## Adoption/Use of Electronic Health Records (EHR)

### Coding Specifications

Codes required to document a visit occurred:

A CPT service code, CPT code, HCPCS D-code or HCPCS G-code is required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

**CPT codes**

- 90801
- 90802
- 90804, 90805, 90806, 90807, 90808, 90809
- 92002, 92004
- 92012, 92014
- 92541, 92542, 92543, 92544, 92548
- 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588
- 92601, 92602, 92603, 92604
- 92620, 92621
- 92625
- 92626, 92627
- 92640
- 95920
- 96150, 96151, 96152
- 97001, 97002
- 97003, 97004
- 97750
- 97802, 97803, 97804
- 98940, 98941, 98942

**OR**

**CPT codes**

- 99201, 99202, 99203, 99204, 99205
- 99211, 99212, 99213, 99214, 99215

**OR**

**HCPCS D-codes**

- D7140, D7210 (oral and maxillofacial surgery)

**OR**

**HCPCS G-codes**

- G0101 (pelvic exam),
- G0108, G0109 (self-management training),
- G0270, G0271 (nutrition therapy)

Quality codes for this measure:

**G-code descriptors**

(Data collection sheet should be used to determine appropriate code.)

- *G8447:* Patient encounter was documented using a CCHIT certified EHR
- *G8448:* Patient encounter was documented using a qualified (non-CCHIT certified) EHR