

**Document Links:**[CGPI PI Module](#)[CGPI MH Module](#)**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  
 5. Administrative exclusion from all measures

**FEFLAG** (rcvd on pull list)  
 FE case flagged for CGPI review / scoring?  
 0. No  
 1. Yes

**DOCHOSPCE** (PI module)

Is one of the following documented in the medical record:  
 - the patient is enrolled in a VHA or community-based Hospice program  
 - the patient has a diagnosis of cancer of the liver, pancreas, or esophagus  
 - on the problem list it is documented the patient's life expectancy is less than 6 months?  
 1. Yes  
 2. No

**DEMENTDX2** (MH)

During the past year, does the record document a diagnosis of dementia/neurocognitive disorder as evidenced by one of the following ICD-10-CM diagnosis codes:

**A8100, A8101, A8109, A812, A8189, A819, Primary I60xx – I69xx + Secondary F0150 or F0151, F0390, F0391, any Primary xxx.xx + Secondary F0280 or F0281, F0390, F0391, F1027, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903**

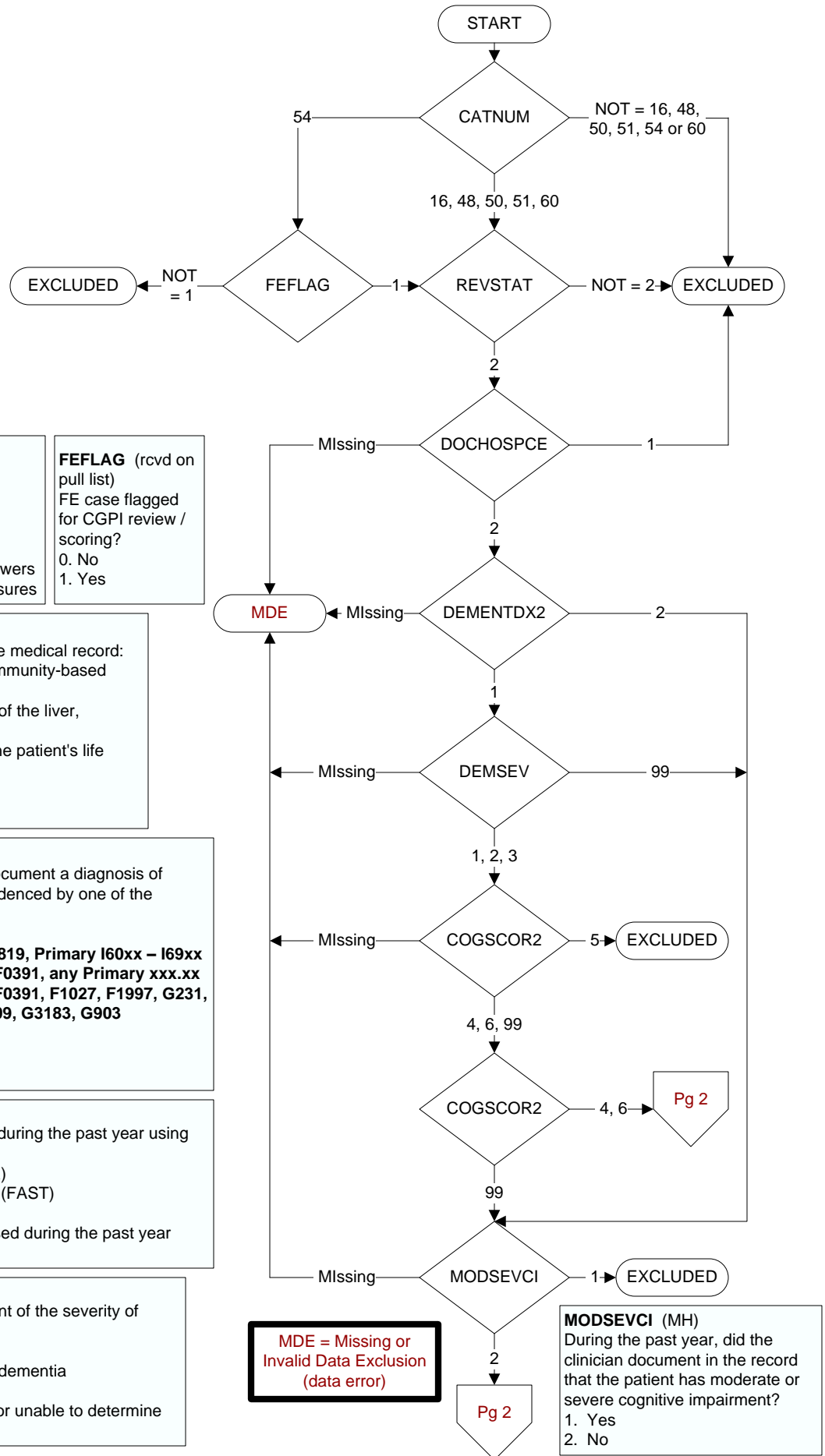
1. Yes  
 2. No

**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



**PTSDX (MH)**

Within the past year, did the patient have at least one clinical encounter where PTSD was identified as a reason for the clinical encounter as evidenced by one of the following:  
ICD-9-CM code (prior to 10/01/15): **309.81**

ICD-10-CM code (on or after 10/01/15): **F431, F4310, F4312**

1. Yes
2. No

**PTSRNPC (MH)**

Within the past five years, was the patient screened for PTSD using the Primary Care PTSD Screen (PC-PTSD)?

1. Yes
2. No

**PCPTSDT (MH)**

Enter the date of the most recent screen for PTSD using the PC-PTSD.

**STDYBEG**

(Rcvd on Pull List)  
Study Interval begin date

**PCPTSD (MH)**

Enter the patient's answers to each of the Primary Care PTSD Screen questions:

Have you ever had any experience that was so frightening, horrible, or upsetting that, **IN THE PAST MONTH**, you: **PCPTSD1**. Have had any nightmares about it or thought about it when you did not want to? **PCPTSD2**. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?

