OHIC Measure Alignment Work Group
2021 Annual Review of the Outpatient Behavioral Health Aligned Measure Sets
Measure Specifications

Quality ID #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2019 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [Stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients with a diagnosis of MDD seen during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure for the primary management of patients with major depressive disorder based on the services provided and the measure-specific denominator coding.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [Stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician

Definition:
Comorbid condition – For the purposes of this measure, only the following comorbid conditions will be included:

1) Diabetes
2) Coronary artery disease
3) Stroke, including ischemic stroke and intracranial hemorrhage
4) Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease
5) Congestive Heart Failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-10-CM): 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 performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99484, 99492, 99493, 99494

AND

Diagnosis for diabetes (ICD-10-CM): E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.3211, E10.3212. E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519, E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, 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, E11.10, E11.11, E11.21, E11.22, E11.29, E11.37X1, E11.37X2, E11.37X3, E11.37X9, E11.319, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599, 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, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

OR

Diagnosis for CAD (ICD-10-CM): I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

Diagnosis for stroke, including ischemic stroke and intracranial hemorrhage (ICD-10-CM): I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.2, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.013, I63.019, I63.02, I63.033, I63.039, I63.09, I63.10, I63.113,, I63.119, I63.12, I63.133, I63.139, I63.19, I63.20, I63.213, I63.219, I63.22, I63.233, I63.239, I63.29, I63.30, I63.311, I63.313, I63.319, I63.323, I63.329, I63.333, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.413, I63.419, I63.423, I63.429, I63.433, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.513, I63.519, I63.523, I63.529, I63.533, I63.539, I63.541, I63.543, I63.549, I63.59, I63.6, I63.8, I63.9

OR

Diagnosis for chronic kidney disease (Stages 4 and 5) and end stage renal disease (ICD-10-CM): N18.4, N18.5, N18.6

OR

Diagnosis for heart failure (ICD-10-CM): I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9

NUMERATOR:
Medical records of patients with communication to the clinician treating the comorbid condition

Definition:
Communication – Transmission of relevant clinical information which specifies that the patient has MDD.

NUMERATOR NOTE: *Denominator Exception(s) are determined on the date of the denominator eligible encounter.*

Numerator Options:

Performance Met:	Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition **(G8959)**
OR	
Denominator Exception:	Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition for specified patient reason (e.g. patient is unable to communicate the diagnosis of a comorbid condition; the patient is unwilling to communicate the diagnosis of a comorbid condition; or he patient is unaware of the comorbid condition, or any other specified patient reason) **(G9232)**
OR	
Performance Not Met:	Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition, reason not given **(G8960)**

RATIONALE:
Depressive disorders are more common among persons with chronic conditions (e.g., obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (e.g., smoking, physical inactivity, and binge drinking). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). The coordination of care for patients with depression and certain comorbid conditions is important for managing both the patient's depression and the other present medical condition. Improvements in the coordination of care between clinicians treating a patient with depression and other clinicians treating comorbid conditions can reduce the symptom exacerbation that depression and other conditions may cause to the other. Any [depression] treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses.

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.

In patients with major depressive disorder, it is important to recognize and address the potential interplay between major depressive disorder and any co-occurring general medical conditions. (APA, 2010)

The clinical assessment should include identifying any potential interactions between medications used to treat depression and those used to treat general medical conditions. In addition, the psychiatrist (clinician) should consider the effects of prescribed psychotropic medications on the patient's general medical conditions, as well as the effects of interventions for such disorders on the patient's psychiatric condition. (APA, 2010)

Many patients with major depressive disorder will be evaluated by or receive treatment from other health care professionals in addition to the psychiatrist (clinician). If more than one clinician is involved in providing the care, all treating clinicians should have sufficient ongoing contact with the patient and with each other to ensure that care is coordinated, relevant information is available to guide treatment decisions, and treatments are synchronized. (APA, 2010)

In ruling out general medical causes of depressive symptoms, it is important to ensure that a general medical evaluation has been done. (APA, 2010)

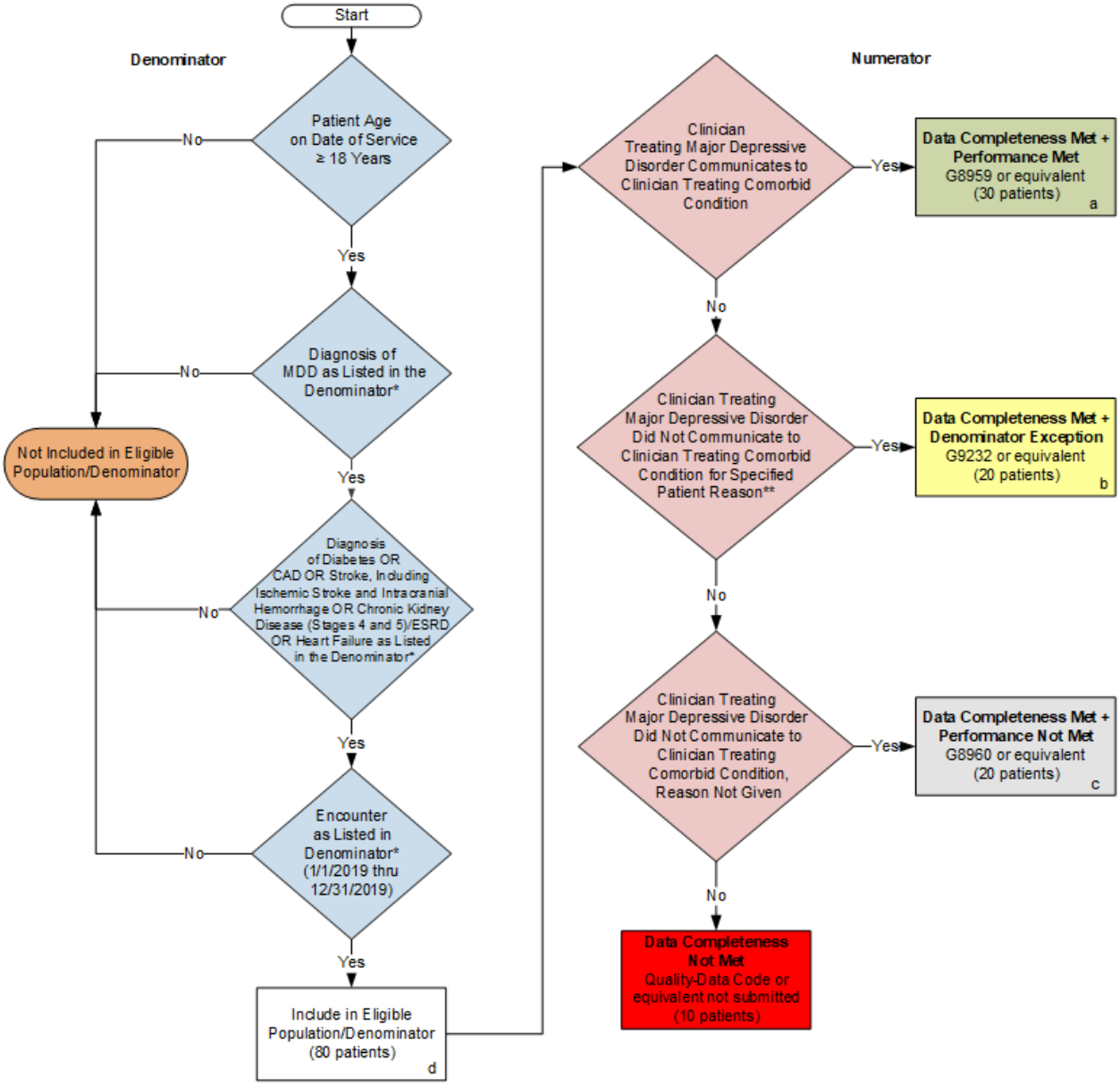
In patients with preexisting hypertension or cardiac conditions, treatment with specific antidepressant agents may suggest a need for monitoring of vital signs or cardiac rhythm (eg, electrocardiogram [ECG] with TCA treatment; heart rate and blood pressure assessment with SNRIs and TCAs). (APA, 2010)

In treating the depressive syndrome that commonly occurs following a stroke, consideration should be given to the potential for interactions between antidepressants and anticoagulating (including antiplatelet) medications. (APA, 2010)

The diagnostic work-up for MDD should include evaluation for existing or emerging medical conditions that may exacerbate the depression. These may include: Cardiovascular diseases, Chronic pain syndrome, Degenerative diseases, Immune disorders, Metabolic endocrine conditions (including kidney and lung diseases), Neoplasms, Trauma. Simultaneous treatment is often required for both the medical problem and psychiatric symptoms and can lead to overall improvement in function. (VA/DoD, 2009)

Indications for referral to a mental health specialist familiar with diabetes management may include gross noncompliance with medical regimen (by self or others), depression with the possibility of self-harm, debilitating anxiety (alone or with depression), indications of an eating disorder, or cognitive functioning that significantly impairs judgment. It is preferable to incorporate psychological assessment and treatment into routine care rather than waiting for identification of a specific problem or deterioration in psychological status. Although the clinician may not feel qualified to treat psychological problems, using the patient-provider relationship as a foundation for further treatment can increase the likelihood that the patient will accept referral for other services. It is important to establish that emotional well-being is part of diabetes management. (ADA, 2010)

2019 Clinical Quality Measure Flow for Quality ID #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions



SAMPLE CALCULATIONS:

Data Completeness=

Performance Met (a=30 patients) + Denominator Exception (b=30 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=30 patients) = 30 patients = **60.00%**

Data Completeness Numerator (80 patients) – Denominator Exception (b=30 patients) = 50 patients

* See the posted Measure Specification for specific coding and instructions to submit this measure.

** See the posted Measure Specification for exclusion criteria for this measure.

NOTE : Submission Frequency - Patient-process

v3

2019 Clinical Quality Measure Flow Narrative for Quality ID #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions

Please refer to the specific section of the specification to identify the denominator and numerator information for use in submitting this Individual Specification.

1. Start with Denominator

2. Check Patient Age:

    a. If Patient Age is greater than or equal to 18 Years at Date of Service equals No during the performance period, do not include in Eligible Population. Stop Processing.

    b. If Patient Age is greater than or equal to 18 Years at Date of Service equals Yes during the performance period, proceed to check Patient Diagnosis.

3. Check Patient Diagnosis:

    a. If Diagnosis of MDD as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

    b. If Diagnosis of MDD as Listed in the Denominator equals Yes, proceed to check Diagnosis of Diabetes OR CAD OR Stroke, Including Ischemic Stroke and Intracranial Hemorrhage OR Chronic Kidney Disease (Stages 4 and 5)/ESRD OR Heart Failure.

4. Check Diagnosis of Diabetes OR CAD OR Stroke, Including Ischemic Stroke and Intracranial Hemorrhage OR Chronic Kidney Disease (Stages 4 and 5)/ESRD OR Heart Failure:

    a. If Diagnosis of Diabetes OR CAD OR Stroke OR Chronic Kidney Disease (Stages 4 and 5)/ESRD OR Heart Failure as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

    b. If Diagnosis of Diabetes OR CAD OR Stroke OR Chronic Kidney Disease (Stages 4 and 5)/ESRD OR Heart Failure as Listed in the Denominator equals Yes, proceed to check Encounter Performed.

5. Check Encounter Performed:

    a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

    b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible Population

6. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

7. Start Numerator

8. Check Clinician Treating Major Depressive Disorder Communicates to Clinician Treating Comorbid Condition:

    a. If Clinician Treating Major Depressive Disorder Communicates to Clinician Treating Comorbid Condition equals Yes, include in Data Completeness Met and Performance Met.

    b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 30 patients in the Sample Calculation.

    c. If Clinician Treating Major Depressive Disorder Communicates to Clinician Treating Comorbid Condition equals No, proceed to check Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition for Specified Patient Reason.

9. Check Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition for Specified Patient Reason:

    a. If Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition for Specified Patient Reason equals Yes, include in the Data Completeness Met and Denominator Exception.

    b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 20 patients in the Sample Calculation.

    c. If Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition for Specified Patient Reason equals No, proceed to check Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition, Reason Not Given.

10. Check Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition, Reason Not Given:

    a. If Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 patients in the Sample Calculation.

    c. If Clinician Treating Major Depressive Disorder Did Not Communicate to Clinician Treating Comorbid Condition, Reason Not Given equals No, proceed to check Data Completeness Not Met.

11. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATIONS:

Data Completeness=

Performance Met (a=30 patients) + Denominator Exception (b=30 patients) + Performance Not Met (c=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a=30 patients) = 30 patients = **60.00%**

Data Completeness Numerator (80 patients) – Denominator Exception (b=30 patients) = 50 patients

FOLLOW-UP, RESPONSE, AND REMISSION MEASURE SPECIFICATIONS AND CALCULATION

Measure Specifications

NOTE: The Index Periods and Assessment Periods detailed in the Measure Specifications below are NOT the dates of service that should be submitted. See the *Data Collection Technical Guide* for instructions to identify the correct service dates for submission.

Summary of Changes	• Preliminary 2021 MY dates added to Measurement Period for reference. • Clarifying language added to Eligible Specialties and Eligible Providers sections. • Clarification regarding permissible administration of the PHQ-9 and PHQ-9M tools added as a footnote. See appendices of Data Collection Technical Guide for specific guidance regarding assessment tool administration.

Depression: Follow-Up, Response & Remission Measurement Period, Denominator & Exclusions		
Description	See measure specific description(s) below.	
Measurement Period	Denominator Identification Period: • FINAL 2020 MY: November 1, 2018 through October 31, 2019 • PRELIMINARY 2021 MY: November 1, 2019 through October 31, 2020 Measure Assessment Period: For each patient, the measure assessment period begins with an index event and is 14 months (12 months + 60 days) in length.	
Eligible Population	**Eligible Specialties for diagnosing Depression/ Dysthymia^**	Family Medicine, Internal Medicine, Geriatric Medicine, Psychiatry, Behavioral Health, Pediatric/Adolescent Medicine
	Eligible Providers for diagnosing Depression/ Dysthymia^	Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN) These providers are also eligible, if supervised by a physician: Licensed Psychologist (LP), Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT)
	Ages	12 years of age or older at the index event

	Event (Index)	An index event occurs when ALL the following criteria are met during an encounter*: • a PHQ-9 or PHQ-9M result greater than nine • an active diagnosis of Major Depression or Dysthymia (*Major Depression or Dysthymia* Value Set) • the patient is NOT in a prior measure assessment period * For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry or psychotherapy visit, telephone, or online encounter. PHQ-9 or PHQ-9M score greater than 9 can be documented on the same date or up to seven days prior to the encounter (index event) and this date occurs during the denominator identification measurement period. This allows for pre-visit planning and administering the PHQ-9 or PHQ-9M just prior to an encounter.
Denominator	The eligible population who had index events during the denominator identification period.	
Numerator	See measure specific numerator definition(s) below.	
Required Exclusions	The following exclusions must be applied to the eligible population: • Patient had an active diagnosis of Bipolar Disorder (*Bipolar Disorder* Value Set) any time prior to the end of their measure assessment period • Patient had an active diagnosis of Schizophrenia or Psychotic Disorder (*Schizophrenia Psychotic Disorder* Value Set) any time prior to the end of their measure assessment period	
Allowable Exclusions	The following exclusions can be applied to the eligible population: • Patient had an active diagnosis of Personality Disorder – Emotionally Labile (*Personality Disorder - Emotionally Labile* Value Set) any time prior to the end of their measure assessment period • Patient had an active diagnosis of Pervasive Developmental Disorder (*Pervasive Disorder* Value Set) any time prior to the end of their measure assessment period • Patient was a permanent nursing home resident at any time during the denominator identification period or measure assessment period • Patient was in hospice or receiving palliative care at any time during the denominator identification period or measure assessment period • Patient died prior to the end of their measure assessment period	
Measure Scoring	Rate/Proportion Results are always stratified by age: • Adolescents (12-17 years of age) • Adults (18 years of age or older)	
Interpretation of Score	Higher score indicates better quality	
Measure Type	Outcome	
^Any member of the health care team can administer a PHQ-9 or PHQ-9M assessment tool to a patient. Additionally, patients can self-administer via patient portal, email, or mail		

Depression: Remission at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who reached remission six months (+/- 60 days) after an index event
Numerator	The number of patients in the denominator who reached remission, with a PHQ-9 or PHQ-9M result less than five, six months (+/- 60 days) after an index event

Depression: Remission at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who reached remission 12 months (+/- 60 days) after an index event
Numerator	The number of patients in the denominator who reached remission, with a PHQ-9 or PHQ-9M result less than five, 12 months (+/- 60 days) after an index event

Depression: Response at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who demonstrated a response to treatment six months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who demonstrated a response to treatment, with a PHQ-9 or PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result, six months (+/- 60 days) after an index event.

Depression: Response at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who demonstrated a response to treatment 12 months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who demonstrated a response to treatment, with a PHQ-9 or PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result, 12 months (+/- 60 days) after an index event.

Depression: Follow-up at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia with an index PHQ-9/PHQ-9M score greater than nine who have a completed PHQ-9 or PHQ-9M tool six months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who have a completed PHQ-9 or PHQ-9M tool six months (+/- 60 days) after an index event.

Depression: Follow-up at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia with an index PHQ-9/PHQ-9M score greater than nine who have a completed PHQ-9 or PHQ-9M tool 12 months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who have a completed PHQ-9 or PHQ-9M tool 12 months (+/- 60 days) after an index event.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Updated the exclusions criteria in the Rules for Allowable Adjustments.

Description

The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Eligible Population

Product lines Medicaid.

Ages 18–64 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

- At least one acute inpatient encounter, with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder. Any of the following code combinations meet criteria:
  - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set).
  - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set.
- At least two of the following, on different dates of service, where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set):

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
- An observation visit (Observation Value Set).
- An ED visit (ED Value Set).
- An ED visit (Visit Setting Unspecified Value Set ***with*** ED POS Value Set).
- A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set).
- A nonacute inpatient encounter (Visit Setting Unspecified Value Set ***with*** Nonacute Inpatient POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).

Step 2: Required exclusions

Exclude members who met any of the following criteria:

- *Members with diabetes.* There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.
  - *Claim/encounter data.* Members who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).
    - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** (Telehealth Modifier Value Set; Telehealth POS Value Set).
    - At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
      1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
      2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
      3. Identify the discharge date for the stay.
    - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges

(instructions below; the diagnosis must be on the discharge claim) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

– *Pharmacy data.* Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

- Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.
  - *Claim/encounter data*. An antipsychotic medication (Long-Acting Injections Value Set).
  - *Pharmacy data*. Dispensed an antipsychotic medication (SSD Antipsychotic Medications List).

SSD Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine	• Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone	• Olanzapine • Paliperidone • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine	• Perphenazine • Prochlorperazine	• Thioridazine • Trifluoperazine
Psychotherapeutic combinations	• Amitriptyline-perphenazine		
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate • Risperidone	

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator

Diabetes Screening A glucose test (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or an HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table SSD-1: Data Elements for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Metric	Data Element	Reporting Instructions
DiabetesScreeningSchizophreniaUsingAntipsychotics	Benefit	Metadata
	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	NumeratorBySupplemental	Report once
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed within a specified age range (ages 18 and older).
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events, medications and diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits, medication use and diagnosis. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Diabetes Screening	No	Value sets and logic may not be changed.

*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)**

***Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	1–17 years as of December 31 of the measurement year. Report two age stratifications and a total rate for each of the three indicators: • 1–11 years. • 12–17 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (Antipsychotic Medications List; Antipsychotic Combination Medications List; Prochlorperazine Medications List) of the same or different medications, on different dates of service during the measurement year.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone	• Pimozide • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine	• Thioridazine • Trifluoperazine	
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate • Risperidone	

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine antipsychotics	• Prochlorperazine

Administrative Specification

Denominator The eligible population.

Numerator

Blood Glucose Members who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol Members who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol Members who received both of the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table APM-1/2: Data Elements for Metabolic Monitoring for Children and Adolescents on Antipsychotics

Metric	Age	Data Element	Reporting Instructions
BloodGlucoseTesting	1-11	Benefit	Metadata
CholesterolTesting	12-17	EligiblePopulation	For each Stratification, repeat per Metric
BloodGlucoseCholesterolTesting	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Guidance for Allowable Adjustments for Metabolic Monitoring for Children and Adolescents on Antipsychotics

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed within a specified age range (ages 1–17+ years). Additionally, the upper age range may be expanded, or no upper age limit may be used.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only dispensing events that contain (or map to) codes in the medication lists and value sets may be used to identify antipsychotic medication events. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Metabolic monitoring	No	Value sets and logic may not be changed.

*Follow-Up After Emergency Department Visit for Mental Illness (FUM)**

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of the ED visit. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUM-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (i.e., age 6 as of the date of the ED visit). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the steps for identifying acute readmission or direct transfer in the event/diagnosis.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added psychiatric collaborative care management to the numerator.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	The total is the sum of the age stratifications. Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Required exclusion

Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up

A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of "mental health provider." Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Hospitalization for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify inpatient stays and diagnoses. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Antidepressant Medication Management (AMM)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Corrected the example in the definition of *treatment days*.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Clarified allowable adjustments to event/diagnosis criteria in the Rules for Allowable Adjustments.
- Updated the exclusions criteria in the Rules for Allowable Adjustments.

Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 82 days counted in the 232-day interval.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.
Anchor date	IPSD.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population, which is used for both rates.
Step 1	Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List) during the Intake Period.
Step 2: Required exclusion	Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population: • An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. • An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set ***with*** Major Depression Value Set. • A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set ***with*** Major Depression Value Set. • An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set ***with*** Major Depression Value Set. • An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set ***with*** Major Depression Value Set. • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set ***with*** Major Depression Value Set. • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set ***with*** Major Depression Value Set.

- A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set ***with*** Major Depression Value Set.
- Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set ***with*** Major Depression Value Set.
- Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set ***with*** Major Depression Value Set.
- A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set ***with*** Major Depression Value Set.
- An observation visit (Observation Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit (ED Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** ED POS Value Set ***with*** Major Depression Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).

Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Step 3 Test for Negative Medication History. Exclude members who were dispensed a prescription for an antidepressant medication 105 days prior to the IPSD.

***Step* 4** Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator The eligible population.

Numerators

Effective Acute Phase Treatment At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide	• Amitriptyline-perphenazine	• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Effective Continuation Phase Treatment At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AMM-1/2/3: Data Elements for Antidepressant Medication Management

Metric	Data Element	Reporting Instructions
Acute	Benefit	Metadata
Continuation	EligiblePopulation	Repeat per Metric
	ExclusionAdminRequired	Repeat per Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Antidepressant Medication Management

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range below age 18 is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed. ***Note:*** *Changes to these criteria can impact how the event/diagnosis would be calculated using the Intake Period, IPSD, Negative Diagnosis History and Treatment Days.*
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. ***Note:*** *The measurement period may be adjusted. Modifying the determination dates in the eligible population can affect timing relationships. The order and relationship of events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Effective Acute Phase treatment • Effective Continuation Phase treatment	No	Medication lists, value sets and logic may not be changed.

eCQM Title	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**
eCQM Identifier (Measure Authoring Tool)	161
eCQM Version Number	9.2.000
NQF Number	0104e
GUID	60176fbf-bfdc-4892-9c9e-604f206553c8
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	PCPI(R) Foundation (PCPI[R])
Measure Developer	American Medical Association (AMA)
Measure Developer	PCPI(R) Foundation (PCPI[R])
Endorsed By	National Quality Forum
Description	All patient visits during which a new diagnosis of MDD or a new diagnosis of recurrent MDD was identified for patients aged 18 years and older with a suicide risk assessment completed during the visit
Copyright	Copyright 2020 PCPI(R) Foundation. All Rights Reserved. The Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The Measure, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measure require a license agreement between the user and the PCPI(R) Foundation (PCPI[R]). Neither the PCPI, nor the American Medical Association (AMA), nor the former AMA-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI), nor their members shall be responsible for any use of the Measure. The PCPI encourages use of the Measure by other health care professionals, where appropriate. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members and former members of the AMA-PCPI disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT[R]) or other coding contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2019 American Medical Association. LOINC(R) is copyright 2004-2019 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2019 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2019 World Health Organization. All Rights Reserved. Due to technical limitations, registered trademarks are indicated by (R) or [R].
Disclaimer	
Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	This measure aims to improve rates of clinician assessment of suicide risk during an encounter where a new or recurrent episode of major depressive disorder is identified. In an epidemiologic study (2010) of mental illness in the United States with a large, representative sample, 69% of respondents with lifetime suicide attempts had also met diagnostic criteria for major depressive disorder. When considering other mood disorders related to depression, such as dysthymia and bipolar disorders, this rate increases to 74% (Bolton & Robinson, 2010). In a 2014 study conducted by Ahmedani et al., 50% of individuals who completed a suicide had been seen in a health care setting within four weeks prior. Better assessment and identification of suicide risk in the health care setting should lead to improved connection to treatment and reduction in suicide attempts and deaths by suicide.
Clinical Recommendation Statement	A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder [I] (American Psychiatric Association, 2010a, reaffirmed 2015). Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., 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 (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness [I] (American Psychiatric Association, 2010a, reaffirmed 2015). 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] (American Psychiatric Association, 2010a, reaffirmed 2015). The patient's risk of harm to him- or herself and to others should also be monitored as treatment proceeds [I] (American Psychiatric Association, 2010a, reaffirmed 2015). Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (from American Psychiatric Association's Practice Guideline for Assessment and Treatment of Patients With Suicidal Behaviors, 2010b): 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 After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated In the presence of suicidal ideation with:

	* Psychosis * Major psychiatric disorder * Past attempts, particularly if medically serious * Possibly contributing medical condition (e.g., 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 (e.g., 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 (e.g., 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.
Improvement Notation	Higher score indicates better quality
Reference	American Psychiatric Association. (2010a). Practice guideline for the treatment of patients with major depressive disorder. 3rd edition. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf (This guideline was reaffirmed in 2015.)
Reference	American Psychiatric Association. (2010b). Guidelines for selecting a treatment setting for patients at risk for suicide or suicidal behaviors. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf
Reference	Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R.,… Solberg, L. I.(2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, 29(6), 870-877. doi:10.1007/s11606-014-2767-3
Reference	Bolton, J. M., & Robinson, J. (2010). Population-attributable fractions of Axis I and Axis II mental disorders for suicide attempts: Findings from a representative sample of the adult, noninstitutionalized U.S. population. American Journal of Public Health, 100(12), 2473-2480. doi:10.2105/ajph.2010.192252
Definition	The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 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 Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Guidance	This eCQM is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population. 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 (e.g., 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 (e.g., 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 (e.g., 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. It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (i.e., at the initial evaluation). For the purposes of this measure, an episode of major depressive disorder (MDD) would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for major depressive disorder (MDD), that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence. In recognition of the growing use of integrated and team-based care, the diagnosis of depression and the assessment for suicide risk need not be performed by the same provider or clinician. Suicide risk assessments completed via telehealth services can also meet numerator performance. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below. The logic statement for the age requirement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure, so long as the minimum criteria noted above is evaluated. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone. This version of the eCQM uses QDM version 5.5. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Patient visits during which a new diagnosis of MDD, single or recurrent episode, was identified
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Patient visits during which a new diagnosis of MDD, single or recurrent episode, was identified and a suicide risk assessment was completed during the visit

Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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Population Criteria

Initial Population

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    such that Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 17
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
    such that SuicideRiskAssessment.relevantDatetime during NewOrRecurrentMDDEncounter.relevantPeriod
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Initial Population

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    such that Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 17
```

Major Depressive Disorder Encounter

```
( ["Encounter, Performed": "Psych Visit - Diagnostic Evaluation"]
  union ["Encounter, Performed": "Emergency Department Visit"]
  union ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Outpatient Consultation"]
  union ["Encounter, Performed": "Psych Visit - Psychotherapy"]
  union ["Encounter, Performed": "Psychoanalysis"]
  union ["Encounter, Performed": "Telehealth Services"] ) ValidEncounter
  where exists ( ValidEncounter.diagnoses EncounterDiagnosis
      where EncounterDiagnosis.code in "Major Depressive Disorder-Active"
  )
```

New or Recurrent Major Depressive Disorder Encounter

```
"Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  without "Major Depressive Disorder Encounter" PriorMDDEpisodeEncounter
    such that PriorMDDEpisodeEncounter !~ NewOrRecurrentMDDEncounter
      and PriorMDDEpisodeEncounter.relevantPeriod ends 104 days or less before day of start of NewOrRecurrentMDDEncounter.relevantPeriod
  where NewOrRecurrentMDDEncounter.relevantPeriod during "Measurement Period"
```

Numerator

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
    such that SuicideRiskAssessment.relevantDatetime during NewOrRecurrentMDDEncounter.relevantPeriod
```

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Functions

Global.CalendarAgeInYearsAt(BirthDateTime DateTime, AsOf DateTime)

years between ToDate(BirthDateTime)and ToDate(AsOf)

Global.ToDate(Value DateTime)

DateTime(year from Value, month from Value, day from Value, 0, 0, 0, 0, timezoneoffset from Value)

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Suicide risk assessment (procedure)" ("SNOMEDCT Code (225337009)")
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Major Depressive Disorder-Active" (2.16.840.1.113883.3.526.3.1491)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Psych Visit - Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- valueset "Psych Visit - Psychotherapy" (2.16.840.1.113883.3.526.3.1496)
- valueset "Psychoanalysis" (2.16.840.1.113883.3.526.3.1141)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telehealth Services" (2.16.840.1.113883.3.464.1003.101.12.1031)

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Telehealth Services" using "Telehealth Services (2.16.840.1.113883.3.464.1003.101.12.1031)"
- "Intervention, Performed: Suicide risk assessment (procedure)" using "Suicide risk assessment (procedure) (SNOMEDCT Code 225337009)"
- "Patient Characteristic Birthdate: Birth date" using "Birth date (LOINC Code 21112-8)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	None

eCQM Title	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment**		
eCQM Identifier (Measure Authoring Tool)	177	**eCQM Version number**	8.1.000
NQF Number	1365e	**GUID**	848d09de-7e6b-43c4-bedd-5a2957ccffe3
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	PCPI(R) Foundation (PCPI[R])		
Measure Developer	American Medical Association (AMA)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	National Quality Forum		
Description	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk		
Copyright	Copyright 2019 PCPI(R) Foundation and American Medical Association. All Rights Reserved.		
Disclaimer	The Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The Measure, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measure require a license agreement between the user and the PCPI(R) Foundation (PCPI[R]) or the American Medical Association (AMA). Neither the AMA, nor the former AMA-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI), nor PCPI, nor their members shall be responsible for any use of the Measure. AMA and PCPI encourage use of the Measure by other health care professionals, where appropriate. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members and former members of the AMA-PCPI disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT[R]) or other coding contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2018 American Medical Association. LOINC(R) is copyright 2004-2018 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2018 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2018 World Health Organization. All Rights Reserved. Due to technical limitations, registered trademarks are indicated by (R) or [R].		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Research has shown that patients with major depressive disorder are at a high risk for suicide attempts and completion - among the most significant and devastating sequelae of the disease. Suicide risk is a critical consideration in children and adolescents with MDD and an important aspect of care that should be assessed at each visit and subsequently managed to minimize that risk. Additionally, the importance of the assessments is underscored by research that indicates that many individuals who die by suicide do make contact with primary care providers and mental health services beforehand. More specifically, approximately 15% of suicide victims aged 35 years or younger had seen a mental health professional within 1 month of suicide while approximately 23% had seen a primary care provider within 1 month of suicide.		
Clinical Recommendation Statement	The evaluation must include assessment for the presence of harm to self or others (MS) (American Academy of Child and Adolescent Psychiatry, 2007). Suicidal behavior exists along a continuum from passive thoughts of death to a clearly developed plan and intent to carry out that plan. Because depression is closely associated with suicidal thoughts and behavior, it is imperative to evaluate these symptoms at the initial and subsequent assessments. For this purpose, low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can be used. Also, it is crucial to evaluate the risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that might influence the desire to attempt suicide. The risk for suicidal behavior increases if there is a history of suicide attempts, comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse), impulsivity and aggression, availability of lethal agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence), and a family history of suicidal behavior (American Academy of Child and Adolescent Psychiatry, 2007). A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder (Category I). Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., 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 (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness (Category I) (American Psychiatric Association, 2010, reaffirmed 2015).		
Improvement Notation	Higher score indicates better quality		
Reference	American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 46(11), 1503-1526. Retrieved from https://www.jaacap.org/article/S0890-8567(09)62053-0/fulltext		
Reference	American Psychiatric Association Work Group on Major Depressive Disorder. (2010, October). Practice guideline for the treatment of patients with major depressive disorder. 3rd edition. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf (This guideline was reaffirmed in October 2015.)		
Reference	Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909-916.		
Definition	Numerator Definition: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g.,		

	religious belief, concern not to hurt family) that may influence the desire to attempt suicide. 2. Current severity of suicidality. 3. Most severe point of suicidality in episode and lifetime. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Guidance	A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. Suicide risk assessments completed via telehealth services can also meet numerator performance. This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone.
Transmission Format	TBD
Initial Population	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Patient visits with an assessment for suicide risk
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Initial Population

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
        such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
            and Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")< 17
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
        such that SuicideRiskAssessment.relevantPeriod during MDDEncounter.relevantPeriod
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Initial Population

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
        such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
            and Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")< 17
```

Major Depressive Disorder Encounter

```
( ["Encounter, Performed": "Office Visit"]
    union ["Encounter, Performed": "Outpatient Consultation"]
    union ["Encounter, Performed": "Psych Visit - Diagnostic Evaluation"]
    union ["Encounter, Performed": "Psych Visit - Family Psychotherapy"]
    union ["Encounter, Performed": "Psych Visit - Psychotherapy"]
```

```
union ["Encounter, Performed": "Psychoanalysis"]
union ["Encounter, Performed": "Group Psychotherapy"]
union ["Encounter, Performed": "Telehealth Services"] ) ValidEncounter
where exists ( ValidEncounter.diagnoses EncounterDiagnosis
            where EncounterDiagnosis in "Major Depressive Disorder-Active"
)
      and ValidEncounter.relevantPeriod during "Measurement Period"
```

Numerator

```
"Major Depressive Disorder Encounter" MDDEncounter
      with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
            such that SuicideRiskAssessment.relevantPeriod during MDDEncounter.relevantPeriod
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.CalendarAgeInYearsAt(BirthDateTime DateTime, AsOf DateTime)

```
years between ToDate(BirthDateTime)and ToDate(AsOf)
```

Global.ToDate(Value DateTime)

```
DateTime(year from Value, month from Value, day from Value, 0, 0, 0, 0, timezone from Value)
```

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Suicide risk assessment (procedure)" ("SNOMEDCT Code (225337009)")
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Group Psychotherapy" (2.16.840.1.113883.3.526.3.1187)
- valueset "Major Depressive Disorder-Active" (2.16.840.1.113883.3.526.3.1491)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Psych Visit - Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- valueset "Psych Visit - Family Psychotherapy" (2.16.840.1.113883.3.526.3.1018)
- valueset "Psych Visit - Psychotherapy" (2.16.840.1.113883.3.526.3.1496)
- valueset "Psychoanalysis" (2.16.840.1.113883.3.526.3.1141)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telehealth Services" (2.16.840.1.113883.3.464.1003.101.12.1031)

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Group Psychotherapy" using "Group Psychotherapy (2.16.840.1.113883.3.526.3.1187)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Family Psychotherapy" using "Psych Visit - Family Psychotherapy (2.16.840.1.113883.3.526.3.1018)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Telehealth Services" using "Telehealth Services (2.16.840.1.113883.3.464.1003.101.12.1031)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Intervention, Performed: Suicide risk assessment (procedure)" using "Suicide risk assessment (procedure) (SNOMEDCT Code 225337009)"
- "Patient Characteristic Birthdate: Birth date" using "Birth date (LOINC Code 21112-8)"

Supplemental Data Elements

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Risk Adjustment Variables

None

Measure Set	None

Quality ID #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention and Treatment of Opioid and Substance Use Disorders

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user

INSTRUCTIONS:
This measure is to be submitted **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for unhealthy alcohol use. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. For the purposes of the measure, the most recent denominator eligible encounter should be used to determine if the numerator action for the submission criteria was performed within the 12-month look back period.

This measure will be calculated with 3 performance rates:

1) Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months
2) Percentage of patients aged 18 years and older who were identified as unhealthy alcohol users who received brief counseling
3) Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as unhealthy alcohol users

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as unhealthy alcohol users received brief counseling. For all patients, submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as unhealthy alcohol users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as unhealthy alcohol users.
NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality

Payment Program (QPP) website.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1) All patients who were screened for unhealthy alcohol use using a systematic screening method

AND

2) All patients who were identified as unhealthy alcohol users who received brief counseling

AND

3) All patients who were screened for unhealthy alcohol use using a systematic screening method and, if identified as unhealthy alcohol users received brief counseling, or were not identified as unhealthy alcohol users

This measure contains three submission criteria which aim to identify patients who were screened for unhealthy alcohol use using a systematic screening method (submission criteria 1), patients who were identified as unhealthy alcohol users and who received brief counseling (submission criteria 2), and a comprehensive look at the overall performance on unhealthy alcohol use screening and brief counseling (submission criteria 3). By separating this measure into various submission criteria, the MIPS eligible professional or MIPS eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (submission criteria 3) should be utilized to compare performance to published versions of this measure prior to the 2021 performance year, when the measure had a single performance rate. For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE

DENOMINATOR (SUBMISSION CRITERIA 1):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

> ***DENOMINATOR NOTE:*** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years
> **AND**
> **At least two patient encounters during the performance period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90845, 96156, 96158, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271
> **OR**
> **At least one preventive encounter during the performance period (CPT or HCPCS):** 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 1):
Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months

> **Definitions:**
> **Systematic screening method** – For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. "Systematic screening methods" and thresholds for defining unhealthy alcohol use include:
> - AUDIT Screening Instrument (score ≥ 4)

- AUDIT-C Screening Instrument (score ≥ 4 for men; score ≥ 3 for women)
- Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 1)

NUMERATOR NOTE:
To satisfy the intent of this measure, a patient must have at least one screening for unhealthy alcohol use during the 12-month period. If a patient has multiple screenings for unhealthy alcohol use during the 12-month period, only the most recent screening, which has a documented status of unhealthy alcohol user or unhealthy alcohol non-user, will be used to satisfy the measure requirements.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

Numerator Options:

Performance Met:	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method **(G2196)**
OR	
Performance Met:	Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user **(G2197)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method (e.g., limited life expectancy, other medical reasons) **(G2198)**
OR	
Performance Not Met:	Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given **(G2199)**

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS UNHEALTHY ALCOHOL USERS AND WHO RECEIVED BRIEF COUNSELING

DENOMINATOR (SUBMISSION CRITERIA 2):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for unhealthy alcohol use and identified as an unhealthy alcohol user

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B PFS. These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years
AND
All eligible instances when **G2196** is submitted for Performance Met (patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method) in the numerator of Submission Criteria 1
AND
At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96156, 96158, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 2):

Patients who received brief counseling

Definitions:

Brief counseling – "Brief counseling" for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE:

In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G2202.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met:	Patient identified as an unhealthy alcohol user received brief counseling **(G2200)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing brief counseling (e.g., limited life expectancy, other medical reasons) **(G2201)**
OR	
Performance Not Met:	Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given **(G2202)**

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE AND, IF IDENTIFIED AS AN UNHEALTHY ALCOHOL USER RECEIVED BRIEF COUNSELING, OR WERE NOT IDENTIFIED AS AN UNHEALTHY ALCOHOL USER

DENOMINATOR (SUBMISSION CRITERIA 3):

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B PFS. These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96156, 96158, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*,

99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 3):
Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within 12 months **AND** who received brief counseling if identified as an unhealthy alcohol user

Definitions:
Brief counseling – "Brief counseling" for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one unhealthy alcohol use screening during the 12-month period. If a patient has multiple unhealthy alcohol use screenings during the 12-month period, only the most recent screening, which has a documented status of unhealthy alcohol user or unhealthy alcohol non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G9624.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met:	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling **(G9621)**
OR	
Performance Met:	Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method **(G9622)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons) **(G9623)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user (e.g., limited life expectancy, other medical reasons) **(G2203)**
OR	
Performance Not Met:	Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given **(G9624)**

RATIONALE:
This measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption, particularly in primary care settings.

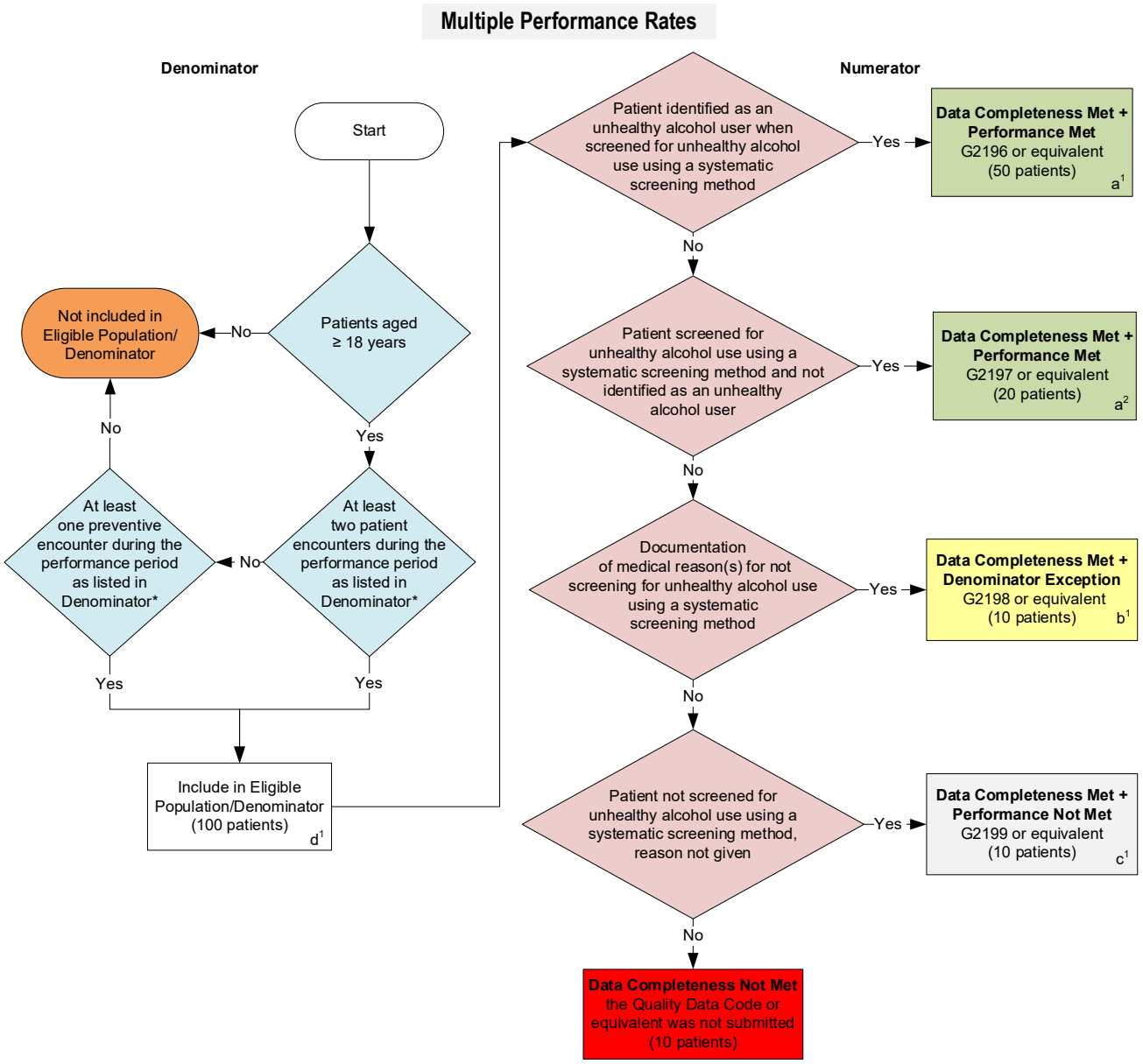
A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings. According to a study analyzing the quality of health care in the United States, on average, 45% of patients (n=6,676) were screened for problem drinking. (MCGlynn, et. al, 2003). In the national Healthcare for Communities Survey, only 8.7% of problem drinkers reported having been asked and counseled about their alcohol use in the last 12 months. (D'Amico, et. al., 2005)) A nationally representative sample of 648 primary care physicians were surveyed to determine how such physicians identify--or fail to identify--substance abuse in their patients, what efforts they make to help these patients and what are the barriers to effective diagnosis and treatment. Of physicians who conducted annual health histories, less than half ask about the quantity and frequency of alcohol use (45.3 percent). Only 31.8 percent say they ever administer standard alcohol or drug use screening instruments to patients. (CASA, 2000) A national systematic sample of 2,000 physicians practicing general internal medicine, family medicine, obstetrics-gynecology, and psychiatry were surveyed to determine the frequency of screening and intervention for alcohol problems. Of the 853 respondent physicians, 88% usually or always ask new outpatients about alcohol use. When evaluating patients who drink, 47% regularly inquire about maximum amounts on an occasion, and 13% use formal alcohol screening tools. Only 82% routinely offer intervention to diagnosed problem drinkers. (Friedman, et. al., 2000). In 2014, the CDC analyzed data from 17 states and the District of Columbia via the Behavioral Risk Factor Surveillance System to estimate the prevalence of adults who reported receiving elements of alcohol screening and brief intervention. While 77.7% of adults reported being asked about alcohol use by a health professional, only 32.9% were asked about binge-level alcohol consumption and among binge drinkers only 37.2% reported being counseled on the harms of binge drinking. Only 18.1% reported being advised to cut down on alcohol consumption or to quit drinking. (McKnight-Eily, et. al., 2017). A multi-site, cross-sectional survey of primary care residents from six primary care residency programs administered from March 2010 through December 2012 found that a minority of the residents appropriately screen or provide intervention for at risk alcohol users. While 60% (125/208) stated they screen patients at an initial visit, only 17% (35/208) screened patients at subsequent visits. 54% (108/202) reported they did not feel they had adequate training to provide brief intervention to patients found to be at-risk alcohol users and 21% (43/208) felt they could really help at-risk drinkers. (Barnes et. al., 2015). A study evaluating self-reported prevalence of alcohol screening using information drawn from the ConsumerStyles survey (a random internet panel) found that only 24.7% (n=2,592) of adults reported being asked about their alcohol use While prevalence among men and women were about the same, there was lower prevalence of screening among Black non-Hispanics than white non-Hispanics (16.2% vs. 26.9%) and college graduates reported a higher prevalence of screening than those with a high school degree or less (38.1% vs. 20.8%). (Denny et. al., 2015). A cross-sectional analysis using 2016 DocStyles data that evaluated with use of different screening tools used to screen for alcohol misuse by 1,506 primary care providers found that while most providers screen for alcohol misuse (96%) only 38% reported using a USPSTF recommended screening tool. (Tan et. al., 2018).

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. (Grade B recommendation) (USPSTF, 2018)

2021 Clinical Quality Measure Flow for Quality ID #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Submission Criteria One

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

Performance Met (a^1+a^2=70 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=10 patients) = 90 patients = **90.00%**

Eligible Population / Denominator (d^1=100 patients) = 100 patients

Performance Rate=

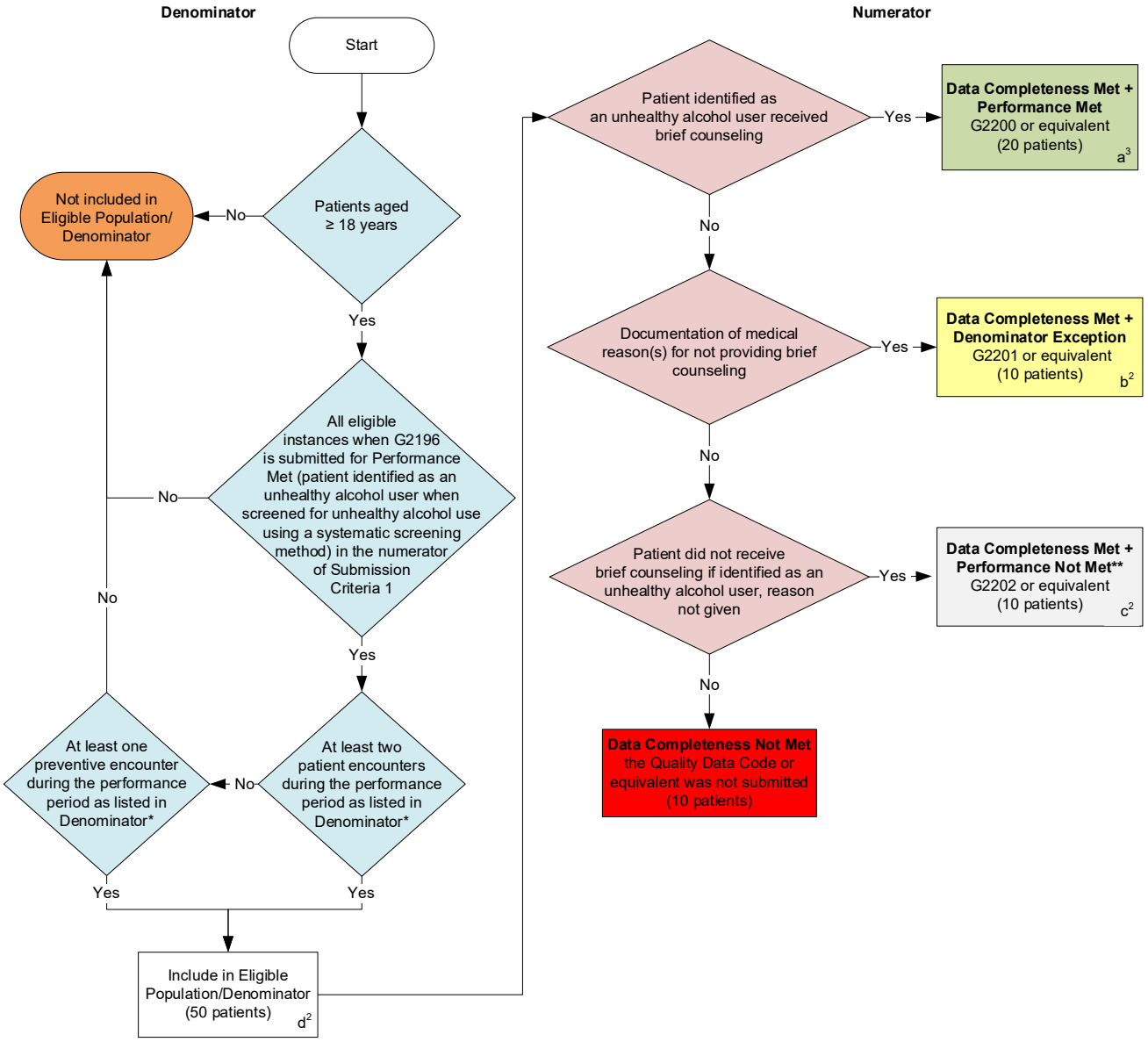
Performance Met (a^1+a^2=70 patients) = 70 patients = **87.50%**

Data Completeness Numerator (90 patients) – Denominator Exception (b^1=10 patients) = 80 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

Note: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a^3=20 patients) + Denominator Exception (b^2=10 patients) + Performance Not Met (c^2=10 patients) = 40 patients = **80.00%**

Eligible Population / Denominator (d^2=50 patients) = 50 patients

Performance Rate=

Performance Met (a^3=20 patients) = 20 patients = **66.67%**

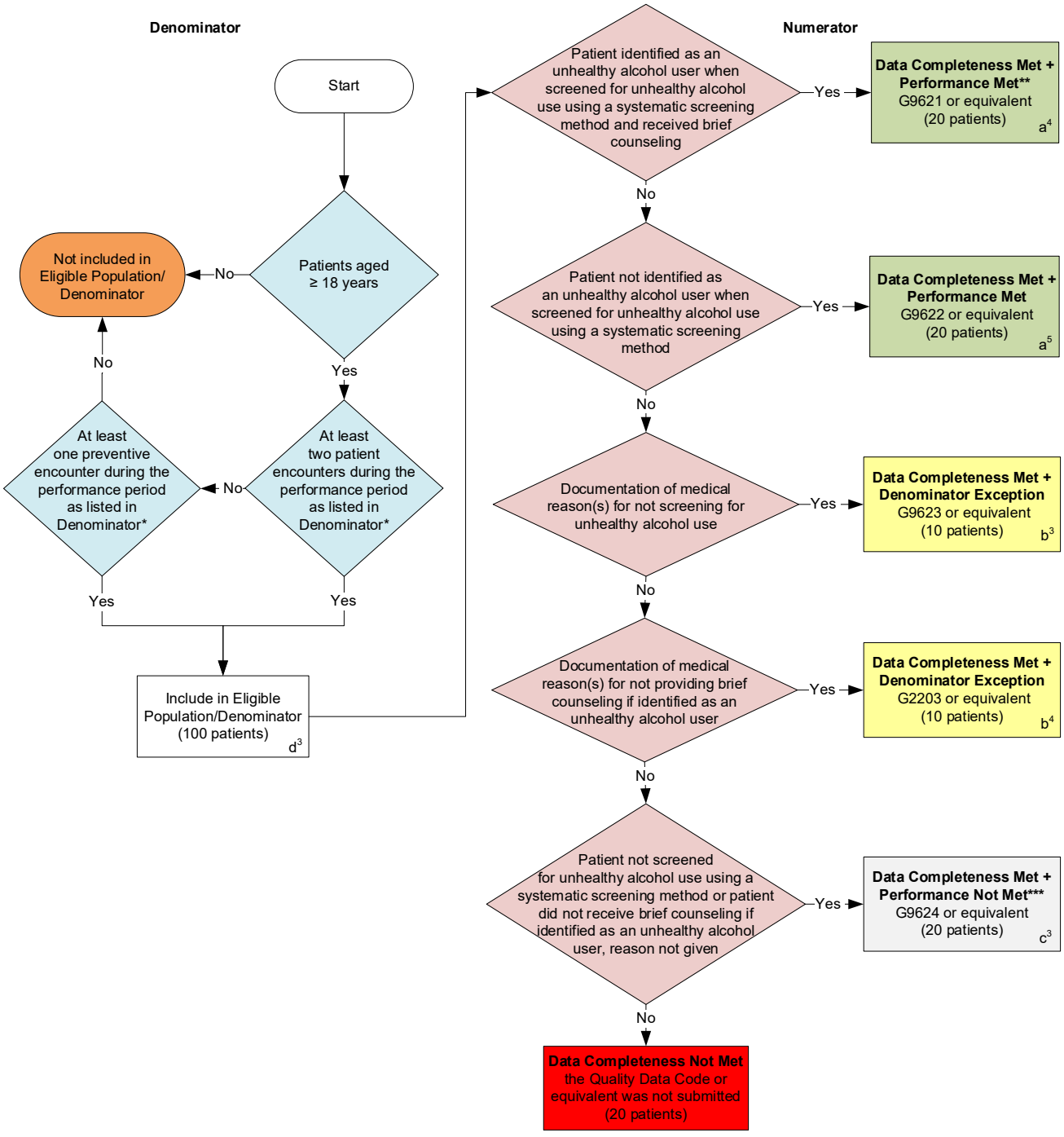
Data Completeness Numerator (40 patients) – Denominator Exception (b^2=10 patients) = 30 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

**In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G2202.

Note: Submission Frequency: Patient-Process

Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

Performance Met (a^4+a^5=40 patients) + Denominator Exception (b^3+b^4=20 patients) + Performance Not Met (c^3=20 patients) = 80 patients = **80.00%**

Eligible Population / Denominator (d^3=100 patients) = 100 patients

Performance Rate=

Performance Met (a^4+a^5=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (80 patients) – Denominator Exception (b^3+b^4=20 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.

**Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

***In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G9624.

Note: Submission Frequency: Patient-Process

2021 Clinical Quality Measure Flow Narrative for Quality ID #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

Multiple Performance Rates

Submission Criteria One:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
3. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 100 patients in the Sample Calculation.
6. Start Numerator
7. Check *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method*:
    a. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 50 patients in the Sample Calculation.
    b. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a*

systematic screening method equals No, proceed to check *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user*.

8. Check *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user*:

    a. If *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user* equals Yes, include *in Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.

    b. If *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user* equals No, proceed to check *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method*.

9. Check *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method*:

    a. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method* equals No, proceed to check *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given*.

10. Check *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given*:

    a. If *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 plus a^2 equals 70 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Not Met (c^1 equals 10 patients) divided by Eligible Population / Denominator (d^1 equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 70 patients) divided by Data Completeness Numerator (90 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

Note: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1*.
3. Check *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1:*
    a. If *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
4. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.

6. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 50 patients in the Sample Calculation.

7. Start Numerator

8. Check *Patient identified as an unhealthy alcohol user received brief counseling*:

    a. If *Patient identified as an unhealthy alcohol user received brief counseling* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 20 patients in the Sample Calculation.

    b. If *Patient identified as an unhealthy alcohol user received brief counseling* equals No, proceed to check *Documentation of medical reason(s) for not providing brief counseling*.

9. Check *Documentation of medical reason(s) for not providing brief counseling*:

    a. If *Documentation of medical reason(s) for not providing brief counseling* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not providing brief counseling* equals No, proceed to check *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*.

10. Check *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*:

    a. If *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Met (a^3 equals 20 patients) plus Denominator Exception (b^2 equals 10 patients) plus Performance Not Met (c^2 equals 10 patients) divided by Eligible Population / Denominator (d^2 equals 50 patients).

All equals 40 patients divided by 50 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^3 equals 20 patients) divided by Data Completeness Numerator (40 patients) minus Denominator Exception (b^2 equals 10 patients). All equals 20 patients divided by 30 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy alcohol user but did not receive brief alcohol cessation counseling submit G2202.

Note: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Three:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
3. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^3 equals 100 patients in the Sample Calculation.
6. Start Numerator

7. Check *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling*:

    a. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 20 patients in the Sample Calculation.

    b. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling* equals No, proceed to check *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method*.

8. Check *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method*:

    a. If *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method* equals Yes, include *in Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^5 equals 20 patients in the Sample Calculation.

    b. If *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method* equals No, proceed to check *Documentation of medical reason(s) for not screening for unhealthy alcohol use*.

9. Check *Documentation of medical reason(s) for not screening for unhealthy alcohol use*:

    a. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use* equals No, proceed to check *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user.*

10. Check *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user*:

    a. If *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^4 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy*

alcohol user equals No, proceed to check *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*.

11. Check *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*:

    a. If *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met****.

        - *Data Completeness Met and Performance Not Met**** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 20 patients in the Sample Calculation.

    b. If *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Met (a^4 plus a^5 equals 40 patients) plus Denominator Exception (b^3 plus b^4 equals 20 patients) plus Performance Not Met (c^3 equals 20 patients) divided by Eligible Population / Denominator (d^3 equals 100 patients). All equals 80 patients divided by 100 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^4 plus a^5 equals 40 patients) divided by Data Completeness Numerator (80 patients) minus Denominator Exception (b^3 plus b^4 equals 20 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

***In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G9624.

Note: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

*Depression Remission or Response for Adolescents and Adults (DRR-E)**

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score. • *Follow-Up PHQ-9*. The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score. • *Depression Remission*. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score. • *Depression Response*. The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score.
Measurement period	January 1–December 31.
Clinical recommendation statement	The Institute for Clinical Systems Improvement recommends that clinicians establish and maintain follow-up with adult patients who have depression. Appropriate, reliable follow-up is highly correlated with improved response and remission scores (Kessler, 2016). The American Academy of Pediatrics recommends that adolescents with depression be assessed for treatment response and remission of symptoms using a depression assessment tool such as the PHQ-9 Modified for Teens (Cheung, 2018).
Citations	Cheung A. H., R. A. Zuckerbrot, P. S. Jensen, K. Ghalib, D. Laraque, and R.E.K. Stein. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management." *Pediatrics* 120, no. 5 (January 2007). https://doi.org/10.1542/peds.2006-1395. Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. *Adult Depression in Primary Care*. Updated March 2013.

Characteristics	
Scoring	Proportion.
Type	Outcome.
Stratification	1. Commercial 12–17 years. 2. Commercial 18–44 years. 3. Commercial 45–64 years. 4. Commercial 65 years and older. 5. Medicaid 12–17 years. 6. Medicaid 18–44 years. 7. Medicaid 45–64 years. 8. Medicaid 65 years and older. 9. Medicare 18–44 years. 10. Medicare 45–64 years. 11. Medicare 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.
Participation Period	May 1 of the year prior to the Measurement Period through December 31 of the Measurement Period.
Intake Period	May 1 of the year prior to the Measurement Period through April 30 of the Measurement Period.
Depression Follow-Up Period	The 120−240-day period after the IESD.
IESD	Index Episode Start Date. The earliest date during the Intake Period where a member has a diagnosis of major depression or dysthymia ***and*** a PHQ-9 total score >9 documented.
Initial Population	Members 12 years and older as of the start of the Intake Period who meet ***both*** of the following criteria: • A diagnosis of major depression or dysthymia that starts before and overlaps or starts when the PHQ-9 total score >9 is documented during the Intake Period. • Participation.

Exclusions	Members with any of the following at any time during the Intake Period or during the Measurement Period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. ***OR*** Members in hospice or using hospice services any time during the Measurement Period.
Denominator	The Initial Population, minus Exclusions.
Numerator	**Numerator 1—Depression Follow-Up** A PHQ-9 total score in the member's record during the Depression Follow-Up Period. **Numerator 2—Depression Remission** Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the Depression Follow-Up Period. **Numerator 3—Depression Response** Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the Depression Follow-Up Period.
Data criteria (element level)	
Value Sets: • **DRRE_HEDIS_MY2022-1.0.0** – Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044) – Major Depression or Dysthymia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1351) – Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399) – Personality Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1355) – Pervasive Developmental Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1356) – Psychotic Disorders (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1352) • **NCQA_Hospice-1.0.0** – Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761) – Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)	

Direct Reference Codes and Codesystems:

- **DRRE_HEDIS_MY2022-1.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from code "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table DRR-E-1/2: Data Elements for Depression Remission or Response for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
FollowUp	12-17	InitialPopulationByEHR	For each Stratification, repeat per Metric
Remission	18-44	InitialPopulationByCaseManagement	For each Stratification, repeat per Metric
Response	45-64	InitialPopulationByHIERegistry	For each Stratification, repeat per Metric
	65+	InitialPopulationByAdmin	For each Stratification, repeat per Metric
	Total	InitialPopulation	(Sum over SSoRs)
		ExclusionsByEHR	For each Stratification, repeat per Metric
		ExclusionsByCaseManagement	For each Stratification, repeat per Metric
		ExclusionsByHIERegistry	For each Stratification, repeat per Metric
		ExclusionsByAdmin	For each Stratification, repeat per Metric
		Exclusions	(Sum over SSoRs)
		Denominator	For each Stratification, repeat per Metric
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table DRR-E-3: Data Elements for Depression Remission or Response for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
FollowUp	18-44	InitialPopulationByEHR	For each Stratification, repeat per Metric
Remission	45-64	InitialPopulationByCaseManagement	For each Stratification, repeat per Metric
Response	65+	InitialPopulationByHIERegistry	For each Stratification, repeat per Metric
	Total	InitialPopulationByAdmin	For each Stratification, repeat per Metric
		InitialPopulation	(Sum over SSoRs)
		ExclusionsByEHR	For each Stratification, repeat per Metric
		ExclusionsByCaseManagement	For each Stratification, repeat per Metric
		ExclusionsByHIERegistry	For each Stratification, repeat per Metric
		ExclusionsByAdmin	For each Stratification, repeat per Metric
		Exclusions	(Sum over SSoRs)
		Denominator	For each Stratification, repeat per Metric
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Depression Remission or Response for Adolescents and Adults

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (12 and older). The denominator age may not be expanded.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. The value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified value sets.
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• PHQ-9 Score • Depression Remission • Depression Response	No	Value sets, Direct Reference Codes and logic may not be changed.

*Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)**

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.
Measurement period	January 1–December 31.
Clinical recommendation statement	Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms (Trangle, 2016). Guidelines for adolescents recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms (Cheung, 2018). The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) criteria symptoms and effects on functioning, and has shown to be highly accurate in discriminating between patients with persistent major depression, partial remission and full remission (Kroenke, 2001).
Citations	Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, D. Laraque, R.E.K. Stein, GLAD-PC Steering Group. 2018. “Guidelines for Adolescent Depression in Primary Care (GLAD- PC): II. Treatment and Ongoing management.” *Pediatrics* 141(3):e20174082. Kroenke, K, R.L. Spitzer, J.B.W. Williams. 2001. The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine* 16(9): 606-13. Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N., Myszkowski, M. Institute for Clinical Systems Improvement. *Adult Depression in Primary Care*. Updated March 2016.

Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	1. Commercial 12–17 years. 2. Commercial 18–44 years. 3. Commercial 45–64 years. 4. Commercial 65 years and older. 5. Medicaid 12–17 years. 6. Medicaid 18–44 years. 7. Medicaid 45–64 years. 8. Medicaid 65 years and older. 9. Medicare 18–44 years. 10. Medicare 45–64 years. 11. Medicare 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.
Participation Period	The Measurement Period.
Assessment Period	The Measurement Period is divided into three assessment periods with specific dates of service: • *Assessment Period 1*: January 1–April 30. • *Assessment Period 2*: May 1–August 31. • *Assessment Period 3*: September 1–December 31.
Interactive Outpatient Encounter	A bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.
Initial Population	**Initial Population 1** Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment Period 1, with a diagnosis of major depression or dysthymia.

	Initial Population 2 Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment Period 2, with a diagnosis of major depression or dysthymia. **Initial Population 3** Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment Period 3, with a diagnosis of major depression or dysthymia.
Exclusions	Members with any of the following at any time during the Measurement Period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. • In hospice or using hospice services.
Denominator	**Denominator 1** The Initial Population 1, minus Exclusions. **Denominator 2** The Initial Population 2, minus Exclusions. **Denominator 3** The Initial Population 3, minus Exclusions.
Numerator	**Numerator 1—Utilization of PHQ-9 Period 1** A PHQ-9 score in the member's record during Assessment Period 1. **Numerator 2—Utilization of PHQ-9 Period 2** A PHQ-9 score in the member's record during Assessment Period 2. **Numerator 3—Utilization of PHQ-9 Period 3** A PHQ-9 score in the member's record during Assessment Period 3.
Data criteria (element level)	
Value Sets: • **DMSE_HEDIS_MY2022-1.0.0** – Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044) – Interactive Outpatient Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1347) – Major Depression or Dysthymia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1351) – Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399) – Personality Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1355)	

  - Pervasive Developmental Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1356)
  - Psychotic Disorders (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1352)
- **NCQA_Hospice-1.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

Direct Reference Codes and Codesystems:

- **DMSE_HEDIS_MY2022-1.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DMS-E-1/2: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

Metric	TimePeriod	Age	Data Element	Reporting Instructions
PHQ9Utilization	1	12-17	InitialPopulationByEHR	For each Stratification
	2	18-44	InitialPopulationByCaseManagement	For each Stratification
	3	45-64	InitialPopulationByHIERegistry	For each Stratification
	Total	65+	InitialPopulationByAdmin	For each Stratification
		Total	InitialPopulation	(Sum over SSoRs)
			ExclusionsByEHR	For each Stratification
			ExclusionsByCaseManagement	For each Stratification
			ExclusionsByHIERegistry	For each Stratification
			ExclusionsByAdmin	For each Stratification
			Exclusions	(Sum over SSoRs)
			Denominator	For each Stratification
			NumeratorByEHR	For each Stratification
			NumeratorByCaseManagement	For each Stratification
			NumeratorByHIERegistry	For each Stratification
			NumeratorByAdmin	For each Stratification
			Numerator	(Sum over SSoRs)
			Rate	(Percent)

Table DMS-E-3: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

Metric	TimePeriod	Age	Data Element	Reporting Instructions
PHQ9Utilization	1	18-44	InitialPopulationByEHR	For each Stratification
	2	45-64	InitialPopulationByCaseManagement	For each Stratification
	3	65+	InitialPopulationByHIERegistry	For each Stratification
	Total	Total	InitialPopulationByAdmin	For each Stratification
			InitialPopulation	(Sum over SSoRs)
			ExclusionsByEHR	For each Stratification
			ExclusionsByCaseManagement	For each Stratification
			ExclusionsByHIERegistry	For each Stratification
			ExclusionsByAdmin	For each Stratification
			Exclusions	(Sum over SSoRs)
			Denominator	For each Stratification
			NumeratorByEHR	For each Stratification
			NumeratorByCaseManagement	For each Stratification
			NumeratorByHIERegistry	For each Stratification
			NumeratorByAdmin	For each Stratification
			Numerator	(Sum over SSoRs)
			Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (12 and older). Expanding the denominator age range to 11 and older is allowed.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. The value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified value sets.
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
PHQ-9 Score	No	Value sets, Direct Reference Codes and logic may not be changed.

*Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)**

***Adapted with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and with permission from the measure developer, the American Medical Association (AMA).**

SUMMARY OF CHANGES FOR HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care. • *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use. • *Alcohol Counseling or Other Follow-up Care*. The percentage of members receiving brief counseling or other follow-up care within 2 months of screening positive for unhealthy alcohol use.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol. (B recommendation)
Citations	U.S. Preventive Services Task Force. 2018. “Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions.” *JAMA* 320(18):1899–1909. DOI:10.1001/jama.2018.16789.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	1. Commercial 18–44 years. 2. Commercial 45–64 years. 3. Commercial 65 years and older. 4. Medicaid 18–44 years. 5. Medicaid 18–44 years. 6. Medicaid 65 years and older. 7. Medicare 18–44 years. 8. Medicare 45–64 years. 9. Medicare 65 years and older.
Risk adjustment	None.

<table>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.</td></tr>
<tr><td>Participation Period</td><td>The Measurement Period.</td></tr>
<tr><td>Unhealthy Alcohol Use Screening</td><td>A standard assessment instrument that has been normalized and validated for the adult patient population to include AUDIT, AUDIT-C and a Single-Question Screen. Screening requires completion of one or more instruments. The threshold for a positive finding is indicated below for each instrument.
<table>
<tr><th>Screening Instrument</th><th>Positive Finding</th></tr>
<tr><td>Alcohol Use Disorders Identification Test (AUDIT) Screening Instrument</td><td>Total Score ≥8</td></tr>
<tr><td>Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Screening Instrument</td><td>Total Score ≥4 for men
Total Score ≥3 for women</td></tr>
<tr><td>Single-Question Screen:
“How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?”</td><td>Total Score ≥1</td></tr>
</table></td></tr>
<tr><td>Alcohol Counseling or Other Follow-Up Care</td><td>Any of the following on or up to 60 days after the first positive screen:
Feedback on alcohol use and harms.
Identification of high-risk situations for drinking and coping strategies.
Increase the motivation to reduce drinking.
Development of a personal plan to reduce drinking.
Documentation of receiving alcohol misuse treatment.</td></tr>
<tr><td>Initial Population</td><td>Members 18 years and older at the start of the Measurement Period who also meet criteria for Participation.</td></tr>
<tr><td>Exclusions</td><td>Members with alcohol use disorder that starts during the year prior to the Measurement Period.
Members with history of dementia any time during the member’s history through the end of the Measurement Period.
Members in hospice or using hospice services any time during the Measurement Period.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The Initial Population, minus Exclusions.</td></tr>
</table>

	Denominator 2 All members in Numerator 1 with a positive finding for unhealthy alcohol use screeningbetween January 1 and November 1 of the Measurement Period.
Numerator	**Numerator 1—Unhealthy Alcohol Use Screening** Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the Measurement Period. **Numerator 2—Counseling or Other Follow-Up on Positive Screen** Members receiving alcohol counseling or other follow-up care on or up to 60 days after the date of the first positive screen (61 days total).

Data criteria (element level)

Value Sets:

- **ASFE_HEDIS_MY2022-1.0.0**
  - Alcohol Counseling or Other Follow Up Care (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1437)
  - Alcohol Use Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1339)
  - Dementia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1074)
- **NCQA_Hospice-1.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

Direct Reference Codes and Codesystems:

- **ASFE_HEDIS_MY2022-1.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - code "Alcohol abuse counseling and surveillance of alcoholic": 'Z71.41' from "ICD-10" display' Alcohol abuse counseling and surveillance of alcoholic'
  - code "How often have you had five or more drinks in one day during the past year [Reported]": '88037-7' from "LOINC" display 'How often have you had five or more drinks in one day during the past year [Reported]'
  - code "How often have you had four or more drinks in one day during the past year [Reported]": '75889-6' from "LOINC" display 'How often have you had four or more drinks in one day during the past year [Reported]'
  - code "Other specified counseling": 'Z71.89' from "ICD-10" display 'Other specified counseling'
  - code "Total score [AUDIT-C]": '75626-2' from "LOINC" display 'Total score [AUDIT-C]'
  - code "Total score [AUDIT]": '75624-7' from "LOINC" display 'Total score [AUDIT]'

- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table ASF-E-1/2/3: Data Elements for Unhealthy Alcohol Use Screening and Follow-Up

Metric	Age	Data Element	Reporting Instructions
Screening	18-44	InitialPopulation	For each Metric and Stratification
FollowUp	45-64	ExclusionsByEHR	For each Metric and Stratification
	65+	ExclusionsByCaseManagement	For each Metric and Stratification
	Total	ExclusionsByHIERegistry	For each Metric and Stratification
		ExclusionsByAdmin	For each Metric and Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Unhealthy Alcohol Use Screening and Follow-Up

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (18 and older). Organizations must consult UPSTSF guidelines when considering whether to expand the age ranges outside of the current thresholds.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Value sets, Direct Reference Codes and logic may not be changed for Denominator 2.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified Direct Reference Codes.
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Unhealthy Alcohol Use Screening • Counseling or Other Follow-Up on Positive Screen	No	Value sets, Direct Reference Codes and logic may not be changed.

SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of April 8, 2021

SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)

- Updated to include guidance on how to attribute patients and providers to AEs.
- Updated to include an example of ICD-10 Z codes in use by at least one AE to capture SDOH screening results electronically.
- Updated to include information about patient and provider attribution to AEs.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[1]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 30 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: ○ The following are the eligible CPT/HCPCS office visit

[1] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

	codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496 ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit: ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Code List below) • Refused to participate

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE provider rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[2]

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

[2] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below: • Z04 ○ Definition: Encounter for examination and observation for other reasons ○ Meaning: SDOH screening completed • Z53 ○ Definition: Persons encountering health services for specific procedure and treatment, not carried out ○ Meaning: SDOH screening offered, but patient refused/declined to complete screen
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR, i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.

Required domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

The following codes should be utilized to identify patients in hospice care:

Code System	Code
UBREV	0115
UBREV	0125
UBREV	0135
UBREV	0145
UBREV	0155
UBREV	0235
UBREV	0650
UBREV	0651
UBREV	0652
UBREV	0655
UBREV	0656
UBREV	0657
UBREV	0658
UBREV	0659
SNOMED CT US EDITION	170935008
SNOMED CT US EDITION	170936009
SNOMED CT US EDITION	183919006
SNOMED CT US EDITION	183920000
SNOMED CT US EDITION	183921001
SNOMED CT US EDITION	305336008
SNOMED CT US EDITION	305911006
SNOMED CT US EDITION	385763009

Code System	Code
CPT	99377
CPT	99378
HCPCS	G0182
HCPCS	G9473
HCPCS	G9474
HCPCS	G9475
HCPCS	G9476
HCPCS	G9477
HCPCS	G9478
HCPCS	G9479
HCPCS	Q5003
HCPCS	Q5004
HCPCS	Q5005
HCPCS	Q5006
HCPCS	Q5007
HCPCS	Q5008
HCPCS	Q5010
HCPCS	S9126
HCPCS	T2042
HCPCS	T2043
HCPCS	T2044
HCPCS	T2045
HCPCS	T2046

Initiation and Engagement of Substance Use Disorder Treatment (IET)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Replaced “alcohol and other drug (AOD)” references with “substance use disorder (SUD).”
- Changed the start of the Intake Period to November 15 of the year prior to the measurement year.
- Changed from a member-based measure to an SUD diagnosis episode-based measure.
- Revised the age stratifications.
- Revised the negative diagnosis history from 60 days to 194 days.
- Added a Negative Medication History to the denominator.
- Revised the Continuous Enrollment criteria from 108 days to 242 days.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Revised the numerator criteria for Initiation of SUD Treatment and Engagement of SUD Treatment.
- Added an *Other* section to the Rules for Allowable Adjustments.
- Clarified allowable adjustments to event/diagnosis criteria in the Rules for Allowable Adjustments.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- *Initiation of SUD Treatment.* The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
- *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Definitions

Intake Period	November 15 of the year prior to the measurement year–November 14 of the measurement year. The Intake Period is used to capture new SUD episodes.
SUD Episode	An encounter during the Intake Period with a diagnosis of SUD. *For visits that result in an inpatient stay*, the inpatient discharge is the SUD Episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD Episode Date	The date of service for an encounter during the Intake period with a diagnosis of SUD. *For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay),* the SUD Episode Date is the date of service. *For an inpatient stay or for medically managed withdrawal event* (i.e., detoxification) that occurred during an inpatient stay, the SUD Episode Date is the date of discharge.

For medically managed withdrawal (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD Episode Date is the date of service.

For direct transfers, the SUD Episode Date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

Date of service for services billed weekly or monthly

For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD Episode Date, negative diagnosis history and numerator events).

Direct transfer

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

Eligible Population

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Age

13 years and older as of the SUD Episode Date. Report three age stratifications and a total:

- 13–17 years.
- 18–64 years.
- 65+ years.
- Total.

The total is the sum of the age stratifications.

SUD diagnosis cohort stratification

Report the following SUD diagnosis cohort stratifications and a total:

- Alcohol use disorder.
- Opioid use disorder.
- Other substance use disorder.
- Total.

The total is the sum of the SUD diagnosis cohort stratifications.

Continuous enrollment

194 days prior to the SUD Episode Date through 47 days after the SUD Episode Date (242 total days).

Allowable gap

None.

Anchor date None.

Benefits Medical, pharmacy and chemical dependency (inpatient and outpatient).

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/diagnosis New episode of SUD during the Intake Period.

Follow the steps below to identify the denominator for both rates.

Step 1 Identify all SUD episodes. Any of the following meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An ED visit (ED Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge ***with*** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).

Step 2 Test for Negative SUD Diagnosis History. Exclude SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) with a diagnosis of SUD (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD Episode Date.

If the SUD Episode was an inpatient stay, use the admission date to determine Negative SUD History.

For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD Episode), use the earliest date of service to determine the Negative SUD Diagnosis History (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).

For direct transfers, use the first admission date to determine the Negative SUD Diagnosis History.

Step 3 Test for Negative SUD Medication History. Exclude SUD episodes if any of the following occurred during the 194 days prior to the SUD Episode Date:

- An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List).
- An SUD medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Step 4 Exclude SUD Episodes that do not meet continuous enrollment criteria. Members must be continuously enrolled from 194 days before the SUD Episode Date through 47 days after the SUD Episode Date (242 total days), with no gaps.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded remain in the denominator.*

Step 5 Identify the SUD diagnosis cohort for each SUD Episode.

- If the SUD Episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort.
- If the SUD Episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort.
- If the SUD Episode has a diagnosis of SUD that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other substance use disorder cohort.

Include SUD Episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD Episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of SUD Treatment Initiation of SUD treatment within 14 days of the SUD Episode Date. Follow the steps below to identify numerator compliance.

Step 1 *If the SUD Episode was an inpatient discharge*, the inpatient stay is considered initiation of treatment and the SUD Episode is compliant.

Step 2 *If the SUD Episode was an opioid treatment service that bills monthly* (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD Episode is compliant.

Step 3 For remaining SUD Episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD Episode Date or during the 13 days after the SUD Episode Date (14 total days).

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD Episode Date must be with different providers in order to count.

Exclude the member from the denominator for both indicators *(Initiation of SUD Treatment* and *Engagement of SUD Treatment)* if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1 Identify all SUD Episodes compliant for the Initiation of SUD Treatment numerator. SUD Episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2 Identify SUD Episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD Episode is compliant.

Step 3 Identify SUD Episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD Episode is compliant. Any of the following meet criteria:

- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection

Medications List) or a medication administration event (Naltrexone Injection Value Set).

- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set).

Step 4 For remaining SUD Episodes identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit.
- Engagement medication treatment event.

Two engagement visits may be on the same date of service, but they must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visits Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and

Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set).

Engagement medication treatment events

Either of the following meets criteria for a medication treatment event:

- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List).
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List
Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List
Partial agonist	• Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.*
- *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table IET-1/2/3: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment

Metric	Diagnosis	Age	Data Element	Reporting Instructions
Initiation	Alcohol	13-17	Benefit	Metadata
Engagement	Opioid	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	Other	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	Total	NumeratorByAdmin	For each Metric and Stratification
			Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Initiation and Engagement of Substance Use Disorder Treatment

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
SUD diagnosis cohorts	Yes, with limits	Reporting each stratum or combined strata is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists and value sets and logic may not be changed. ***Note:*** *The measurement period may be adjusted. Modifying the determination dates in the eligible population can affect timing relationships. The order and relationship of events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Initiation of SUD Treatment • Engagement of SUD Treatment	No	Medication lists, value sets and logic may not be changed.

*Follow-Up After Emergency Department Visit for Substance Use (FUA)**

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Revised the measure name from *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* to *Follow-Up After Emergency Department Visit for Substance Use.*
- Revised terminology from "alcohol or other drug abuse or dependence (AOD)" to "substance use" or substance use disorder (SUD)."
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added a pharmacy benefit requirement.
- Added ED visits with a diagnosis of unintentional and undetermined drug overdose to the denominator.
- Revised and restructured the numerator logic and value sets.
- Added required exclusions in the Rules for Allowable Adjustments.

Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	13 years and older as of the ED visit. Report two age stratifications and a total rate: • 13–17 years. • 18 and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.

Benefit

Medical, chemical dependency and pharmacy.

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/diagnosis

An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) ***or*** any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

Multiple visits in a 31-day period

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusion

Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a mental health provider.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An observation visit (Observation Value Set) ***with*** a mental health provider.
- A peer support service (Peer Support Services Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- A telephone visit (Telephone Visits Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telephone visit (Telephone Visits Value Set), ***with*** a mental health provider.
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** a mental health provider.
- A substance use disorder service (Substance Use Disorder Services Value Set).
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set).
- A substance use service (Substance Use Services Value Set).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*
- *Refer to Appendix 3 for the definition of "mental health provider." Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	13-17	Benefit	Metadata
FollowUp7Day	18+	EligiblePopulation	For each Stratification, repeat per Metric
	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for Substance Use

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of ED visit). Changing denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

MEASURE COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

Pharmacy Quality Alliance

A. DESCRIPTION

Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older. Age groups should be based on age as of January 1 of the measurement year.
- The opioid medications used to calculate this measure are in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10 codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice may be identified using the codes in the Hospice Encounter Value Set and Hospice Intervention Value Set available in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip.
- More information on the Pharmacy Quality Alliance value set directory is available at https://www.pqaalliance.org/assets/Measures/PQA_Value_Set_Redesign_FAQs.pdf.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- When determining the eligible population, under Step 1 of the Event/Diagnosis, the process for counting the total days' supply when there are multiple prescriptions with overlapping days of supply depends on whether the prescriptions are filled on the same day or on different days.
  - If prescriptions are filled on the **same day**, states should count only the days' supply for the prescription filled with the longest supply toward the total. For example, if an individual had two prescriptions filled on October 15 during the measurement year, one with a 7-day supply and the other with a 30-day supply, of the two claims filled, the state should count only the 30 days' supply claim toward the cumulative days' supply.
  - If prescriptions are dispensed on **different days** with overlapping days' supply, states should not account for overlapping days' supply. Each day of overlap should be counted separately towards the total days' supply. For example, if a beneficiary has two claims that were dispensed during the measurement year, the first on

January 15, 2019 for a 30-day supply, and the second, on January 20, 2019 for a 7-day supply, then the beneficiary's cumulative days' supply is 37 days.

- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

The following coding systems are used in this measure: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table COB-A.
Benzodiazepine	See medications listed in Table COB-B.
Concurrent Use	Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days. Concurrent use is identified using the dates of service and days' supply of a beneficiary's prescription claims. The days of concurrent use is the count of days with overlapping days' supply for an opioid and a benzodiazepine.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 30 days before the end of the measurement year. (i.e., January 1 – December 2).
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip.
Cancer Diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip.
Sickle Cell Disease Diagnosis	Any beneficiary with an ICD-10 diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/Diagnosis	Use the steps below to determine the eligible population. Step 1 Identify beneficiaries with 2 or more prescription claims for opioid medications (Table COB-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. Step 2 Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year. Step 3 Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice • Cancer Diagnosis • Sickle Cell Disease Diagnosis

Table COB-A. Opioid Medications[a,b]

Benzohydrocodone	Hydrocodone	Morphine	Oxymorphone
Buprenorphine[c]	Hydromorphone	Opium	Pentazocine
Butorphanol	Levorphanol	Oxycodone	Tapentadol
Codeine	Meperidine		Tramadol
Dihydrocodeine	Methadone		
Fentanyl			

[a] Includes combination products and prescription opioid cough medications.

[b] Excludes the following: injectable formulations; sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries from the denominator with:

- Two or more prescription claims for any benzodiazepine (Table COB-B) with different dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days

Follow the steps below to identify beneficiaries for the numerator.

Step 1

From the denominator population, identify beneficiaries with two or more prescription claims with different dates of service for any benzodiazepine (Table COB-B) during the measurement year.

Step 2

Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioids and benzodiazepine prescriptions during the measurement year. Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of supply and overlap that occur after the end of the measurement year.

NOTE:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 3

Count the number of beneficiaries with concurrent use for 30 or more cumulative days. This is the numerator.

Table COB-B. Benzodiazepine Medications[a,b]

Alprazolam Chlordiazepoxide Clobazam Clonazepam	Clorazepate Diazepam Estazolam Flurazepam	Lorazepam Midazolam Oxazepam Quazepam	Temazepam Triazolam

[a] Excludes injectable formulations.

[b] Includes combination products.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources.

eCQM Title	**Closing the Referral Loop: Receipt of Specialist Report**
eCQM Identifier (Measure Authoring Tool)	50
eCQM Version Number	9.2.000
NQF Number	Not Applicable
GUID	f58fc0d6-edf5-416a-8d29-79afbfd24dea
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Measure Developer	PCPI(R) Foundation (PCPI[R])
Endorsed By	None
Description	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred
Copyright	Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. PCPI disclaims all liability for use or accuracy of any CPT or other codes contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2019 American Medical Association. LOINC(R) is copyright 2004-2019 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2019 International Health Terminology Standards Development Organisation.
Disclaimer	This performance Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R].
Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	Problems in the outpatient referral and consultation process have been documented, including lack of timeliness of information and inadequate provision of information between the specialist and the requesting physician (Gandhi et al., 2000; Forrest et al., 2000; Stille, Jerant, Bell, Meltzer, & Elmore, 2005). In a study of physician satisfaction with the outpatient referral process, Gandhi et al. (2000) found that 68% of specialists reported receiving no information from the primary care provider prior to referral visits, and 25% of primary care providers had still not received any information from specialists 4 weeks after referral visits. In another study of 963 referrals (Forrest et al., 2000), pediatricians scheduled appointments with specialists for only 39% and sent patient information to the specialists in only 51% of the time. In a 2006 report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that care coordination programs improved quality of care for patients, reduced hospitalizations, and improved adherence to evidence-based care guidelines, especially among patients with diabetes and CHD. Associations with cost-savings were less clear; this was attributed to how well the intervention group was chosen and defined, as well as the intervention put in place. Additionally, cost-savings were usually calculated in the short-term, while some argue that the greatest cost-savings accrue over time (MedPAC, 2006). Improved mechanisms for information exchange could facilitate communication between providers, whether for time-limited referrals or consultations, on-going co-management, or during care transitions. For example, a study by Branger, van't Hooft, van der Wouden, Moorman & van Bemmel (1999) found that an electronic communication network that linked the computer-based patient records of physicians who had shared care of patients with diabetes significantly increased frequency of communications between physicians and availability of important clinical data. There was a 3-fold increase in the likelihood that the specialist provided written communication of results if the primary care physician scheduled appointments and sent patient information to the specialist (Forrest et al., 2000). Care coordination is a focal point in the current health care reform and our nation's ambulatory health information technology (HIT) framework. The National Priorities Partnership (2008) recently highlighted care coordination as one of the most critical areas for development of quality measurement and improvement.
Clinical Recommendation Statement	None
Improvement Notation	A higher score indicates better quality
Reference	Branger, P. J., van't Hooft, A., van der Wouden, J. C., Moorman, P.W., & van Bemmel, J.H. (1999). Shared care for diabetes: Supporting communication between primary and secondary care. International Journal of Medical Informatics, 53(2-3), 133-142. doi: 10.1016/s1386-5056(98)00154-3
Reference	Forrest, C. B., Glade, G. B., Baker, A. E., Bocian, A., von Schrader, S., & Starfield, B. (2000). Coordination of specialty referrals and physician satisfaction with referral care. Archives of Pediatrics and Adolescent Medicine, 154(5), 499-506. doi: 10.1001/archpedi.154.5.499
Reference	Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A.J., Fairchild, D.G., & Bates, D.W. (2000). Communication breakdown in the outpatient referral process. Journal of General Internal Medicine, 15(9), 626-631. doi: 10.1046/j.1525-1497.2000.91119.x
Reference	MedPAC. (2006, March). Report to the Congress: Medicare payment policy. Retrieved from http://medpac.gov/docs/default-source/reports/Mar06_EntireReport.pdf?sfvrsn=0
Reference	National Priorities Partnership. (2008). National priorities and goals: Aligning our efforts to transform America's healthcare. Washington, DC: National Quality Forum.
Reference	Stille, C. J., Jerant, A., Bell, D., Meltzer, D., & Elmore, J.G. (2005). Coordinating care across diseases, settings, and clinicians: A key role for the generalist in practice. Annals of Internal Medicine, 142(8), 700-708. doi: 10.7326/0003-4819-142-8-200504190-00038
Definition	Referral: A request from one physician or other eligible provider to another practitioner for evaluation, treatment, or co-management of a patient's condition. This term encompasses referral and consultation as defined by Centers for Medicare & Medicaid Services. Report: A written document prepared by the eligible clinician (and staff) to whom the patient was referred and that accounts for his or her findings, provides summary of care information about findings, diagnostics, assessments and/or plans of care, and is provided to the referring eligible clinician.
Guidance	The provider who refers the patient to another provider is the provider who should be held accountable for the performance of this measure. The provider to whom the patient was referred should be the same provider that sends the report.

	If there are multiple referrals for a patient during the measurement period, use the first referral. The consultant report that will fulfill the referral should be completed after the referral and should be related to the referral for which it is attributed. If there are multiple consultant reports received by the referring provider which pertain to a particular referral, use the first consultant report to satisfy the measure. Eligible professionals or eligible clinicians reporting on this measure should note that all data for the reporting year is to be submitted by the deadline established by CMS. Therefore, eligible professionals or eligible clinicians who refer patients towards the end of the reporting period (i.e., November - December), should request that providers to whom they referred their patients share their consult reports as soon as possible in order for those patients to be counted in the measure numerator during the measurement period. When providers to whom patients are referred communicate the consult report as soon as possible with the referring providers, it ensures that the communication loop is closed in a timely manner and that the data are included in the submission to CMS. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.5. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission Format	TBD
Initial Population	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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Population Criteria

Initial Population

exists "Face to Face Encounter During Measurement Period"
  and "First Referral During Measurement Period" is not null

Denominator

"Initial Population"

Denominator Exclusions

None

Numerator

exists "Referring Provider Receives Consultant Report to Close Referral Loop"

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

"Initial Population"

Face to Face Encounter During Measurement Period

(["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Ophthalmological Services"]
  union ["Encounter, Performed": "Preventive Care Services - Established Office Visit, 18 and Up"]
  union ["Encounter, Performed": "Preventive Care Services, Initial Office Visit, 0 to 17"]
  union ["Encounter, Performed": "Preventive Care Services-Initial Office Visit, 18 and Up"]

```
  union ["Encounter, Performed": "Preventive Care, Established Office Visit, 0 to 17"] ) FaceToFaceEncounter
  where FaceToFaceEncounter.relevantPeriod during "Measurement Period"
```

First Referral During Measurement Period

```
First((("Intervention, Performed": "Referral"] ReferralPerformed
      where ReferralPerformed.relevantDatetime during "Measurement Period"
  )
    union(["Intervention, Order": "Referral"] ReferralOrder
       where ReferralOrder.authorDatetime during "Measurement Period"
       return "Intervention, Performed" { id: ReferralOrder.id, relevantDatetime: ReferralOrder.authorDatetime }
    ))ReferralInterventions
    sort by relevantDatetime
)
```

Initial Population

```
exists "Face to Face Encounter During Measurement Period"
  and "First Referral During Measurement Period" is not null
```

Numerator

```
exists "Referring Provider Receives Consultant Report to Close Referral Loop"
```

Referring Provider Receives Consultant Report to Close Referral Loop

```
["Communication, Performed": "Consultant Report"] ConsultantReportCommunicated
  with "First Referral During Measurement Period" FirstReferral
    such that FirstReferral.id in ConsultantReportCommunicated.relatedTo
      and ConsultantReportCommunicated.receivedDatetime after FirstReferral.relevantDatetime
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

None

Terminology

- valueset "Consultant Report" (2.16.840.1.113883.3.464.1003.121.12.1006)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Ophthalmological Services" (2.16.840.1.113883.3.526.3.1285)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services, Initial Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1022)
- valueset "Preventive Care Services-Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Preventive Care, Established Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1024)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Referral" (2.16.840.1.113883.3.464.1003.101.12.1046)

Data Criteria (QDM Data Elements)

- "Communication, Performed: Consultant Report" using "Consultant Report (2.16.840.1.113883.3.464.1003.121.12.1006)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Ophthalmological Services" using "Ophthalmological Services (2.16.840.1.113883.3.526.3.1285)"
- "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" using "Preventive Care Services - Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services, Initial Office Visit, 0 to 17" using "Preventive Care Services, Initial Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1022)"
- "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up" using "Preventive Care Services-Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Preventive Care, Established Office Visit, 0 to 17" using "Preventive Care, Established Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1024)"
- "Intervention, Order: Referral" using "Referral (2.16.840.1.113883.3.464.1003.101.12.1046)"
- "Intervention, Performed: Referral" using "Referral (2.16.840.1.113883.3.464.1003.101.12.1046)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	Not Applicable

*Pharmacotherapy for Opioid Use Disorder (POD)**

***Adapted with permission by NCQA from the "Continuity of Pharmacotherapy for Opioid Use Disorder" measure owned by The RAND Corporation.**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Clarified in step 4 of the event/diagnosis to count overlapping direct transfer days only once and added an example.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of OUD.

Definitions

Intake period
A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

OUD dispensing event
OUD pharmacotherapy identified using pharmacy data (medication lists).

OUD medication administration event
OUD pharmacotherapy identified using medical claims data (value sets).

Treatment period start date
The date of an OUD dispensing event or OUD medication administration event with a negative medication history during the Intake Period.

Negative medication history
To qualify for Negative Medication History, the following criteria must be met:

- A period of 31 days prior to the OUD dispensing event or OUD medication administration event when the member had no OUD dispensing events or OUD medication administration events.
- A period of 31 days prior to the OUD dispensing event or OUD medication administration event when the member was not already receiving OUD pharmacotherapy. For example, if an OUD dispensing event has a date of service of January 1, the 31 days prior includes December 1–31. If the member had received a buprenorphine implant (180 days supply) any time during the 179 days prior to December 1, the member is already receiving OUD pharmacotherapy on December 1 and does not have a negative medication history.

Treatment period
A period of 180 calendar days, beginning on the Treatment Period Start Date through 179 days after the Treatment Period Start Date.

Note: *Members can have multiple Treatment Period Start Dates and Treatment Periods during the measurement year. Treatment Periods can overlap.*

Determining same or different medications	Medication lists and value sets that are in the same row of the Opioid Use Disorder Treatment Medications table are the "same medication." For example, if a member has a dispensing event from the Buprenorphine Oral Medications List and an encounter with a code from the Buprenorphine Oral Value Set, this is considered two dispensing events for the same medication. Medication lists and value sets that are in different rows of the Opioid Use Disorder Treatment Medications table are "different medications." For example, if a member has a dispensing event from the Buprenorphine Oral Medications List and a dispensing event from the Buprenorphine Injection Medications List, this is considered two dispensing events for different medications.
Direct transfer	A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	16 years and older as of December 31 of the measurement year. Report two age stratifications and total rate: • 16–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	31 days prior to the Treatment Period Start Date through 179 days after the Treatment Period Start Date (211 total days).
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.

Event/diagnosis Follow the steps below to identify eligible events.

Step 1 Identify members with any diagnosis of OUD (Opioid Abuse and Dependence Value Set) during the Intake Period.

Step 2 For each member identified in step 1, identify all OUD dispensing events or OUD medication administration events during the Intake Period. Use all medication lists and value sets in the Opioid Use Disorder Treatment Medications table below to identify OUD dispensing events and OUD administration events.

Step 3 Test for Negative Medication History. For each OUD dispensing event or OUD medication administration event in step 2, test for a Negative Medication History. Exclude events that do not have a negative medication history. All remaining events with a negative medication history are considered Treatment Period Start Dates.

Step 4 Exclude any Treatment Period Start Dates where the member had an acute or nonacute inpatient stay of eight or more days during the Treatment Period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.
3. Calculate length of stay (LOS) as the admission date through and including the discharge date. If there are direct transfers between stays, add the LOS from any subsequent direct transfers to the initial LOS to calculate a total LOS. If direct transfer days overlap, count each day only once.

For example:

- Exclude a July 1 Treatment Period Start Date where a member was admitted for an inpatient hospital stay on August 1 and discharged on August 8 (LOS = 8 days).
- Exclude a July 1 Treatment Period Start Date where a member had an acute inpatient stay (admission date August 1; discharge date August 4; LOS = 4 days), followed by a direct transfer to a nonacute inpatient facility (admission date August 5; discharge date August 8; LOS = 4 days). Total LOS = 8 days.
- Do not exclude a July 1 Treatment Period Start Date where a member had an acute inpatient stay (admission date August 1; discharge date August 4; LOS = 4 days), followed by a direct transfer to a nonacute inpatient facility (admission date August 4; discharge date August 7, LOS = 4 days). Total LOS = 7 days (do not double count August 4).

Step 5 Calculate continuous enrollment. Members must be continuously enrolled from 31 days prior to the Treatment Period Start Date through 179 days after the Treatment Period Start Date (211 total days).

Note: *All Treatment Period Start Dates (OUD dispensing events or OUD medication administration events) that were not excluded remain in the denominator. The denominator for this measure is based on events, not members.*

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days. Use the steps below to identify the numerator.

Step 1 Identify the Treatment Period for each Treatment Period Start Date in the denominator. Follow the steps below for each Treatment Period in the denominator.

Step 2 Identify all OUD dispensing events and OUD medication administration events during the Treatment Period. Use all the medication lists and value sets in the Opioid Use Disorder Treatment Medications table to identify OUD dispensing events and OUD medication administration events.

Step 3 Identify start and end dates for OUD dispensing events and OUD medication administration events. The start date is the event date and the end date is the start date plus the days supply minus one.

For OUD dispensing events and OUD medication administration events with overlapping days supply, apply the following rules:

- For multiple OUD dispensing events or OUD medication administration events for different medications on the same or different dates of service with overlapping days supply, calculate the start and end dates for each medication individually. For example, if there is a 7-days supply of Oral Buprenorphine on January 1 and a 31-days supply of Buprenorphine Injection on January 5:
  - The Oral Buprenorphine start date is January 1 and the end date is January 7.
  - The Buprenorphine Injection start date is January 5 and the end date is February 4.
- For multiple OUD dispensing events or OUD medication administration events for the same medication on the same date of service or on different dates of service with overlapping days supply, sum the days supply and then calculate start and end dates. For example:
  - If a 7-days supply and a 14-days supply of buprenorphine are dispensed on January 1, the start date is January 1 and the end date is January 21.
  - If a 7-days supply of buprenorphine is dispensed on January 1 and January 5, the start date is January 1 and the end date is January 14.
  - If a member has three codes (or one code billed as three units) from the Buprenorphine Oral Weekly Value Set on January 1, the start date is January 1 and the end date is January 21.
  - If a member has four codes (or one code billed as four units) from the Methadone Oral Weekly Value Set on January 1, the start date is January 1 and the end date is January 28.

For OUD medication administration events identified using a value set, use the days supply listed in the Opioid Use Disorder Treatment Medications table. For OUD dispensing events identified using a medication list, use days supply in the pharmacy data. If days supply is not available in the pharmacy data then

use the days supply listed for the corresponding value set. If the pharmacy data for a buprenorphine oral medication does not contain days supply, count as a 7-days supply.

Step 4 For each Treatment Period, using the start and end dates identified in step 3, determine calendar days covered by an OUD dispensing event or OUD medication administration event. These covered days are referred to as treatment days.

Step 5 Identify gaps in treatment days of 8 or more consecutive days.

Step 6 Determine numerator compliance.

If the Treatment Period does not contain any gaps in treatment of 8 or more consecutive calendar days, the event is numerator compliant.

If the Treatment Period contains at least one gap in treatment of 8 or more consecutive calendar days, the event is not numerator compliant.

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists	Value Sets and Days Supply
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List	• NA—Codes do not exist
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List	• Naltrexone Injection Value Set (31 days supply)
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List	• Buprenorphine Oral Value Set (1 day supply) • Buprenorphine Oral Weekly Value Set (7 days supply)
Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List	• Buprenorphine Injection Value Set (31 days supply)
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List	• Buprenorphine Implant Value Set (180 days supply)
Partial agonist	• Buprenorphine/ naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List	• Buprenorphine Naloxone Value Set (1 day supply)
Agonist	• Methadone (oral)	• NA (refer to *Note* below)	• Methadone Oral Value Set (1 day supply) • Methadone Oral Weekly Value Set (7 days supply)

Note

- *Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

- *The allowable gaps in the measure numerator of 7 or fewer consecutive days are used to account for weekly billing and other variations in billing practices and do not necessarily indicate that OUD pharmacotherapy ended. For example, members receiving daily methadone treatment over their 180-day Treatment Period meet numerator criteria if their treatment is billed weekly.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table POD-1/2/3: Data Elements for Pharmacotherapy for Opioid Use

Metric	Age	Data Element	Reporting Instructions
PharmacotherapyOpioidUseDisorder	16-64	Benefit	Metadata
	65+	EligiblePopulation	For each Stratification
	Total	ExclusionAdminRequired	For each Stratification
		NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Pharmacotherapy for Opioid Use Disorder

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets and medication lists may be used to identify visits with a diagnosis. Value sets, medication lists and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of pharmacotherapy events with OUD pharmacotherapy for 180 or more days with a diagnosis of OUD).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Pharmacotherapy events	No	Medication lists, value sets and logic may not be changed.

*Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**

***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).**

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the T*echnical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation) The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	1. Commercial 12–17 years. 2. Commercial 18–64 years. 3. Commercial 65 years and older. 4. Medicaid 12–17 years. 5. Medicaid 18–64 years.

<table>
<tr><td></td><td>6. Medicaid 65 years and older.
7. Medicare 18–64 years.
8. Medicare 65 years and older.</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the Participation Period.</td></tr>
<tr><td>Participation Period</td><td>The Measurement Period.</td></tr>
<tr><td>Depression Screening Instrument</td><td>A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adolescents (≤17 years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire Modified for Teens (PHQ- 9M)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></tr>
<tr><td>PROMIS Depression</td><td>Total Score (T Score) ≥60</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Beck Depression Inventory (BDI-II)</td><td>Total Score ≥20</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
</table></td></tr>
</table>

	<table><tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>Total Score ≥30</td></tr><tr><td>Geriatric Depression Scale Short Form (GDS)[1]</td><td>Total Score ≥5</td></tr><tr><td>Geriatric Depression Scale Long Form (GDS)</td><td>Total Score ≥10</td></tr><tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></tr><tr><td>My Mood Monitor (M-3)®</td><td>Total Score ≥5</td></tr><tr><td>PROMIS Depression</td><td>Total Score (T Score) ≥60</td></tr><tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>Total Score ≥31</td></tr></table> [1]Brief screening instrument. All other instruments are full-length. [2]Proprietary; may be cost or licensing requirement associated with use.
Initial Population	Members 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.
Exclusions	• Members with bipolar disorder in the year prior to the Measurement Period. • Members with depression that starts during the year prior to the Measurement Period. • Members in hospice or using hospice services any time during the Measurement Period.
Denominator	**Denominator 1** The Initial Population, minus Exclusions. **Denominator 2** All members from Numerator 1 with a positive depression screen finding between January 1 and December 1 of the Measurement Period.
Numerator	**Numerator 1—Depression Screening** Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the Measurement Period. **Numerator 2—Follow-Up on Positive Screen** Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.

	• A behavioral health encounter, including assessment, therapy, collaborative care or medication management. • A dispensed antidepressant medication. **OR** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*
Data criteria (element level)	

Value Sets:

- **DSFE_HEDIS_MY2022-1.0.0**
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044)
  - Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1390)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
- **NCQA_Hospice-1.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

Direct Reference Codes and Codesystems:

- **DSFE_HEDIS_MY2022-1.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - codesystem "SNOMEDCT": 'http://snomed.info/sct'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205- 9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'

- code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
- code "Exercise counseling": 'Z71.82' from "ICD-10" display 'Exercise counseling'
- code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
- code "Geriatric depression scale (GDS) short version total": '48545-8' from "LOINC" display 'Geriatric depression scale (GDS) short version total'
- code "Geriatric depression scale (GDS) total": '48544-1' from "LOINC" display 'Geriatric depression scale (GDS) total'
- code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
- code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
- code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
- code "Symptoms of depression (finding)": '394924000' from "SNOMEDCT" display 'Symptoms of depression (finding)'
- code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
- code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode’
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table DSF-E-1/2: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
Screening	12-17	InitialPopulation	For each Metric and Stratification
FollowUp	18-64	ExclusionsByEHR	For each Metric and Stratification
	65+	ExclusionsByCaseManagement	For each Metric and Stratification
	Total	ExclusionsByHIERegistry	For each Metric and Stratification
		ExclusionsByAdmin	For each Metric and Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table DSF-E-3: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
Screening	18-64	InitialPopulation	For each Metric and Stratification
FollowUp	65+	ExclusionsByEHR	For each Metric and Stratification
	Total	ExclusionsByCaseManagement	For each Metric and Stratification
		ExclusionsByHIERegistry	For each Metric and Stratification
		ExclusionsByAdmin	For each Metric and Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments for Depression Screening and Follow-Up for Adolescents and Adults

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age 12 during the measurement year). The denominator age may be changed if the range is within the specified age range (12 years and older). The denominator age may not be expanded.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Value sets and logic may not be changed for Denominator 2.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified value sets.
Exclusion: Hospice	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Depression Screening • Follow-Up on Positive Screen	No	Value sets, Direct Reference Codes and logic may not be changed.

Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to 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 eligible encounter

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent screening submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians 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".

NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Definition:
Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –

- Patients who have been diagnosed with depression- F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
- Patients who have been diagnosed with bipolar disorder- F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

DENOMINATOR NOTE: The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from

the measure.

**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401*, 99402*, 99403*, 99483, 99484, 99492, 99493, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444
AND NOT
DENOMINATOR EXCLUSION:
Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717

NUMERATOR:
Patients screened for depression on the date of the encounter or up to 14 days prior to 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 eligible 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..

Examples of standardized 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), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2
- **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 for Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
- **Perinatal Screening Tools**
  Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

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

- 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

Examples of a follow-up plan include but are not limited to:

- Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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 Instructions:

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan must be documented on the date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions or other interventions for the treatment of depression.

Depression screening is required once per measurement period, not at all encounters. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. 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 on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualifying encounter or up to 14 days prior to the date of the qualifying encounter.

The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool.

Should a patient screen positive for depression, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool, will not qualify as a follow-up plan.

Numerator Options:

Performance Met: Screening for depression is documented as being positive AND a follow-up plan is documented **(G8431)**

OR

Performance Met: Screening for depression is documented as negative, a follow-up plan is not required **(G8510)**

OR

Denominator Exception: Screening for depression not completed, documented reason **(G8433)**

OR

Performance Not Met: Depression screening not documented, reason not given **(G8432)**

OR

Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given **(G8511)**

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning (Katon, 2003; Wells et al., 1989). 2016 U.S. survey data indicate that 12.8 percent of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment. The same data indicate that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and also are at an increased risk of suicide (Siu on behalf of the U.S. Preventive Services Task Force [USPSTF], 2016). Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 12% of women (Woody, Ferrari, Siskind, Whiteford, & Harris, 2017). Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (American College of Obstetricians and Gynecologists, 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (Palladino, Singh, Campbell, Flynn, & Gold, 2011).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, Braunstein, St. Victor, & Pollack, 2010). "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Siu on behalf of USPSTF, 2016, p. 360 & p. 364). Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs: "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" (Siu & USPSTF, 2016, p. 383-384).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for 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, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be

implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Siu on behalf of USPSTF, 2016, p. 360).

Adult Recommendation (18 years and older)

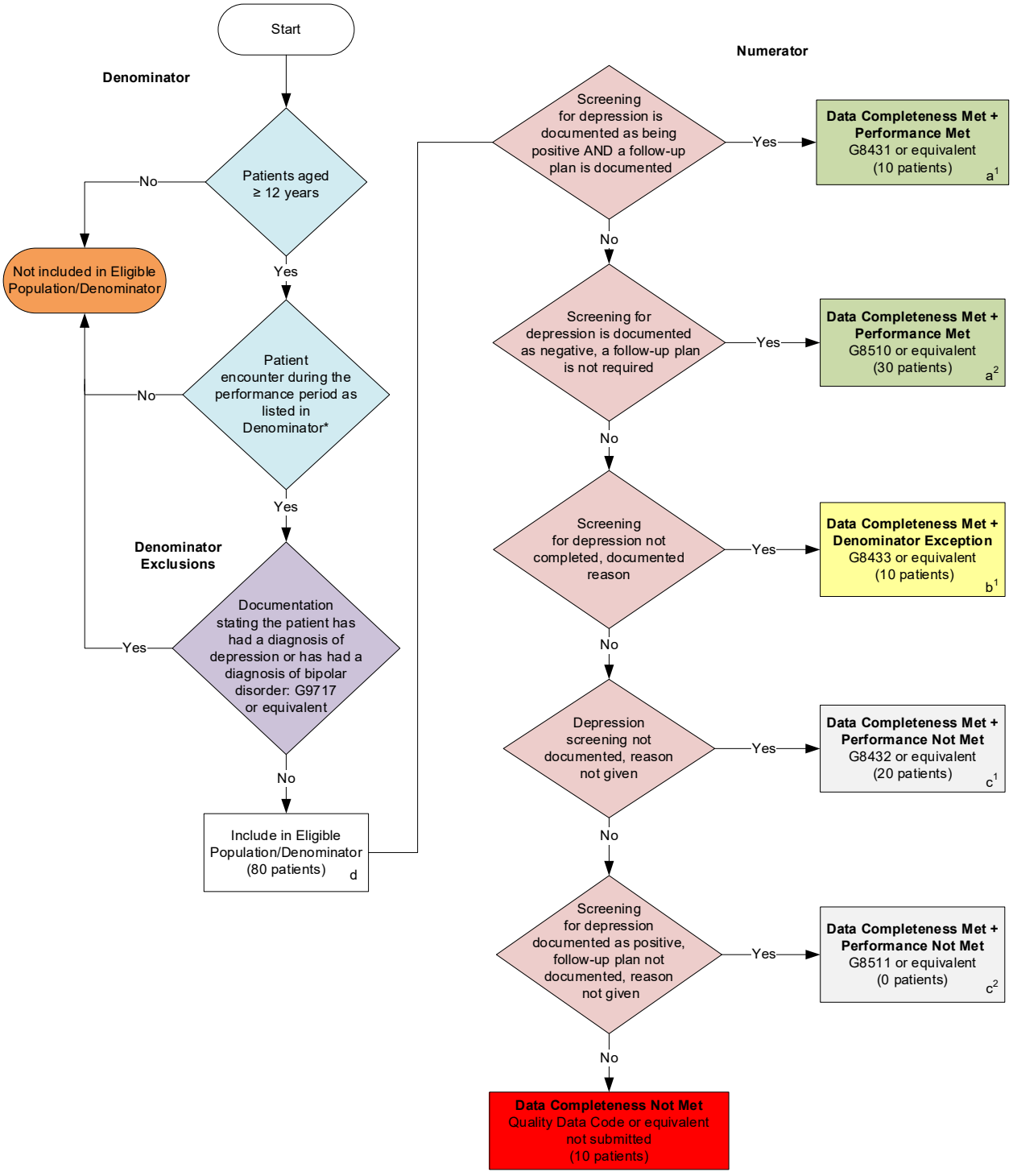
"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Siu & USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."
2. "Clinicians should establish and maintain follow-up with patients."
3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle et al., 2016 p.. 8 – 10).

2021 Clinical Quality Measure Flow for Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness Rate=

Performance Met (a^1+a^2=40 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1+c^2=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a^1+a^2=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) - Denominator Exception (b^1=10 patients) = 60 patients

*See the posted measure specification for specific coding and instruction to submit this measure.

NOTE: Submission Frequency: Patient-Intermediate

2021 Clinical Quality Measure Flow Narrative for Quality ID #134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator

2. Check *Patients aged greater than or equal to 12 years*:

    a. If *Patients aged greater than or equal to 12 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 12 years* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.

3. Check *Patient encounter during the performance period as listed in Denominator**:

    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder*.

4. Check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder:*

    a. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals No, include in *Eligible Population/Denominator*.

5. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.

6. Start Numerator

7. Check *Screening for depression is documented as being positive AND a follow-up plan is documented*:

    a. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 10 patients in the Sample Calculation.

    b. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals No, proceed to check *Screening for depression is documented as negative, a follow-up plan is not*

required.

8. Check *Screening for depression is documented as negative, a follow-up plan is not required*:

    a. If *Screening for depression is documented as negative, a follow-up plan is not required* equals Yes, include *in Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 30 patients in the Sample Calculation.

    b. If *Screening for depression is documented as negative, a follow-up plan is not required* equals No, proceed to check *Screening for depression not completed, documented reason*.

9. Check *Screening for depression not completed, documented reason* :

    a. If *Screening for depression not completed, documented reason* equals Yes, include in the *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.*

    b. If *Screening for depression not completed, documented reason* equals No, proceed to check *Depression screening not documented, reason not given*.

10. Check *Depression screening not documented, reason not given*:

    a. If *Depression screening not documented, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met.*

        - *Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 patients in the Sample Calculation.*

    b. If *Depression screening not documented, reason not given* equals No, proceed to check *Screening for depression documented as positive, follow-up plan not documented, reason not given.*

11. Check *Screening for depression documented as positive, follow-up plan not documented, reason not given*:

    a. If *Screening for depression documented as positive, follow-up plan not documented, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 0 patients in the Sample Calculation.*

    b. If *Screening for depression documented as positive, follow-up plan not documented, reason not given* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness Rate equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Not Met (c^1 plus c^2 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.5 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instruction to submit this measure.

NOTE: Submission Frequency: Patient-Intermediate

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention and Treatment of Opioid and Substance Use Disorders

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months **AND** who received tobacco cessation intervention if identified as a tobacco user

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who provided the measure-specific denominator coding. For this implementation of the measure, the 12 month look back period includes the program year and the year prior. For Quality Payment Program (QPP) 2021, the 12 month period would be from 1/1/2021-12/31/2021.

This measure will be calculated with 3 performance rates:

1) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months
2) Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention
3) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as tobacco users.

NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1) All patients who were screened for tobacco use

AND

2) All patients who were identified as a tobacco user and who received tobacco cessation intervention

AND

3) All patients who were screened for tobacco use and, if identified as a tobacco user received tobacco cessation intervention, or identified as a tobacco non-user

This measure contains three submission criteria which aim to identify patients who were screened for tobacco use (submission criteria 1), patients who were identified as tobacco users and who received tobacco cessation intervention (submission criteria 2), and a comprehensive look at the overall performance on tobacco screening and cessation intervention (submission criteria 3). By separating this measure into various submission criteria, the MIPS eligible professional or MIPS eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (submission criteria 3) can be utilized to compare performance to published versions of this measure prior to the 2018 performance year, when the measure had a single performance rate. For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE

DENOMINATOR (SUBMISSION CRITERIA 1):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

> ***DENOMINATOR NOTE:*** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years
> **AND**
> **At least two patient encounters during the performance period (CPT):** 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
> **OR**
> **At least one preventive encounter during the performance period (CPT or HCPCS):** 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 1):
Patients who were screened for tobacco use at least once within 12 months

> **Definitions:**
> **Tobacco Use** – Includes any type of tobacco.
>
> ***NUMERATOR NOTE:*** *To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 12-month period. If a patient has multiple tobacco use screenings during the 12-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for tobacco use and tobacco status is unknown, submit G9905. Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met: Patient screened for tobacco use AND identified as a tobacco user **(G9902)**

OR

Performance Met: Patient screened for tobacco use AND identified as a tobacco non-user **(G9903)**

OR

Denominator Exception: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) **(G9904)**

OR

Performance Not Met: Patient not screened for tobacco use, reason not given **(G9905)**

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

DENOMINATOR (SUBMISSION CRITERIA 2):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B PFS. These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years
AND
All eligible instances when **G9902** is submitted for Performance Met (patient screened for tobacco use and identified as a tobacco user) in the numerator of Submission Criteria 1
AND
At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
OR
At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 2):
Patients who received tobacco cessation intervention

Definitions:

Tobacco Cessation Intervention Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

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

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met:	Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy) **(G9906)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason) **(G9907)**
OR	
Performance Not Met:	Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given (**G9908)**

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE AND, IF IDENTIFIED AS A TOBACCO USER RECEIVED TOBACCO CESSATION INTERVENTION, OR IDENTIFIED AS A TOBACCO NON-USER

DENOMINATOR (SUBMISSION CRITERIA 3):

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B PFS. These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 3):

Patients who were screened for tobacco use at least once within 12 months **AND** who received tobacco cessation intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco.

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 12-month period. If a patient has multiple tobacco use screenings during the 12-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention or if tobacco status is unknown, submit 4004F with 8P.

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

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit CPT II 4004F.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met:	Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user **(4004F)**
OR	
Performance Met:	Current tobacco non-user **(1036F)**

OR

Denominator Exception:	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) **(4004F *with* 1P)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other

	medical reason) **(G9909)**
OR	
Performance Not Met:	Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified **(4004F *with* 8P)**

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 using tobacco lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

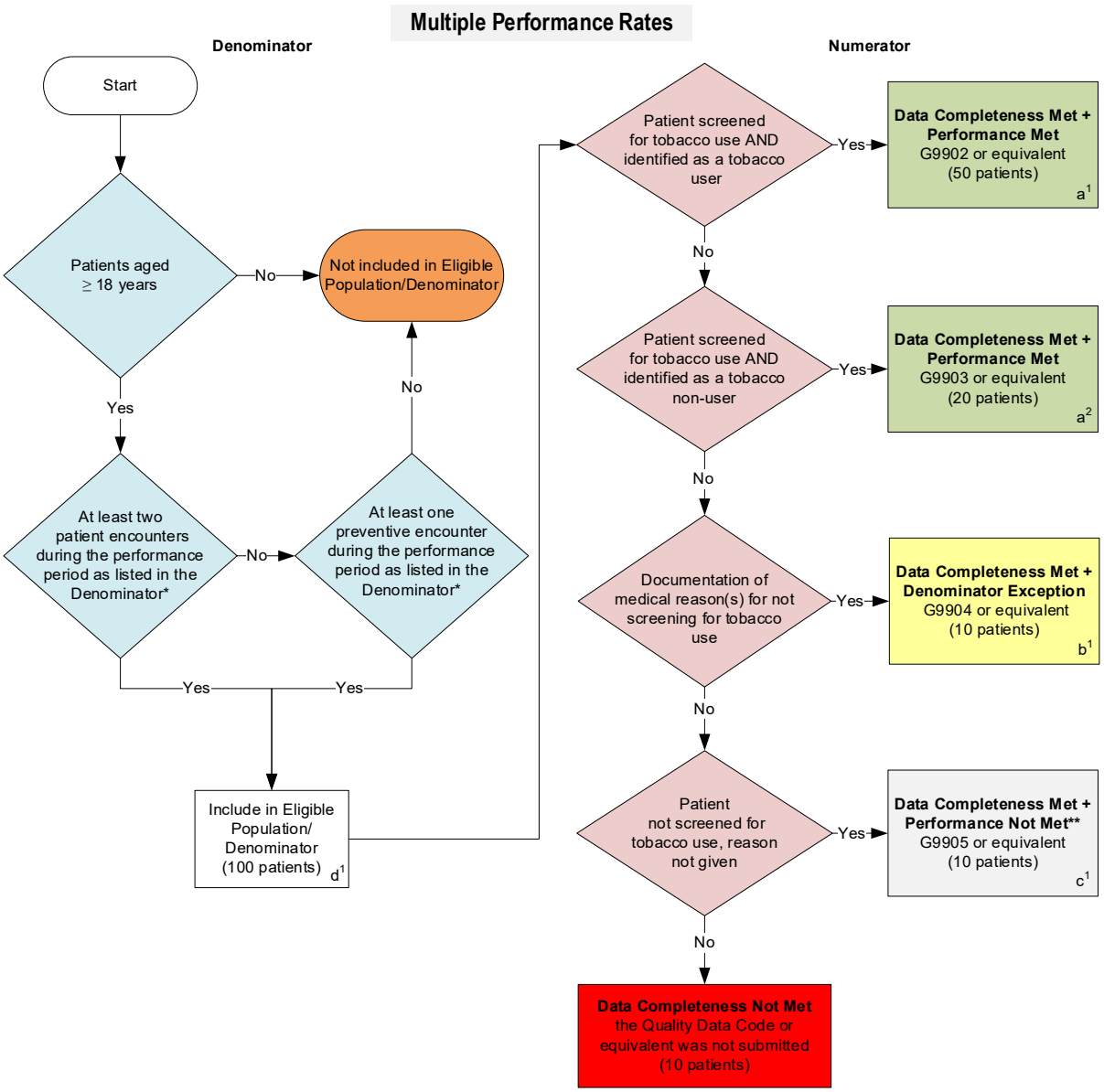
The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety (previously stated) (Grade I Statement) (U.S. Preventive Services Task Force, 2015).

COPYRIGHT:

2021 Clinical Quality Measure for Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Submission Criteria One

Disclaimer: *Refer to the measure specification for the specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

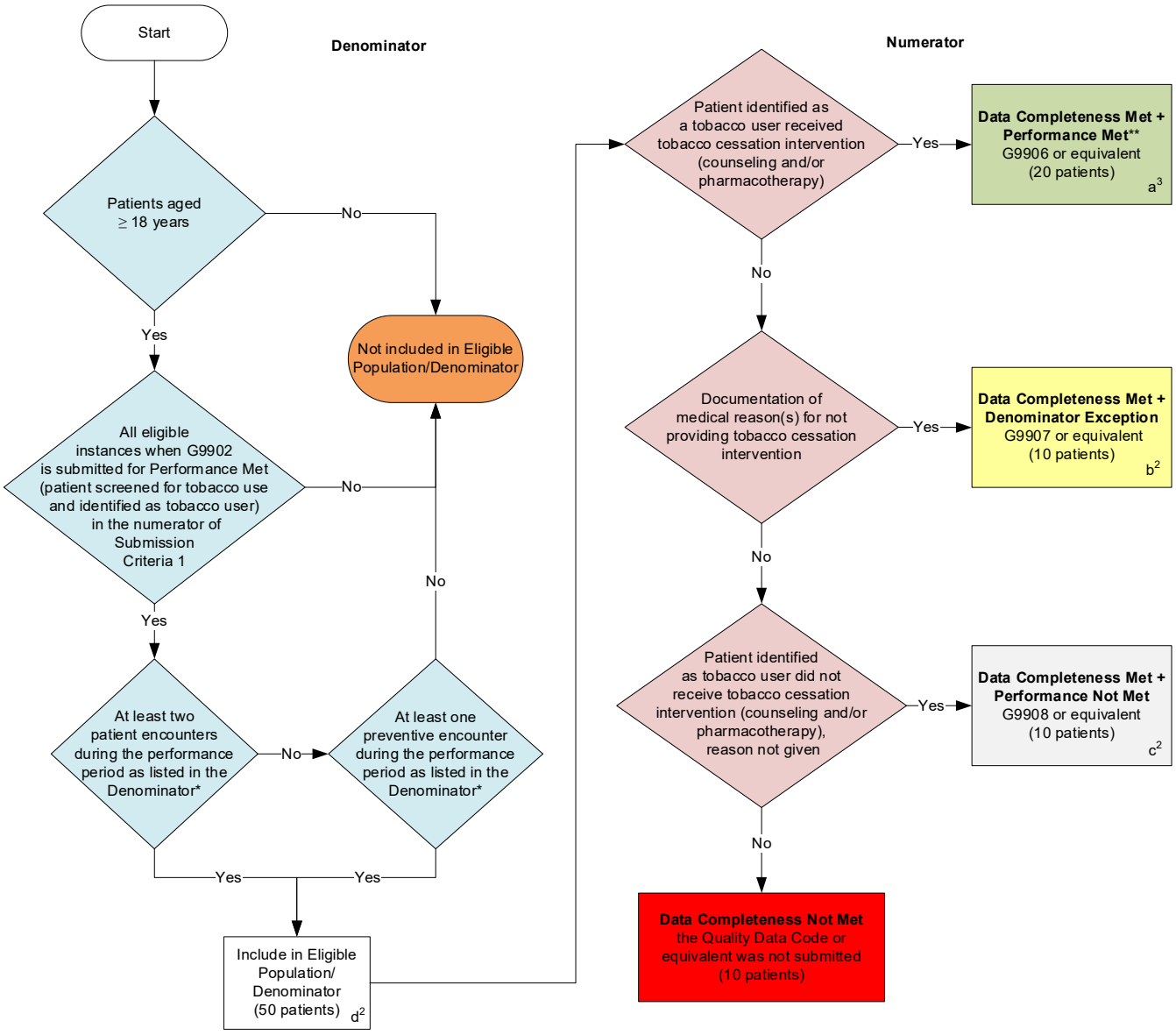
Performance Met (a^1+a^2=70 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=10 patients) / Eligible Population / Denominator (d^1=100 patients) = 90 patients / 100 patients = **90.00%**

Performance Rate=

Performance Met (a^1+a^2=70 patients) / Data Completeness Numerator (90 patients) – Denominator Exception (b^1=10 patients) = 70 patients / 80 patients = **87.50%**

*See the posted measure specification for specific coding and instructions to submit this measure.
**In the event that the tobacco status is unknown submit G9905.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients}) + \text{Denominator Exception } (b^2=10 \text{ patients}) + \text{Performance Not Met } (c^2=10 \text{ patients})}{\text{Eligible Population / Denominator } (d^2=50 \text{ patients})} = \frac{40 \text{ patients}}{50 \text{ patients}} = \mathbf{80.00\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients})}{\text{Data Completeness Numerator (40 patients)} - \text{Denominator Exception } (b^2=10 \text{ patients})} = \frac{20 \text{ patients}}{30 \text{ patients}} = \mathbf{66.67\%}$$

*See the posted measure specification for specific coding and instructions to submit this measure.
**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Three

SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

Performance Met (a^4+a^5=40 patients) + Denominator Exception (b^3+b^4=20 patients) + Performance Not Met (c^3=20 patients) = 80 patients = **80.00%**

Eligible Population / Denominator (d^3=100 patients) = 100 patients

Performance Rate=

Performance Met (a^4+a^5=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (80 patients) – Denominator Exception (b^3+b^4=20 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit 4004F.
***In the event that a patient is identified as a user but did not receive tobacco cessation intervention submit 4004F *with* 8P.
NOTE: Submission Frequency: Patient-Process

2021 Clinical Quality Measure Flow Narrative for Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

Multiple Performance Rates

Submission Criteria One:

1. Start with Denominator
2. Check *Patient aged greater than or equal to 18 years*:
    a. If *Patient aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient aged greater than or equal to 18 years* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in the Denominator**.
3. Check *At least two patient encounters during the performance period as listed in the Denominator**:
    a. If *At least two patient encounters during the performance period as listed in the Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in the Denominator**.
    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in the Denominator**:
    a. If At least one preventive encounter during the performance period as listed in the Denominator* equals No, do not include in Eligible Population/Denominator. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in the Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 100 patients in the Sample Calculation.
6. Start Numerator
7. Check *Patient screened for tobacco use AND identified as a tobacco user*:
    a. If Patient screened for tobacco use AND identified as a tobacco user equals Yes, include in Data Completeness Met and Performance Met.
        - *Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 50 patients in the Sample Calculation.*
    b. If *Patient screened for tobacco use AND identified as a tobacco user* equals No, proceed to check *Patient screened for tobacco use AND identified as a tobacco non-user*.

8. Check *Patient screened for tobacco use AND identified as a tobacco non-user*:

    a. If *Patient screened for tobacco use AND identified as a tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.*

    b. If *Patient screened for tobacco use AND identified as a tobacco non-user* equals No, proceed to check *Documentation of medical reason(s) for not screening for tobacco use*.

9. Check *Documentation of medical reason(s) for not screening for tobacco use*:

    a. If *Documentation of medical reason(s) for not screening for tobacco use* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.*

    b. If *Documentation of medical reason(s) for not screening for tobacco use* equals No, proceed to check *Patient not screened for tobacco use, reason not given*.

10. Check *Patient not screened for tobacco use, reason not given*:

    a. If *Patient not screened for tobacco use, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.*

    b. If *Patient not screened for tobacco use, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 plus a^2 equals 70 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Not Met (c^1 equals 10 patients) divided by Eligible Population/Denominator (d^1 equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 70 patients) divided by Data Completeness Numerator (90 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**In the event that the tobacco status is unknown submit G9905.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Two:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1*.
3. Check *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1*:
    a. If *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
4. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
6. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 50 patients in the Sample Calculation.

7. Start Numerator

8. Check *Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)*:

    a. If *Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 20 patients in the Sample Calculation.

    b. If *Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)* equals No, proceed to check *Documentation of medical reason(s) for not providing tobacco cessation intervention*.

9. Check *Documentation of medical reason(s) for not providing tobacco cessation intervention*:

    a. If *Documentation of medical reason(s) for not providing tobacco cessation intervention* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not providing tobacco cessation intervention* equals No, proceed to check *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given*.

10. Check *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given*:

    a. If *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Met (a^3 equals 20 patients) plus Denominator Exception (b^2 equals 10 patients) plus Performance Not Met (c^2 equals 10 patients) divided by Eligible Population/Denominator (d^2 equals 50 patients). All equals 40 patients divided by 50 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^3 equals 20 patients) divided by Data Completeness Numerator (40 patients) minus Denominator Exception (b^2 equals 10 patients). All equals 20 patients divided by 30 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Submission Criteria Three:

1. Start with Denominator
2. Check *Patient aged greater than or equal to 18 years*:
    a. If *Patient aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient aged greater than or equal to 18 years* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
3. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^3 equals 100 patients in the Sample Calculation.
6. Start Numerator
7. Check *Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user*:

a. If *Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user* equals Yes, include in *Data Completeness Met and Performance Met***.

    - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 20 patients in the Sample Calculation.

b. If *Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user* equals No, proceed to check *Current tobacco non-user*.

8. Check *Current tobacco non-user*:

    a. If *Current tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^5 equals 20 patients in the Sample Calculation.

    b. If *Current tobacco non-user* equals No, proceed to check *Documentation of medical reason(s) for not screening for tobacco use*.

9. Check *Documentation of medical reason(s) for not screening for tobacco use*:

    a. If *Documentation of medical reason(s) for not screening for tobacco use* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not screening for tobacco use* equals No, proceed to check *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user*.

10. Check *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user*:

    a. If *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^4 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user* equals No, proceed to check *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified*.

11. Check *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified*:

    a. If *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise*

specified equals Yes, include in the *Data Completeness Met and Performance Not Met****.

- *Data Completeness Met and Performance Not Met**** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 20 patients in the Sample Calculation.

b. If *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified* No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Met (a^4 plus a^5 equals 40 patients) plus Denominator Exception (b^3 plus b^4 equals 20 patients) plus Performance Not Met (c^3 equals 20 patients) divided by Eligible Population/Denominator (d^3 equals 100 patients). All equals 80 patients divided by 100 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^4 plus a^5 equals 40 patients) divided by Data Completeness Numerator (80 patients) minus Denominator Exception (b^3 plus b^4 equals 20 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit 4004F.

***In the event that a patient is identified as a user but did not receive tobacco cessation intervention submit 4004F *with* 8P.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO HEDIS MY 2022

- No changes to this measure.

Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit	A rolling average[5] represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
Discussing Cessation Medications	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
Discussing Cessation Strategies	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year. *Medicaid:* The last 6 months of the measurement year. *Medicare:* Six months prior to the CMS administration of the survey.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

[5] Refer to the *Calculations* section in the MSC measure specifications for additional details about Medicare reporting/ scoring.

Protocol and Survey Instrument

Commercial, Medicaid

Collected annually as part of the CAHPS Health Plan Survey 5.1H, Adult Version using rolling average methodology.

Refer to *HEDIS Volume 3: Specifications for Survey Measures* for the CAHPS questionnaires and data collection protocols.

Medicare

Collected by CMS using the Medicare CAHPS Survey. Only the Advising Smokers and Tobacco Users to Quit rate is collected for the Medicare product line (no rolling average methodology is used).

To learn more about the MA and PDP CAHPS surveys, including background information, policy updates, survey administration protocols and procedures, training opportunities and participating in the survey, visit the MA and PDP CAHPS website at www.MA-PDPCAHPS.org.

Questions Included in the Measure

Table MSC-1: Medical Assistance With Smoking and Tobacco Use Cessation—Commercial Product Line

	Question	Response Choices
Q35	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 39 Don't know ➔If Don't know, Go to Question 39
Q36	In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q37	In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q38	In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Table MSC-2: Medical Assistance With Smoking and Tobacco Use Cessation—Medicaid Product Line

	Question	Response Choices
Q32	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 36 Don't know ➔If Don't know, Go to Question 36
Q33	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q34	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q35	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Table MSC-3: Medical Assistance With Smoking and Tobacco Use Cessation—Medicare Product Line

	Question	Response Choices
Q54	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 56 Don't know ➔If Don't know, Go to Question 56
Q55	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?	Never Sometimes Usually Always I had no visits in the last 6 months

Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

For the commercial and Medicaid product lines, rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

- If the denominator is less than 100, NCQA assigns a measure result of *NA.*
- If the denominator is 100 or more, NCQA calculates a rate.

If the health plan did not report results for the current year (Year 2) NCQA assigns a measure result of *NR*. If the health plan did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, NCQA calculates a rate; if the denominator is less than 100, NCQA assigns a measure result of *NA*.

Changes in submission entity	If a health plan, for example, reports HMO and POS products separately in the prior year and reports HMO/POS combined in the current year, Year 1 numerators and denominators are created by combining data from the separate HMO and POS results using the methodology described below. The combined Year 1 numerators and denominators and Year 2 numerators and denominators are used for rolling average calculations. Alternatively, if the health plan, for example, reports HMO/POS combined in the prior year and reports HMO and POS separately in the current year, the reporting entity is considered changed and prior year data are not used for rolling average calculations.

Calculating Combined Year 1 Numerators and Denominators for Rolling Average Calculations

Rotate Submission ID1:	The submission ID of the HMO survey sample in Year 1.
Rotate Submission ID2:	The submission ID of the POS survey sample in Year 1.
Yr1_Num1:	Year 1 Numerator for Rotate Submission ID1.
Yr1_Num2:	Year 1 Numerator for Rotate Submission ID2.
Yr1_Denom1:	Year 1 Denominator for Rotate Submission ID1.
Yr1_Denom2:	Year 1 Denominator for Rotate Submission ID2.
SampleFrame1Yr1:	The sample frame size in year 1 of Rotate Submission ID1.
SampleFrame2Yr1:	The sample frame size in year 1 of Rotate Submission ID2.
Yr1_Num =	[Yr1_Num1 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))] + [Yr1_Num2 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))]
Yr1_Denom =	[Yr1_Denom1 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))] + [Yr1_Denom2 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))]

Question numbers reference the adult survey for the commercial product line. The rate for the Medicaid product line is calculated by substituting the corresponding questions and response options.

Advising Smokers and Tobacco Users to Quit—Commercial and Medicaid Product Lines

Denominator	The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator: *Q35* = “Every day” or “Some days.” *Q36* = “Never” or “Sometimes” or “Usually” or “Always.”
Numerator	The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to Q36.

Advising Smokers and Tobacco Users to Quit—Medicare Product Line

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q54 = "Every day" or "Some days."

Q55 = "Never" or "Sometimes" or "Usually" or "Always."

Note: *Medicare results for the Advising Smokers and Tobacco Users to Quit rate requires a minimum denominator of at least 30 responses.*

Numerator The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to Q55.

Discussing Cessation Medications—Commercial and Medicaid Product Lines

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q35 = "Every day" or "Some days."

Q37 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering "Sometimes" or "Usually" or "Always" to Q37.

Discussing Cessation Strategies—Commercial and Medicaid Product Lines

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q35 = "Every day" or "Some days."

Q38 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering "Sometimes" or "Usually" or "Always" to Q38.

Percentage of Current Smokers and Tobacco Users—Supplemental Calculation

This calculation is provided to support analysis of Medical Assistance With Smoking and Tobacco Use Cessation rates and provides additional context for NA results. A health plan with a small number of smokers or tobacco users may not be able to obtain a large enough denominator to achieve reportable rates (and may receive *NA* results).

The percentage of current smokers and tobacco users is calculated using data collected during the current reporting year only (not calculated as a rolling average).

Denominator	The number of members who responded “Every day,” “Some days,” “Not at all” or “Don’t know” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”
Numerator	The number of members in the denominator who responded “Every day” or “Some days” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”