

## PQRI Measures for Psychiatry

The following measures are the most pertinent to psychiatry, but others may apply to individual practices. The complete list of PQRI measures is available at <http://www.primarydatacorp.com/whitepapers.htm>.

A physician is required to report on at least 3 of the 119 measures to be eligible for the full bonus. There are 3 measures specifically targeting Major Depressive Disorder (MDD):

PQRI Measure	Quality Measure
9	Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression
106	Patients who have Major Depressive Disorder (MDD) who meet DSM-IV™ Criteria
107	Patients who have Major Depressive Disorder (MDD) who are Assessed for Suicide Risks

There are other measures that are pertinent to psychiatrists who are using Electronic Health Records or electronic prescribing:

PQRI Measure	Quality Measure
124	HIT - Adoption/Use of Health Information Technology (Electronic Health Records)
125	HIT - Adoption/Use of e-Prescribing

General measures may also apply for psychiatrists who routinely use certain general medical CPT evaluation and management codes (e.g. 99201):

PQRI Measure	Quality Measure	Description
46	Medication Reconciliation.	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.
47	Advance Care Plan.	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan in the medical record.
114	Inquiry Regarding Tobacco Use.	Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months.
115	Advising Smokers to Quit.	Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking.

For more information on these codes, review [http://www.primarydatacorp.com/documents/PQRI\\_Simplified.pdf](http://www.primarydatacorp.com/documents/PQRI_Simplified.pdf).

## **PQRI Measurement #9**

### **Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression**

*This measure is to be reported for each occurrence of MDD during the reporting period for all patients aged 18 years and older.*

#### **Measure description**

Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (MDD) and documented as treated with antidepressant medication during the entire 84-day (12 week) acute treatment phase.

#### **What will you need to report for each occurrence of MDD for this measure?**

If you select this measure for reporting, you will need to determine:

- Whether or not the patient is being seen for a new episode<sup>1</sup> of MDD.

If the patient is being seen for a new episode of MDD, you will then need to report:

- Whether or not you prescribed (or the patient completed) an 84-day (12-week) acute treatment of antidepressant medication.

#### **What if this process or outcome of care is not appropriate for your patient?**

There may be times when it is not appropriate to complete an 84-day (12-week) acute treatment of antidepressant medication, due to:

- Documented reasons (eg, patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment).

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

<sup>1</sup>A “new episode” is defined as a patient with major depression who has not been seen or treated for major depression by any practitioner in the prior 4 months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression.

#### **Coding Specifications**

Codes required to document patient has major depressive disorder and a visit occurred:

An ICD-9 diagnosis code for major depressive disorder and a CPT E/M service code are required to identify patients to be included in this measure.

#### **Major depressive disorder ICD-9 diagnosis codes**

- 296.20, 296.21, 296.22, 296.23, 296.24 (major depressive disorder, single episode),
- 296.30, 296.31, 296.32, 296.33, 296.34 (major depressive disorder, recurrent episode)

- 298.0 (other nonorganic psychoses),
- 300.4 (dysthymic disorder),
- 309.1 (prolonged depressive reaction),
- 311 (major depression)

#### **CPT E/M service codes**

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 90862 (pharmacologic management),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home visit)

#### **Quality codes for this measure (one of the following for every eligible patient):**

##### **G-Code descriptors**

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **G8126:** Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase.  
A "new episode" is defined as a patient with major depression who has not been seen or treated for major depression by any practitioner in the prior 4 months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression.
- **G8128:** Clinician documented that patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment or patient did not have a new episode of MDD
- **G8127:** Patient with new episode of MDD not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

#### **Rationale**

The consequences of untreated, or inadequately treated, depression are significant; therefore, adherence to antidepressant medication is very important. Clinical guidelines for depression stress the importance of effective clinical management in increasing patients' medication compliance, monitoring treatment effectiveness, and identifying and managing side effects. If pharmacological treatment is initiated, appropriate dosing and continuation of therapy through the acute and continuation phases decreases recurrence of depression. Thus, evaluation of length of treatment serves as an important indicator of success in promoting patient compliance with the establishment and maintenance of an effective medication regimen.

## PQRI Measurement #106

### Patients who have Major Depressive Disorder (MDD) who meet DSM-IV™ Criteria

*This measure is to be reported **once** for an occurrence<sup>1</sup> of major depressive disorder during the reporting period for all patients aged 18 years and older.*

### Measure description

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who met the DSM-IV™ criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period.

### What will you need to report for each occurrence of MDD for this measure?

If you select this measure for reporting, **once per patient**, you will report:

- Whether or not the patient is undergoing active treatment for a new diagnosis or recurrent episode of major depressive disorder; OR
- Whether or not the patient is in remission (ie, not undergoing active treatment for MDD).

If patient is undergoing active treatment for a new diagnosis or recurrent episode of major depressive disorder, you will then need to report:

- Whether or not you documented DSM-IV™ criteria<sup>2</sup> for major depressive disorder, at the initial visit in which the new diagnosis or recurrent episode was identified.

### What if this process or outcome of care is not appropriate for your patient?

Some measures provide an opportunity for the physician or non-physician provider to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

<sup>1</sup> An occurrence of MDD is either: 1) A new diagnosis of MDD; OR 2) A new episode of MDD for a patient with a history of MDD. This includes patients whose occurrences of MDD began prior to the reporting period and are still receiving treatment for an occurrence of MDD.

<sup>2</sup> DSM-IV™ criteria includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation.

### Coding Specifications

Codes required to document patient has major depressive disorder and a visit occurred:

An ICD-9 diagnosis code for major depressive disorder and a CPT E/M service code are required to identify patients to be included in this measure.

#### Major depressive disorder ICD-9 diagnosis codes

- 296.20, 296.21, 296.22, 296.23, 296.24 (major depressive disorder, single episode),

- 296.30, 296.31, 296.32, 296.33, 296.34 (major depressive disorder, recurrent episode).

#### **CPT E/M service codes**

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815 (individual psychotherapy),
- 90845 (psychoanalysis),
- 90862 (pharmacologic management [with no more than minimal psychotherapy])
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult).

#### **Quality codes for this measure (at least one of the following for every eligible patient):**

##### **G-Code and CPT II Code descriptors**

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **G8467:** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder,
- **G8466:** Report if patient is not eligible for this measure because their MDD is in remission,
- **CPT II 1040F:** DSM-IVTM criteria for major depressive disorder documented at the initial evaluation,
- **CPT II 1040F-8P:** DSM-IVTM criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified.

#### **Rationale**

Thorough assessment of depressive symptoms sets the basis for accurate diagnosis and treatment of major depressive disorder.

## **PQRI Measurement #107**

### **Patients who have Major Depressive Disorder (MDD) who are Assessed for Suicide Risks**

*This measure is to be reported at **each visit** during an episode of major depressive disorder during the reporting period for all patients aged 18 years and older.*

### **Measure description**

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit during the measurement period.

### **What will you need to report for each visit for patients with major depressive disorder for this measure?**

If you select this measure for reporting, at each visit, you will report:

- Whether or not the patient is undergoing active treatment for a new diagnosis or recurrent episode of major depressive disorder; OR
- Whether or not the patient is in remission (ie, not undergoing active treatment for MDD).

If patient is undergoing active treatment for an episode of Major Depressive Disorder, you will then need to report:

- Whether or not you assessed for suicide risk at each visit.

### **What if this process or outcome of care is not appropriate for your patient?**

Some measures provide an opportunity for the physician or non-physician provider to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

### **Coding Specifications**

Codes required to document patient has major depressive disorder and a visit occurred:

An ICD-9 diagnosis code for major depressive disorder and a CPT E/M service code are required to identify patients to be included in this measure.

#### **Major depressive disorder ICD-9 diagnosis codes**

- 296.20, 296.21, 296.22, 296.23, 296.24 (major depressive disorder, single episode),
- 296.30, 296.31, 296.32, 296.33, 296.34 (major depressive disorder, recurrent episode).

#### **CPT E/M service codes**

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815 (individual psychotherapy),
- 90845 (psychoanalysis),
- 90862 (pharmacologic management [with no more than minimal psychotherapy]),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),

- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult).

**Quality codes for this measure (at least one of the following for every eligible patient):**

#### **CPT II Code descriptors**

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **CPT II 3093F:** Documentation of new diagnosis of initial or recurrent episode of major depressive disorder,
- **CPT II 3092F:** Major depressive disorder, in remission,
- **CPT II 3085F:** Suicide risk assessed,
- **CPT II 3085F–8P:** Suicide risk not assessed, reason not otherwise specified.

#### **Rationale**

Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment an important aspect of care that should be assessed at each visit.

## **PQRI Measurement #124**

### **HIT - Adoption/Use of Health Information Technology (Electronic Health Records)**

*Note:* This measure applies only to physicians who have already adopted an Electronic Health Record.

#### **Measure description**

Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following:

- Generating a medication list,
- Generating a problem list,
- Entering laboratory tests as discrete searchable data elements.

#### **What will you need to report for each visit for this measure?**

If you select this measure for reporting, you will report:

- Whether or not the patient encounter was documented using either a CCHIT certified EMR or other qualified non-CCHIT certified EMR (as described above).

#### **What if the EMR was not used for this visit?**

There may be times when it is not possible to use a CCHIT certified EMR or other qualified non-CCHIT certified EMR, due to:

- System Reasons (eg, the system was inoperable at the time of the visit).

In these cases, you will need to indicate that the system reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

#### **Coding Specifications**

Codes required to document a visit occurred:

A CPT service code, CPT E/M service code, HCPCS D-code or HCPCS G-code is required to identify patients to be included in this measure.

##### **CPT E/M service codes**

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 96150, 96151 (health behavior assessment),
- 96152 (health and behavior intervention),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult).

**Quality codes for this measure (one of the following for every eligible patient):**

**G-code descriptors**

(Data Collection sheet should be used to determine appropriate combination of codes.)

- G8447: Patient encounter was documented using a CCHIT certified EMR,
- G8448: Patient encounter was documented using a non-CCHIT certified EMR. To qualify, the system must be capable of all of the following:
  - Generating a medication list,
  - Generating a problem list,
  - Entering laboratory tests as discrete searchable data elements.
- G8449: Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit. Use of this code implies that an EMR is in place and generally available.

**Rationale**

The need for clinical information systems to provide high-quality, safe care is a well recognized fact. A comprehensive clinical information system can enhance the care of individual patients by:

- Providing timely reminders about needed services;
- Summarizing data to track and plan care;
- Identifying groups of patients needing additional care;
- Facilitating performance monitoring and quality improvement efforts

## **PQRI Measurement #125**

### **HIT - Adoption/Use of e-Prescribing**

*Note:* This measure applies to physicians who have already adopted electronic prescribing.

### **Measure description**

Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting. To qualify this system must be capable of ALL of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available,
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below),
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any),
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

### **What will you need to report for each visit for this measure?**

If you select this measure for reporting, you will report:

- Whether or not all prescriptions created during the encounter were generated using a qualified e-Prescribing system (as described above).

### **What if the e-Prescribing system was not used for this visit?**

There may be times when it is not possible to generate a prescription using an e-Prescribing system, due to:

- No prescriptions generated during the encounter,
- System/Patient Reasons (eg, some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable).

In these cases, you will need to indicate which reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

### **Coding Specifications**

Codes required to document a visit occurred:

A CPT service code, CPT E/M service code or HCPCS G-code is required to identify patients to be included in this measure.

#### **CPT E/M service codes**

- 90801 (psychiatric diagnostic interview examination),
- 90802 (interactive psychiatric diagnostic interview examination),
- 90804, 90805, 90806, 90807, 90808, 90809 (individual psychotherapy),
- 96150, 96151, 96152 (health and behavior intervention),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),

- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult).

**Quality codes for this measure (one of the following for every eligible patient):**

**G-code descriptors**

(Data Collection sheet should be used to determine appropriate combination of codes.)

- G8443: All prescriptions created during the encounter were generated using a qualified e-Prescribing system,
- G8445: No prescriptions were generated during the encounter. Provider does have access to a qualified e-Prescribing system,
- G8446: Some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable.

**Rationale**

Automation of the ambulatory prescribing process has many potential benefits including:

- Patient safety through computerized transmission of legible prescriptions directly to the pharmacy and checks for harmful interactions.
- Patient satisfaction in a process that results in fewer errors and less waiting time;
- Avoidance of unnecessary phone calls for clarification between Providers and Pharmacies;
- Easier data collection of physician prescribing patterns and improved formulary compliance for Health plans, pharmacy benefit managers and employers.