

Substance Use Disorders
Physician Performance Measurement Set

PCPI Approved
July 2008

Statement of Intent

The purpose of the APA/PCPI/NCQA Substance Use Disorders Work Group is to develop clinician-level performance measures that will help to improve the quality of care for patients with substance use disorders. These measures focus on measuring performance of *individual clinicians* and are restricted to measuring aspects of care actionable by the individual clinician. In addition, the measures must be technically feasible, impose only a reasonable burden on the clinician, have a strong clinical evidence base and address known gaps in care.

Scope of the Substance Use Disorders Work Group

Clinical practice guidelines serve as the foundation for the development of performance measures. Performance measures, however, are not clinical practice guidelines and cannot measure the full spectrum of care for all patients with substance use disorders. The Work Group is tasked with developing measures that reflect the most rigorous clinical evidence and address areas most in need of performance improvement. The resulting measurement set includes measures that address effective therapeutic options for patients with alcohol and opioid dependence and encourage early identification of the most common co-occurring psychiatric disorder – depression.

Target Patient Population for the Substance Use Disorders Work Group

The Substance Use Disorders Work Group includes a multidisciplinary group of stakeholders from the psychiatry, addiction medicine, pain medicine, primary care, psychology, social work, addiction counselor, government, health policy, substance use and addiction research, and healthcare accreditation communities. The Work Group was charged with developing measures for patients with known substance use disorders. While early identification of substance use disorders through screening is vital as the gateway to initiation and engagement in treatment, the PCPI determined that general population screening measures fall under the purview of the Preventive Care & Screening Work Group

To create the strongest possible measures with largest consensus, the Preventive Care and Substance Use Disorders Work Groups were charged with collaborating on a screening measure for unhealthy alcohol use.

This screening for unhealthy alcohol use measure is currently in draft form with expected completion in September 2008. In addition, measures for tobacco screening and cessation intervention(s) are under development as part of the Preventive Care Work Group.

American Psychiatric Association/
Physician Consortium for Performance Improvement® (PCPI)/
National Committee for Quality Assurance

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Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA).

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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Purpose of Measures:

These clinical performance measures, developed by the American Psychiatric Association, the Physician Consortium for Performance Improvement® (PCPI), and the National Committee for Quality Assurance, are designed for individual quality improvement. Unless otherwise indicated, the measures are also appropriate for accountability if appropriate methodological, statistical, and implementation rules are achieved.

Accountability Measures:

Measure #1: Counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence *(approved 05/08)*

Measure #2: Counseling regarding psychosocial and pharmacologic treatment options for opioid addiction *(approved 07/08)*

Measure #3: Screening for depression among patients with substance abuse or dependence *(approved 05/08)*

Intended Audience and Patient Population:

These measures are designed for use by physicians and eligible health professionals and for calculating reporting or performance measurement at the individual level. When existing hospital-level or plan-level measures are available for the same measurement topics, the PCPI attempts to harmonize the measures to the extent feasible.

Measure 1 is designed for any physician or eligible health professional caring for patients aged 18 years and older with a diagnosis of current alcohol dependence.

Measure 2 is designed for any physician or eligible health professional caring for patients aged 18 years and older with a diagnosis of current opioid addiction.

Measure 3 is designed for any physician or eligible health professional caring for patients aged 18 years and older with a diagnosis of current substance abuse or dependence.

Measure Specifications

The PCPI seeks to specify measures for implementation using multiple data sources, including paper medical record, administrative (claims) data, and particular emphasis on Electronic Health Record Systems (EHRS). Specifications to report on these measures for Substance Use Disorders using administrative (claims) data are included in this document. We have identified codes for these measures, including ICD-9 and CPT (Evaluation & Management Codes, Category I and where Category II codes would apply). Specifications for additional data sources, including EHRS, will be fully developed at a later date.