**PCPTSD3**. Were constantly on guard, watchful, or easily startled?

**PCPTSD4**. Felt numb or detached from others, activities, or your surroundings?

1. Yes
2. No
95. Not applicable
99. No answer documented

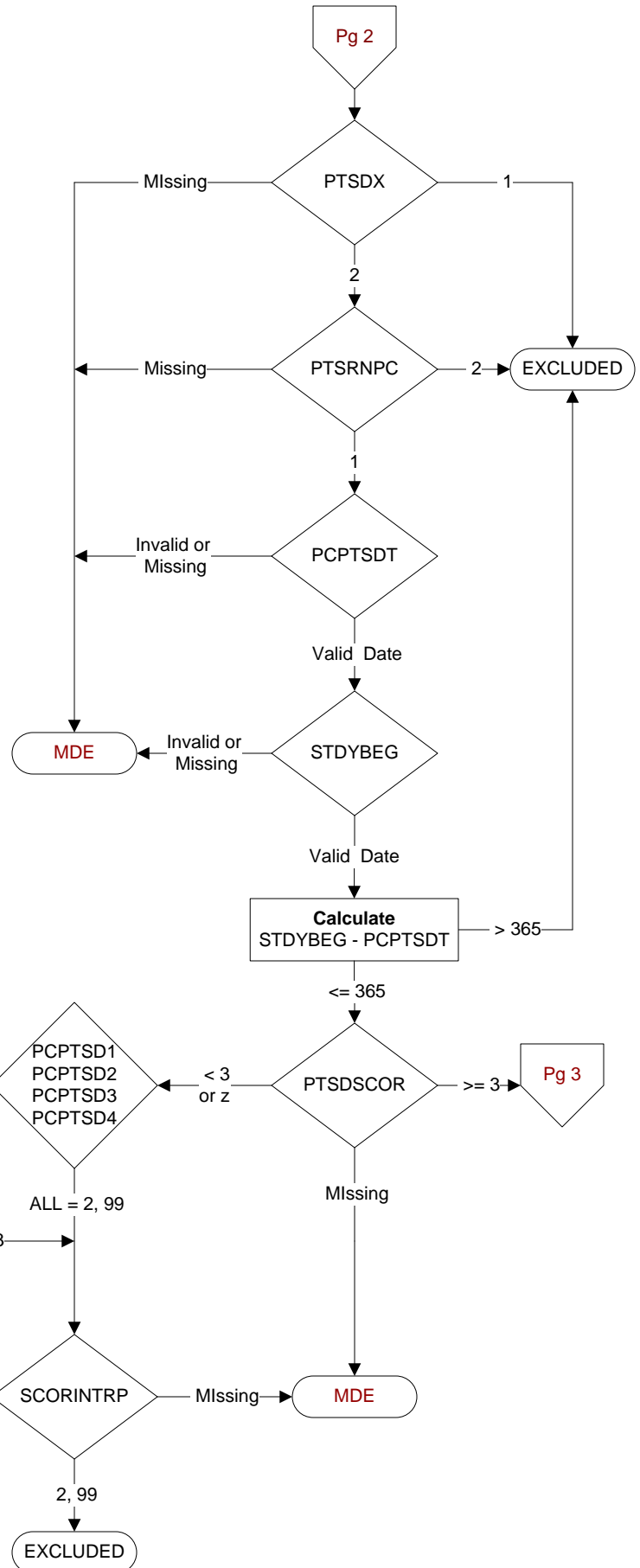
**PTSDSCOR (MH)**

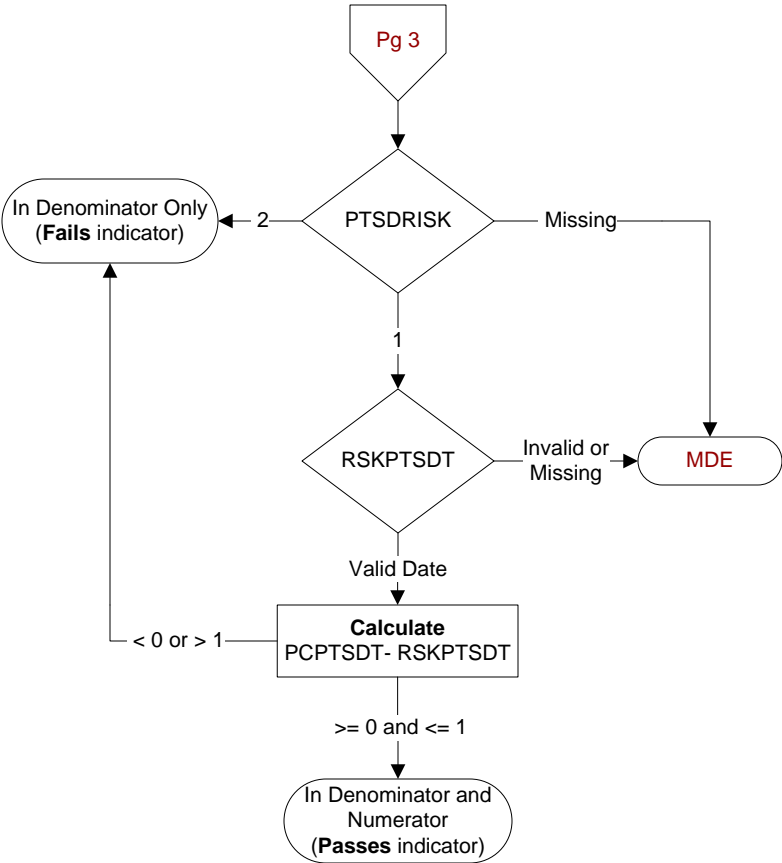
Enter the total score for the screen documented in the record. (Abstractor can enter default z if no total score is documented)

**SCORINTRP (MH)**

Enter the interpretation of the score, as documented in the medical record.

1. Positive
2. Negative
95. Not applicable
99. No interpretation documented





**PTSDRISK (MH)**  
Following the positive PC-PTSD screen, did the licensed independent provider document a suicide ideation/behavior evaluation?  
1. Yes  
2. No

**RSKPTSDT (MH)**  
Enter the date of the suicide ideation/behavior evaluation.