

▲ Measure #106 (NQF 0103): Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:

This measure is to be reported a minimum of **once per reporting period** for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34

Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9

AND

Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:

Patients with evidence that they met the DSM-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

Definitions:

MDD diagnosis (DSM-5) - For a diagnosis of MDD a patient must endorse five of nine symptoms, with one of those five being either 1) depressed mood or 2) loss of interest or pleasure. The other symptoms include significant weight loss or gain, or decrease or increase in appetite nearly every day; fatigue or loss of energy nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; feelings of worthlessness or guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; and recurrent thoughts of death or suicidal ideation.

These symptoms must be present for a duration of 2 weeks or longer, represent a change from previous functioning, and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These symptoms must:

- **Not** be due to the physiological effects of a substance or to another general medical condition
- **Not** be better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- **Never** have been accompanied by a manic or hypomanic episode

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in the DSM-5 criteria, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

Severity – According to DSM-IV-TR (2000), severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. See the Rationale and Clinical Recommendation Statements Sections for Supporting Guidelines and Other References for additional information on defining severity levels. (**Note: DSM-5 does not address severity. As such, DSM-IV-TR is the most up to date resource to use for assessment of severity.**)

NUMERATOR NOTES:

For clinicians who use the term relapse, generally that refers to an episode of MDD that occurs within 6 months after either response or remission, which may be a variation on the initial episode. This measure is intended to capture either an initial or recurrent episode.

This measure is intended for use by clinicians who are qualified to diagnose and treat depression.

It can be helpful to use screening tools such as the PHQ-9 in order to substantiate the need for further evaluation and accurate diagnosis of MDD; however, simply using a tool alone would not constitute making a successful MDD diagnosis. A validated depression screening tool may include the PHQ-9, which is based on the DSM criteria for MDD. Other validated tools based on the DSM criteria may be available; this list is not intended to be all-inclusive.

Please refer to the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (version 5 as of 2013) for more information regarding diagnosing Major Depressive Disorder.

It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.

FOR PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD:

The clinician should report that DSM-5 criteria and depression severity was assessed during the visit in which the new diagnosis or recurrent episode was identified.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

DSM-5 Criteria for Major Depressive Disorder Documented

(One CPT II code & one quality data code [1040F & G8930] are required on the claim form to submit this numerator option)

1040F: DSM-5 criteria for major depressive disorder documented at the initial evaluation

AND

G8930: Assessment of depression severity at the initial evaluation

OR

DSM-5 Criteria for Major Depressive Disorder not Documented, Reason not Otherwise Specified

(One CPT II code [1040F-8P] or one quality data code [G8931] is required on the claim form to submit this numerator option)

1040F with 8P: DSM-5 criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified

OR

G8931: Assessment of depression severity not documented, reason not given

RATIONALE:

Chronic depression often goes unrecognized and untreated. The recognition and appropriate treatment of MDD is dependent on a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs. It can help clinicians rule-out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. An assessment of severity can also help clinicians tailor a patient's treatment. As noted in clinical guidelines, treatment methods should vary by the severity of depression. A diagnostic evaluation should be instituted for all patients with major depressive disorder to determine whether a diagnosis of depression is warranted and to reveal the presence of other conditions that may have an impact on treatment.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Patients should receive a thorough diagnostic assessment in order to establish the diagnosis of major depressive disorder, identify other psychiatric or general medical conditions that may require attention, and develop a comprehensive plan for treatment [1]. (APA, 2010)

Criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly attributable to another medical condition)
1. Depressed mood most of the day, nearly every day as indicated by either subjective report (eg, feels sad, empty, hopeless) or observation made by others (eg, appears tearful)
 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
 3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day
 4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 6. Fatigue or loss of energy nearly every day
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self esteem is generally preserved whereas in MDE feelings of worthlessness and self loathing are common. If self derogatory ideation is present in grief, it typically involves perceived failings vis-a-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition. (DSM-5, 2013)

Major depressive disorder can alter functioning in numerous spheres of life including work, school, family, social relationships, leisure activities, or maintenance of health and hygiene. The psychiatrist (clinician) should evaluate the patient's activity in each of these domains and determine the presence, type, severity, and chronicity of any dysfunction [1]. (APA, 2010)