Measure Exclusions:

For process measures, the PCPI provides three categories of reasons for which a patient may be excluded from the denominator of an individual measure:

- Medical reasons
Includes:
 - not indicated (absence of organ/limb, already received/performed, other)
 - contraindicated (patient allergic history, potential adverse drug interaction, other)

- Patient reasons
Includes:
 - patient declined
 - economic, social, or religious reasons
 - other patient reasons

- System reasons
Includes:
 - resources to perform the services not available
 - insurance coverage/payor-related limitations
 - other reasons attributable to health care delivery system

These measure exclusion categories are not available uniformly across all measures; for each measure, there must be a clear rationale to permit an exclusion for a medical, patient, or system reason. The exclusion of a patient may be reported by appending the appropriate modifier to the CPT Category II code designated for the measure:

- Medical reasons: modifier 1P
- Patient reasons: modifier 2P
- System reasons: modifier 3P

Although this methodology does not require the external reporting of more detailed exclusion data, the PCPI recommends that physicians and eligible health professionals document the *specific* reasons for exclusion in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's and eligible health professional's exclusions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians and eligible health professionals have identified as meeting the criteria for exclusion.

Please refer to documentation for each individual measure for information on the acceptable exclusion categories and the codes and modifiers to be used for reporting.

Measures 1 through 3 in the Substance Use Disorders measurement set are process measures.

For outcome measures, the PCPI specifically identifies all acceptable reasons for which a patient may be excluded from the denominator. Each specified reason is reportable with a CPT Category II code designated for that purpose.

There are no outcome measures in the Substance Use Disorders measurement set.

The PCPI continues to evaluate and likely will evolve its methodology for handling exclusions as it gains experience in the use of the measures.

Data Capture and Measure Calculation

The PCPI intends for physicians and eligible health professionals to collect data on each patient eligible for a measure. Feedback on measures should be available to physicians and eligible health professionals by patient to facilitate patient management and in aggregate to identify opportunities for improvement across the patient population.

Measure calculations will differ depending on whether a rate is being calculated for performance or reporting purposes.

The method of calculation for performance follows these steps: first, identify the patients who meet the eligibility criteria for the denominator (PD); second, identify which of those patients meet the numerator criteria (A); and third, for those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies and subtract those patients from the denominator (C). (see examples below)

The methodology also enables implementers to calculate the rates of exclusions and to further analyze both low and high rates, as appropriate (see examples below).

The method of calculation for reporting differs. One program which currently focuses on reporting rates is the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI). Currently, under that program design, there will be a reporting denominator determined solely from claims data (CPT and ICD-9), which in some cases result in a reporting denominator that is much larger than the eligible population for the performance denominator. Additional components of the reporting denominator are explained below.

The components that make up the numerator for reporting include all patients from the eligible population for which the physician and eligible health professionals has reported, including: the number of patients who meet the numerator criteria (A), the number of patients for whom valid exclusions apply (C) and also the number of patients who do not meet the numerator criteria (D). These components, where applicable, are summed together to make up the inclusive reporting numerator. The calculation for reporting will be the reporting numerator divided by the reporting denominator. (see examples below).

Examples of calculations for reporting and performance are provided for each measure.

Calculation for Performance

For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

Numerator (A) Includes:

Number of patients meeting numerator criteria

Performance Denominator (PD) Includes:

Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (C) Include:

Number of patients with valid medical, patient or system exclusions (where applicable; will differ by measure)

Performance Calculation

$$\frac{A \text{ (\# of patients meeting numerator criteria)}}{PD \text{ (\# patients in denominator)} - C \text{ (\# patients with valid denominator exclusions)}}$$

It is also possible to calculate the percentage of patients excluded overall, or excluded by medical, patient, or system reason where applicable:

Overall Exclusion Calculation

$$\frac{C \text{ (\# of patients with any valid exclusion)}}{PD \text{ (\# patients in denominator)}}$$

OR

Exclusion Calculation by Type

$$\frac{C_1 \text{ (\# patients with medical reason)}}{PD \text{ (\# patients in denominator)}}$$

$$\frac{C_2 \text{ (\# patients with patient reason)}}{PD \text{ (\# patients in denominator)}}$$

$$\frac{C_3 \text{ (\# patients with system reason)}}{PD \text{ (\# patients in denominator)}}$$

Calculation for Reporting

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following components, where applicable. (There may be instances where there are no patients to include in A, C, D, or E).

