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PCMH QUALITY METRICS GUIDANCE PACKET

Report Deadline: March 31, 2017

Introduction

Montana PCMHs are required by the [Patient-Centered Medical Home Act \(Act\)](#) to report annually on compliance with a uniform set of healthcare quality and performance metrics. According to New Rule I, Mar. Notice 6-211, the **annual deadline for quality metric reporting from PCMHs is March 31**. The PCMH administrative rules are posted on the CSI website at <http://csimt.gov/issues-reports/pcmh/pcmh-stakeholders/>.

Quality Metrics

Montana PCMHs must submit data from calendar year 2016 on at least **four** of five quality metrics: controlling hypertension, tobacco use cessation and intervention, poor A1c control, rate of immunized 2-year-olds, and screening for clinical depression and follow-up plan. PCMHs must use the same metrics as reported in 2015 and 2016. However, a PCMH may report on additional metrics at any time. (A PCMH pediatric practice shall choose at least the child immunization performance measure. Reporting on depression screening is optional for pediatric practices until the 2017 measurement period, for the report due in March 2018. At that time, all pediatric clinics shall report on both the depression and immunization measures.)

The metrics were carefully selected by primary care providers, insurers, and patient advocates because they create a narrow focus in areas that produce data with potential for actionable change that is achievable for all PCMHs. The data reporting instructions are aligned with the CMS eCQM standards. Two options exist for the 2017 report: patient-level data or attested aggregate data. While not required, if your clinic has the capability, please report patient-level data. Research and consultation with national PCMH experts has shown that patient-level data is necessary for accurate and meaningful PCMH evaluation. Please be certain that patient-level data is de-identified.

It is the goal of the Montana PCMH program to collect meaningful data, but not be an administrative burden. That is why we chose performance metrics related to high-cost, chronic diseases which are already reported to other entities. The five measures will track how PCMHs improve the quality of care and health of their patients.

Privacy & Data Usage

Administrative Rules of Montana (ARM) state that the Commissioner may only report to the public aggregate information about quality metrics. Clinic names will not be publically tied to their data. The quality metrics data contributes to the Commissioner's required annual Public Report.

Instructions

Please complete the (1) Reporting Form and report the data **in the format prescribed** by the (2) Quality Metric Reporting Guidance. If reporting patient-level data (Option 1), refer to the [excel spreadsheet template linked here](#) and complete according to the (3) specified data elements. **Reports must be submitted through the State of Montana File Transfer Service to csipcmh@mt.gov by March 31, 2017.**

ATTACHMENTS: (1) Reporting Form (2) Quality Metric Reporting Guidance (3) Patient-Level Reporting Data Elements (4) State of Montana File Transfer Service Instructions.



ATTACHMENT 1:
2017 Reporting Form for Quality Metrics
(Measurement Period: Calendar Year 2016)

THIS IS A FILLABLE FORM, PLEASE COMPLETE ELECTRONICALLY

PCMH Organization name: _____
 (PCMH Name)

PCMH Official providing report: _____
 (Name) (Title)

 (Phone) (E-mail)

Date report submitted: __/__/____
 (Mo/Da/Year)

If the CSI has questions pertaining to the data provided in this report, the data contact person for your organization is: _____

(Name) (Title)

 (Phone) (E-mail)

DATA FROM CALENDAR YEAR 2016

Two options exist for reporting in 2017. Which one are you using?

_____ **Option 1: A patient-level data report** with the data elements required from Attachment 3 for each measure, for each patient, provided in a separate electronic file. Also complete the form below.

OR

_____ **Option 2: An attested aggregate data report**, using the form below, with data confirmed by the staff in the organization.

You can use the following to report MT PCMH measures for Option 2:

- Meaningful Use Clinical Quality Measure (CQM) reports out of your 2014 certified E.H.R for the full reporting period to provide the numerators and denominators for Option 2 for the measures with the corresponding CMS/NQF numbers.

Which report did you use to create the data you are submitting?

- _____ Standard Clinical Quality Measure (CQM) report out of your 2014 certified EHR
- _____ Standard Uniform Data System (UDS) report out of your 2014 certified EHR
- _____ Customized report out of your 2014 certified EHR
- _____ Combination of customized reports out of your 2014 certified EHR and chart abstraction
- _____ Other - Please define: _____
- _____ Unsure

Please Note:

- In 2017, 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 at least four out of five metrics.

The form below is required for BOTH Options 1 and 2. Please fill in the numerator and denominator for at least four of the five metrics.

Metric 1: Controlling High Blood Pressure
MEASURE NUMBERS: CMS 165v4/NQF 0018

1. _____ (#): denominator - number of 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 2016.
2. _____ (#): numerator - number of patients in the denominator whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Metric 2: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v4/NQF 0028

1. _____ (#): denominator - All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period of calendar year 2016.
2. _____ (#): numerator - Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Metric 3: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122v4/NQF 0059

1. _____ (#): denominator – number of 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.
2. _____ (#): numerator - number of patients in the denominator population whose most recent HbA1c level (performed during the measurement period of calendar year 2016) is > 9.0%

Metric 4: Childhood Immunization Status
MEASURE NUMBERS: CMS117v4/NQF 0038

PLEASE NOTE: Patients with a medical contraindication to any immunization should be excluded from (1). Patients who refused an immunization should be included in (1).

1. _____ (#): denominator - Children who turn 2 years of age during the measurement period and who have a visit during the measurement period of calendar year 2016.
2. Numerators – 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.

NUMERATORS

	4 DTAP
	3 polio
	1 MMR
	3 Hib
	3 HepB
	1 VZV
	4 PCV
	1 HepA
	2 or 3 RV
	2 Flu

3. _____ number of children meeting criteria '1' who received all of the following: ≥4 doses of DTaP, ≥3 doses of HepB, ≥3 doses of Hib, ≥3 doses of IPV, ≥1 dose of MMR, ≥4 doses of PCV, ≥1 dose of VZV, 1 dose of HepA, 2 or 3 of RV, and 2 Flu.

Metric 5: Screening for Clinical Depression and Follow-up Plan
MEASURE NUMBERS: CMS 2v5/NQF 0418

1. _____ (#): denominator - 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.
2. _____ (#): 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.



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 four out of five 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 165v4/NQF 0018

[Click here for a flow chart showing how to pull the patient population for the numerator and denominator.](#)

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 2016.

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 2016.

Denominator Criteria (Eligible Cases):

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

AND

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**

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.

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 Attachment 3.

METRIC: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v4/NQF 0028

[Click here for a flow chart showing how to pull the patient population for the numerator and the denominator.](#)

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.

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 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**

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

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 is unknown 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 Attachment 3.

METRIC: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122v4/NQF 0059

[Click here for a flow chart showing how to pull the patient population for the numerator and the denominator.](#)

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.

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-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**

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

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 on Attachment 3.

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

METRIC: Childhood Immunization Status
MEASURE NUMBERS: CMS 117v4/NQF 0038

[Click here for a flow chart showing how to pull the patient population for the numerator and the denominator for each immunization.](#)

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.

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.

Denominator criteria:

A patient with a documented “medical contraindication” to any immunizations is *excluded* from the denominator; a patient who “refused” any immunization is *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.

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 Attachment 3.

Immunizations for children aged 2 years:

- 4 DTAP
- 3 Polio
- 1 MMR
- 3 Hib
- 3 Hep B
- 1 VZV
- 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

[Click here for a flow charts showing how to pull the patient population for the numerator and the denominator.](#)

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.

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.

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**

Denominator Exclusions: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder.

Denominator Exceptions:

- a) Patient Reason(s): Patient refuses to participate;
- OR
- b) 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
- c) 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.

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.