In developing a treatment plan, interventions should be aimed at maximizing the patient's level of functioning as well as helping the patient to set specific goals appropriate to his or her functional impairments and symptom severity [1]. (APA, 2010)

If criteria are currently met for the major depressive episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe with Psychotic Features. [The fifth digit (in the diagnostic codes for Major Depressive Disorder) indicates the severity as follows: 1 for mild severity, 2 for moderate severity, 3 for severe without psychotic features, and 4 for severe with psychotic features.] (DSM-IV-TR, 2000)

Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. (DSM-IV-TR, 2000)

- Mild episodes are characterized by the presence of only five or six depressive symptoms and either mild disability or the capacity to function normally but with substantial and unusual effort.
- Episodes that are Severe Without Psychotic Features are characterized by the presence of most of the criteria symptoms and clear-cut, observable disability (eg, inability to work or care for children).
- Moderate episodes have a severity that is intermediate between mild and severe.
- [Severe With Psychotic Features] indicates the presence of either delusions or hallucinations (typically auditory). The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features [ie, content of the delusions or hallucinations are consistent with the depressive themes] or With Mood-Incongruent Features (ie, content of the delusions or hallucinations has no apparent relationship to depressive themes).

▲ Measure #107 (NQF 0104): Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:

This measure is to be reported a minimum of **once during the reporting period** for all patients with an active diagnosis of major depressive disorder (MDD) seen individually during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34

Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9

AND

Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

Definition:

Suicide risk assessment - Must include questions about the following:

- 1) Suicidal ideation
- 2) Patient's intent of initiating a suicide attempt
AND, if either is present,
- 3) Patient plans for a suicide attempt
- 4) Whether the patient has means for completing suicide

NUMERATOR NOTE: *It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Suicide Risk Assessed

G8932: Suicide risk assessed at the initial evaluation

OR

Suicide Risk not Assessed, Reason not Given

G8933: Suicide risk not assessed at the initial evaluation, reason not given

RATIONALE:

Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder. Depression is the cause of over two-thirds of the reported suicides in the U.S. each year. The intent of this measure is for a clinician to assess suicide risk at initial intake or at the visit in which depression was diagnosed. As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (eg, psychosis, severe anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (eg, positive reasons for living, strong social support), family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (eg, giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout MDD treatment.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder [I]. (APA, 2010)

Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (eg, psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (eg, positive reasons for living, strong social support); and identification of any family history of suicide or mental illness [I]. (APA, 2010)
As part of the assessment process, impulsivity and potential for risk to others should also be evaluated, including any history of violence or violent or homicidal ideas, plans, or intentions [I]. (APA, 2010)

The patient's risk of harm to him- or herself and to others should also be monitored as treatment proceeds [I]. (APA, 2010)

Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (from APA's Practice Guideline for Assessment and Treatment of Patients With Suicidal Behaviors-2010, Downloaded from <http://psychiatryonline.org/> on 6/25/12):

Admission generally indicated

After a suicide attempt or aborted suicide attempt if:

- Patient is psychotic
- Attempt was violent, near-lethal, or premeditated
- Precautions were taken to avoid rescue or discovery
- Persistent plan and/or intent is present
- Distress is increased or patient regrets surviving
- Patient is male, older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking
- Patient has limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
- Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

In the presence of suicidal ideation with:

- Specific plan with high lethality
- High suicidal intent

Admission may be necessary

[In addition to the list above, these additional circumstances may warrant admission]

After a suicide attempt or aborted suicide attempt

In the presence of suicidal ideation with:

- Psychosis
- Major psychiatric disorder
- Past attempts, particularly if medically serious
- Possibly contributing medical condition (eg, acute neurological disorder, cancer, infection)
- Lack of response to or inability to cooperate with partial hospital or outpatient treatment
- Need for supervised setting for medication trial or ECT
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family and/or social support, including lack of stable living situation
- Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
- Evidence of putting one's affairs in order (eg, giving away possessions, writing a will)

In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk.

Release from emergency department with follow-up recommendations may be possible

After a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (eg, exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department
- Plan/method and intent have low lethality
- Patient has stable and supportive living situation
- Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment

Outpatient treatment may be more beneficial than hospitalization

Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing.