A. Number of patients meeting additional denominator criteria (for measures where true denominator cannot be determined through ICD-9 and CPT Category I coding alone) AND numerator criteria

C. Number of patients with valid medical, patient or system exclusions (where applicable; will differ by measure)

D. Number of patients not meeting numerator criteria and without a valid exclusion

E. All other patients not meeting additional denominator criteria (for measures where true denominator cannot be determined through ICD-9 and CPT Category I coding alone)

Reporting Denominator (RD) Includes:

RD. Denominator criteria (identifiable through ICD-9 and CPT Category I coding)

$$\frac{A(\text{\# of patients meeting additional denominator criteria AND numerator criteria}) + C(\text{\# of patients with valid exclusions}) + D(\text{\# of patients NOT meeting numerator criteria}) + E(\text{\# of patients not meeting additional denominator criteria})}{RD (\text{\# of patients in denominator})}$$

Substance Use Disorders

Measure #1: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence

This measure may be used as an Accountability measure

Clinical Performance Measure
<p>Numerator: Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period</p> <p>Denominator: All patients aged 18 years and older with a diagnosis of current alcohol dependence</p> <p>Denominator exclusions: None</p> <p>Measure: Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>Psychosocial treatments found effective for some patients with an alcohol use disorder include motivational enhancement therapy (MET) (Category I), cognitive-behavioral therapy (CBT) (Category I), behavioral therapies (Category I), 12-step facilitation (TSF) (Category I), marital and family therapies (Category I), group therapies (Category II), and psychodynamic therapy/interpersonal therapy (IPT) (Category III). (APA, 2006)¹</p> <p>Specific pharmacotherapies for alcohol-dependent patients have well-established efficacy and moderate effectiveness:</p> <ul style="list-style-type: none"> • Naltrexone may attenuate some of the reinforcing effects of alcohol, although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may promote adherence, but published research is limited and FDA approval is pending. [<i>Note: Extended-release naltrexone for injection has since received FDA approval</i>] (Category I) • Acamprosate, a γ-aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated patients who are concomitantly receiving psychosocial treatment. (Category I) • Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated patients whose drinking may be triggered by events that suddenly increase alcohol craving. (Category II) (APA, 2006)¹ <p>Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. (NQF, 2007)²</p>
<p>Rationale for the measure:</p> <p>Research has shown that among patients diagnosed with alcohol dependence, only 4.64% were referred for psychosocial treatment in the form of substance abuse counseling, inpatient rehabilitation programs, outpatient rehabilitation programs, or mutual help groups.³ While pharmacologic therapy has established efficacy, often in combination with psychosocial therapy, in promoting abstinence and preventing relapse in alcohol-dependent patients, physician rates of prescribing pharmacologic therapy for alcohol dependence are also considerably low. A recent study found that these low rates prevail even among addiction medicine physicians who prescribed naltrexone to only 13% of their alcohol-dependent patients.⁴ Pharmacotherapy and psychosocial treatment should be routinely considered for all patients with alcohol dependence, and patients should be informed of this option .</p>

Data capture and calculations:

Calculation for Performance

For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

Performance Numerator (A) Includes:

- Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period

Performance Denominator (PD) Includes:

- All patients aged 18 years and older
AND
- Diagnosis of current alcohol dependence

Performance Calculation

$$\frac{A \text{ (\# of patients meeting measure criteria)}}{PD \text{ (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period
PD	# of patients aged 18 years and older with a diagnosis of current alcohol dependence

Calculation for Reporting

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following instances:

A. Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period

D. Patients who were not counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period

Reporting Denominator (RD) Includes:

- All patients aged 18 years and older with a diagnosis of current alcohol dependence

Reporting Calculation

$$\frac{A(\text{\# of patients meeting numerator criteria}) + D(\text{\# of patients NOT meeting numerator criteria})}{RD \text{ (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period
D	# of patients who were <u>not</u> counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period
RD	# of patients aged 18 years and older with a diagnosis of current alcohol dependence

Measure Specifications – *Measure #1*: Counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence
Measure specifications for data sources other than administrative claims will be developed at a later date.

