

**CATNUM**

Sample category  
 16. AMI - Outpatient visit  
 36. SCI Dx  
 48. Female, age 20-69  
 50. Random Sample  
 51. Random Sample MH  
 54. Frail/Elderly  
 60. DM Outpatient  
 61. Inpatient SC  
 68. Contract CBOC

**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

**FEFLAG** (rcvd on pull list)

FE case flagged for CGPI review / scoring?  
 0. No  
 1. Yes

**DEMENTDX2** (MH)

During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-9-CM codes?

(046.1, 046.11, 046.19, 046.3, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 291.2, 292.82, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.2, 331.7, 331.82, 331.89, 331.9, 333.0 or 333.4)  
 1. Yes  
 2. No

**DEMSEV** (MH)

Was the severity of dementia assessed during the past year using one of the following standardized tools?

1. Clinical Dementia Rating Scale (CDR)  
 2. Functional Assessment Staging Tool (FAST)  
 3. Global Deterioration Scale (GDS)  
 99. Severity of dementia was not assessed during the past year using one of the specified tools

**COGSCOR2** (MH)

What was the outcome of the assessment of the severity of dementia assessment?

4. Score indicated mild dementia  
 5. Score indicated moderate to severe dementia  
 6. Score indicated no dementia  
 99. No score documented in the record or unable to determine outcome

**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

**DEPTXYR** (MH)

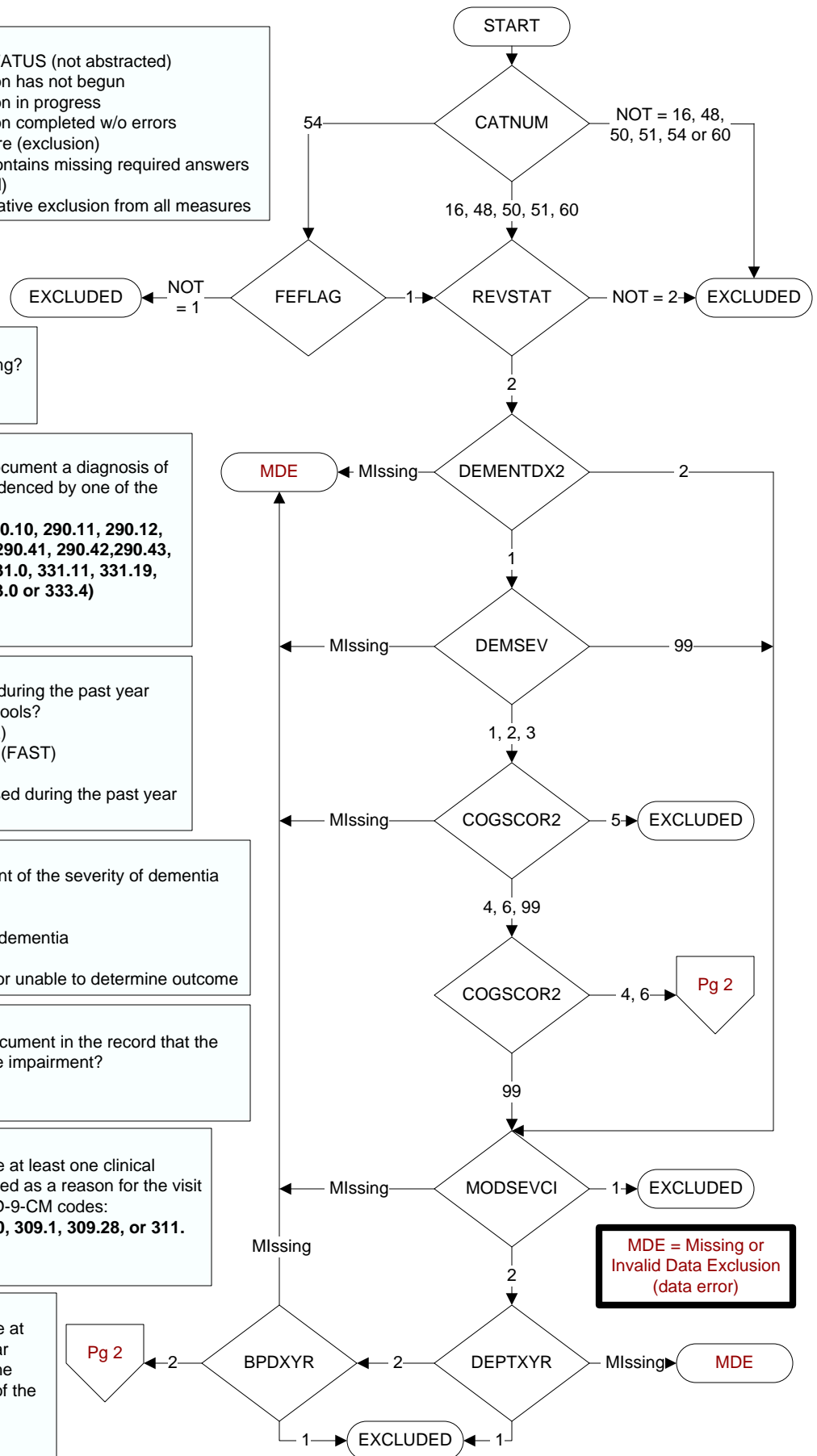
Within the past year, did the patient have at least one clinical encounter where depression was identified as a reason for the visit as evidenced by one of the following ICD-9-CM codes:

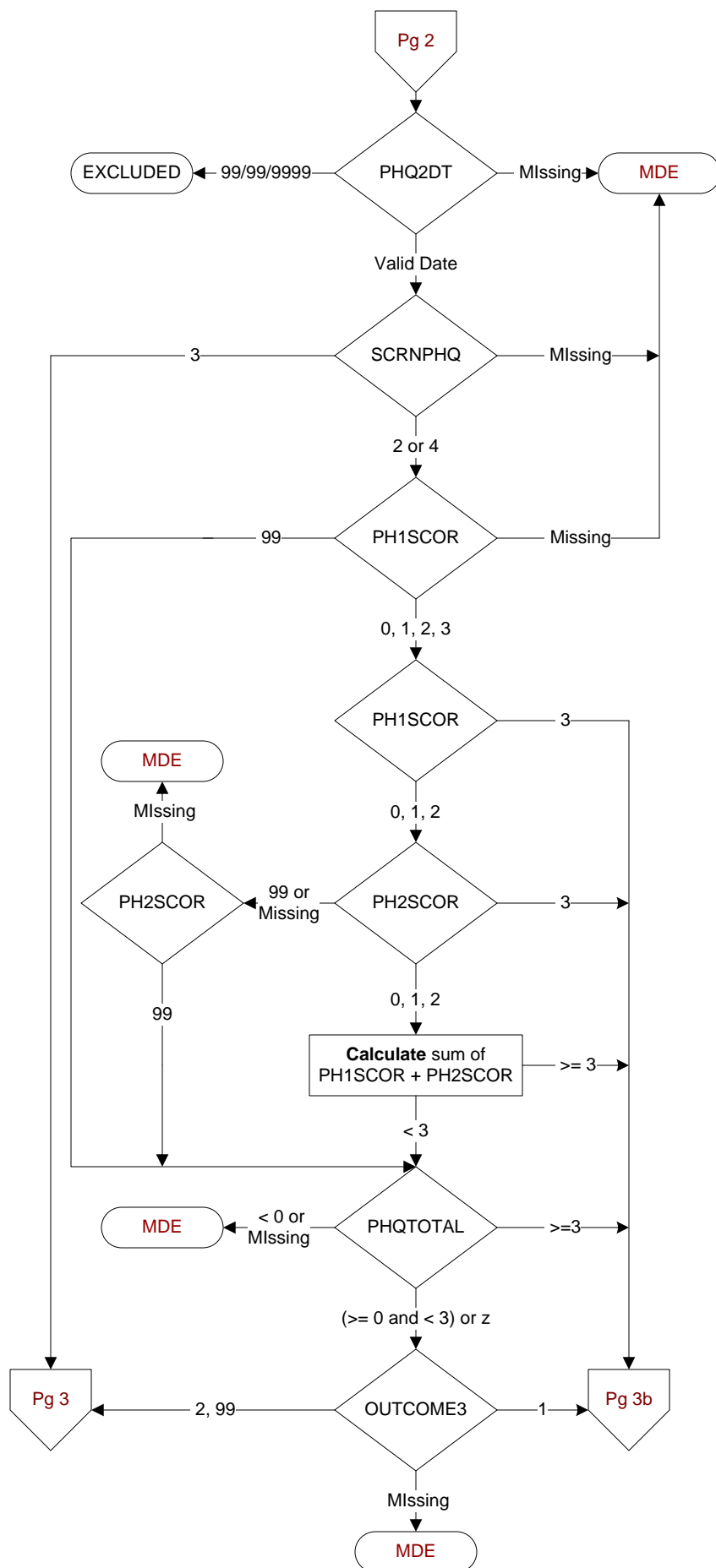
296.2-296.3, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, or 311.  
 1. Yes  
 2. No

**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, 296.7, and 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
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 --> 399. No answer documented

PHQTOTAL (MH)

Enter the total score for the **PHQ-2** documented in the medical record.

**OUTCOME3 (MH)**

What was the outcome of the PHQ-2 documented in the record?

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