📌 **Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**

**2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY**

DESCRIPTION:

Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is **outside of normal parameters**, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30
Age 18 – 64 years BMI ≥ 18.5 and < 25

INSTRUCTIONS:

This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. *The most recent quality code submitted will be used for performance calculation.* There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI documented in the medical record may be reported if done in the provider's office/facility or if a BMI is documented within the previous six months in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented within six months of the abnormal BMI. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters".

Measure Reporting via Claims:

CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged >18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

NUMERATOR:

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters

Numerator Instructions: An eligible professional or their staff is required to measure both height and weight. Both the height and the weight must be measured within the same six months. Self-reported values cannot be used. The documentation of a follow-up plan must be based on the most recent documented BMI within the previous six months

Definitions:

BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H²) and is commonly used to classify weight categories. BMI can be calculated using:

$$\text{Metric Units: BMI} = \text{Weight (kg)} / (\text{Height (m)} \times \text{Height (m)})$$

OR

$$\text{English Units: BMI} = \text{Weight (lb)} / (\text{Height (in)} \times \text{Height (in)}) \times 703$$

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up may include but is not limited to: documentation education, a referral (e.g., a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.

Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate
- 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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

BMI Documented as Normal, No Follow-Up Plan Required

(One quality-data code [G8417, G8418 or G8420] is required on the claim form to submit this numerator option)

G8420: BMI is documented within normal parameters and no follow-up plan is required

OR

BMI Documented as Above Normal Parameters, AND Follow-Up Documented

G8417: BMI is documented above normal parameters and a follow-up plan is documented

OR

BMI Documented as Below Normal Parameters, AND Follow-Up Documented

G8418: BMI is documented below normal parameters and a follow-up plan is documented

OR

BMI not Documented, Patient not Eligible

(One quality-data code [G8422 or G8938] is required on the claim form to submit this numerator option)

G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible

G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI not Documented, Reason not Given

(One quality-data code [G8419 or G8421] is required on the claim form to submit this numerator option)

G8421: BMI not documented and no reason is given

OR

BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given

G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

RATIONALE:

BMI Above Upper Parameters

Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC) reported that in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent (2010). Flegal, Carroll, Kit and Ogden (2012) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups. In addition to the continued high prevalence rate for adults in general, there has been a significant increase for men and for non-Hispanic black and Mexican American women over the 12-year period from 1999 through 2010 (2012). Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with higher use of health care services and costs among obese patients (p. 373).

Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011).

Finkelstein, Trogon, Cohen and Dietz (2009) found that in 2006, across all payers, per capita medical spending for the obese is \$1,429 higher per year, (42 percent) than for someone of normal weight. Using 2008 dollars, this was estimated to be equivalent to \$147 billion dollars in medical care costs related to obesity.

In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

BMI Below Normal Parameters

In the National Center for Health Statistics Health E-Stat, Fryer and Ogden reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANE), using measured heights and weights, indicate an estimated 1.7% of U.S. adults are underweight with women more likely to be underweight than men (2012).

Ranhoff, Gjoen and Mowe (2005) recommended using BMI < 23 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

CLINICAL RECOMMENDATION STATEMENTS:

Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) recommends screening all adults (aged 18 years and older) for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. This is a B recommendation (Moyer, 2012)

As cited in Wilkinson et al. (2012), Institute for Clinical Systems Improvement (ICSI) *Preventive Services for Adults, Obesity Screening* (Level II) Recommendation provides the following guidance:

- Record height, weight and calculate body mass index at least annually
- A BMI greater or equal to 30 is defined as obese
- A BMI of 25-29 is defined as overweight
- Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight.

Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration

INSTRUCTIONS:

This measure is to be reported **each visit** during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97110, 97140, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:

Eligible professional attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list **must** include ALL prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND **must** contain the medications' name, dosages, frequency and route of administration

Definitions:

Current Medications - Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.

Route - Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

Not Eligible - A patient is **not** eligible if the following reason is documented:

- 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

NUMERATOR NOTE: *The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Current Medications Documented

G8427: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

OR

Current Medications not Documented, Patient not Eligible

G8430: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given

G8428: Current list of medications **not** documented as obtained, updated, or reviewed by the eligible professional, reason not given

RATIONALE:

In the American Medical Association's (AMA) *Physician's Role in Medication Reconciliation* (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs of \$1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million VADEs in 2001 might have been prevented with improved systems of care and better patient education,

yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of \$946 million to \$2.4 billion.

