



## ATTACHMENT 2: MONTANA PCMH PROGRAM 2016 Quality Metric Reporting Guidance (Reporting Period: Calendar Year 2015)

- *The following instructions apply to both patient-level (option 1) and attested aggregate (option 2) data reporting.*
- *In both 2016 and 2017, a PCMH must use the same metrics as reported in 2015*

**METRIC: Controlling High Blood Pressure**  
**MEASURE NUMBERS: CMS 165v3/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 reporting period of calendar year 2015.

### **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 2015.

#### **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

**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 2015.

**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.

**REPORT:** (D#) and (N#); specify if the denominator was the entire patient population of adults (18-85 years) with hypertension or a sample of that population 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 138v3/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 age 18 years and older during the reporting period of calendar year 2015.

**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

**NUMERATOR (N#):**

- Patients who were screened for tobacco use at least once within 24 months
- Patients who were screened and identified as a tobacco user
- Identified tobacco users who received tobacco cessation counseling

**Definitions:**

**Tobacco Use** – Includes use of any type of tobacco.

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

**REPORT:** (D#) and (N#); specify if the denominator was the entire patient population or a random sample, 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 (eg, limited life expectancy, other medical reasons)

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**METRIC: Diabetes: Hemoglobin A1c Poor Control**  
**MEASURE NUMBERS: CMS 122V3/NQF 0059/PQRS 001**

**DESCRIPTION:**

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1C > 9.0% and had a visit during the reporting period of calendar year 2015.

**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 18-75 years of age who have the diagnosis of diabetes mellitus (type 1 or type 2), and had a visit during the reporting period of calendar year 2015.

**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

**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 year with an HbA1c level > 9.0% and all patients with diabetes that did not have an HbA1c test during the measurement year. A lower calculated performance rate for this measure indicates better clinical care or control. Patient is numerator compliant if most recent HbA1c level >9% is missing a result or if an HbA1c test was not done during the measurement year.

**REPORT:** (D#) and (N#); specify if the denominator was the entire patient population of adults (aged 18-75) with diabetes or a sample of that population, 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.*

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**METRIC: Immunizations: Rate of Fully Immunized 3-Year-Old Children**

**DESCRIPTION:**

Percentage of children with their 3rd birthday during the reporting period of calendar year 2015 who were fully immunized before their 3rd birthday.

**DENOMINATOR (D#):** Number of children, who had their 3rd birthday and at least one medical visit during the reporting period calendar year 2015, or a sample of 70 of these children.

**NUMERATOR (N#):** 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.

**REPORT:** (D#) and (N#); specify if the denominator was the entire population of children who had one visit and their 3<sup>rd</sup> birthday during the reporting period or a sample of the population, 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. Patients documented as a “refusal” should be included in the number of non-immunized patients, but patients with a “medical contraindication” should be excluded.

Immunizations for children aged 3 years:

- 4 DTAP
- 3 Polio
- 1 MMR
- 3 Hib
- 3 Hep B
- 1 Var
- 4 PCV

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

**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.

**Patients Not Eligible/Exclusions** – 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 a diagnosed 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  $\geq$  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

**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

**REPORT:** (D#) and (N#); specify if the denominator was the entire population of patients aged 12 years and older or a sample of the population, and the date of the assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in Table 1.

**Please Note:** Screening for clinical depression is documented as negative, a follow-up plan is not required. Screening for clinical depression not documented, documentation stating the patient is not eligible.

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