

**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, A8182, A8189, A819, F0150, F0151, F0280, F0281, F0390, F0391, F1027, F1097, F1327, F1397, F1817, F1827, F1897, F1917, F1927, F1997, G231, G300, G301, G308, G309, G3101, G3109, G3183, G903**

1. Yes  
 2. No

**DEMSEV** (MH)

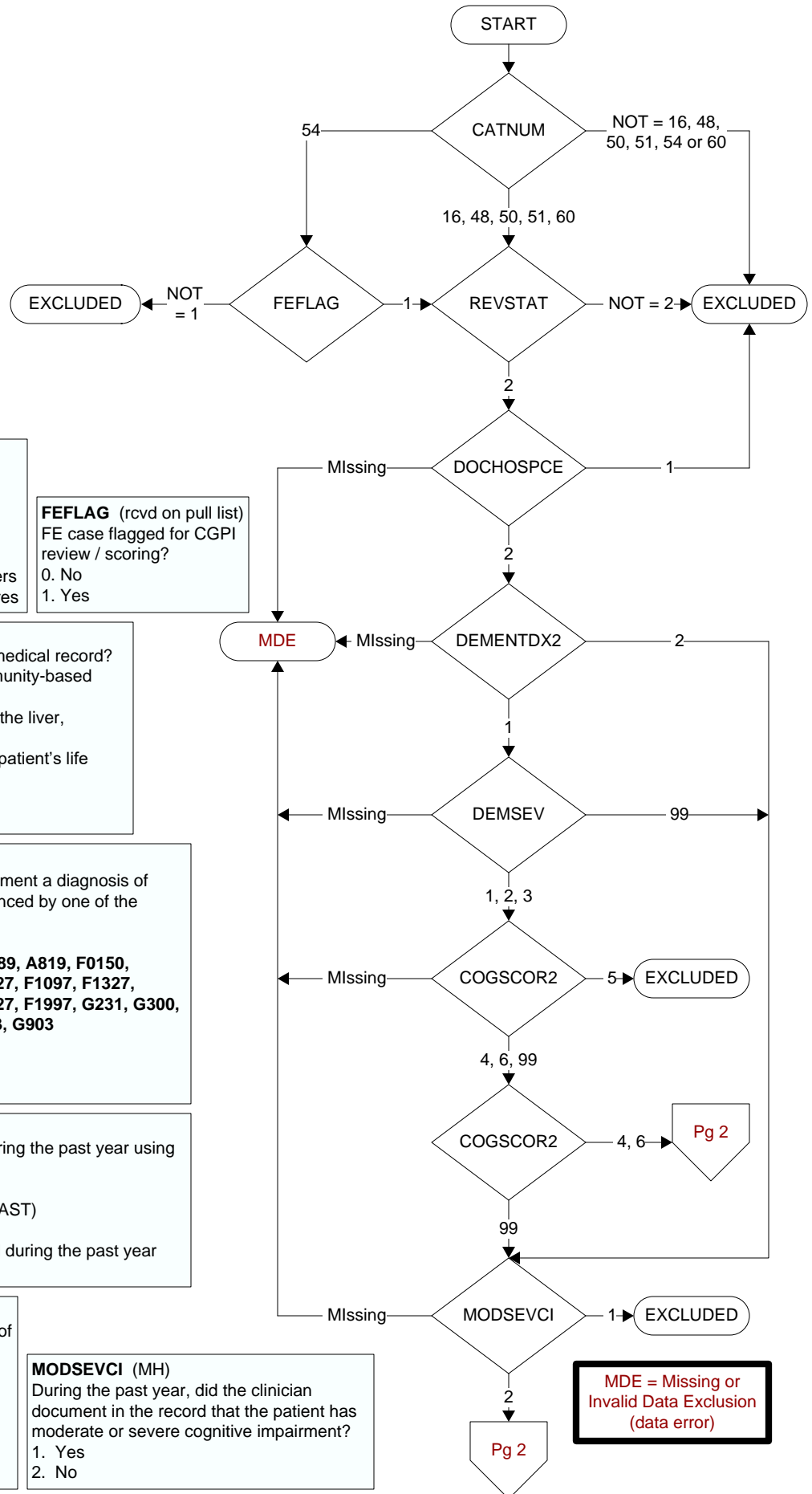
Was the severity of dementia assessed during the past year using one of the following standardized tools?  
 1. Clinical Dementia Rating Scale (CDR)  
 2. Functional Assessment Staging Tool (FAST)  
 3. Global Deterioration Scale (GDS)  
 99. Severity of dementia was not assessed during the past year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

**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 clinical encounter as evidenced by one of the following ICD-10-CM diagnosis codes:

**F0151, F320 - F325, F328, F3281, F3289, F329- F333, F3342, F339, F341, F4321, F4323**

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-10-CM diagnosis codes:

**F3010 – F3013, F302 – F304, F308 - F310, F3110 – F3113, F312, F3130 – F3132, F314, F315, F3160 – F3164, F3170 – F3178, F3181, F3189, F319**

1. Yes  
2. No

**SCRPHQ2 (MH)**

During the past year and prior to 10/01/2018, was the patient screened for depression by the PHQ-2?  
1. Yes  
2. No

**SCRPHQi9 (MH)**

During the past year was the patient screened for depression by the PHQ-2 + I9?  
1. Yes  
2. No  
98. Patient refused depression screening

**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?**

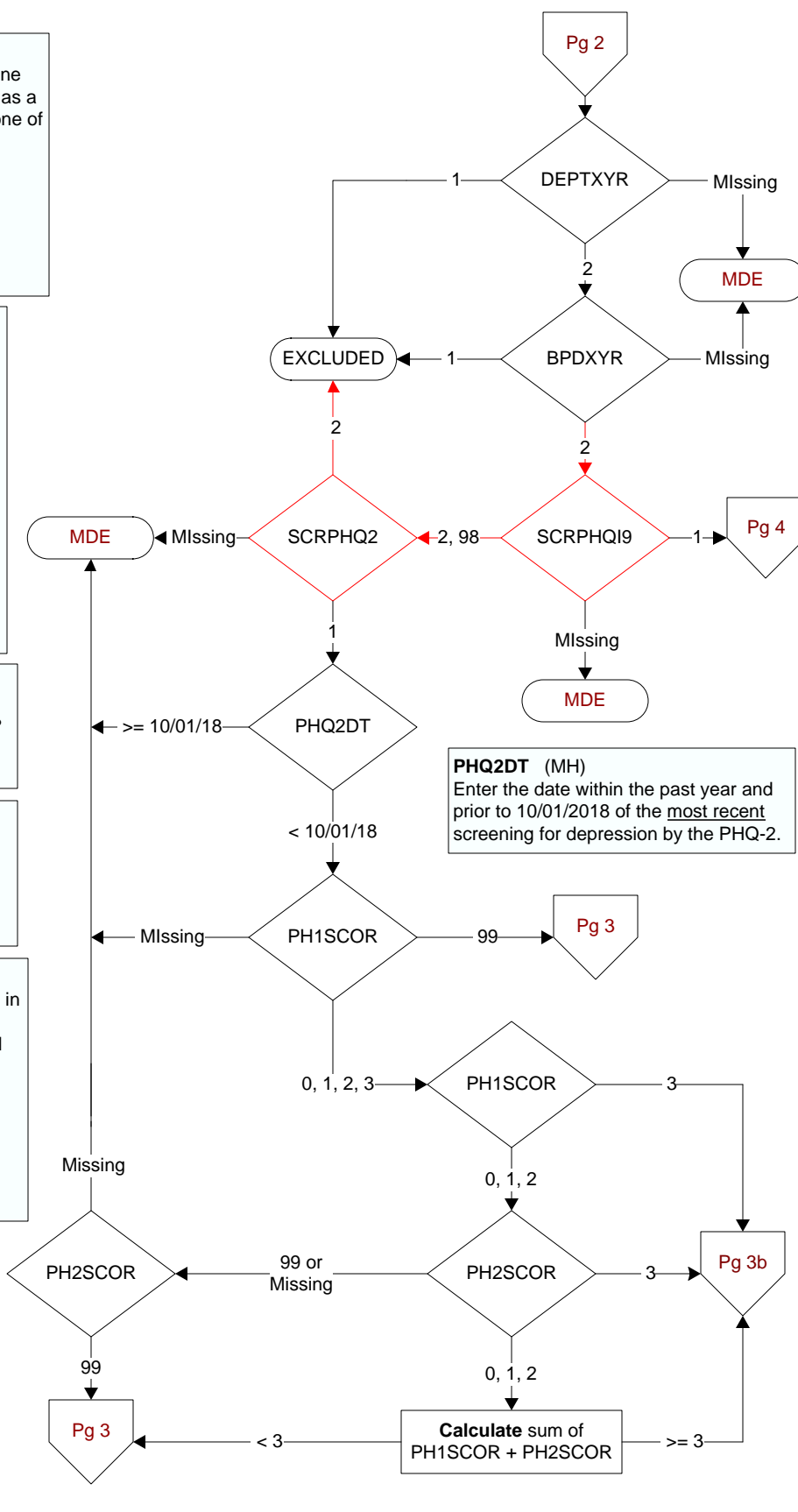
0. Not at all --> 0  
1. Several days --> 1  
2. More than half the days --> 2  
3. Nearly every day --> 3  
95. Not applicable  
99. No answer documented