In the Institute for Safe Medication Practices, *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than \$75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated \$20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of \$8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

The Agency for Healthcare Quality's (AHRQ) *The National Healthcare Disparities Report* (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the all the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2011 National Patient Safety Goals guides providers to maintain and communicate accurate patient medication information guiding elements of performance to obtain and/or update information on the medications the patient is currently taking. The National Quality Forum's 2010 update of the *Safe Practices for Better Healthcare*, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA's published report, *The Physician's Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and--in all settings of care--will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as

possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

Measure #131 (NQF 0420): Pain Assessment and Follow-Up

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

INSTRUCTIONS:

This measure is to be reported **each visit** occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain" or "Return in two weeks for re-assessment of pain".

Measure Reporting via Claims:

CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

NUMERATOR:

Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

Numerator Note: *The standardized tool used to assess the patient's pain must be documented in the medical record (exception; A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)*

Definitions:

Pain Assessment - Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This **must** include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.

Not Eligible – A patient is **not** eligible if one or more of the following reason(s) is documented:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pain Assessment Documented as Positive AND Follow-Up Plan Documented

(One quality-data code [G8730 or G8731] is required on the claim form to submit this numerator option)

G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

OR

Pain Assessment Documented as Negative, No Follow-Up Plan Required

G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment NOT Documented Patient not Eligible

(One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option)

G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

OR

Pain Assessment not Documented, Reason not Given

(One quality-data code [G8732 or G8509] is required on the claim form to submit this numerator option)

G8732: **No** documentation of pain assessment, reason not given

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given

G8509: Pain assessment documented as positive using a standardized tool, follow-up plan **not** documented, reason not given

RATIONALE:

Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care

- Establishing a training program to improve the skills of health care professionals to assess and treat pain
- Enhancing the pain research agenda for the National Institute of Health (NIH)

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- 76.5 million Americans suffering from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at \$100 billion annually in healthcare expenses, lost income, and lost productivity– extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings. Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.)
- Increase in obesity which is associated with chronic conditions that have painful symptoms
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain
- Surgical patients are at risk for acute and chronic pain
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

Persistent chronic pain costs \$560 to \$635 billion in the USA. Additional healthcare costs due to pain range from \$261 to \$300 billion. Lost productive time amounts to \$299 to \$334 billion. Productivity is affected by number of days missed, number of annual hours worked and hourly wages (Gaskin, 2012). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President's Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between \$261 to \$300 billion. The value of lost productivity based on estimates of days of work missed is \$11.6 to 12.7 billion, hours of work lost is \$95.2 to \$96.5 billion and lower wages is \$190.6 to \$226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from \$560 to \$635 billion in 2010 dollars (*Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*, Appendix C, 2011).

"Medical care, specifically specialty care, rather than primary care, chiropractic care, or physical therapy is responsible for the rising costs of ambulatory care for spine conditions" (Davis 2012).

Chronic pain is defined as persistent pain which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient's well-being, level of function, and quality of life. If the patient has not been previously evaluated, attempt to differentiate between untreated acute pain and ongoing chronic pain. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted. (ICSI, 2011).

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (The Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003, Chronic Pain Research Alliance 2011). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

CLINICAL RECOMMENDATION STATEMENTS:

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors, spiritual and cultural issues are also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2011) *Assessment and Management of Chronic Pain Guideline, Fifth Edition* was chosen because it addresses the key factors of the plan of care, pain assessment, and outcomes. In addition, it is based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult acute and sub-acute low back pain guideline: Provides guidelines for more expedient evaluation, treatment, use of outcome measures and collaboration among healthcare professionals to allow patients to make informed decisions.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012). Provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

“Early physical therapy following a new primary care consultation can decrease risk of subsequent healthcare” (Fritz, 2012) and does not increase healthcare costs or utilization (Fritz, 2013).

Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

INSTRUCTIONS:

This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Measure Reporting via Claims:

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 12 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 12 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92557, 92567, 92568, 92625, 92626, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

NUMERATOR:

Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

Numerator Instructions: The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Documented follow-up for a positive depression screening **must** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Not Eligible – A patient is **not** eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Screening for Clinical Depression Documented as Positive, AND Follow-Up Plan Documented

(One quality-data code [G8431 or G8510] is required on the claim form to submit this numerator option)

G8431: Screening for clinical depression is documented as being positive AND a follow-up plan is documented

OR

Screening for Clinical Depression Documented as Negative, Follow-Up Plan not Required

G8510: Screening for clinical depression is documented as negative, a follow-up plan is not required

OR

Screening for Clinical Depression not Documented, Patient not Eligible

(One quality-data code [G8433 or G8940] is required on the claim form to submit this numerator option)

G8433: Screening for clinical depression not documented, documentation stating the patient is not eligible

OR

Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

G8940: Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible

OR

Screening for Clinical Depression not Documented, Reason not Given

(One quality-data code [G8432 or G8511] is required on the claim form to submit this numerator option)

G8432: Clinical depression screening **not** documented, reason not given

OR

Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given

G8511: Screening for clinical depression documented as positive, follow-up plan not documented, reason not given

RATIONALE:

The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, rates of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) concluded that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. In 2011, Healthy People 2020 recommended routine screening for mental health problems as a part of primary care for both children and adults. (U.S. Department of Health and Human Services, 2011)

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Gil Zalsman et al., (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated \$83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years)

The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (AHRQ, 2010, p.141).

Level II Child Preventive Services should be assessed and offered to each patient; as such services have been shown to be effective. Such Level II services include: Screening adolescents ages 12-18 for major depressive disorder when systems are in place for accurate diagnosis, treatment, and follow-up (ICSI, 2010).

Adult Recommendation (18 years and older)

The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2010, p.136).

Routine depression screening should be performed for adult patients (including older adults) but only if the practice has staff-assisted "systems in place to ensure that positive results are followed by accurate diagnosis, effective treatment, and careful follow-up" (ICSI, 2010).

Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: **CLAIMS, REGISTRY**

DESCRIPTION:

Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen

INSTRUCTIONS:

This measure is to be reported **once during the reporting period** for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding at the time of the qualifying visit. The documented follow up plan must be related to positive elder maltreatment screening, example: "Patient referred for protective services due to positive elder maltreatment screening."

Measure Reporting via Claims:

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 65 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 96116, 96150, 96151, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0270, G0402, G0438, G0439

NUMERATOR:

Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of the encounter and follow-up plan documented on the date of the positive screen

Definitions:

Screen for Elder Maltreatment – An elder maltreatment screen should include assessment and documentation of all of the following components: (1) physical abuse, (2) emotional or psychological abuse,

- (3) neglect (active or passive), (4) sexual abuse, (5) abandonment, (6) financial or material exploitation and (7) unwarranted control.

Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.

Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes acts or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect – Involves attitudes of others or actions caused by others—such as family members, friends, or institutional caregivers—that have an extremely detrimental effect upon well-being.

Active – Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.

Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

Sexual Abuse – The forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.

Elder Abandonment – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit.

Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care.

***Note:** Self neglect is a prevalent form of abuse in the elderly population. Screening for self neglect and screening tools for self neglect are not included in this measure. Resources for suspected self neglect are listed below.*

Follow-Up Plan – Must include a documented report to state or local Adult Protective Services (APS) agency. Note: **APS does not have jurisdiction in all states to investigate maltreatment of patients in long-term care facilities. In those states where APS does not have jurisdiction, APS may refer the provider to another state agency -- such as the state facility licensure agency – for appropriate reporting.** *Federal reporting: In addition to state requirements, some types of providers are required by federal law to report suspected maltreatment. For example, nursing facilities certified by Medicare and/or Medicaid are required to report suspected maltreatment to the applicable State Survey and Certification Agency.*

For state-specific information to report suspected elder maltreatment, including self neglect, the following resources are available:

1. National Adult Protective Services Association- <http://www.napsa-now.org/get-help/help-in-your-area/>
2. Eldercare Locator: 1-800-677-1116 www.eldercare.gov
3. National Center on Elder Abuse
http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/State_Resources.aspx

Disclaimer: The follow-up plan recommendations set forth in this quality measure are not intended to supersede any mandatory state, local or federal reporting requirements.

Not Eligible – A patient is not eligible if one or more of the following reasons is documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: Documentation of an elder maltreatment screening must include identification of the tool used. Examples of screening tools for elder maltreatment include, but are not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS) and Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Elder Maltreatment Screen Documented as Positive AND Follow-Up Plan Documented

(One quality-data code [G8733 or G8734] is required on the claim form to submit this numerator option)

G8733: Elder maltreatment screen documented as positive AND a follow-up plan is documented

OR

Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required

G8734: Elder maltreatment screen documented as negative, follow-up is not required

OR

Elder Maltreatment Screen not Documented, Patient not Eligible

(One quality-data code [G8535 or G8941] is required on the claim form to submit this numerator option)

G8535: Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen

OR

Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible for Follow-Up Plan

G8941: Elder maltreatment screen documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan

OR

Elder Maltreatment Screen not Documented, Reason not Given

(One quality-data code [G8536 or G8735] is required on the claim form to submit this numerator option)

G8536: No documentation of an elder maltreatment screen, reason not given

OR

Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Reason not Given

G8735: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given

RATIONALE:

"Most cases of elder abuse go unidentified and unreported (Cohen, 2011, p.261). Elder maltreatment is prevalent and occurs predominantly in the community, not in nursing care facilities. One in ten seniors reported being abused, neglected or exploited in the past twelve months; 5.2% for financial abuse, 4.6% for emotional, 1.6% for physical abuse and 0.6% for sexual abuse. Financial exploitation by family members and by strangers was increased among the more physically disabled adults (Aceirno et al., 2010). Elder Abuse and Neglect: In Search of Solutions (2013), reports that every year an estimated 4 million older Americans are victims of physical, psychological, or other forms of abuse and neglect, and for every reported case there may be as many as 23 unreported. Although less prevalent, patients in nursing homes do experience maltreatment. In a 2010 study performed by Natan et al., more than half of nursing facility surveyed staff reported they identified abuse of elderly residents over the past year with approximately two-thirds reporting incidents of neglect.

There are many complex reasons for underreporting; minimal screening, a lack of knowledge and skills for interventions (Cohen, 2011) on the part of health care providers and failure of the abused patient to report due to fear of retaliation by the abuser (APA, 2010), inability of the victim to report due to a cognitive deficit or initiating family discord. This lack of identifying victims of elder abuse leads to increased rates of hospitalization (Dong & Simon, 2013), morbidity (Cohen, 2011), mortality (Dong, et al., 2009) and admission into a nursing home (Lachs et al., 2011). These outcomes are costly. As cited in Dong (2011), the Government Accounting Office reported spending \$11.9 million dollars in 2009 for all activities related to elder abuse and this amount was not enough to provide basic

protection for older adults from abuse, neglect and exploitation. It is clear that additional screening, education of victims and health care providers and financial support is needed in order to unveil the depth of the problem and provide aid those who are being abused and neglected.

CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement).

Though the USPSTF does not support elder maltreatment screening, it is important to remember that absence of hard evidence supporting screening is not evidence that it is not effective. There have been many qualitative reports that do support the benefits of screening. Expert consensus and public policy for mandatory reporting support the value of screening this vulnerable population.

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user

INSTRUCTIONS:

This measure is to be reported **once per reporting period** for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:

CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:

Patients who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes use of any type of tobacco.

Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report **4004F** with **8P**.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator

4004F **with** 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F **with** 8P: Tobacco screening OR tobacco cessation intervention **not** performed, reason not otherwise specified

RATIONALE:

This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of

effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

Measure #247: Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence

**2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

INSTRUCTIONS:

This measure is to be reported a minimum of **once per reporting period** for patients with a diagnosis of alcohol dependence seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of current alcohol dependence

Denominator Criteria (Eligible Cases):

Patient aged \geq 18 years on date of encounter

AND

Diagnosis for alcohol dependence (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 303.90, 303.91, 303.92

Diagnosis for alcohol dependence (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29

AND

Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence

CPT II 4320F: Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence

OR

Patient not Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **4320F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4320F with 8P: Patient was **not** counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence, reason not otherwise specified

RATIONALE:

Research has shown that among patients diagnosed with alcohol dependence, only 4.64% were referred for psychosocial treatment in the form of substance abuse counseling, inpatient rehabilitation programs, outpatient rehabilitation programs, or mutual help groups. While pharmacologic therapy has established efficacy, often in combination with psychosocial therapy, in promoting abstinence and preventing relapse in alcohol-dependent patients, physician rates of prescribing pharmacologic therapy for alcohol dependence are also considerably low. A recent study found that these low rates prevail even among addiction medicine physicians who prescribed naltrexone to only 13% of their alcohol-dependent patients. Pharmacotherapy and psychosocial treatment should be routinely considered for all patients with alcohol dependence, and patients should be informed of this option.

CLINICAL RECOMMENDATION STATEMENTS:

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Psychosocial treatments found effective for some patients with an alcohol use disorder include motivational enhancement therapy (MET) (Category I), cognitive-behavioral therapy (CBT) (Category I), behavioral therapies (Category I), 12-step facilitation (TSF) (Category I), marital and family therapies (Category I), group therapies (Category II), and psychodynamic therapy/interpersonal therapy (IPT) (Category III). (APA, 2006)

Specific pharmacotherapies for alcohol-dependent patients have well-established efficacy and moderate effectiveness:

- Naltrexone may attenuate some of the reinforcing effects of alcohol, although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may promote adherence, but published research is limited and FDA approval is pending. [*Note: Extended-release naltrexone for injection has since received FDA approval*] (Category I)
- Acamprosate, a γ -aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated patients who are concomitantly receiving psychosocial treatment. (Category I)
- Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated patients whose drinking may be triggered by events that suddenly increase alcohol craving. (Category II) (APA, 2006)

Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. (NQF, 2007)

Measure #248: Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period

INSTRUCTIONS:

This measure is to be reported a minimum of **once per reporting period** for patients with a diagnosis of current substance abuse or dependence seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilizes claims data.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of current substance abuse or dependence

Denominator Criteria (Eligible Cases):

Patient aged \geq 18 years on date of encounter

AND

Diagnosis for substance abuse or dependence (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92

Diagnosis for substance abuse or dependence (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F11.10, F11.120, F11.121, F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19,

F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29

AND

Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were screened for depression within the 12-month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Depression

CPT II 1220F: Patient screened for depression

OR

Patient not Screened for Depression for Medical Reasons

Append a modifier (1P) to CPT Category II code 1220F to report documented circumstances that appropriately exclude patients from the denominator.

1220F *with* 1P: Documentation of medical reason(s) for not screening for depression

OR

Patient not Screened for Depression, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1220F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1220F *with* 8P: Patient was not screened for depression, reason not otherwise specified

RATIONALE:

Depression is one of the most common co-occurring psychiatric conditions in patients with substance use disorders and a condition for which a variety of screening methods have proven effective. Identifying depression and other co-occurring psychiatric disorders in patients with substance use disorders is essential for proper management and key to developing an integrated treatment approach, which is associated with better outcomes. Despite its importance, research has shown that more than 30% of patients with risk factors for depression, including alcohol or other drug abuse, were not asked about the presence or absence of depression or depressive symptoms.

CLINICAL RECOMMENDATION STATEMENTS:

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

All patients with a substance use disorder should be carefully assessed for the presence of co-occurring psychiatric disorders, including additional substance use disorders. (APA, 2006)

All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (ie, those from the fourth edition of Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and co-morbid psychological problems (eg, anxiety, panic attacks, or substance abuse) should be addressed. (USPSTF, 2002)

In general, treatment of depressive symptoms of moderate to severe intensity should begin concurrently or soon after initiating treatment of the co-occurring substance use disorder, particularly if there is evidence of prior mood episodes. In individuals without prior episodes of depression or a family history of mood disorders, it may be appropriate to delay the treatment of mild to moderate depressive symptoms for the purpose of diagnostic clarification. Clinicians are advised to monitor symptoms, assess and reassess for suicidal ideation, provide education, encourage abstinence from substances, and observe changes in mental status during the substance-free period while actively considering whether antidepressant intervention is indicated. (APA, 2006)