

eCW Clinical Documentation Guide

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation 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 had one follow-up visit with a practioner with prescribing authority during the 30-day Initiation Phase in the Measurement Period</i></p>
Measurement Period	<p>The Measurement Period is defined as the current calendar year (January 1 - December 31)</p>
Intake Period	<p>The Intake Period 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>Index Prescription Start Date (IPSD) 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 Medication History	<p>Negative Medication History 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 Initiation Phase is defined as the 30 days following the IPSD</p>
Denominator	<p>The Denominator consists of patients who:</p> <ul style="list-style-type: none"> I. Are ≥ 6 and < 12 years of age at the beginning of the Measurement Period II. AND, Had their first prescription for an ADHD medication issued ≤ 90 days prior to, or ≤ 60 days after, the start of the Measurement Period III. AND, Were seen for an applicable E&M encounter during the Measurement Period <p style="text-align: center;"><i>(continued)</i></p>

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<p>Numerator</p>	<p>The Numerator consists of patients, from the Denominator, who were seen for an applicable visit encounter \leq 30 days after the ADHD medication, from the Denominator, was prescribed</p>
<p>Exclusions and/or Exceptions</p>	<p>Patients are excluded from this measure for one of the following reasons:</p> <ul style="list-style-type: none"> I. They have an active diagnosis for Narcolepsy during the Measurement Period II. OR, They had an inpatient encounter within the Initiation Phase <ul style="list-style-type: none"> A. AND, They had an active diagnosis for a mental health disorder at the time of the inpatient encounter B. OR, They had an active, and primary, diagnosis of substance abuse at the time of the inpatient encounter
<p>Measure Documentation</p>	<p style="text-align: center;"><u>To Qualify For This Measure</u> <i>(Denominator Documentation)</i></p> <ul style="list-style-type: none"> I. 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) <ul style="list-style-type: none"> A. The following (generic) medications are considered ADHD medications (see Table ADD-A_2017 @www.ncqa.com) <ol style="list-style-type: none"> 1. Amphetamine-Dextroamphetamine 2. Atoxmetine 3. Clonidine 4. Dexmethylphenidate 5. Dextroamphetamine 6. Guanfacine 7. Lisdexamfetamine 8. Methamphetamine 9. Methylphenidate <p style="text-align: right;"><i>(continued)</i></p>

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<p>Measure Documentation <i>(continued)</i></p>	<p>B. Document the ADHD medication in the "Current Medications" section of the patient's chart in eCW</p> <p>1. Record the prescription from one of the following locations:</p> <ul style="list-style-type: none"> a. <i>Progress Notes</i> → <i>Treatment</i> → <i>Add</i> b. <i>Telephone/Web Encounter</i> → <i>Rx Tab</i> → <i>Select Rx</i> c. <i>Telephone/Web Encounter</i> → <i>Virtual Visit Tab</i> → <i>Treatment</i> → <i>Add</i> d. <i>Progress Notes</i> → <i>Current Medications</i> <p>2. 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</p> <p>3. 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</p> <p>II. The patient must be seen for an applicable visit encounter during the Measurement Period</p> <p>A. The following E&M codes identify applicable visit encounters</p> <ul style="list-style-type: none"> 1. 99201 - 99205 and 99212 - 99215 2. 99341 - 99345, 99347 - 99350, 99381 - 99384 and 99391 - 99394 <p>B. Record the appropriate E&M code in the Billing section of the Progress Note for the visit <i>(Progress Notes</i> → <i>Billing</i>)</p>
	<p style="text-align: center;"><u>To Satisfy This Measure</u> <i>(Numerator Documentation)</i></p> <p style="text-align: center;">See the patient for an applicable visit encounter ≤ 30 days after prescribing the ADHD medication</p> <p style="text-align: center;"><i>(continued)</i></p>