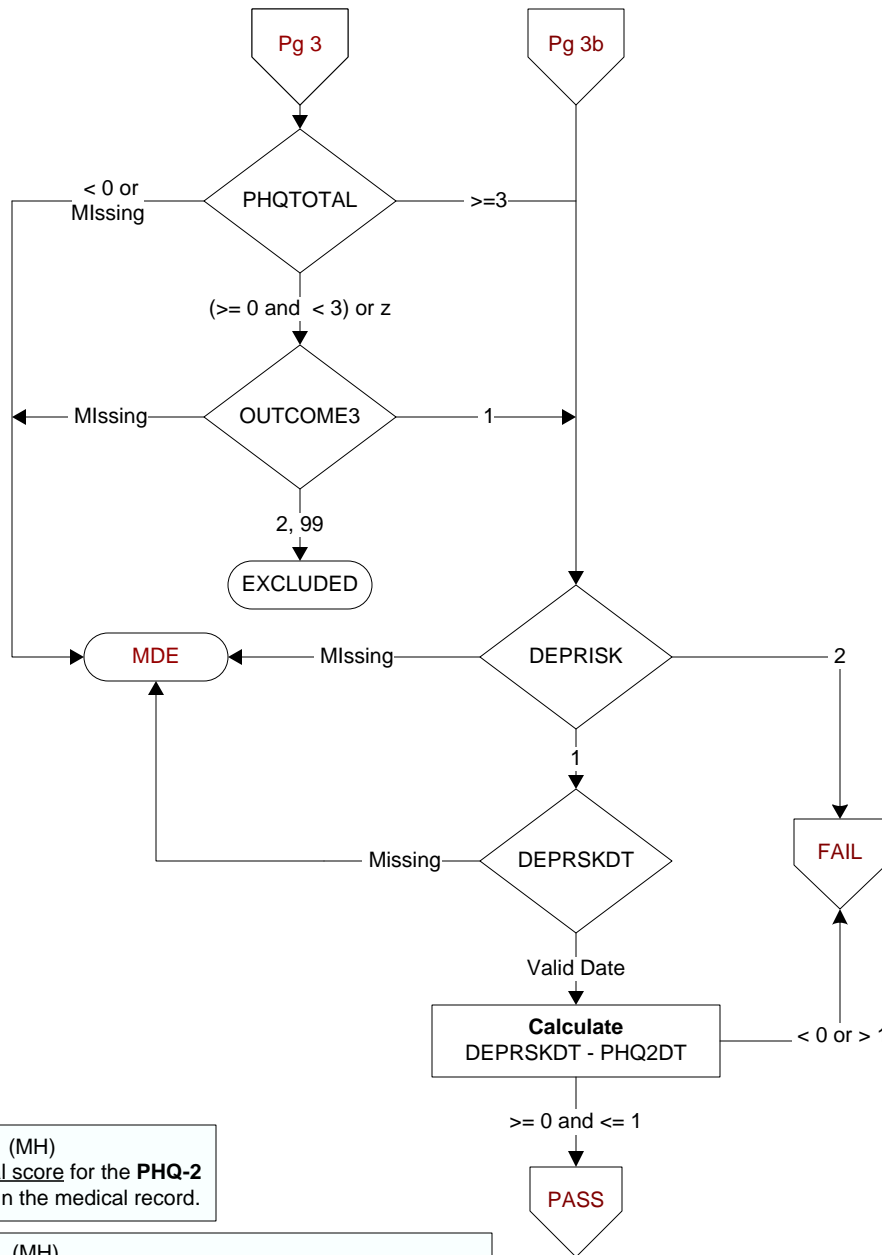
**PH2SCOR (MH)**

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



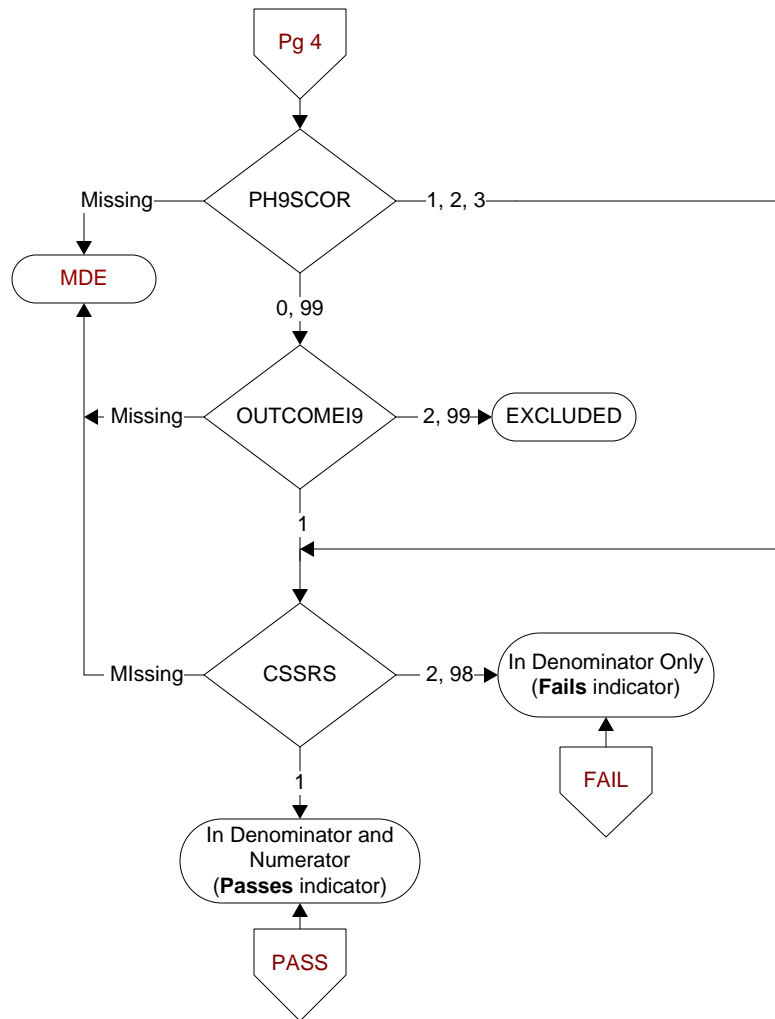


**PHQTOTAL (MH)**  
Enter the total score for the **PHQ-2** documented in the medical record.

**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

**DEPRISK (MH)**  
On the day of or the day after the positive PHQ-2, did the provider document a suicide ideation/behavior evaluation?  
1. Yes  
2. No

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

**PH9SCOR (MH)**

Enter the score for item 9/question #3 of the PHQ-2 + I9 screen documented in the record:  
**Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?**

- 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

**OUTCOME19 (MH)**

Enter the interpretation of item 9/question #3 of the PHQ-2 + I9 screen as documented in the medical record.

- 1. Positive
- 2. Negative
- 99. No interpretation documented

**CSSRS (MH)**

On (computer to display **phqi9dt**), the day of the positive **I 9**, did the acceptable provider complete the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener?

- 1. Yes
- 2. No
- 98. Patient refused to complete the C-SSRS screener