



ATTACHMENT 2:

2017 Quality Metric Reporting Guidance (Measurement Period: Calendar Year 2016)

Please Note:

- A PCMH must use the same metrics as reported in 2015 and 2016. However, a PCMH may report on additional metrics at any time.
- In 2017, for the 2016 measurement period, PCMHs must report on **4 out of 5 metrics**.
- The following instructions apply to both patient-level (option 1) and attested aggregate (option 2) data reporting.

METRIC: Controlling High Blood Pressure

MEASURE NUMBERS: CMS 165v~~43~~/NQF 0018/~~PQRS 236~~

DESCRIPTION:

Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) and who had a visit during the measurement period of calendar year 201~~6~~5.

INSTRUCTIONS:

~~This measure is to be reported a minimum of once per reporting period for patients with hypertension seen during the reporting period. The performance period for this measure is 12 months. 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.~~

~~In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Do not include blood pressure readings that meet the following criteria:~~

- ~~• Blood pressure readings from the patient's home (including readings directly from monitoring devices).~~
- ~~• Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).~~
- ~~• Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).~~

~~Note: If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."~~

DENOMINATOR (D#): Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period of calendar year 201~~6~~5.

Denominator Criteria (Eligible Cases):

Patients 18 through 85 years of age on date of encounter.

AND

Diagnosis for hypertension (ICD-9-CM) [for use 01/01/2015-09/30/2015]: 401.0, 401.1, 401.9

Diagnosis for hypertension (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I10

AND

Encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438, G0439, **99385, 99386, 99387, 99395, 99396, 99397**

Please Note: The bolded codes are NOT in a standard PQRS report and are new to the MT PCMH Program report in March 2016.

Denominator Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

NUMERATOR (N#): Patients whose most recent blood pressure was adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period of calendar year 2016.

~~**Numerator Instructions:** To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.~~

GUIDANCE:

In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable.

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed *not controlled*.

REPORT: (D#) and (N#), and the date of assessment. If reporting patient-level data (option 1), the excel data file must include the variables specified ~~in the table~~ in Attachment 3.

~~**Exclusions:** Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy.~~

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METRIC: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v43/NQF 0028/PQRS 226

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.

DENOMINATOR (D#): All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period~~All patients aged 18 years and older who had a visit during the measurement period of calendar year 2016.~~

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, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439, **99385, 99386, 99387, 99395, 99396, 99397**

Please Note: The bolded codes are NOT in a standard PQRS report, and are new to the MT-PCMH Program report in March 2016.

Denominator Exceptions: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

NUMERATOR (N#): 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.

Guidance: If a patient uses any type of tobacco (ie, smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure. Instances where tobacco use status of unknown is recorded include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. If the patient does not meet the screening component of the numerator but has an allowable medical exception, then the patient should be removed from the denominator of the measure and reported as a valid exception.

Exceptions only apply to the screening data element of the measure; once a patient has been screened, there are no allowable exceptions for not providing the intervention

REPORT: (D#) and (N#), and the date of assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in ~~the table on~~ Attachment 3.

~~Exclusions: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reasons).~~

METRIC: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122V43/NQF 0059/PQRS-001

DESCRIPTION:

Percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1c > 9.0% and had a visit during the measurement period of calendar year 2016.

INSTRUCTIONS:

~~This measure is to be reported a minimum of once per reporting period for patients with diabetes 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.~~

DENOMINATOR (D#): Patients 18 through 75 years of age who have the diagnosis of diabetes mellitus (type 1 or type 2), and had a visit during the measurement period of calendar year 2016.

Denominator Criteria (Eligible Cases):

Patients 18 through 75 years of age on date of encounter.

AND

Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402, G0438, G0439, **99385, 99386, 99387, 99395, 99396, 99397**

Please Note: The bolded codes are NOT in a standard PQRS report. *and are new to the MT-PCMH Program report in March 2016.*

NUMERATOR (N#): Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%.

~~**Numerator Instructions:** Report all patients with diabetes that had an HbA1c test during the measurement period with an HbA1c level > 9.0% and all patients with diabetes that did not have an HbA1c test during the measurement period. A lower calculated performance rate for this measure indicates better clinical care or control.~~

~~Patient is included in the numerator if:~~

- ~~a. most recent HbA1c level > 9.0%~~
- ~~b. is missing a result~~
- ~~c. if an HbA1c test was not done during the measurement period.~~

Guidance: Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period.

Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.

