DOCUMENTATION TIPS

Measure 226: Preventive Care and Screening:

Tobacco Use: Screening and Cessation Intervention

Electronic health records (EHRs) collect and organize notes, medication lists, and patient information using various formats. With providers also documenting this information in unique ways, this can potentially cause confusion and an increased timeline for measure mapping with DataDerm. This tip sheet can help you manage reporting requirements for performance measures and streamline standard documentation practices to allow seamless data pull into DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make the process as smooth as possible, it helps to document key elements of patient care. DataDerm cannot read scanned images of any kind, including scanned images for labs, letters to physicians, pathology reports, follow-up plans, and dates. If you have scanned images with information needed for your measures, please add a note in your chart with the date and required patient information for this data to be accurately collected.

This tip sheet can assist paper-based practices in standardizing documentation practices. Keeping notes in the patient's paper chart of all documentation requirements will assist you when reporting for this measure.

Measure 226:

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For all patients 18 years and older, document the following in your notes:

• The CPT code for **at least two patient encounters** during the reporting period 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

OR

- The CPT or HCPCS code for **at least one preventative patient encounter** during the reporting period (92521, 92522, 92523, 92524, 92540, 92557, 92625, 96160, 96161, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439)
- Note in the medical record that:
 - The patient was screened for tobacco use one or more times within 24 months (criteria 1).
 - The patient was screened for tobacco use, identified as a user and previously received tobacco cessation intervention (criteria 2).
 - The patient was screened for tobacco use, identified as a user, AND received tobacco cessation intervention during the encounter (criteria 3).
- All three submission criteria are required to report this measure and the tobacco cessation intervention includes:
 - Brief counseling (3 minutes or less)
 - Pharmacotherapy
 - Self-help materials or alternative therapies do NOT qualify as cessation intervention

(Continued)

Page 1 of 2



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(Continued)

- If tobacco screening or cessation intervention is not provided, document medical reason(s) for not preforming the screening or intervention. If applicable, include:
 - Limited life expectancy; or
 - Other medical reason

Additional Tips:

- Collect for **each denominator eligible visit** during the performance period.
- Measure includes all forms of tobacco use (e.g. cigarettes, chewing tobacco, etc.)
- See measure specifications for additional codes that can assist in seamless measure mapping from your EHR to DataDerm, if applicable (e.g. G9902, G9906).
- GQ, GT, 95, and POS 02 telehealth modifiers make cases ineligible.