

**CATNUM**  
Sample category

16. AMI - Outpatient visit	57. OEF/OIF scrnd TBI+
36. SCI Dx	60. DM Outpatient
48. Female, age 20-69	61. Inpatient SCI
50. Random Sample	64. CHF Outpatient
51. Random Sample MH	68. Contract CBOC
54. Frail/Elderly	

**FEFLAG** (rcvd on pull list)  
FE case flagged for CGPI review / scoring?

0. No  
1. Yes

**REVSTAT**  
REVIEW STATUS (not abstracted)

0. Abstraction has not begun  
1. Abstraction in progress  
2. Abstraction completed w/o errors  
3. TVG failure (exclusion)  
4. Record contains missing required answers (error record)  
5. Administrative exclusion from all measures

**MODSEVCI** (MH)  
During the past year, did the clinician document in the record that the patient has moderate or severe cognitive impairment?

1. Yes  
2. No

**COGSCOR** (MH)  
What was the outcome of the screen for cognitive impairment?

4. Score indicated mild cognitive impairment  
5. Score indicated moderate to severe impairment  
6. Score indicated no cognitive impairment  
95. Not applicable  
99. No score documented in the record or unable to determine outcome

**DEMENTDX** (MH)  
During the past year, does the record document a diagnosis of dementia as evidenced by one of the following ICD-9-CM codes?

-- Dementia (290.XX)  
-- Alcohol-induced persisting amnesic disorder (291.1)  
-- Alcohol-induced persisting dementia (291.2)  
-- Dementia in conditions classified elsewhere (294.XX)