REPORT: (D#) and (N#), and the date of assessment. If reporting patient-level data (option 1), the excel file must include the variables specified ~~in the table~~ on Attachment 3.

Note: If A1c is not documented during the measurement period, then A1c is not controlled for this measure.

METRIC: ~~Rate of Fully Immunized 3-year old children~~Childhood Immunization Status
MEASURE NUMBERS: ~~N/A (HRS Quality of Care Measure)~~CMS 117v4/NQF 0038

DESCRIPTION:

~~Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Percentage of children with their 3rd birthday during the measurement period of calendar year 2015 who were fully immunized before their 3rd birthday.~~

DENOMINATOR (D#): ~~Children who turn 2 years of age during the measurement period and who have a visit during the measurement period of calendar year 2016. Number of children who had their 3rd birthday and at least one medical visit during the reporting period calendar year 2015.~~

Denominator criteria:

A patient is excluded from the denominator if they have a documented “medical contraindication” to any immunizations. Patients who “refused” any immunization are included in the denominator.

Patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394

NUMERATOR (N#): Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday Number of children among those included in the denominator who were fully immunized before their 3rd birthday; a child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for ALL of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate, prior to her/his third birthday. Also include number of children included in the denominator who received each of the vaccine series; number who received 4 DTP/DTaP, number who received 3 IPV, etc.

GUIDANCE: For the MMR, hepatitis B, VZV and hepatitis A vaccines, numerator inclusion criteria include: evidence of receipt of the recommended vaccine; documented history of the illness; or, a seropositive test result for the antigen. For the DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza vaccines, numerator inclusion criteria include only evidence of receipt of the recommended vaccine. Patients may be excepted from a particular antigen if they had an anaphylactic reaction to the vaccine. Patients may be excepted from the DTaP vaccine if they have encephalopathy. Patients may be excepted from the IPV vaccine if they have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin. Patients may be excepted from the influenza vaccines if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, or have had an anaphylactic reaction to neomycin. Patients may be excepted from the MMR or VZV vaccines if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, or have had an anaphylactic reaction to neomycin. Patients may be excepted from the hepatitis B vaccine if they have had an anaphylactic reaction to common baker's yeast.

The measure allows a grace period by measuring compliance with these recommendations between birth and age two.

REPORT: (D#) and (N#), and the date of the assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in the table on Attachment 3.

Note: If there is documentation that a child has a medical contraindication (MC) for an immunization, or that the immunization was offered but refused (R), you may report the number with MC or R.

Immunizations for children aged 3 years:

4 DTAP

3 Polio

1 MMR

3 Hib

3 Hep B

1 Var

4 PCV

[1 Hep A](#)

[2 or 3 RV](#)

[2 Flu](#)

METRIC: Screening for Clinical Depression and Follow-Up Plan
MEASURE NUMBERS: CMS 2V4/NQF 0418/PQRS 134

~~PLEASE NOTE: Reporting on depression screening in 2016 is optional, but highly encouraged. Reporting requirements in 2017 will change to four out of five metrics. CSI appreciates clinics willing to optionally submit depression screening data now, in preparation for next year.~~

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."~~

DENOMINATOR (D#): ~~All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period of calendar year 2016. All patients aged 12 years and older in the entire clinic population with a visit during the measurement period.~~

~~Please Note: If you are unable to run a report which includes the patient eligibility exceptions listed below, please submit the report as you are best able and indicate which, if any, exceptions were included in your report.~~

~~**Patients Not Eligible/Exceptions**—A patient is not eligible for this metric and may be excluded if one or more of the following conditions are documented:~~

- ~~● Patient has an active diagnosis of Depression~~
- ~~● Patient has an active diagnosis of Bipolar Disorder~~
- ~~● 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~~

Denominator Criteria (Eligible Cases):

Patients aged ≥ 12 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444, **99384, 99385, 99386, 99387, 99395, 99396, 99397**

Please Note: The bolded codes are NOT in a standard PQRS report.

Denominator Exclusions:

Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder

Denominator Exceptions:

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

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

OR

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

NUMERATOR (N#): 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. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter.~~

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

Guidance:

A clinical depression screen is completed 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.

Screening Tools:

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

The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter

The screening and encounter must occur on the same date

Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record

Follow-Up Plan:

The follow-up plan must be related to a positive depression screening, example: Patient referred for psychiatric evaluation due to positive depression screening.

REPORT: (D#) and (N#), and the date of the assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in Attachment 3.

Please Note: If a screening for clinical depression is documented as negative, a follow-up plan is not required.