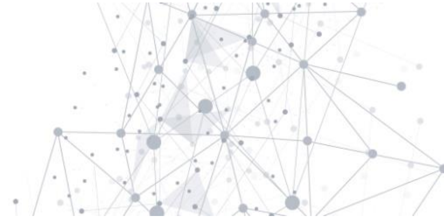

Blood Pressure Screening and Follow-Up (CMS22)

The following is for educational purposed only and is not intended to be clinical or legal advice. The information provided in the Measure Details section is based on specification published by CMS at https://ecqi.healthit.gov/ecqm/ec/2023/cms022v11

Measure Details

Description *

Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.

Initial Population

All patient visits for patients aged 18 years and older at the beginning of the measurement period.

Denominator

Equals Initial Population

Numerator

Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is elevated or hypertensive.

Denominator Exclusion/Exceptions

- Patient has an active diagnosis of hypertension.
- Documentation of medical reason(s) for not screening for high blood pressure (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
- Documentation of patient reason(s) for not screening for blood pressure measurements or for not ordering an appropriate follow-up intervention if patient BP is elevated or hypertensive (e.g., patient refuses)

Numerator Exclusion

NA

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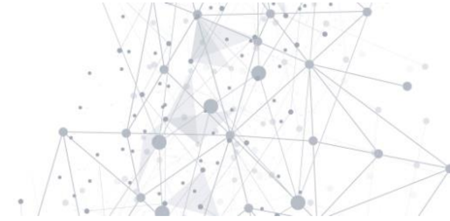


Overview

What is Documented	When is it Documented	Where in QMER
Qualifying Encounter	During Measurement Period (2023)	Coded SOAP Note
Blood Pressure	Each visit during measurement period (2023)	Vitals Module
Follow-Up if Blood Pressure is outside range: SBP < 120 mmHg AND DBP < 80 mmHg	Each visit BP is outside range	History Module

Exclusions/Exceptions	Where in QEMR
Active Diagnosis of hypertension	DxCPT Module or History Module
Medical or Personal Reason	History Module

2022 to 2023 Changes
NA

Set Up

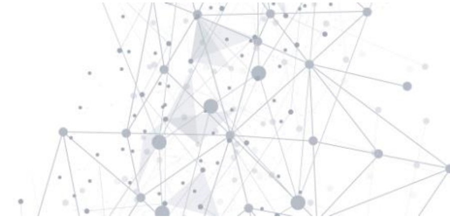
All codification shown is an example for incrementation, for a full list of accepted codes please visit [Value Set Authority Center.]

Qualifying Encounter

No set up required

Blood Pressure

No set up required



Follow-Up, Active Dx of Hypertension and Refusal

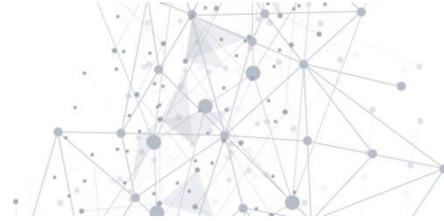
Build the history items below:

1. Log into **QEMR** > Navigate to **Edit** > **History**
2. Highlight ***desired*** **History Category** list on left side bar
3. Click **New** hot button
4. **Complete the Update History** Screen as seen below
5. Click **Save & Close** hot button

Update History
Save&Cls Close
* History Category : Health Maintenance Screening
* Item Description : BP Outside Normal Limits - PCP Follow Yp
Comments :
History Type : Procedure
SNOMED : 308470006-Referral to general physician
ICD9/10 :
CPT :
LOINC Code :
Refusal\Reason Code : 24184005 ; Finding of increased blood pres
CVX Code :

Update History
Save&Cls Close
* History Category : Past Medical History
* Item Description : Hypertension
Comments :
History Type : Diagnosis
SNOMED :
ICD9/10 : I10 : Essential (primary) hypertension
CPT :
LOINC Code :
Refusal\Reason Code :

Update History
Save&Cls Close
* History Category : Health Maintenance Screening
* Item Description : BP - Refusal
Comments :
History Type : Procedure
SNOMED : 413312003-Patient non-compliant - refu...
ICD9/10 :
CPT :
LOINC Code : 8480-6 : Systolic blood pressure
Refusal\Reason Code : 413312003 ; Patient non-compliant - refus
CVX Code :



Workflow

Qualifying Encounter

Following standard office workflow, document patient visit(s) via SOAP notes and code with CPT and diagnosis codes using either DxCPT, SmartDx or Smart CPT modules.

Document Blood Pressure

BMI must be documented each visit via the Vitals module following standard office protocol.

Follow-Up if BP Outside Normal Range or Refusal

To document smoking status, follow steps below:

1. Navigate to **History** Module > **Health Maintenance Screening** category
    a. Double-click **BP Outside Normal Limits or BP Refusal**
    b. Enter **Occur Date**

Category	Item	Comments	Smoking Status	Active	Occur Date	Date Entered	Source
Health Maintenance Screening							
	BP Outside Normal Limits - PCP Fol	Advise Patient to Follow Up with PCP			10/27/2022	10/27/2022 11:33 AM	gloEMR

Category	Item	Comments	Smoking Status	Active	Occur Date	Date Entered	Source
Health Maintenance Screening							
	BP - Refusal				04/06/2023	4/6/2023 12:03 PM	gloEMR

Active Dx of Hypertension

To document exclusion, follow steps below:

1. Navigate to **History** Module > select **Medical History** category
    a. Hospice
    b. Enter **Occur Date**

Category	Item	Comments	Smoking Status	Active	Occur Date	Date Entered	Source
Past Medical History							
	Hypertension			☑	10/12/2022	10/12/2022 11:55 AM	gloEMR

Incrementing Details

Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be documented using appropriate date based upon Measure Description.

Exam Coding

If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

Measure Specific Codes

The codification shown in this document are examples of qualifying documentation. To see a full list please visit Value Set Authority Center.

CMS Guidance *

This eCQM is an episode-based measure. An episode is defined as each eligible encounter for patients aged 18 years and older during the measurement period.

- This measure should be reported for every visit. The measure requires that blood pressure measurements (i.e., diastolic and systolic) be obtained during each visit in order to determine the blood pressure reading used to evaluate if an intervention is needed.
- Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures obtained during a patient visit, only the last, or most recent, pressure measurement will be used to evaluate the measure requirements.
- The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. The documented follow-up plan must be related to the current blood pressure reading as indicated, example: "Patient referred to primary care provider for BP management."
- Telehealth encounters are not eligible for this measure because the measure requires a clinical action that cannot be conducted via telehealth.