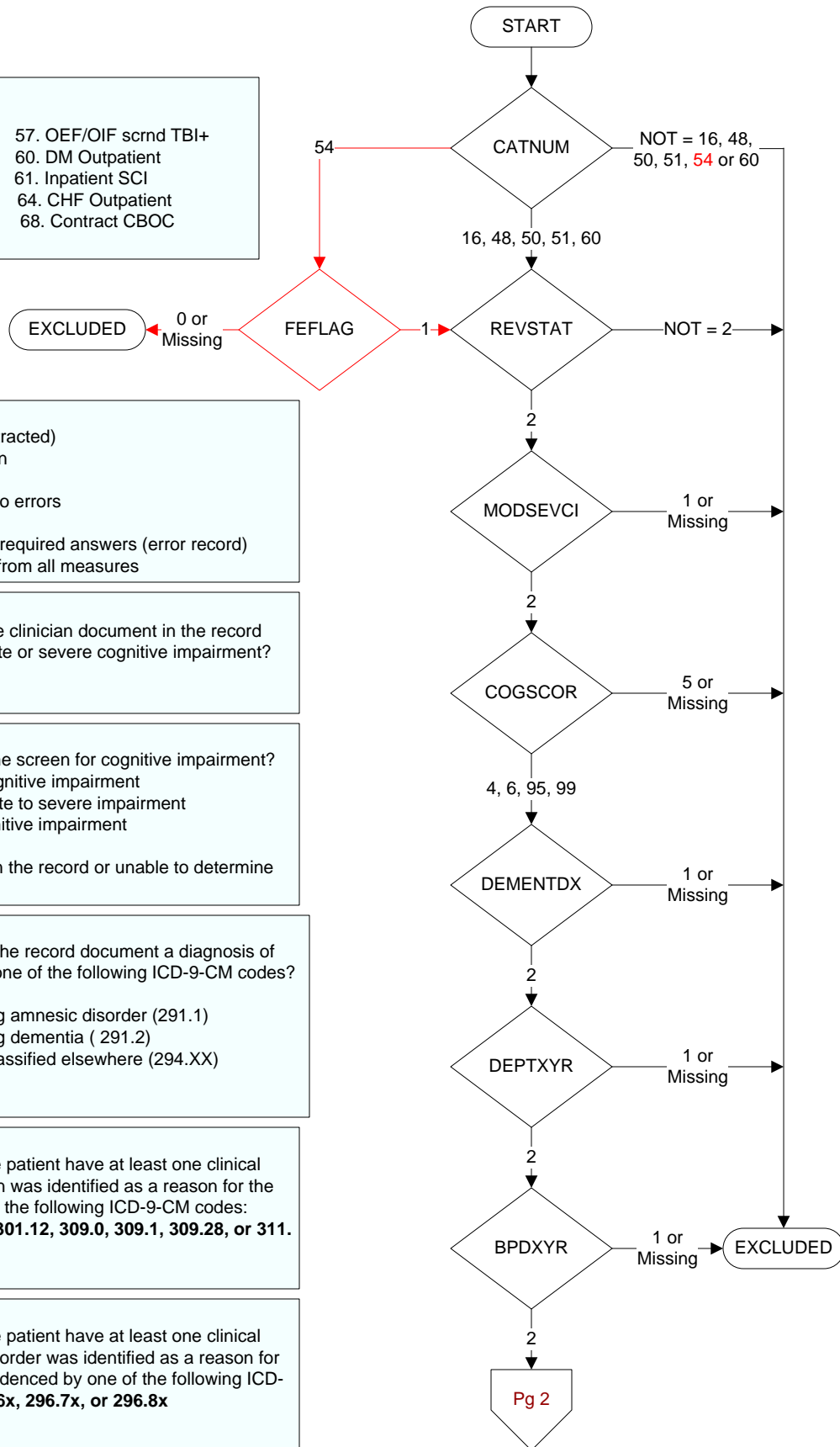
1. Yes  
2. No

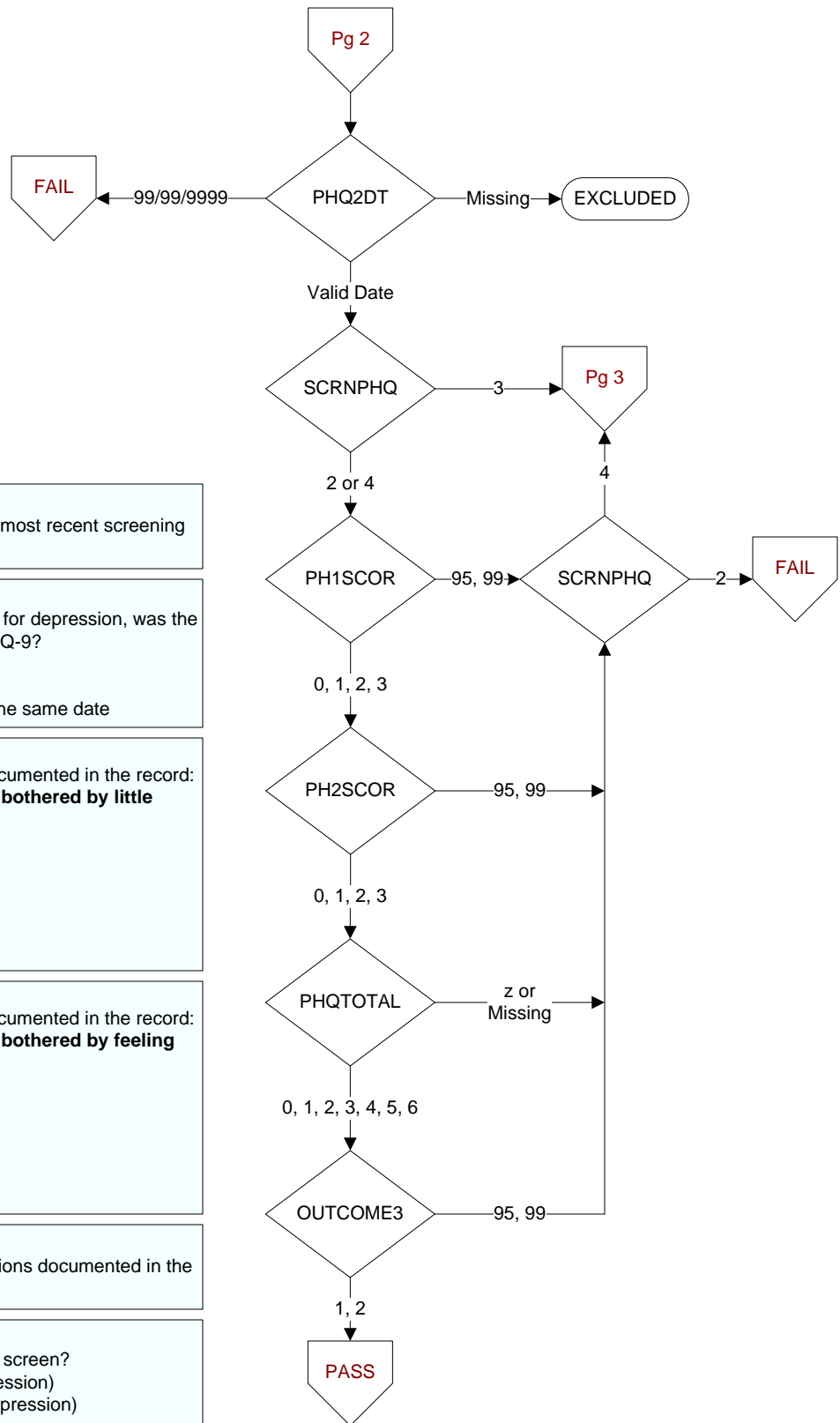
**DEPTXYR** (MH)  
Within the past year, did the patient have at least one clinical encounter where depression was identified as a reason for the visit as evidenced by one of the following ICD-9-CM codes:  
**296.2-296.3, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, or 311.**

1. Yes  
2. No

**BPDXYR** (MH)  
Within the past year, did the patient have at least one clinical encounter where bipolar disorder was identified as a reason for the clinical encounter as evidenced by one of the following ICD-9-CM codes: **296.5x, 296. 6x, 296.7x, or 296.8x**

1. Yes  
2. No





**PHQ2DT (MH)**  
Enter the date within the past year of the most recent screening for depression by the PHQ-2 or PHQ-9.

**SCRNPHQ (MH)**  
On the date of the most recent screening for depression, was the patient screened by the PHQ-2 or the PHQ-9?

2. Screened by PHQ-2
3. Screened by PHQ-9
4. Screened by PHQ-2 AND PHQ-9 on the same date

**PH1SCOR** (MH)

Enter the score for PHQ-2 Question 1 documented in the record:

**Over the past 2 weeks, have you been bothered by little interest or pleasure in doing things?**

0. Not at all --> 0

1. Several days --> 1

2. More than half the days --> 2

3. Nearly every day --> 3

95. Not applicable

99. No answer documented

**PH2SCOR** (MH)

Enter the score for PHQ-2 Question 2 documented in the record:

**Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?**

0. Not at all --> 0

1. Several days --> 1

2. More than half the days --> 2

3. Nearly every day --> 3

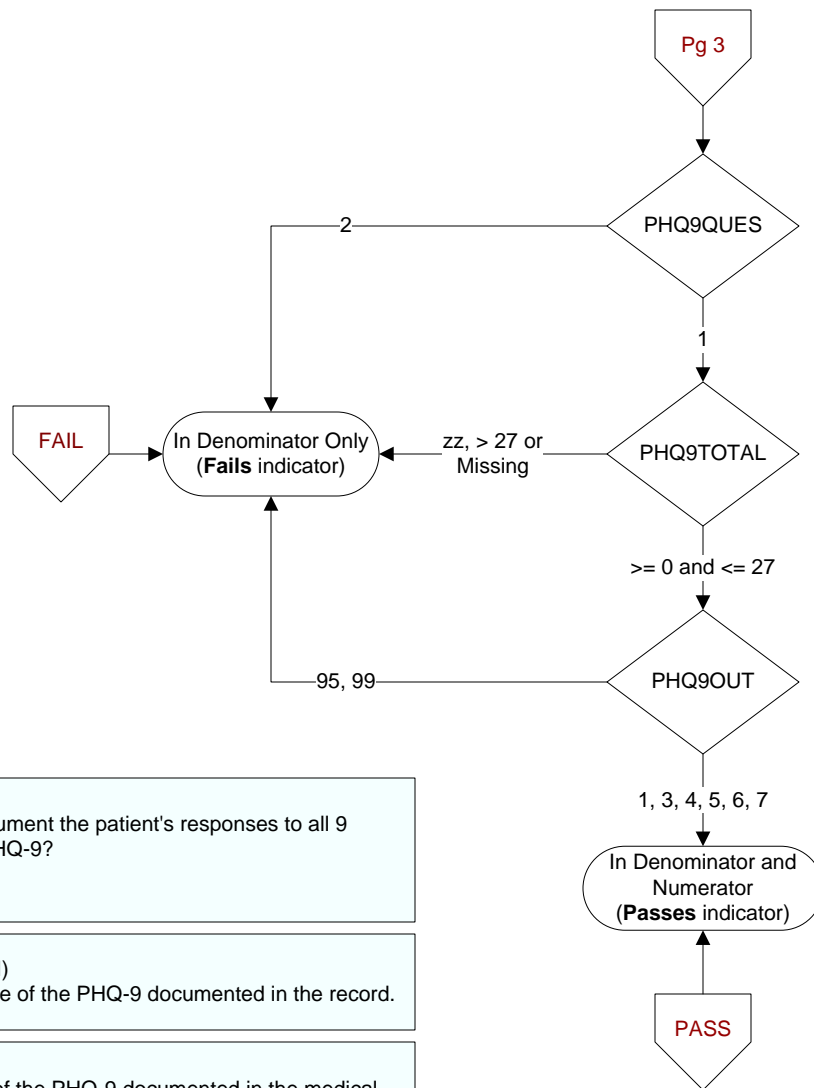
95. Not applicable

99. No answer documented

**PHQTOTAL (MH)**  
Enter the total score for the PHQ-2 questions documented in the medical record.

**OUTCOME3 (MH)**  
What was the outcome of the depression screen?

1. Outcome positive (suggestive of depression)
2. Outcome negative (no indication of depression)
95. Not applicable
99. Outcome not documented



**PHQ9QUES (MH)**  
Did the record document the patient's responses to all 9 questions of the PHQ-9?  
1. Yes  
2. No

**PHQ9TOTAL (MH)**  
Enter the total score of the PHQ-9 documented in the record.

**PHQ9OUT (MH)**  
Was the outcome of the PHQ-9 documented in the medical record?  
1. Outcome positive  
3. Score suggestive of no depression  
4. Score suggestive of mild depression  
5. Score suggestive of moderate depression  
6. Score suggestive of moderately severe depression  
7. Score suggestive of severe depression  
95. Not applicable  
99. No documentation of outcome