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<p>Measure Documentation <i>(continued)</i></p>	<p>A. The following E&M codes identify applicable ADHD visit encounters</p> <ol style="list-style-type: none"> 1. 90791 - 90792, 90832, 90834, 90837, 90845, 90847, 90849, 90853, 90875 and 90876 2. 96150 - 96154 3. 98960 - 98962 4. 99078, 99201 - 99205, 99212 - 99215, 99217 - 99220, 99241 - 99245, 99341 - 99345, 99347 - 99350, 99381 - 99384 99391 - 99394, 99401 - 99404, 99411 - 99412 and 99510 <p>B. Record the appropriate E&M Code in the Billing section of the Progress Note for the visit <i>(Progress Notes → Billing)</i></p>
<p>Exclusion and/or Exception Documentation</p>	<p style="text-align: center;"><u>To Exclude a Patient From This Measure</u> <i>(Exclusion/Exception Documentation)</i></p> <p>I. If applicable, document a diagnosis for Narcolepsy in the patient's chart in eCW</p> <p>A. The following ICD-10 codes identify Narcolepsy: G47.411, G47.419, G47.421 and G47.429</p> <p>B. Record the appropriate ICD-10 code in the Problem List of the patient's chart in eCW, as follows</p> <ol style="list-style-type: none"> 1. <i>Progress Note (or Virtual Visit) → Assessments → Problem List → Add</i> <u>OR</u> 2. From the ICW (Right-Hand Chart Panel), click the "Overview" tab <ol style="list-style-type: none"> a. Click the orange button (with three dots) in the Progress Note band b. Click "Add" 3. Helpful Tip: When adding a new diagnosis to the Problem List, enter the onset date (if known) in the associated "Onset Date" field <p style="text-align: right;"><i>(continued)</i></p>

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<p>Exclusion and/or Exception Documentation <i>(continued)</i></p>	<p>II. If applicable, document the following in the patient's chart in eCW</p> <p>A. Record an inpatient encounter occurring ≤ 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> → Transition of care from hospital → Date of admission to hospital</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>Interin History</i> → Transition of care from other inpatient facility → Date of admission to other inpatient facility</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" is not an available option</p> <p>(1) Click the carat next to the "Custom" button</p> <p>(2) Select "New Item"</p> <p>(a) A new window will open</p> <p><i>(continued)</i></p>

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<p>Exclusion and/or Exception Documentation (continued)</p>	<ul style="list-style-type: none"> (b) Type "Transition of care from hospital" or "Transition of care from other inpatient facility" in the "Name" field (c) Check the "Structured Data" box (d) Click "OK" to save and close <p>2) If necessary, map the structured fields in your EMR to their Community counterparts in eCW</p> <ul style="list-style-type: none"> a) From within eCW, click the "Community" tab (top Menu bar) b) Select "Mappings" c) Select "Structured Data" from the list of options <ul style="list-style-type: none"> (1) A "Mapper" window will open (2) Complete the following fields for both sides (Community and Local) <ul style="list-style-type: none"> (a) Section = HPI (b) Category = Interim History (c) Item = "Transition of care from hospital" or "Transition of care from inpatient facility" (3) From the Community side, select the desired reporting field <ul style="list-style-type: none"> (a) E.g., "Date of admission to the hospital" (b) E.g., "Date of admission to an other inpatient facility" (4) Click "Add" <ul style="list-style-type: none"> (a) The field will automatically be added to the Local side (b) The fields will automatically be mapped to each other (c) (Mapped fields display in blue font) (d) Associated options are also automatically added and mapped <p style="text-align: right;"><i>(continued)</i></p>

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase <i>(continued)</i>
<p>Exclusion and/or Exception Documentation (continued)</p>	<p style="text-align: center;">b. Enter the date of the inpatient admission in the appropriate structured data field</p> <p>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</p> <p style="text-align: center;">1. The following ICD-10 codes identify Mental Health Disorders</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>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 style="text-align: center;">2. Document the appropriate diagnosis in a Progress Note associated with the inpatient visit <i>(Progress Notes → Assessments → Problem List)</i> <i>(continued)</i></p>

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<p>Exclusion and/or Exception Documentation (continued)</p>	<p>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</p> <p>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</p> <p>1. The following ICD-10 codes indicate Substance Abuse disorders</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>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</p> <p style="text-align: right;"><i>(continued)</i></p>