A. Administrative claims data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

(Note: The specifications listed below are those needed for performance calculation.)

Denominator (Eligible Population): All patients aged 18 years and older with a diagnosis of current alcohol dependence

- ICD-9 Diagnosis Codes: 303.90, 303.91, 303.92

AND

- CPT Service Codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

Numerator: Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period

- Report CPT Category II code: 4320F- Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence

Denominator Exclusion: *None*

B. Electronic Health Record System *(in development)*

C. Paper Medical Record *(in development)*

Substance Use Disorders

Measure #2: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Opioid Addiction

This measure may be used as an Accountability measure

Clinical Performance Measure
<p>Numerator: Patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period</p> <p>Denominator: All patients aged 18 years and older with a diagnosis of current opioid addiction*</p> <p>*Note: The term "opioid addiction" in this context corresponds to the DSM-IV classification of opioid dependence that is characterized by a maladaptive pattern of substance use causing clinically significant impairment or distress, and manifesting by 3 (or more) of the 7 designated criteria. This classification is distinct from and not to be confused with physical dependence (ie, tolerance and withdrawal) that is commonly experienced by patients with chronic pain who are treated with opioid analgesics. Please refer to the section below for additional information regarding this distinction.</p> <p>Denominator Exclusion: None</p> <p>Measure: Percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. (NQF, 2007)⁵</p> <p>Pharmacotherapy should be recommended and available to all adults patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. (NQF, 2007)⁵</p> <p>Maintenance treatment with methadone or buprenorphine is appropriate for patients with a prolonged history (>1 year) of opioid dependence. (Category I) (APA, 2006)⁶</p> <p>Maintenance treatment with naltrexone is an alternative strategy, although the utility of this strategy is often limited by lack of patient adherence and low treatment retention. (Category I) (APA, 2006)⁶</p> <p>Psychosocial treatments are effective components of a comprehensive treatment plan for patients with an opioid use disorder (Category II). Behavioral therapies (e.g., contingency management) (Category II), CBTs (Category II), psychodynamic psychotherapy (Category III), and group and family therapies (Category III) have been found to be effective for some patients with an opioid use disorder. (APA, 2006)⁶</p> <p>Note: Federal and state regulations govern the use of methadone, levo-alpha-acetylmethadol (LAAM), and buprenorphine, the three opioids approved by the FDA for the treatment of opioid dependence. (APA, 2006)⁶ [Note: since the publication of the APA practice guideline, LAAM is no longer available in the United States for agonist maintenance treatment]</p> <p>The American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine issued a</p>

consensus statement to recognize and recommend definitions related to the use of opioids for the treatment of pain. They are as follows:

Addiction: Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical Dependence: Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance: Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.⁷

Addiction in the context of pain treatment with opioids is characterized by a persistent pattern of opioid misuse that may involve any or all of the following:

- Use of prescription opioids in an unapproved or inappropriate manner (such as cutting time-release preparations, injecting oral formulations, and applying fentanyl topical patches to oral or rectal mucosa)
- Obtaining opioids outside of medical settings
- Concurrent abuse of alcohol or illicit drugs
- Repeated requests for dose increases or early refills, despite the presence of adequate analgesia
- Multiple episodes of prescription "loss"
- Repeatedly seeking prescriptions from other clinicians or from emergency rooms without informing prescriber, or after warnings to desist
- Evidence of deterioration in the ability to function at work, in the family, or socially, which appears to be related to drug use
- Repeated resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug
- Positive urine drug screen—other substance use (cocaine, opioids, amphetamines or alcohol)
- Meets DSM IV criteria for dependence on opioids (VA/DoD)⁸

