

2008 EHR Measure Specifications

ANALYTIC NARRATIVES

■ PQRI Measure #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

† **Description:** Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent hemoglobin A1c greater than 9.0%

Measurement Period: Twelve consecutive months

Eligible Cases: Patients aged 18-75 years with the diagnosis of diabetes

Inclusions:

All patients with a documented diagnosis of diabetes and patient is ≥ 18 and ≤ 75 years of age. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4), HCPCS (HCPCS) and ICD-9 (I9) codes for inclusion:

ENCOUNTER CODE (C4)	ENCOUNTER CODE (HCPCS)
92002, 92004, 92012, 92014, 97802, 97803, 97804,	G0270, G0271
99201, 99202, 99203, 99204, 99205, 99211, 99212,	
99213, 99214, 99215, 99217, 99218, 99219, 99220,	
99221, 99222, 99223, 99231, 99232, 99233, 99234,	
99235, 99236, 99238, 99239, 99241, 99242, 99243,	
99244, 99245, 99251, 99252, 99253, 99254, 99255,	
99281, 99282, 99283, 99284, 99285, 99291, 99304,	
99305, 99306, 99307, 99308, 99309, 99310, 99315,	
99316, 99318, 99324, 99325, 99326, 99327, 99328,	
99334, 99335, 99336, 99337, 99341, 99342, 99343,	
99344, 99345, 99347, 99348, 99349, 99350, 99385,	
99386, 99387, 99395, 99396, 99397, 99401, 99402,	
99403, 99404, 99411, 99412, 99420, 99429, 99455,	
99456, 99499	

AND

2008 EHR MEASURES

♦ **Disclaimer:** See page 1.

† The “Percentage of patients...” who meet the criteria for this measure will be calculated by the QIO Outpatient Clinical Warehouse and available on Quality Measure Reports via QualityNet Exchange. All measure-related EHR coding/data should be submitted to the QIO Outpatient Clinical Warehouse to ensure accurate performance rates.

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ANALYTIC NARRATIVES

DX CODE (I9)
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20,
250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41,
250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62,
250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83,
250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04,
362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 684.03, 648.04

OR

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis and DRUG_EXCLUSION = N.

AND NOT

Exclusions:

Diabetes patients with a diagnosis of *polycystic ovaries, gestational diabetes, and/or steroid induced diabetes.

MEDICAL_EXCLUSION_CODES Table lists applicable ICD-9 (I9) codes for exclusion:

EXCLUSION CODE (I9)
251.8, 256.4, 648.80, 648.81, 648.82,
648.83, 648.84, 962.0

2008 EHR MEASURES

Increases Performance Rates: Patients with most recent hemoglobin A1c level > 9.0%

Inclusions:

Patients with most recent A1c > 9.0% or result is missing or was not performed during the measurement period.

TOPIC_EVALUATION_CODES Table lists an applicable CPT (C4) and LOINC (LN) code for inclusion:

A1C CODE (C4)	A1C CODE (LN)
83036	4548-4, 4549-2,
	17855-8, 17856-6
AND documentation of A1c > 9.0%	

2008 EHR Measure Specifications

ANALYTIC NARRATIVES

Rationale:

Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

Clinical Recommendation Statements:

A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. (AACE/ACE)

The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values $\leq 6.5\%$. (AACE/ACE)

Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of evidence: E) (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c $< 7\%$. (Level of evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1C of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered. (AGS)

➤ *List of Data Elements located in Appendix A*

2008
EHR
MEASURES

2008 EHR Measure Specifications

ANALYTIC NARRATIVES

■ PQRI Measure #2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

†Description: Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (less than 100 mg/dl)

Measurement Period: Twelve consecutive months

Eligible Cases: Patients aged 18-75 years with the diagnosis of diabetes

Inclusions:

All patients with a documented diagnosis of diabetes and patient is ≥ 18 and ≤ 75 years of age. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4), HCPCS (HCPCS) and ICD-9 (I9) codes for inclusion:

ENCOUNTER CODE (C4)	ENCOUNTER CODE (HCPCS)
92002, 92004, 92012, 92014, 97802, 97803, 97804,	G0270, G0271
99201, 99202, 99203, 99204, 99205, 99211, 99212,	
99213, 99214, 99215, 99217, 99218, 99219, 99220,	
99221, 99222, 99223, 99231, 99232, 99233, 99234,	
99235, 99236, 99238, 99239, 99241, 99242, 99243,	
99244, 99245, 99251, 99252, 99253, 99254, 99255,	
99281, 99282, 99283, 99284, 99285, 99291, 99304,	
99305, 99306, 99307, 99308, 99309, 99310, 99315,	
99316, 99318, 99324, 99325, 99326, 99327, 99328,	
99334, 99335, 99336, 99337, 99341, 99342, 99343,	
99344, 99345, 99347, 99348, 99349, 99350, 99385,	
99386, 99387, 99395, 99396, 99397, 99401, 99402,	
99403, 99404, 99411, 99412, 99420, 99429, 99455,	
99456, 99499	

AND

2008 EHR MEASURES

◆ Disclaimer: See page 1.

†The “Percentage of patients...” who meet the criteria for this measure will be calculated by the QIO Outpatient Clinical Warehouse and available on Quality Measure Reports via QualityNet Exchange. All measure-related EHR coding/data should be submitted to the QIO Outpatient Clinical Warehouse to ensure accurate performance rates.

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ANALYTIC NARRATIVES

DX CODE (I9)
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20,
250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41,
250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62,
250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83,
250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04,
362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 684.03, 648.04

OR

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis and DRUG_EXCLUSION = N.

AND NOT

Exclusions:

Diabetes patients with a diagnosis of *polycystic ovaries, gestational diabetes, and/or steroid induced diabetes.

MEDICAL_EXCLUSION_CODES Table lists applicable ICD-9 (I9) codes for exclusion:

EXCLUSION CODE (I9)
251.8, 256.4, 648.80, 648.81,
648.82, 648.83, 648.84, 962.0

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Successful Performance Options: Patients with most recent LDL-C < 100 mg/dL

Patients with most recent LDL-C < 100 mg/dL during the measurement period.

TOPIC_EVALUATION_CODES Table lists an applicable CPT (C4) and LOINC (LN) code for inclusion:

LDL CODE (C4)	LDL CODE (LN)
80061, 83700,	2089-1, 12773-8,
83701, 83704,	13457-7, 18261-8,
83715, 83716,	18262-6, 22748-8,
83721	39469-2
AND documentation of LDL < 100 mg/dL	

2008 EHR Measure Specifications

ANALYTIC NARRATIVES

Rationale:

Persons with diabetes are at increased risk for coronary heart disease (CHD). Lowering serum cholesterol levels can reduce the risk for CHD events.

Clinical Recommendation Statements:

A fasting lipid profile should be obtained during an initial assessment, each follow-up assessment, and annually as part of the cardiac-cerebrovascular-peripheral vascular module. (AACE/ACE)

A fasting lipid profile should be obtained as part of an initial assessment. Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglycerides, HDL cholesterol, and calculated LDL cholesterol measurements. If values fall in lower-risk levels, assessments may be repeated every two years. (Level of evidence: E) (ADA)

Patients who do not achieve lipid goals with lifestyle modifications require pharmacological therapy. Lowering LDL cholesterol with a statin is associated with a reduction in cardiovascular events. (Level of evidence: A)

Lipid-lowering therapy should be used for secondary prevention of cardiovascular mortality and morbidity for all patients with known coronary artery disease and type 2 diabetes. (ACP)

Statins should be used for primary prevention against macrovascular complications in patients with type 2 diabetes and other cardiovascular risk factors.

Once lipid-lowering therapy is initiated, patients with type 2 diabetes mellitus should be taking at least moderate doses of a statin.

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. (AGS)

➤ *List of Data Elements located in Appendix A*

2008 EHR Measure Specifications

ANALYTIC NARRATIVES

■ PQRI Measure #3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

† **Description:** Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg)

Measurement Period: Twelve consecutive months

Eligible Cases: Patients aged 18-75 years with the diagnosis of diabetes

Inclusions:

All patients with a documented diagnosis of diabetes and patient is ≥ 18 and ≤ 75 years of age. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4), HCPCS (HCPCS) and ICD-9 (I9) codes for inclusion:

ENCOUNTER CODE (C4)	ENCOUNTER CODE (HCPCS)
92002, 92004, 92012, 92014, 97802, 97803, 97804,	G0270, G0271
99201, 99202, 99203, 99204, 99205, 99211, 99212,	
99213, 99214, 99215, 99217, 99218, 99219, 99220,	
99221, 99222, 99223, 99231, 99232, 99233, 99234,	
99235, 99236, 99238, 99239, 99241, 99242, 99243,	
99244, 99245, 99251, 99252, 99253, 99254, 99255,	
99281, 99282, 99283, 99284, 99285, 99291, 99304,	
99305, 99306, 99307, 99308, 99309, 99310, 99315,	
99316, 99318, 99324, 99325, 99326, 99327, 99328,	
99334, 99335, 99336, 99337, 99341, 99342, 99343,	
99344, 99345, 99347, 99348, 99349, 99350, 99385,	
99386, 99387, 99395, 99396, 99397, 99401, 99402,	
99403, 99404, 99411, 99412, 99420, 99429, 99455,	
99456, 99499	

AND

DX CODE (I9)
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20,
250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41,
250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62,
250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83,
250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04,
362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 684.03, 648.04

OR

2008 EHR MEASURES

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† The "Percentage of patients..." who meet the criteria for this measure will be calculated by the QIO Outpatient Clinical Warehouse and available on Quality Measure Reports via QualityNet Exchange. All measure-related EHR coding/data should be submitted to the QIO Outpatient Clinical Warehouse to ensure accurate performance rates.

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ANALYTIC NARRATIVES

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis and DRUG_EXCLUSION = N.

AND NOT

Exclusions:

Diabetes patients with a diagnosis of *polycystic ovaries, gestational diabetes, and/or steroid induced diabetes.

MEDICAL_EXCLUSION_CODES Table lists applicable ICD-9 (I9) codes for exclusion:

EXCLUSION CODE (I9)
251.8, 256.4, 648.80, 648.81,
648.82, 648.83, 648.84, 962.0

Successful Performance Options: Patients whose most recent blood pressure < 140/80 mm Hg

Inclusions:

Patients with most recent blood pressure measurement recorded during the measurement period.

Note: Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

TOPIC_EVALUATION_CODES Table lists applicable SNOMED (SNM) codes for inclusion:

SYSTOLIC CODE (SNM)
271649006, 72313002
AND documentation of Systolic BP < 140 mm Hg

AND

DIASTOLIC CODE (SNM)
271650006, 67726005
AND documentation of Diastolic BP < 80 mm Hg

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ANALYTIC NARRATIVES

Rationale:

Intensive control of blood pressure in patients with diabetes reduces diabetes complications, diabetes-related deaths, strokes, heart failure, and microvascular complications.

Clinical Recommendation Statements:

Recommends that a blood pressure determination during the initial evaluation, including orthostatic evaluation, be included in the initial and every interim physical examination. (AACE/ACE)

Blood pressure control must be a priority in the management of persons with hypertension and type 2 diabetes. (ACP)

Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure >130 mmHg or diastolic >80 mmHg should have blood pressure confirmed on a separate day. Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy. (Level of Evidence: E) (ADA)

Older persons with diabetes are likely to benefit greatly from cardiovascular risk reduction, therefore monitor and treat hypertension and dyslipidemias. (AGS)

Measurement of blood pressure in the standing position is indicated periodically, especially in those at risk for postural hypotension. At least two measurements should be made and the average recorded. After BP is at goal and stable, follow-up visits can usually be at 3- to 6-month intervals. Comorbidities such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. (JNC)

All individuals should be evaluated during health encounters to determine whether they are at increased risk of having or of developing chronic kidney disease. This evaluation of risk factors should include blood pressure measurement. (NKF)

➤ *List of Data Elements located in Appendix A*

2008 EHR Measure Specifications

ANALYTIC NARRATIVES

*PQRI Measure #5: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

†**Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy

Measurement Period: Twelve consecutive months

Eligible Cases: Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

Inclusions:

All patients with a documented diagnosis of heart failure who also have LVSD (defined as ejection fraction < 40% - use most recent value) or with moderately or severely depressed left ventricular systolic function and patient is 18 years of age or older. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable CPT (C4), ICD-9 (I9), and SNOMED (SNM) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213,
99214, 99215, 99238, 99239, 99241, 99242, 99243,
99244, 99245, 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

AND

DX CODE (I9)
402.01, 402.11, 402.91, 404.01, 404.03,
404.11, 404.13, 404.91, 404.93, 428.0,
428.1, 428.20, 428.21, 428.22, 428.23,
428.30, 428.31, 428.32, 428.33, 428.40,
428.41, 428.42, 428.43, 428.9

AND

2008 EHR MEASURES

♦ **Disclaimer:** See page 1.

†The “Percentage of patients...” who meet the criteria for this measure will be calculated by the QIO Outpatient Clinical Warehouse and available on Quality Measure Reports via QualityNet Exchange. All measure-related EHR coding/data should be submitted to the QIO Outpatient Clinical Warehouse to ensure accurate performance rates.

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LVF ASSMT CODE (C4)	LVF ASSMT CODE (SNM)	EJECTION FRACTION CODE (SNM)
78414, 78468, 78472,	250907009,	41466009,
78473, 78480, 78481,	366188009	46258004,
78483, 78494, 93303,		70822001,
93304, 93307, 93308,		250908004
93312, 93314, 93315,		
93317, 93350, 93543		
AND documentation of LVEF < 40%		

AND NOT

Exclusions: (*Exclusions only applied if the patient did not receive ACE/ARB therapy*)

The EXCLUSION code can occur anytime before the end of the measurement period while the PREGNANCY codes must occur during the measurement period.

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9 (I9) codes for medical exclusions:

EXCLUSION CODE (I9)
39.95, 54.98, 277.6, 395.0, 395.2, 396.0,
396.2, 396.8, 403.01, 403.11, 403.91,
404.02, 404.03, 404.12, 404.13, 404.92,
404.93, 425.1, 440.1, 584.5, 584.6,
584.7, 584.8, 584.9, 585.5, 585.6,
586, 747.22, 788.5, V56.0, V56.8

OR

PREGNANCY CODE (I9)
V22.0, V22.1, V22.2, V23.0, V23.1,
V23.2, V23.3, V23.41, V23.49,
V23.5, V23.7, V23.81, V23.82,
V23.83, V23.84, V23.89, V23.9,

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable SNOMED (SNM) codes for allergy or intolerance to ACE inhibitor therapy and to ARB therapy:

ALLERGY CODE (SNM)
1001288, 293500009,
295036000, 407579007,
407590002, 407593000

OR

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ANALYTIC NARRATIVES

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for medical reason for exclusion:

MEDICAL REASON (C4)
4009F-1P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for patient reason for exclusion:

PATIENT REASON (C4)
4009F-2P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for system reason for exclusion:

SYSTEM REASON (C4)
4009F-3P

Successful Performance Options: Patients who were prescribed ACE inhibitor or ARB therapy

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed ACE inhibitor or ARB therapy during the measurement period and DRUG_EXCLUSION = N.

Rationale:

In the absence of contraindications, ACE Inhibitors or ARBs are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function, as measured by left ventricular ejection fraction (LVEF). Both drugs have been shown to decrease mortality and hospitalizations.

Clinical Recommendation Statements:

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A)(ACC/AHA)

Angiotensin II receptor blockers approved for the treatment of HF are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

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ANALYTIC NARRATIVES

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

➤ *List of Data Elements located in Appendix A*

2
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ANALYTIC NARRATIVES

*PQRI Measure #7: Beta-Blocker Therapy for Coronary Artery Disease (CAD) Patients with Prior Myocardial Infarction (MI)

†**Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease and prior myocardial infarction (MI) who were prescribed beta-blocker therapy

Measurement Period: Twelve consecutive months

Eligible Cases: Patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior myocardial infarction (MI) at any time

Inclusions:

All patients with a documented diagnosis of coronary artery disease (CAD)* who also had prior MI at any time and patient is 18 years of age or older. To be eligible for performance calculations, patients must have at least two face-to-face office visits with the physician, physician assistant, or nurse practitioner during the measurement period.

TOPIC_EVALUATION_CODES Table lists applicable ICD-9 (I9) and CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214,
99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245,
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

AND

DX CODE (I9)	DX CODE (C4)
411.0, 411.1, 411.81, 411.89,	92980, 92981, 92982,
413.0, 413.1, 413.9, 414.00,	92984, 92995, 92996, 33140, 33510,
414.01, 414.02, 414.03, 414.04,	33511, 33512, 33513, 33514, 33516,
414.05, 414.06, 414.07,	33517, 33518, 33519, 33521, 33522,
414.8, 414.9, V45.81, V45.82	33523, 33533, 33534, 33535, 33536

AND

2008 EHR MEASURES

♦ **Disclaimer:** See page 1.

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*Eligible cases for this measure require the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure)

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ANALYTIC NARRATIVES

MI DX CODE (I9)
410.00, 410.01, 410.02, 410.10, 410.11,
410.12, 410.20, 410.21, 410.22, 410.30,
410.31, 410.32, 410.40, 410.41, 410.42,
410.50, 410.51, 410.52, 410.60, 410.61,
410.62, 410.70, 410.71, 410.72, 410.80,
410.81, 410.82, 410.90, 410.91, 410.92, 412

OR

All patients with a documented diagnosis of CAD* and aged 18 years and older and have prior MI at any time.

TOPIC_EVALUATION_CODES Table lists applicable ICD-9 (I9) and CPT (C4) codes for inclusion:

ENCOUNTER CODE (C4)
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214,
99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245,
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

AND

MI DX CODE (I9)
410.00, 410.01, 410.02, 410.10, 410.11,
410.12, 410.20, 410.21, 410.22, 410.30,
410.31, 410.32, 410.40, 410.41, 410.42,
410.50, 410.51, 410.52, 410.60, 410.61,
410.62, 410.70, 410.71, 410.72, 410.80,
410.81, 410.82, 410.90, 410.91, 410.92, 412

AND NOT

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♦Disclaimer: See page 1.

*Eligible cases for this measure require the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure)

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ANALYTIC NARRATIVES

Exclusions: (*Exclusions only applied if the patient did not receive beta-blocker therapy*)

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9 (I9) and SNOMED (SNM) codes for medical exclusions:

EXCLUSION CODE (I9)	EXCLUSION CODE (SNM)
427.81, 427.89, 458.0, 458.1,	36083008, 42177007,
458.21, 458.29, 458.8, 458.9,	44602002, 48867003,
493.00, 493.01, 493.02, 493.10,	49044005, 49710005,
493.11, 493.12, 493.20, 493.21,	207585002, 293963004,
493.22, 492.81, 493.82, 493.90,	407577009, 407591003
493.91, 493.92	

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable SNOMED (SNM) code for documentation of bradycardia as defined by two consecutive heart rate readings < 50 bpm that occur during the measurement period:

HEART RATE CODE (SNM)
364075005
<i>AND documentation of two consecutive Heart Rates < 50 bpm</i>

OR

TOPIC_MEDICAL_EXCLUSION Table lists applicable ICD-9 (I9) codes for history of 2nd or 3rd degree AV block without permanent pacemaker. An AV_BLOCK_CODE must be present without the PERM_PACEMAKER_CODE:

AV BLOCK CODE (I9)
426.0, 426.12, 426.13

WITHOUT

PERM PACEMAKER CODE (I9)
V45.01

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for medical reason for exclusion:

MEDICAL REASON (C4)
4006F-1P

OR

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ANALYTIC NARRATIVES

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for patient reason for exclusion:

PATIENT REASON (C4)
4006F-2P

OR

TOPIC_MEDICAL_EXCLUSION Table lists an applicable CPT Category II (C4) code for system reason for exclusion:

SYSTEM REASON (C4)
4006F-3P

Successful Performance Options: Patients who were prescribed beta-blocker therapy

TOPIC_DRUG_CODES Table lists applicable drug codes for patients who were prescribed beta-blocker therapy during the measurement period and DRUG_EXCLUSION = N.

Rationale:

In the absence of contraindications, beta blocker therapy has been shown to reduce the risk of a recurrent MI and decrease mortality for those patients with a prior MI.

Clinical Recommendation Statements:

Chronic Stable Angina: Class I – Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI. Class I – Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. (ACC/AHA/ACP-ASIM)

Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Class I – Drugs required in the hospital to control ischemia should be continued after hospital discharge in patients who do not undergo coronary revascularization, patients with unsuccessful revascularization, or patients with recurrent symptoms after revascularization. Upward or downward titration of the doses may be required. Class I – Beta-blockers in the absence of contraindications. (ACC/AHA)

Acute Myocardial Infarction: Class I – All but low-risk patients without a clear contraindication to β -adrenoceptor blocker therapy. Treatment should begin within a few days of the event (if not initiated acutely) and continue indefinitely. Class IIa – Low-risk patients without a clear contraindication to β -adrenoceptor blocker therapy. Survivors of non-ST-elevation MI. Class IIb – Patients with moderate or severe LV failure or other relative contraindications to β -adrenoceptor blocker therapy, provided they can be monitored closely. (ACC/AHA)

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ANALYTIC NARRATIVES

Although no study has determined if long-term β -adrenoceptor blocker therapy should be administered to survivors of MI who subsequently have successfully undergone revascularization, there is no reason to believe that these agents act differently in coronary patients who have undergone revascularization. (ACC/AHA)

➤ *List of Data Elements located in Appendix A*

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APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

Ambulatory Care Measure	Short Name	Description
PQRI Measure #1 HbA1c Management: Poor Control		
	TOPIC TYPE	Topic that is being reported on
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement year begins
	MEASURE END DATE	Date the measurement year ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT4, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD9)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	A1C CODING SYSTEM	Type of coding system applicable for A1C testing (CPT4, LOINC)
	A1C CODE	Code used for A1C test performed
	A1C DATE	Date A1C testing was performed
	A1C RESULT	Numeric result for HbA1c value
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for insulin or oral hypoglycemics/antihyperglycemics drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable for medical exclusions (ICD9)
	EXCLUSION CODE	Code used for medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented

Shaded data elements apply to each measure

2008 EHR MEASURES

APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

Ambulatory Care Measure	Short Name	Description
PQRI Measure #2 Lipid Management: Control (< 100 mg/dL)		
	TOPIC TYPE	Topic that is being reported on
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement year begins
	MEASURE END DATE	Date the measurement year ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT4, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD9)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	LDL CODING SYSTEM	Type of coding system applicable for a LDL-C test (CPT4, LOINC)
	LDL CODE	Code used for LDL-C testing
	LDL DATE	Date LDL-C test was performed
	LDL RESULT	Numeric result for LDL-C value
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for insulin or oral hypoglycemics/antihyperglycemics drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable for medical exclusions (ICD9)
	EXCLUSION CODE	Code used for medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented

Shaded data elements apply to each measure

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MEASURES

APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

Ambulatory Care Measure	Short Name	Description
*PQRI Measure #3 Blood Pressure Management		
	TOPIC TYPE	Topic that is being reported on
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement year begins
	MEASURE END DATE	Date the measurement year ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT4, HCPCS)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD9)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	SYSTOLIC CODING SYSTEM	Type of coding system applicable for a systolic blood pressure measurement (SNOMED)
	SYSTOLIC CODE	Code used for systolic blood pressure
	SYSTOLIC DATE	Date systolic blood pressure was documented
	SYSTOLIC RESULT	Result of systolic blood pressure measurement
	DIASTOLIC CODING SYSTEM	Type of coding system applicable for a diastolic blood pressure measurement (SNOMED)
	DIASTOLIC CODE	Code used for diastolic blood pressure
	DIASTOLIC DATE	Date diastolic blood pressure was documented
	DIASTOLIC RESULT	Result of diastolic blood pressure measurement
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for insulin or oral hypoglycemics/antihyperglycemics drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable for medical exclusions (ICD9)
	EXCLUSION CODE	Code used for medical exclusion
	EXCLUSION DATE	Date medical exclusion was documented

Shaded data elements apply to each measure

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APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

2008 PQRI	Short Name	Description
*PQRI Measure #5 ACE Inhibitor or ARB Therapy		
	TOPIC TYPE	Topic that is being reported on
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT4)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD9)
	DX CODE	Diagnosis code
	DX DATE	Date of diagnosis
	EJECTION FRACTION CODING SYSTEM	Type of coding system applicable for an ejection fraction code (SNOMED)
	EJECTION FRACTION CODE	Code used for an ejection fraction
	EJECTION FRACTION DATE	Date ejection fraction was documented
	EJECTION FRACTION RESULT	Numeric result of ejection fraction percentage
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	ACE Inhibitor and ARB drug codes
	ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	LVF ASSMT CODING SYSTEM	Type of coding system applicable for a LVF assessment code (CPT4, SNOMED)
	LVF ASSMT CODE	Code used for a LVF assessment
	LVF ASSMT DATE	Date LVF assessment was documented
	EXCLUSION CODING SYSTEM	Type of coding system applicable for an exclusion code (ICD9)
	EXCLUSION CODE	Code used for an exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	PREGNANCY CODING SYSTEM	Type of coding system applicable for a pregnancy diagnosis code (ICD9)
	PREGNANCY CODE	Code used for pregnancy diagnosis
	PREGNANCY DATE	Date pregnancy diagnosis was documented
	ALLERGY CODING SYSTEM	Type of coding system applicable for an allergy diagnosis code (SNOMED)
	ALLERGY CODE	Code used for an allergy diagnosis
	ALLERGY DATE	Date allergy diagnosis was documented
	PATIENT REASON CODING SYSTEM	Type of coding system used for patient reason for exclusion (CPT Category II)
	PATIENT REASON	Code used for patient reason for exclusion

Shaded data elements apply to each measure

APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

2008 PQRI	Short Name	Description
	PATIENT REASON DATE	Date patient reason for exclusion was identified
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified
	SYSTEM REASON CODING SYSTEM	Type of coding system used for system reason for exclusion (CPT Category II)
	SYSTEM REASON	Code used for system reason for exclusion
	SYSTEM REASON DATE	Date system reason for exclusion was identified

Shaded data elements apply to each measure

2008 EHR MEASURES

APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

2008 PQRI	Short Name	Description
*PQRI Measure #7 Beta-Blocker Therapy		
	TOPIC TYPE	Topic that is being reported on
	TOPIC INDICATOR	The specific indicator or measure
	BIRTHDATE	Birth date
	MEASURE START DATE	Date the measurement period begins
	MEASURE END DATE	Date the measurement period ends
	ENCOUNTER CODING SYSTEM	Type of coding system applicable to face-to-face office visit (CPT4)
	ENCOUNTER CODE	Code used for encounter
	ENCOUNTER DATE	Date of encounter
	DX CODING SYSTEM	Type of coding system applicable to the diagnosis code (ICD9)
	DX CODE	Diagnosis and procedure codes to identify patients with a chronic condition
	DX DATE	Date of diagnosis
	MI DX CODING SYSTEM	Type of coding system applicable to the diagnosis code for myocardial infarction (ICD9)
	MI DX CODE	Myocardial infarction diagnosis code
	MI DX DATE	Date of myocardial infarction diagnosis
	DRUG CODING SYSTEM	Type of coding system applicable for drug codes (NDC)
	DRUG CODE	Code used for beta-blocker drugs
	DRUG ORDER DATE	Date the drug was prescribed
	DRUG EXCLUSION	Is drug used as an exclusion to the measure (Yes or No)
	EXCLUSION CODING SYSTEM	Type of coding system applicable for an exclusion code (ICD9, SNOMED)
	EXCLUSION CODE	Code used for an exclusion
	EXCLUSION DATE	Date medical exclusion was documented
	HEART RATE CODING SYSTEM	Type of coding system applicable for a heart rate code (SNOMED)
	HEART RATE CODE	Code used for heart rate
	HEART RATE DATE	Date heart rate measurement documented
	AV BLOCK CODING SYSTEM	Type of coding system applicable to the AV block diagnosis code (ICD9)
	AV BLOCK CODE	Diagnosis code used for AV block
	AV BLOCK DATE	Date AV block was documented
	PERM PACEMAKER CODING SYSTEM	Type of coding system applicable for a permanent pacemaker code (ICD9)
	PERM PACEMAKER CODE	Code used for a permanent pacemaker
	PERM PACEMAKER DATE	Date permanent pacemaker was documented
	PATIENT REASON CODING SYSTEM	Type of coding system used for patient reason for exclusion (CPT Category II)
	PATIENT REASON	Code used for patient reason for exclusion
	PATIENT REASON DATE	Date patient reason for exclusion was identified

Shaded data elements apply to each measure

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APPENDIX A

PQRI MEASURES WITH CORRESPONDING DATA ELEMENTS

2008 PQRI	Short Name	Description
	MEDICAL REASON CODING SYSTEM	Type of coding system used for medical reason for exclusion (CPT Category II)
	MEDICAL REASON	Code used for medical reason for exclusion
	MEDICAL REASON DATE	Date medical reason for exclusion was identified
	SYSTEM REASON CODING SYSTEM	Type of coding system used for system reason for exclusion (CPT Category II)
	SYSTEM REASON	Code used for system reason for exclusion
	SYSTEM REASON DATE	Date system reason for exclusion was identified

Shaded data elements apply to each measure

2008 EHR MEASURES