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<p>Exclusion and/or Exception Documentation (continued)</p>	<p>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>Trouble-Shooting</p>	<p style="text-align: center;"><u>Having Problems? Check Out the Following Trouble-Shooting Tips</u></p> <p>I. Verify that an applicable visit encounter E&M code was recorded in the Billing section of a Progress Note within the required timeframe (< 30 days after the ADHD medication was prescribed)</p> <hr/> <p>II. Verify that all structured data fields used are mapped to the correct Community elements in your EMR</p> <p style="padding-left: 40px;">A. For further assistance with mapping problems, contact an eCW Technical Service representative</p> <p style="padding-left: 40px;">B. OR, Contact Ed Worthington or Kelly Saxton @ NPO</p> <hr/> <p>III. Document a new allergy or intolerance in the "Allergies" section of the patient's chart, as follows"</p> <p style="padding-left: 40px;">A. Access the "Allergies" section of the patient's chart in one of the following ways:</p> <ol style="list-style-type: none"> From the "Allergies/Intolerance" window, click "Add" The "Past Medical History" window will open <p style="text-align: right;"><i>(continued)</i></p>

Measure Name	Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase <i>(continued)</i>
<p>Trouble-Shooting <i>(continued)</i></p>	<ul style="list-style-type: none"> a. "Structured/Non-Structured" Field <ul style="list-style-type: none"> 1) Select "Structured" if documenting a Drug allergy 2) Select "Non-Structured" if documenting a non-Drug allergy b. "Agent/Substance" Field <ul style="list-style-type: none"> 1) For a Structured (Drug) Allergy <ul style="list-style-type: none"> a) Click on the field to open the "Select Rx" window b) Find and select the appropriate medication c) Click "OK" to save the information and exit the window 2) For a Non-Structured A (Non-Drug/Other) Allergy <ul style="list-style-type: none"> a) Click in the empty field to reveal a carat for a drop-down box b) Click the carat to reveal a list of (Non-Drug/Other) Allergy options c) Select an Allergy from the list of options in the drop-down box d) <u>Or</u>, free-type an Allergy into the "Agent/Substance" field c. "Reaction" Field <ul style="list-style-type: none"> 1) For any Allergy, click in the empty "Reaction" field to reveal a carat for a drop-down list of options 2) Select the appropriate Reaction from the list of options (i.e., anaphylaxis) 3) <u>Or</u>, free-type a reaction into the empty field d. "Type" Field <ul style="list-style-type: none"> 1) For any Allergy, click in the empty "Type" field to reveal a carat for a drop-down list of options 2) Select the appropriate type (i.e., Allergy versus Intolerance) from the list of options e. "Status" Field <ul style="list-style-type: none"> 1) For any Allergy, click in the empty "Status" field to reveal a carat for a drop-down list of options <p style="text-align: right;"><i>(continued)</i></p>

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<p>Trouble-Shooting <i>(continued)</i></p>	<p>2) Select the current status (i.e., Active versus Inactive) for the Allergy/Intolerance from the list</p>
	<p>IV. Verify that all applicable diagnoses have been added to the patient's Problem List</p> <ul style="list-style-type: none"> A. Be aware of diagnoses assessed by other physicians involved in the patient's care B. Add and remove diagnoses, as necessary, to keep the patient's Problem List accurate
	<p>V. Verify that all medications, currently being used by the patient, are listed in the "Current Medications" section of the patient's chart</p> <ul style="list-style-type: none"> 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 B. Add new medications and remove old medications, as necessary, to keep the patient's Current Medication list accurate
	<p>VI. For further assistance, contact Ed Worthington (eworthington@npoinc.org) or Kelly Saxton (ksaxton@npoinc.org) at NPO (231-421-8505)</p>
<p>For More Information</p>	<p style="text-align: center;"><u>For More Information</u></p> <ul style="list-style-type: none"> I. 2017 HEDIS for QRS Version : "Follow-Up Care for Children Prescribed ADHD Medication (ADD)" II. eClinicalWorks "MIPS - CMS 136 - ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication"