

eCW Clinical Documentation Guide

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase
Relevance	<p>NPO Population Clinical Quality Dashboard [NQF 0108-1: Behavioral Measure]                      MIPS Clinical Quality Measure [CMS 136 (EHR): Process Measure]</p>
Measure Definition	<p><i>The percentage of patients, 6-12 years old and newly dispensed a medication for Attention-DeficitHyperactivity Disorder (ADHD), who remained on ADHD medication for at least 7 months (210 days) <b>AND</b> who, in addition to the visit in the Initiation Phase, had at least two additional follow-ups with a practioner within the 9 months (270 days) after the Initiation Phase ended</i></p>
Measurement Period	<p>The <b>Measurement Period</b> is defined as the current calendar year (January 1 - December 31)</p>
Intake Period	<p>The <b>Intake Period</b> is defined as the 12-month window beginning March 1 of the year prior to the Measurement Period and ending February 28 of the Measurement Period</p>
Index Prescription Start Date	<p><b>Index Prescription Start Date (IPSD)</b> is defined as the earliest dispensing date, for an ADHD medication, that falls within the Intake Period and for which there is a Negative Medication History</p>
Negative Prescription Start Date	<p><b>Negative Medication History</b> is defined as a period of 4 months (120 days), prior to the IPSD, when the patient had no ADHD medications dispensed for either new or refill prescriptions</p>
Initiation Phase	<p>The <b>Initiation Phase</b> is defined as the 30 days following the IPSD</p>
Denominator	<p>The <b>Denominator</b> consists of patients who:</p> <ol style="list-style-type: none"> <li>I. Are <math>\geq 6</math> and <math>&lt; 12</math> years of age at the beginning of the Measurement Period</li> <li>II. <b>AND</b>, Had their first prescription for an ADHD medication issued <math>\leq 90</math> days prior to, or <math>\leq 60</math> days after, the start of the Measurement Period</li> </ol> <p style="text-align: right;"><i>(continued)</i></p>

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<b>Denominator</b> <i>(continued)</i>	III. <b>AND</b> , Had a sum total medication duration of $\geq 210$ and $\leq 300$ cumulative days (7-10 months) beginning with the start date of the first prescription for ADHD medication IV. <b>AND</b> , Were seen for an applicable E&M encounter during the Measurement Period
<b>Numerator</b>	<p style="text-align: center;">The <b>Numerator</b> consists of patients, from the Denominator, who:</p> I. Were seen for an applicable visit encounter $\leq 30$ days after the ADHD medication from the Denominator was prescribed II. <b>AND</b> , Were seen for two or more additional applicable visit encounters $\geq 31$ and $\leq 300$ days (1-10 months) after the ADHD medication from the Denominator was prescribed <p style="text-align: center;"><b>OR</b></p> III. Were seen for at least one applicable visit encounter $\geq 31$ days and $\leq 300$ days after the ADHD medication from the Denominator was prescribed IV. <b>AND</b> , Received at least one applicable Telehealth and/or Telephone Management service encounters $\geq 31$ and $\leq 300$ days after the ADHD medication from the Denominator was prescribed
<b>Exclusions and/or Exceptions</b>	<p>Patients are <b>excluded</b> from this measure for one of the following reasons:</p> I. They have an active diagnosis for Narcolepsy during the Measurement Period II. <b>OR</b> , They had an inpatient encounter within the Initiation Phase <p style="margin-left: 40px;">A. <b>AND</b>, They had an active diagnosis for a mental health disorder at the time of the inpatient encounter            B. <b>OR</b>, They had an active, and primary, diagnosis of substance abuse at the time of the inpatient encounter</p>
<b>Measure Documentation</b>	<p style="text-align: center;"><b><u>To Qualify For This Measure</u></b> <i>(Denominator Documentation)</i></p> I. <b>The patient was issued a new prescription for an ADHD medication (within 90 days prior to the beginning of the Measurement Period through 60 days after the beginning of the Measurement Period)</b> <p style="text-align: right;"><i>(continued)</i></p>

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<p>Measure Documentation <i>(continued)</i></p>	<p><b>A. The following (generic) medications are considered ADHD medications</b> (see Table ADD-A_2017 @www.ncqa.com)</p> <ol style="list-style-type: none"> <li>1. Amphetamine-Dextroamphetamine</li> <li>2. Atoxmetine</li> <li>3. Clonidine</li> <li>4. Dexmethylphenidate</li> <li>5. Dextroamphetamine</li> <li>6. Guanfacine</li> <li>7. Lisdexamfetamine</li> <li>8. Methamphetamine</li> <li>9. Methylphenidate</li> </ol> <p><b>B. Document the ADHD medication in the "Current Medications" section of the patient's chart in eCW</b></p> <ol style="list-style-type: none"> <li>1. The prescription must contain enough dispensing events to cover the next 7-10 months (210 - 300 cumulative days)</li> <li>2. Record the prescription from one of the following locations:             <ol style="list-style-type: none"> <li>a. <i>Progress Notes → Treatment → Add</i></li> <li>b. <i>Telephone/Web Encounter → Rx Tab → Select Rx</i></li> <li>c. <i>Telephone/Web Encounter → Virtual Visit Tab → Treatment → Add</i></li> <li>d. <i>Progress Notes → Current Medications</i></li> </ol> </li> <li>3. If a medication cannot be prescribed due to a medication allergy or intolerance, document the allergy/intolerance in the "Allergies" section of the patient's chart in eCW</li> <li>4. If a medication is discontinued, document the reason for stopping the medication in a Progress Note or Telephone/Web Encounter in the patient's chart in eCW</li> </ol> <p><b>II. The patient must be seen for an applicable visit encounter during the Measurement Period</b> <i>(continued)</i></p>

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<p><b>Measure Documentation</b> <i>(continued)</i></p>	<p><b>A. The following E&amp;M codes identify applicable visit encounters</b></p> <ol style="list-style-type: none"> <li>1. 99201 - 99205 and 99212 - 99215</li> <li>2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394</li> </ol> <p><b>B. Record the appropriate E&amp;M code in the Billing section of the Progress Note for the visit</b> <i>(Progress Notes → Billing)</i></p>
	<p style="text-align: center;"><b><u>To Satisfy This Measure</u></b> <i>(Numerator Documentation)</i></p> <p><b>I. See the patient for an applicable visit encounter ≤ 30 days after prescribing the ADHD medication</b></p> <p><b>A. The following E&amp;M codes identify applicable ADHD visit encounters</b></p> <ol style="list-style-type: none"> <li>1. 90791 - 90792, 90832, 90834, 90837, 90845, 90847, 90849, 90853, 90875 and 90876</li> <li>2. 96150 - 96154</li> <li>3. 98960 - 98962</li> <li>4. 99078, 99201 - 99205, 99212 - 99215, 99217 - 99220, 99241 - 99245, 99341 - 99345, 99347 - 99350, 99381 - 99384, 99391 - 99394, 99401 - 99404, 99411 - 99412 and 99510</li> </ol> <p><b>B. Record the appropriate E&amp;M Code in the Billing section of the Progress Note for the visit</b> <i>(Progress Notes → Billing)</i></p> <p><b>II. <u>AND</u>, See the patient for at least two additional applicable visit encounters ≥ 31 and ≤ 300 days after the ADHD medication was prescribed</b></p> <p><b>A.</b> The E&amp;M codes identifying applicable visit encounters are the same as above (Numerator Documentation Step I)</p> <p><b>B. Record the appropriate E&amp;M Code in the Billing section of the Progress Note for the visit</b> <i>(Progress Notes → Billing)</i></p> <p style="text-align: right;"><i>(continued)</i></p>

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<p><b>Measure Documentation</b> <i>(continued)</i></p>	<p><b>III. <u>OR</u>, See the patient for at least 1 applicable visit encounter (as above) and at least 1 applicable Telehealth and/or Telephone Management services encounter (<math>\geq 31</math> and <math>\leq 300</math> days, or 1-10 months, after the ADHD medication was prescribed)</b></p> <p><b>A. The following E&amp;M codes identify an applicable Telehealth encounter:</b></p> <ol style="list-style-type: none"> <li>1. 99444</li> <li>2. OR, Bill a traditional E&amp;M code with a Telehealth modifier (GT , GQ, or 95)</li> </ol> <p><b>B. The following E&amp;M codes identify an applicable Telephone Management service</b></p> <ol style="list-style-type: none"> <li>1. 98966 - 98968</li> <li>2. 99441 - 99444</li> </ol> <p><b>C. Record the appropriate E&amp;M Code in the Billing section of the Progress Note for the visit</b> <i>(Progress Notes → Billing )</i></p>
<p><b>Exclusion and/or Exception Documentation</b></p>	<p style="text-align: center;"><b><u>To Exclude a Patient From This Measure</u></b> <i>(Exclusion/Exception Documentation)</i></p> <p><b>I. If applicable, document a diagnosis for Narcolepsy in the patient's chart in eCW</b></p> <p><b>A. The following ICD-10 codes identify Narcolepsy: G47.411, G47.419, G47.421 and G47.429</b></p> <p><b>B. Record the appropriate ICD-10 code in the Problem List of the patient's chart in eCW, as follows</b></p> <ol style="list-style-type: none"> <li>1. <i>Progress Note (or Virtual Visit) → Assessments → Problem List → Add</i> <b><u>OR</u></b></li> <li>2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab             <ol style="list-style-type: none"> <li>a. Click the orange button (with three dots) in the Progress Note band</li> </ol> </li> </ol> <p style="text-align: right;"><i>(continued)</i></p>

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<p>Exclusion and/or Exception Documentation <i>(continued)</i></p>	<p>b. Click "Add"</p> <p>3. <b>Helpful Tip:</b> When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field</p>
	<p>II. If applicable, document the following in the patient's chart in eCW</p> <p>A. Record an inpatient encounter occurring <math>\leq</math> 30 days after issuing the prescription for the ADHD medication</p> <p>1. Document the inpatient encounter in one of the following structured data fields</p> <p>a. For a discharge from the hospital, use the following structured data path:</p> <p><i>Progress Notes</i> → <i>HPI</i> → <i>Interim History</i> → <b>Transition of care from hospital</b> → <b>Date of admission to hospital</b></p> <p>b. For discharge from another inpatient facility, use the following structured data path:</p> <p><i>Progress Notes</i> → <i>HPI</i> → <i>Interim History</i> → <b>Transition of care from other inpatient facility</b> → <b>Date of admission to other inpatient facility</b></p> <p>2. For each of the above options, the required structured data fields are outlined (boxed)</p> <p>3. Record the admission to the inpatient facility in the appropriate structured data field</p> <p>a. Some configuration and mapping may first be required</p> <p>1) If necessary, add the "Transition of care from hospital" and/or "Transition of care from other inpatient facility" items to the "Interim History" folder in HPI, as follows:</p> <p>a) From within a Progress Note or Virtual Visit, click the "HPI" link</p> <p>b) Click on the "Interim History" folder</p> <p>c) If "Transition of care from hospital" or "Transition of care from other inpatient facility"</p> <p style="text-align: right;"><i>(continued)</i></p>

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<p><b>Exclusion and/or Exception Documentation</b> <i>(continued)</i></p>	<p>facility" is not an available option</p> <ol style="list-style-type: none"> <li>(1) Click the carat next to the "Custom" button</li> <li>(2) Select "New Item"             <ol style="list-style-type: none"> <li>(a) A new window will open</li> <li>(b) Type "Transition of care from hospital" or "Transition of care from other inpatient facility" in the "Name" field</li> <li>(c) Check the "Structured Data" box</li> <li>(d) Click "OK" to save and close</li> </ol> </li> </ol> <p><b>2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW</b></p> <ol style="list-style-type: none"> <li>a) From within eCW, click the "Community" tab (top Menu bar)</li> <li>b) Select "Mappings"</li> <li>c) Select "Structured Data" from the list of options             <ol style="list-style-type: none"> <li>(1) A "Mapper" window will open</li> <li>(2) Complete the following fields for both sides (Community and Local)                 <ol style="list-style-type: none"> <li>(a) Section = HPI</li> <li>(b) Category = Interim History</li> <li>(c) Item = "Transition of care from hospital" or "Transition of care from inpatient facility"</li> </ol> </li> <li>(3) From the Community side, select the desired reporting field                 <ol style="list-style-type: none"> <li>(a) E.g., "Date of admission to the hospital"</li> <li>(b) E.g., "Date of admission to an other inpatient facility"</li> </ol> </li> <li>(4) Click "Add"</li> </ol> <p style="text-align: right;"><i>(continued)</i></p> </li></ol>

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<p><b>Exclusion and/or Exception Documentation (continued)</b></p>	<p>(a) The field will automatically be added to the Local side</p> <p>(b) The fields will automatically be mapped to each other</p> <p>(c) (Mapped fields display in blue font)</p> <p>(d) Associated options are also automatically added and mapped</p> <p><b>b. Enter the date of the inpatient admission in the appropriate structured data field</b></p> <p><b>B. <u>AND</u>, Record a diagnosis for a Mental Health Disorder, active at the time of the above inpatient encounter, in the patient's chart in eCW</b></p> <p><b>1. The following ICD-10 codes identify Mental Health Disorders</b></p> <p>F03.90 and F03.91</p> <p>F20.0 - F20.3, F20.5, F20.81, F20.89, F20.9, F21 - F24, F25.0, F25.1, F25.8, F25.9, F28 and F29</p> <p>F30.10 - F30.13, F30.2 - F30.4, F30.8 - F30.9, F31.0, F31.10 - F31.13, F31.2, F31.30 - F31.32, F31.4 - F31.5, F31.60 - F31.64, F31.70 - F31.78 , F31.81 F31.89, F31.9, F32.0 - F32.5, F32.8 - F32.9, F33.0 - F33.3, F33.40 - F33.42, F33.8 - F33.9, F34.0 - F34.1, F34.8 - F34.9 and F39</p> <p>F40.00 - F40.02, F40.10 - F40.11, F40.210, F40.218, F40.220, F40.228, F40.230 - F4-.233, F40.240 - F40.243, F40.248, F40.290 - F40.291, F40.298 F40.8 - F40.9, F41.0 -F41.1, F41.2, F41.8 - F41.9, F42, F43.0, F43.10 - F43.12, F43.20 - F43.25, F43.29, F43.8 - F43.9, F44.0 - F44.2, F44.4 - F44.7 F44.81, F44.89, F44.9, F45.0 - F45.1, F45.20 - F45.22, F45.29, F45.41 - F45.42, F45.8 - F45.9, F48.1 - F48.2 and F48.8 - F48.9</p> <p>F50.00 - F50.02, F50.2, F50.8 - F50.9, F51.01 - F51.09, F51.11 - F51.13, F51.19, F51.3 - F51.5, F51.8 - F51.9, F52.0 - F52.1, F52.21 - F52.22, F52.31, F52.32, F52.4 - F52.6, F52.8 - F52.9, F53 and F59</p> <p>F60.0 - F60.7, F60.81, F60.89, F60.9, F63.0 - F63.3, F63.81, F63.89, F63.9, F64.1 - F64.2, F64.8 - F64.9, F65.0 - F65.4, F65.50 - F65.52, F65.81, F65.89 F65.9, F66, F68.10 - F68.13, F68.8 and F69</p> <p>F80.0 - F80.2, F80.4, F80.81, F80.89, F80.9, F81.0, F81.2, F81.81, F81.89, F81.9, F82, F84.0, F84.2 - F84.3, F84.5, F84.8 - F84.9, F88 and F89</p> <p><i>(continued)</i></p>



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<p>Exclusion and/or Exception Documentation <i>(continued)</i></p>	<p>F90.0 - F90.2, F90.8 - F90.9, F91.0 - F91.3, F91.8 - F91.9, F93.0, F93.8 - F93.9, F94.0 - F94.2, F94.8 - F94.9, F95.0 - F95.2, F95.8 - F95.9, F98.0 - F98.1, F98.21, F98.29, F98.3 - F98.5, F98.8 - F98.9 and F99</p> <p><b>2. Document the appropriate diagnosis in a Progress Note associated with the inpatient visit</b> <i>(Progress Notes → Assessments → Problem List)</i></p> <p><b>3. Helpful Hint: When adding a new diagnosis to a Problem list, enter the onset date for the disorder, of known, in the associated "Onset Date" field</b></p> <p><b>C. <u>OR</u>, Record a diagnosis for Substance Abuse, active at the time of the above inpatient encounter, in the patient's chart in eCW</b></p> <p><b>1. The following ICD-10 codes indicate Substance Abuse disorders</b></p> <p>F10.10, F10.120 - F10.121, F10.129, F10.14, F10.150 - F10.151, F10.159, F10.180 - F10.182, F10.188, F10.19, F10.20 - F10.21, F10.220 - F10.221 F10.229 - F10.232, F10.239, F10.24, F10.250 - F10.251, F10.259, F10.26 - F10.27, F10.280 - F10.282, F10.288, F10.29, F10.920 - F10.921, F10.929 F10.94, F10.950 - F10.951, F10.959, F10.96 - F10.97, F10.980 - F10.982, F10.988 and F10.99</p> <p>F11.10, F11.120 - F11.122, F11.129, F11.14, F11.150 - F11.151, F11.159, F11.181 - F11.182, F11.188, F11.19 - F11.21, F11.220 - F11.222, F11.229 F11.23 - F11.24, F11.250 - F11.251, F11.259, F11.281 - F11.282, F11.288, F11.29, F11.90, F11.920 - F11.922, F11.929, F11.93 - F11.94, F11.950 - F11.951, F11.959, F11.981 - F11.982, F11.988 and F11.99</p> <p>F12.10, F12.120 - F12.122, F12.129, F12.150 - F12.151, F12.159, F12.180, F12.188, F12.19 - F12.21, F12.220 - F12.222, F12.229, F12.250 - F12.251 F12.259, F12.280, F12.288, F12.29, F12.90, F12.920 - F12.922, F12.929, F12.950 - F12.951, F12.959, F12.980, F12.988 and F12.99</p> <p>F13.10, F13.120 - F13.121, F13.129, F13.14, F13.150 - F13.151, F13.159, F13.180 - F13.182, F13.188, F13.19 - F13.21, F13.220 - F13.221, F13.229 F13.230 - F13.232, F13.239, F13.24, F13.250 - F13.251, F13.259, F13.26 - F13.27, F13.280 - F13.282, F13.288, F13.29, F13.90, F13.920 - F13.921 F13.929 - F13.932, F13.939, F13.94, F13.950 - F13.951, F13.959, F13.96 - F13.97, F13.980 - F13.982, F13.988 and F13.99</p> <p>F14.10, F14.120 - F14.122, F14.129, F14.14, F14.150 - F14.151, F14.159, F14.180 - F14.182, F14.188, F14.19 - F14.21, F14.220 - F14.222, F14.229 F14.23 - F14.24, F14.250 - F14.251, F14.259, F14.280 - F14.282, F14.288, F14.29, F14.90, F14.920 - F14.922, F14.929, F14.94, F14.950 - F14.951 F14.959, F14.980 - F14.982, F14.988 and F14.99</p> <p style="text-align: right;"><i>(continued)</i></p>

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<p><b>Exclusion and/or Exception Documentation</b> <i>(continued)</i></p>	<p>F15.10, F15.120 - F15.122, F15.129, F15.14, F15.150 - F15.151, F15.159, F15.180 - F15.182, F15.188. F15.19 - F15.21, F15.220 - F15.222, F15.229 F15.23 - F15.24, F15.250 - F15.251, F15.259, F15.280 - F15.282, F15.288, F15.29, F15.90, F15.920 - F15.922, F15.929, F15.93 - F15.94, F15.950 - F15.951, F15.959, F15.980 - F15.982, F15.988 and F15.99</p> <p>F16.10, F16.120 - F16.122, F16.129, F16.14, F16.150 - F16.151, F16.159, F16.180, F16.183, F16.188, F16.19 - F16.21, F16.220 - F16.221, F16.229 F16.24, F16.250 - F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F16.920 - F16.921, F16.929, F16.94, F16.950 - F16.951, F16.959 F16.980, F16.983, F16.988 and F16.99</p> <p>F18.10, F18.120 - F18.121, F18.129, F18.14, F18.150 - F18.151, F18.159, F18.17, F18.180, F18.188, F18.19 - F18.21, F18.220 - F18.221, F18.229 F18.24, F18.250 - F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F18.920 - F18.921, F18.929, F18.94, F18.950 - F18.951, F18.959 F18.97, F18.980, F18.988 and F18.99</p> <p>F19.10, F19.120 - F19.122, F19.129, F19.14, F19.150 - F19.151, F19.159, F19.16 - F19.17, F19.180 - F19.182, F19.188, F19.19 - F19.21, F19.220 - F19.222, F19.229 - F19.232, F19.239, F19.24, F19.250 - F19.251, F19.259, F19.26 - F19.27, F19.280 - F19.282, F19.288, F19.29, F19.90, F19.920 - F19.922, F19.929 - F19.932, F19.939, F19.94, F19.950 - F19.951, F19.959, F19.96 - F19.97, F19.980 - F19.982, F19.988 and F19.99</p> <p><b>2. Document the appropriate diagnosis in a Progress Note associated with the inpatient visit</b> <i>(Progress Notes → Assessments → Problem List)</i></p> <p><b>3. Helpful Hint: When adding a new diagnosis to a Problem list, enter the onset date for the disorder, of known, in the associated "Onset Date" field</b></p>
<p><b>Trouble-Shooting</b></p>	<p style="text-align: center;"><b><u>Having Problems? Check Out the Following Trouble-Shooting Tips</u></b></p> <p><b>I. Verify that an applicable visit encounter E&amp;M code was recorded in the Billing section of a Progress Note within the required timeframe (&lt; 30 days after the ADHD medication was prescribed)</b></p> <hr/> <p><b>II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR</b></p> <p style="text-align: right;"><i>(continued)</i></p>

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase <i>(continued)</i>
<p><b>Trouble-Shooting</b> <i>(continued)</i></p>	<p>A. For further assistance with mapping problems, contact an eCW Technical Service representative</p> <p>B. <b>OR</b>, Contact Ed Worthington or Kelly Saxton @ NPO</p> <hr/> <p><b>III. Document a new allergy or intolerance in the "Allergies" section of the patient's chart, as follows"</b></p> <p>A. Access the "Allergies" section of the patient's chart in one of the following ways:</p> <ol style="list-style-type: none"> <li>1. From the "Allergies/Intolerance" window, click "Add"</li> <li>2. The "Past Medical History" window will open</li> </ol> <p><b>B. Add a new Allergy or Intolerance as follows:</b></p> <ol style="list-style-type: none"> <li>1. From the "Allergies/Intolerance" window, click "Add"</li> <li>2. The "Past Medical History" window will open               <ol style="list-style-type: none"> <li>a. <b>"Structured/Non-Structured"</b> Field                   <ol style="list-style-type: none"> <li>1) Select "Structured" if documenting a Drug allergy</li> <li>2) Select "Non-Structured" if documenting a non-Drug allergy</li> </ol> </li> <li>b. <b>"Agent/Substance"</b> Field                   <ol style="list-style-type: none"> <li>1) For a Structured (Drug) Allergy                       <ol style="list-style-type: none"> <li>a) Click on the field to open the "Select Rx" window</li> <li>b) Find and select the appropriate medication</li> <li>c) Click "OK" to save the information and exit the window</li> </ol> </li> <li>2) For a Non-Structured A (Non-Drug/Other) Allergy</li> </ol> </li> </ol> </li> </ol> <p style="text-align: right;"><i>(continued)</i></p>

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase <i>(continued)</i>
<p><b>Trouble-Shooting</b> <i>(continued)</i></p>	<ul style="list-style-type: none"> <li>a) Click in the empty field to reveal a carat for a drop-down box</li> <li>b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options</li> <li>c) Select an Allergy from the list of options in the drop-down box</li> <li>d) <u>Or</u>, free-type an Allergy into the "Agent/Substance" field</li> </ul> <p>c. "Reaction" Field</p> <ul style="list-style-type: none"> <li>1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options</li> <li>2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis)</li> <li>3) <u>Or</u>, free-type a reaction into the empty field</li> </ul> <p>d. "Type" Field</p> <ul style="list-style-type: none"> <li>1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options</li> <li>2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options</li> </ul> <p>e. "Status" Field</p> <ul style="list-style-type: none"> <li>1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options</li> <li>2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list of options</li> </ul>
	<p><b>IV. Verify that all applicable diagnoses have been added to the patient's Problem List</b></p> <ul style="list-style-type: none"> <li>A. Be aware of diagnoses assessed by other physicians involved in the patient's care</li> <li>B. Add and remove diagnoses, as necessary, to keep the patient's Problem List accurate</li> </ul>
	<p><b>V. Verify that all medications, currently being used by the patient, are listed in the "Current Medications" section of the patient's chart</b></p> <p style="text-align: right;"><i>(continued)</i></p>

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation Phase <i>(continued)</i>
<p><b>Trouble-Shooting</b> <i>(continued)</i></p>	<p>A. Reconcile the Current Medication list provided from other physicians in the patient's Care Team with the Current Medication List in the patient's chart in your EMR</p> <p>B. Add new medications and remove old medications, as necessary, to keep the patient's Current Medication list accurate</p> <hr/> <p><b>VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org ) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)</b></p>
<p><b>For More Information</b></p>	<p style="text-align: center;"><u><b>For More Information</b></u></p> <p>I. 2017 HEDIS for QRS Version : "<b>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</b>"</p> <p>II. eClinicalWorks "<b>MIPS - CMS 136 - ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</b>"</p>