Rationale for the measure:

Methadone and buprenorphine, in combination with psychosocial treatment, are effective in reducing drug use and supporting treatment retention. Until recently, their use had been limited due to regulatory requirements with capacity at approved facilities only able to meet the treatment needs of 15% of opioid dependent individuals.⁹ While the increased access to opioid agonist treatments has resulted in an increase in their use, a large number of clinicians have yet to gain eligibility to prescribe the appropriate medications. Moreover, among physicians with waivers to prescribe buprenorphine, 33% were not actively prescribing.¹⁰ Pharmacotherapy and psychosocial treatment should be routinely considered for all patients with opioid addiction, and patients should be informed of this option.

Data capture and calculations:

Calculation for Performance

For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

Performance Numerator (A) Includes:

- Patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period

Performance Denominator (PD) Includes:

- All patients aged 18 years and older
AND
- Diagnosis of current opioid addiction

Performance Calculation

$$\frac{A \text{ (\# of patients meeting measure criteria)}}{PD \text{ (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period
PD	# of patients aged 18 years and older with a diagnosis of current opioid addiction

Calculation for Reporting

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following instances:

A. Patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period

D. Patients who were not counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period

Reporting Denominator (RD) Includes:

- All patients aged 18 years and older with a diagnosis of current opioid addiction

Reporting Calculation

$$\frac{A(\text{\# of patients meeting numerator criteria}) + D(\text{\# of patients NOT meeting numerator criteria})}{RD \text{ (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period
D	# of patients who were <u>not</u> counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period
RD	# of patients aged 18 years and older with a diagnosis of current opioid addiction

Measure Specifications – Measure #2: Counseling regarding psychosocial and pharmacologic treatment options for opioid addiction

Measure specifications for data sources other than administrative claims will be developed at a later date.

A. Administrative claims data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

(Note: The specifications listed below are those needed for performance calculation.)

Denominator (Eligible Population): All patients aged 18 years and older with a diagnosis of current opioid addiction

- ICD-9 Diagnosis Codes: 304.00, 304.01, 304.02, 304.70, 304.71, 304.72

AND

- CPT Service Codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

Numerator: Patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period

- Report the CPT Category II code 4306F-Patient counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction

Denominator Exclusion: *None*

B. Electronic Health Record System *(in development)*

C. Paper Medical Record *(in development)*

Substance Use Disorders

Measure #3: Screening for Depression among Patients with Substance Abuse or Dependence

This measure may be used as an Accountability measure

Clinical Performance Measure
<p>Numerator: Patients who were screened for depression within the 12 month reporting period</p> <p>Denominator: All patients aged 18 years and older with a diagnosis of current substance abuse or dependence</p> <p>Denominator Exclusions: Documentation of medical reason(s) for not screening for depression</p> <p>Measure: Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>All patients with a substance use disorder should be carefully assessed for the presence of co-occurring psychiatric disorders, including additional substance use disorders. (APA, 2006)¹</p> <p>All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (i.e., those from the fourth edition of Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and comorbid psychological problems (e.g., anxiety, panic attacks, or substance abuse) should be addressed. (USPSTF, 2002)¹¹</p> <p>In general, treatment of depressive symptoms of moderate to severe intensity should begin concurrently or soon after initiating treatment of the co-occurring substance use disorder, particularly if there is evidence of prior mood episodes. In individuals without prior episodes of depression or a family history of mood disorders, it may be appropriate to delay the treatment of mild to moderate depressive symptoms for the purpose of diagnostic clarification. Clinicians are advised to monitor symptoms, assess and reassess for suicidal ideation, provide education, encourage abstinence from substances, and observe changes in mental status during the substance-free period while actively considering whether antidepressant intervention is indicated. (APA, 2006)¹</p>
<p>Rationale for the measure:</p> <p>Depression is one of the most common co-occurring psychiatric conditions in patients with substance use disorders and a condition for which a variety of screening methods have proven effective. Identifying depression and other co-occurring psychiatric disorders in patients with substance use disorders is essential for proper management and key to developing an integrated treatment approach, which is associated with better outcomes. Despite its importance, research has shown that more than 30% of patients with risk factors for depression, including alcohol or other drug abuse, were not asked about the presence or absence of depression or depressive symptoms.³</p>
<p>Data capture and calculations:</p> <p><u>Calculation for Performance</u> For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.</p>

Performance Numerator (A) Includes:

- Patients who were screened for depression within the 12 month reporting period

Performance Denominator (PD) Includes:

- All patients aged 18 years and older

AND

- Diagnosis of current substance abuse or dependence

Performance Denominator Exclusions (C) Include:

- Documentation of medical reason(s) for not screening for depression within the 12 month reporting period

Performance Calculation

$$\frac{A \text{ (\# of patients meeting measure criteria)}}{PD \text{ (\# of patients in denominator)} - C \text{ (\# of patients with valid denominator exclusions)}}$$

Components for this measure are defined as:

A	# of patients who were screened for depression within the 12 month reporting period
PD	# of patients aged 18 years and older with a diagnosis of current substance abuse or dependence
C	# of patients with documented medical reason(s) for not screening for depression within the 12 month reporting period

Calculation for Reporting

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following instances:

- A. Patients who were screened for depression within the 12 month reporting period
- C. Documentation of medical reason(s) for not screening for depression within the 12 month reporting period
- D. Patients who were not screened for depression within the 12 month reporting period and there is no documented reason for not doing so

Reporting Denominator (RD) Includes:

- All patients aged 18 years and older with a diagnosis of current substance abuse or dependence

Reporting Calculation

$$\frac{A \text{ (\# of patients meeting numerator criteria)} + C \text{ (\# of patients with valid exclusions)} + D \text{ (\# of patients NOT meeting numerator criteria)}}{RD \text{ (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who were screened for depression within the 12 month reporting period
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C	# of patients who were not screened for depression within the 12 month reporting period and there is a documented medical reason for not doing so
D	# of patients who were <u>not</u> screened for depression within the 12 month reporting period and there is <u>no</u> documented reason for not doing so
RD	# of patients aged 18 years and older with a diagnosis of current substance abuse or dependence

Measure Specifications – Measure #3: Screening for depression among patients with substance abuse or dependence
Measure specifications for data sources other than administrative claims will be developed at a later date.

A. Administrative claims data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

(Note: The specifications listed below are those needed for performance calculation.)

Denominator (Eligible Population): All patients aged 18 years and older with a diagnosis of current substance abuse or dependence

- ICD-9 Diagnosis Codes: 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92

AND

- CPT Service Codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215

Numerator: Patients who were screened for depression within the 12 month reporting period

- Report CPT Category II code: 1220F- Patient screened for depression

Denominator Exclusion: Documentation of medical reason(s) for not screening for depression

- Append modifier to CPT Category II code: 1220F-1P

B. Electronic Health Record System *(in development)*

C. Paper Medical Record *(in development)*

EVIDENCE CLASSIFICATIONS / RATING SCHEMES

American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients With Substance Use Disorders¹

Each recommendation is identified as meriting one of three categories of endorsement, based on the level of clinical confidence regarding the recommendation. The three categories are as follows:

- [Category I]: Recommended with substantial clinical confidence.
- [Category II]: Recommended with moderate clinical confidence.
- [Category III]: May be recommended on the basis of individual circumstances.

U.S. Preventive Services Task Force (USPSTF) Recommendations & Ratings¹¹

The Task Force grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

- A. The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.
- B. The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.
- C. The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.
- D. The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.
- I. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

References

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- ¹¹ U.S. Preventive Services Task Force. *Screening for Depression: Recommendations and Rationale*. May 2002. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm>