



American Academy of Neurology

Epilepsy Update Quality Measurement Set

Approved by the AAN Quality and Safety Subcommittee on July 3, 2014; by the AAN Practice Committee on July 18, 2014; and by the AANI Board of Directors on August 6, 2014

This measurement set was endorsed by the Child Neurology Society on July 29, 2014 and the Epilepsy Foundation on August 7, 2014. This measurement set received a qualified endorsement by the American Epilepsy Society (AES) on July 29, 2013. The AES definition of qualified endorsement: Quality measurement sets developed by external organizations that may not meet optimal levels of evidence and/or may not provide complete clinical decision support will be considered for qualified endorsement. The AES may not agree with every recommendation in such a document but overall considers the information to be of educational value to its members and to provide the basis for further analysis and validated measure development.

Quality Measures (Measures) and related data specifications developed by the American Academy of Neurology (AAN) are intended to facilitate quality improvement activities by providers.

These measures are intended to assist providers in enhancing quality of care. Measures are designed for use by any provider who manages the care of a patient for a specific condition or for prevention. These Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The AAN encourages testing and evaluation of its Measures.

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Epilepsy 2014 Update Work Group Members

Co-Chairs

Nathan Fountain, MD
Paul C. Van Ness, MD

American Academy of Neurology

Jerome Engel, Jr., MD, PhD, FAAN
David S. Gloss, MD
Christiane Heck, MD, MMM
Diego A. Morita, MD
Marianna V. Spanaki, MD, PhD, MBA
Thaddeus Walczak, MD

American Academy of Family Physicians

Mark C. Potter, MD

American Academy of Pediatrics

Edwin Trevathan, MD, MPH

American Association of Neurological Surgeons/Congress of Neurosurgeons

Joseph Neimat, MD

American Association of Neuroscience Nurses

Mona Stecker, DNP, NP-BC, CNRN, SCRN

American Board of Internal Medicine

Sharon M. Hibay, RN, DNP

American Clinical Neurophysiology Society

Susan T. Herman, MD

American College of Emergency Physicians

J. Stephen Huff, MD

American Epilepsy Society

Gabriel U. Martz, MD

American Society of Neuroradiology/ American College of Radiology

Marvin Nelson, MD

Child Neurology Society

Inna Hughes, MD, PhD

Citizens United for Research in Epilepsy

Tracy Dixon-Salazar, PhD

Epilepsy Foundation

Janice M. Buelow, RN, PhD

National Academy of Neuropsychology

Daniel Drane, PhD, ABPP(CN)

National Association of Epilepsy Centers

Ramon Bautista, MD, MBA

OptumInsight

Kay Schwebke, MD, MPH, MA

Veterans Affairs Epilepsy Centers of Excellence

Karen Parko, MD, FAAN

Independent Representatives

Laurie A. Olmon
Mary Jo Pugh, PhD, RN

Work Group Facilitators

John R. Absher, MD, FAAN
Anup D. Patel, MD
Kevin N. Sheth, MD, FAHA, FCCM, FNCS

American Academy of Neurology Staff

Amy Bennett, JD
Gina Gjorvad
Becky Schierman, MPH
Rebecca J. Swain-Eng, MS, CAE

DECLINED/DID NOT RESPOND: American Academy of Neuromuscular and Electrodiagnostic Medicine, American Academy of Physical Medicine and Rehabilitation, American College of Emergency Physicians, American College of Physicians, American College of Rheumatology, American Neurological Association, American Osteopathic Association, American Occupational Therapy Association, American Physical Therapy Association, Society of Nuclear Medicine and Molecular Imaging, MN Health Action Group, Midwest Business Group on Health, Aetna, Humana, Palmetto GBA, Highmark, Cigna, Kaiser Permanente, WellPoint

TOWARDS IMPROVING OUTCOMES FOR PATIENTS WITH EPILEPSY

In 2008-2009, the American Academy of Neurology (AAN) and the American Medical Association-convened Physicians Consortium for Performance Improvement developed eight quality measures for patients with epilepsy.¹ In 2013, the AAN formed a multi-disciplinary Epilepsy Work Group (Work Group) to review and update the existing epilepsy quality measurement set.

Importance of Topic

Epilepsy data is lacking. In 2012, the Institute of Medicine released *Epilepsy across the Spectrum: Promoting Health and Understanding*, detailing epilepsy research disparities and highlighting specific areas where further research is needed, including the extent of epilepsy, consequences, comorbid conditions and outcomes of epilepsy.² The following statistics only touch on the magnitude of epilepsy given lack of research and stigma:

- It is estimated 2.2 million people in the United States are diagnosed with epilepsy, and 150,000 new cases of epilepsy are diagnosed in the United States annually.²
- Epilepsy prevalence might be underestimated because of underreporting associated with repercussions and stigma in disclosing epilepsy.³
- Common comorbidities among people with epilepsy include somatic (i.e., fractures, asthma, diabetes, and heart disease), neurological (i.e., stroke, Alzheimer's disease, Autism spectrum disorders, chronic pain), and mental health conditions (i.e., mood disorders, attention deficit hyperactivity disorders, anxiety disorders, suicidality).^{2,4}
- It is estimated the number of people with epilepsy who die of sudden unexpected death in epilepsy (SUDEP) range from 1 of every 10,000 who are newly diagnosed to 9 of every 1,000 candidates for epilepsy surgery.²
- People with epilepsy are more likely to be unemployed or unable to work, have low annual household incomes, be obese and physically inactive, and to smoke.^{2,4}
- People with epilepsy have poorer overall health status, impaired intellectual and physical functioning, a greater risk for accidents and injuries, and negative side effects from seizure medications.^{1,2,4}
- It is estimated the annual direct medical cost of epilepsy in the United States is \$9.6 billion. This estimate does not include community service costs or indirect costs from losses in quality of life and productivity.²

Opportunities for Improvement

Additional data on opportunities for improvement and gaps in care specific to the epilepsy measures can be located in the updated epilepsy measures.

- A review of 261 patient responses using the PatientsLikeMe survey system indicated a gap remains between recommended care detailed in the 2009 epilepsy measurement set and the care delivered to patients with epilepsy.⁵
- The Institute of Medicine noted several gaps in care and opportunities for improvement, including 1) timely referrals and access to treatments, 2) epilepsy care and prevention, 3) education of persons with epilepsy and their families, and 4) the stigma of epilepsy.²
- Surgery continues to be heavily underutilized as a treatment for epilepsy, with significant disparities by race and insurance coverage.⁶

Clinical Evidence Base

When possible, every effort was made to support measure recommendations with Randomized Clinical Trials (RCT). Lacking sufficient RCT data, clinical practice guidelines and peer-reviewed papers served as the foundation for the development of these performance measures. Some guidelines, such as those

developed by National Institute for Health and Clinical Excellence (NICE)⁷ and Pugh et al.⁸, are consensus based. These recommendations are listed as supporting several of the measures.

Epilepsy Evidence-Based Processes and Desired Outcomes

The Work Group identified the following evidence-based processes and desired outcomes for patients with epilepsy prior to drafting the measurement set:

Desired Outcomes:

1. Freedom from seizures
2. Reduction of seizure frequency
3. Reduced risk of death associated with seizures (e.g., sudden unexpected death in epilepsy (SUDEP), accident, or suicide)
4. Increased and earlier recognition of patients who have treatment resistant (intractable) epilepsy
5. Reduce and address safety issues (e.g., falls, injury, etc.)
6. Increased independence
7. Reduction of mental health and behavioral health comorbidities
8. Recognition and reduction of cognitive morbidity
9. Increased patient engagement in care and self-management
10. Reduction of Emergency Department visits and emergency services
11. Improved quality of life
12. Reduction of cost of care
13. Improved patient experience

Evidence-Based Processes:

1. Timely and appropriate referrals to an epilepsy specialist for patients with treatment resistant (intractable) epilepsy
2. Early and accurate diagnosis
3. Reduction of and monitoring of anti-seizure therapy side effects
4. Referral to appropriate testing and reduction of unnecessary testing (e.g., neuroimaging, electroencephalogram (EEG), etc.)
5. Improved coordination of care
6. Patient centered care provided

Intended Audiences, Care Settings, and Patient Population

The Work Group considered the development of process and outcome quality measures assessing care at the individual provider and/or practice level. The Work Group focused on developing measures for outpatient settings. The Work Group recognized that it is impossible to create one measurement set that would address all seizure and epilepsy quality of care issues. It was determined that febrile seizures, neonatal seizures, and status epilepticus measures would be excluded from project scope.

Epilepsy Work Group Recommendations

The 2009 epilepsy measurement set was reviewed. The Work Group recommended three measures be retired (i.e., Electroencephalogram (EEG) Results Reviewed, Requested, or Test Ordered; Magnetic Resonance Imaging/Computed Tomography Scan (MRI/CT Scan) Results Reviewed, Requested, or Scan Ordered; Surgical Therapy Referral Consideration for Intractable Epilepsy), four measures were revised, and the Counseling for Women of Childbearing Potential with Epilepsy measure was affirmed. Two new measures were created.

2014 Updated Epilepsy Measures

1A. Seizure Frequency (Paired Measure) (2009 measure revised)
1B. Seizure Intervention (Paired Measure) (2009 measure revised)
2. Etiology, Seizure Type, or Epilepsy Syndrome (2009 measure revised)
3. Querying and Intervention for Side Effects of Anti-seizure Therapy (2009 measure revised)
4. Personalized Epilepsy Safety Issue and Education Provided (2009 measure revised)
5. Screening for Psychiatric or Behavioral Health Disorders
6. Counseling for Women of Childbearing Potential with Epilepsy (2009 measure with updated specifications)
7. Referral to Comprehensive Epilepsy Center

Other Potential Measures

The Work Group considered several other important constructs in care for people with epilepsy, including ensuring correct diagnosis for treatment resistant (intractable) epilepsy, quality of life, and self-management. The Work Group determined that the evidence was too weak, the gap in care was too small, or the opportunity for improvement from the measure was too low to continue with the development of the measure, and they were not suitable for inclusion in this measurement set at this time.

The Work Group proposed and accepted public comments on a draft measure proposing a two year wait to withdraw anti-seizure medications for children with epilepsy with a history of focal seizures and abnormal EEG. As a result of public comments, including concern about the evidence base, this measure was withdrawn from the measure update set.

Measure Harmonization

The Work Group reviewed the existing epilepsy quality measurement set, as well as, additional measures created by the British Medical Association (BMA).⁹ The BMA released three epilepsy measurements, but the Work Group felt additional detail was needed beyond BMA specification:

- contractor establishes and maintains a register of patients age 18 or over receiving drug treatment for epilepsy
- the percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
- the percentage of women aged 18 or over and who have not attained the age of 55 who are taking anti-seizure medication who have a record of information and counseling about contraception, conception and pregnancy in the preceding 12 months.

Existing Quality Improvement (QI) Initiative or Collaborative for Measure Implementation

Three out of the eight epilepsy measures created in 2009 were adopted by the Centers for Medicaid and Medicare Services (CMS) into the Physician Quality Reporting System (PQRS) pay for reporting program. Once published, the updated measure set will be reviewed for possible adoption by CMS and National Quality Forum (NQF) endorsement for accountability programs.

The AAN has developed a performance in practice program for maintenance of certification (MOC), NeuroPI (<http://tools.aan.com/practice/pip/>), which meets the American Board of Psychiatry and Neurology (ABPN) requirements for MOC Performance in Practice requirements. The NeuroPI currently contains a module for epilepsy based upon the 2009 measures developed. The AAN anticipates that the NeuroPI epilepsy module will be updated to reflect the revisions to past epilepsy measures and incorporation of the new measures below.

Measure Exceptions

A denominator exclusion is a factor supported by the clinical evidence that removes a patient from inclusion in the measure population. For example, if the denominator indicates the measure is for all patients aged 0 to 18 years of age, a patient who is 19 years of age is excluded.

A denominator exception is a condition that should remove the patient, procedure or unit of measurement from the denominator only if the numerator criteria are not met. The AAN includes three possible types of exceptions for reasons why a patient should not be included in a measure denominator: medical (e.g., contraindication), patient (e.g., declination or religious belief), or system (e.g., resource limitation) reasons.

For each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. The Work Group provided explicit exceptions when applicable for ease of use in eMeasure development.

Testing and Implementation of the Measurement Set

In 2012, the AAN submitted epilepsy quality measures to the NQF. The AAN received conditional endorsement of its Counseling for Women with Epilepsy measure. To receive full endorsement the AAN was required to field test the measure for feasibility, reliability, and validity prior to NQF's review of this measure in March 2014. The AAN contracted with Minnesota Community Measurement (MNCM), a non-profit organization specializing in health care quality measurement and reporting, to collect data pertaining to this measure from neurology practices. MNCM concluded the rate calculation and any additional data analysis can be completed using validated and reliable data. MNCM suggested there may need to be a consideration for adding a component of indicating that the patient is sexually active or has the potential to be sexually active, and not physically handicapped. During the validation audit, it was noted on several occasions that the practices provided excellent, personalized progress notes about the counseling that was being provided, that were above and beyond a "check the box". NQF endorsed the Women with Epilepsy measure.

The new epilepsy measures are being made available without any prior testing. The AAN encourages testing of this measurement set for feasibility and reliability by organizations or individuals positioned to do so.

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 7. National Institute of Clinical Health and Excellence. The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care (update). 2012. Clinical guideline 137. Available at: <http://www.nice.org.uk/nicemedia/live/13635/57779/57779.pdf> Accessed on February 18, 2014.
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 9. British Medical Association. Quality and Outcomes Framework guidance for GMS contract 2013/14. British Medical Association, National Health Service Confederation. 2013 Mar. 203 p.

MEASURE #6:

Counseling for Women of Childbearing Potential with Epilepsy

Measure Description	
All female patients of childbearing potential (12-44 years old) diagnosed with epilepsy who were counseled or referred for counseling for how epilepsy and its treatment may affect contraception OR pregnancy at least once a year.	
Measure Components	
Numerator Statement	<p>Female patients or caregivers counseled* at least once a year about how epilepsy and its treatment may affect contraception OR pregnancy.</p> <p>*Counseling should include a discussion about folic acid supplementation, contraception, <u>potential</u> anti-seizure medications effect(s) on pregnancy, safe pregnancies, and breastfeeding.</p>
Denominator Statement	All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy. Excluded: patients diagnosed with menopause or surgically sterile.
Denominator Exceptions	<ul style="list-style-type: none"> • Patient has a diagnosis of neurodevelopmental disorder, encephalopathy, hydrocephalus, brain injury, or cerebral palsy. • Patient has a diagnosis of severe cognitive impairment or severe intellectual disability.
Supporting Guideline & Other References	<p>The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:</p> <ul style="list-style-type: none"> • If a woman with epilepsy is of childbearing potential and receives oral contraceptives in conjunction with an enzyme inducing AED [Antiepileptic Drug], THEN decreased effectiveness of oral contraception should be addressed. (higher doses of the oral contraceptive, alternative birth control methods, or change AED). (Level A 2++/Primary)¹ • Patients with epilepsy should receive an annual review of information including topics such as: ... Contraception, family planning, and how pregnancy and menopause may affect seizures (evidence grade C)¹ • Women with epilepsy (WWE) should be counseled that seizure freedom for at least 9 months prior to pregnancy is probably associated with a high rate (84%-92%) of remaining seizure-free during pregnancy.² • Women with epilepsy who smoke should be counseled that they possibly have a substantially increased risk of premature contractions and premature labor and delivery during pregnancy. There is possibly a substantially increased risk of premature contractions and premature labor and delivery during pregnancy for WWE who smoke. (Level C)² • Counseling of WWE who are contemplating pregnancy should reflect that there is probably no increased risk of reduced cognition in the offspring of WWE not taking AEDs (Level B).³

	<ul style="list-style-type: none">• To reduce the risk of MCMs, avoidance of the use of VPA during the first trimester of pregnancy, if possible, may be considered, compared to the use of PHT or LTG. [MCMs=major congenital malformations; VPA=valproate; PHT=phenytoin; LTG=lamotrigine] (Level C)³• In order to enable informed decisions and choice, and to reduce misunderstandings, women and girls with epilepsy and their partners, as appropriate, must be given accurate information and counselling about contraception, conception, pregnancy, caring for children and breastfeeding, and menopause. (Level III)⁴• Information about contraception, conception, pregnancy, or menopause should be given to women and girls in advance of sexual activity, pregnancy or menopause, and the information should be tailored to their individual needs. This information should also be given, as needed, to people who are closely involved with women and girls with epilepsy. These may include her family and/or carers. (Level III)⁴• All healthcare professionals who treat, care for, or support women and girls with epilepsy should be familiar with relevant information and the availability of counselling. (Level III)⁴• Discuss with women and girls of childbearing potential (including young girls who are likely to need treatment into their childbearing years), and their parents and/or carers if appropriate, the risk of AEDs causing malformations and possible neurodevelopmental impairments in an unborn child. Assess the risks and benefits of treatment with individual drugs. There are limited data on risks to the unborn child associated with newer drugs. Specifically discuss the risk of continued use of sodium valproate to the unborn child, being aware that higher doses of sodium valproate (more than 800 mg/day) and polytherapy, particularly with sodium valproate, are associated with greater risk. (Evidence comes from three systematic reviews; one review focused on incidence of malformation and the other two on child neurodevelopmental outcomes. No individual RCTs were reviewed. This recommendation was also based on GDG consensus opinion.)⁴• In women of childbearing potential, the possibility of interaction with oral contraceptives should be discussed and an assessment made as to the risks and benefits of treatment with individual drugs. (Level III)⁴• In girls of childbearing potential, including young girls who are likely to need treatment into their childbearing years, the possibility of interaction with oral contraceptives should be discussed with the child and/or her carer, and an assessment made as to the risks and benefits of treatment with individual drugs. (Level III)⁴• In women and girls of childbearing potential, the risks and benefits of different contraceptive methods, including hormone-releasing intrauterine devices (IUDs), should be discussed.• (Level III)⁴
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	<ul style="list-style-type: none"> • If a woman or girl taking enzyme-inducing AEDs chooses to take the combined oral contraceptive pill, guidance about dosage should be sought from the SPC and current edition of the BNF (available at http://bnf.org External Web Site Policy). (Level III)⁴ • Women and girls with epilepsy need accurate information during pregnancy, and the possibility of status epilepticus and sudden death in epilepsy (SUDEP) should be discussed with all women and girls who plan to stop AED therapy (see the section 'Withdrawal of Pharmacologic Treatment' above).⁴
<p>Rationale for the Measure</p>	<p>Epilepsy is associated with reduced fertility, increased pregnancy risks, and risks for malformations in the infant. Treatment of seizures with anti-seizure medications may alter hormone levels, render oral contraceptives less effective and may interfere with embryonic and fetal development. Certain anti-seizure medications may have specific malformation risks. Folic acid supplementation, monotherapy for epilepsy, using lower doses of medication when possible, and proper obstetrical, prenatal and pre-pregnancy care all should be discussed with the patient so they understand the risks involved and how to mitigate these risks.</p>
<p>Opportunity for Improvement</p>	<p>In 2013, the AAN tested its Women with Epilepsy of Childbearing potential measure and evidence of a gap in care remains. Data from the testing project showed that on average less than 40% of women received counseling about epilepsy and how its treatment may affect contraception and pregnancy.⁵ Additionally, the QUality Indicators for Epilepsy Treatment in adults (QUIET) study demonstrated that only 34% of female patients receive counselling on aspects of epilepsy care specific to women (neurologist alone=32.88%; shared (neurologists and primary care=44.83%; and primary care alone=11.11%).⁶</p> <p>For babies whose mothers take seizure medication, the risk of birth defects is 4% to 8% compared with 2% to 3% for all babies.⁷ Despite the availability of practice guidelines, knowledge about the use of seizure medications during pregnancy was low with less than half of neurologists able to identify which medications were linked to adverse events during pregnancy.⁸</p>
<p>References</p>	<p>¹ Pugh MJ, Berlowitz DR, Montouris G, et al. What constitutes high quality of care for adults with epilepsy? <i>Neurology</i> 2007;69:2020-2027</p> <p>² Harden CL, Hopp J, Ting TY, et al. Practice Parameter update: Management issues for women with epilepsy-Focus on pregnancy (an evidence-based review): Obstetrical complications and change in seizure frequency: Report of the Quality Standards Subcommittee and Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and American Epilepsy Society. <i>Neurology</i> 2009;73:126-132.</p> <p>³ Harden CL, Meador KJ, Pennell PB, et al. Practice Parameter update: Management issues for women with epilepsy – Focus on pregnancy (an evidence-based review): Teratogenesis and perinatal outcomes: Report of the Quality Standards Subcommittee and Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and American Epilepsy Society. <i>Neurology</i> 2009;73:133-141.</p>

	<p>⁴ National Institute of Clinical Health and Excellence. The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care (update). 2012. Clinical guideline 137. Available at: http://www.nice.org.uk/nicemedia/live/13635/57779/57779.pdf Accessed on February 18, 2014.</p> <p>⁵ MN Community Measure, Women with Epilepsy Draft Testing Report. December 18, 2013.</p> <p>⁶ Pugh MJ, Berlowitz DR, Rao JK, et al. The quality of care for adults with epilepsy: an initial glimpse using the QUIET measure. BMC Health Services Research 2011;11:1. Available at: http://www.biomedcentral.com/1472-6963/11/1 Accessed on February 25, 2014.</p> <p>⁷ Epilepsy Foundation. Pregnancy issues website. Available at: www.epilepsyfoundation.org/living/women/pregnancy/weipregnancy.cfm. Accessed on February 25, 2014.</p> <p>⁸ Roberts, JI, Metcalfe A, Abdulla F, et al. Neurologists’ and neurology residents’ knowledge of issues related to pregnancy for women with epilepsy. Epilepsy Behav. 2011;22(2):358-363.</p>
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Measure Designation

Measure purpose	<input checked="" type="checkbox"/> Quality improvement <input checked="" type="checkbox"/> Accountability <input checked="" type="checkbox"/> MOC
Type of measure	<input checked="" type="checkbox"/> Process <input type="checkbox"/> Outcome <input type="checkbox"/> Structure
Level of Measurement	<input checked="" type="checkbox"/> Individual Provider <input checked="" type="checkbox"/> Practice
National Quality Strategy Domains	<input checked="" type="checkbox"/> Patient and Family Engagement <input checked="" type="checkbox"/> Patient Safety <input checked="" type="checkbox"/> Care Coordination <input type="checkbox"/> Population/Public Health <input type="checkbox"/> Efficient Use of Healthcare Resources <input type="checkbox"/> Clinical Process/Effectiveness
Care setting	<input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Departments and Urgent Care
Data Sources	<input checked="" type="checkbox"/> Electronic health record (EHR) data <input checked="" type="checkbox"/> Administrative Data/Claims

Technical Specifications: Electronic Health Record (EHR) Data

The AAN is in the process of creating code value sets and the logic required for electronic capture of the quality measures with EHRs. A listing of the quality data model elements, code value sets, and measure

logic (through the CMS Measure Authoring Tool) for each of the epilepsy measures will be made available at a later date.

Technical Specifications: Electronic Administrative Data (Claims)

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.

Denominator (Eligible Population)	ICD-9 and ICD-10 Diagnosis Codes:	
	ICD-9 Codes	ICD-10 Codes
	345.00, generalized nonconvulsive epilepsy, without mention of intractable epilepsy	G40.A09 absence epileptic syndrome, not intractable, without status epilepticus
	345.01, generalized nonconvulsive epilepsy, with intractable epilepsy	G40.A19 absence epileptic syndrome, intractable, without status epilepticus
	345.10, generalized convulsive epilepsy, without mention of intractable epilepsy	G40.309 Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus OR G40.409 Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus
	345.11, generalized convulsive epilepsy, with intractable epilepsy	G40.411 Other generalized
	345.40, Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, without mention of intractable epilepsy	G40.209 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
	345.41, Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures, with intractable epilepsy	G40.219 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
	345.50, Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures, without mention of intractable epilepsy	G40.109 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
	345.51, Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple	G40.119 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus

partial seizures, with intractable epilepsy	
345.60, Infantile spasms, without mention of intractable epilepsy	G40.822 Epileptic spasms, not intractable, without status epilepticus
345.61, Infantile spasms, with intractable epilepsy	G40.824 Epileptic spasms, intractable, without status epilepticus
345.70, Epilepsia partialis continua, without mention of intractable epilepsy	G40.109 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
345.71, Epilepsia partialis continua, with intractable epilepsy	G40.119 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
345.90, Epilepsy, unspecified, without mention of intractable epilepsy	G40.909 Epilepsy, unspecified, not intractable, without status epilepticus

AND

CPT E/M Service Code:

99201, 99202, 99203, 99204, 99205 (Office or other outpatient visit-New Patient);

99211, 99212, 99213, 99214, 99215 (Office or other outpatient visit-Established Patient);

99241, 99242, 99243, 99244, 99245 (Office or Other Outpatient Consultation-New or Established Patient)

AND

Female gender

AND

Age ages 12 to 44 years old

Contact Information

For more information about quality measures please contact:

American Academy of Neurology
201 Chicago Avenue
Minneapolis, MN 55415
Phone: (612) 928-6100
Fax: 612-454-2744
quality@aan.com

Measure Testing Summary Report: Counseling for Women of Childbearing Potential with Epilepsy

Prepared for: American Academy of Neurology

12/18/2013

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Project Background

In 2012, the AAN submitted epilepsy quality measures to the National Quality Forum (NQF), a national, nonprofit organization that reviews and endorses health care quality measures for use by public and private payers. The AAN received conditional endorsement of its Counseling for Women with Epilepsy measure. To receive full endorsement the AAN must field test the Counseling for Women with Epilepsy measure for feasibility, reliability, and validity prior to NQF's review of this measure in March 2014. To achieve the goal of testing the Counseling for Women with Epilepsy measure the AAN contracted with Minnesota Community Measurement (MNCM), a non-profit organization specializing in health care quality measurement and reporting, to collect data pertaining to this measure from Neurology practices.

Purpose

This project aims to successfully collect de-identified patient-level data from Neurology practices that have the capability to report accurate denominator and numerator information for the Counseling for Women with Epilepsy measure. In order to achieve a reliable sample of patients for this measure MNCM and AAN are seeking a minimum of 1,000 combined patient records from the Neurology sites that agree to participate.

Methods

The AAN identified and recruited Neurology practices in Minnesota that have experience treating patients with epilepsy. As part of the recruitment process MNCM and the AAN hosted an informational webinar explaining the purpose of the measurement testing project for the Counseling for Women with Epilepsy measure. Three Neurology practices volunteered to participate and submit retrospective data from the 2012 calendar year (i.e. dates of service 01/01/2012 – 12/31/2012).

MNCM produced a data collection guide, measure flow and detailed file specifications to educate and assist each medical group in the data collection and submission process. As a requirement of participating in the measure testing each group had to submit a denominator certifications form (see appendix A). The denominator certification process helps ensure that each medical group is using the appropriate measure parameters and collecting data in a standardized way.

Once the denominator certifications were complete each group submitted their data files using a secure FTP transfer process. Once the files were received MNCM performed quality checks on each files using the methods outlined in Appendix B. Once the files passed the quality checks MNCM calculated and sent the results back to each group for review. If the group did not find any issues with the measure results then MNCM conducted an audit to validate the accuracy of data using the auditing principles outlined in Appendix C.

The final step in testing the Women with Epilepsy measure was a post-data submission survey that was sent to each of the participating medical groups. The intent of the survey was to shed light on the amount of resources that were required to produce the data as well as gauge the level of data collection burden that each data field presented to the group. The results of the survey can be found in Appendix E.

Results & Findings

Descriptive Measure Statistics

Table 1: Patient Payer Information

Payer Type	Clinic A	Clinic B	Clinic C	Grand Total
Medicaid		76		76
Medicare	105	72	7	184
Self-Pay/Uninsured	9	11	2	22
Commercial	461	422	45	928
Medicaid	176		5	181

Table 2: Patient Place of Residence (based on zip code)

State	Group A Patients	Group B Patients	Group C Patients	Total
Minnesota	32	649	561	1242
Iowa	7	19	3	29
Wisconsin	4	49	14	67
North Dakota		9		9
South Dakota	3	11	1	15
Alaska		1		1
Arkansas	1			1
Colorado	1	1		2
Illinois	1	1		2
Maryland		1	1	2
Michigan	2	1		3
Nebraska	1	5	1	7
New York		1		1
North Carolina	1			1
Oklahoma	2			2
Ohio		1		1
Pennsylvania	1			1
Blank	3	2		5

Table 3: Patient Race and Ethnicity Information

Race	Group A Patients	Group B Patients	Group C Patients	Total
American Indian/Alaska Native (Code 1)		6	3	9
Asian (Code 2)	2	12	8	22
Black/African American (Code 3)		19	18	37
Hispanic/Latino (Code 4)		12		12
Native Hawaiian/Other Pacific Islander (Code 5)		3		3

White (Code 6)	54	335	236	625
Some Other Race (Code 7)	3	2		5
Unknown (Code 98)		1	4	5
Chose not to disclose (Code 97)			11	11
Blank		361	301	662

Table 4: Patient Age Breakdown

Total by clinic	Group A Patients	Group B Patients	Group C Patients	Total
Ages 12-17	14	170	112	296
Ages 18-25	13	206	175	394
Ages 26-30	8	129	113	250
Age 31-35	13	111	73	197
Ages 36-40	8	93	60	161
Ages 41-44	3	42	48	93

Measure Results

Measure Results	Clinic A	Clinic B	Clinic C	Total
Number of Providers (NPI)	9	36	22	67
Number of Patients Submitted	751	581	59	1391
Number of Patients Excluded; intellectual disability codes	127	32	2	161
Number of Patients Excluded; surgically sterile	18	12	5	35
Number of Patients with valid exclusions	145	44	7	196
Denominator: Number of Patient Eligible for Counseling	606	537	52	1195
Number of Patients with Counseling for Contraception	420	26	11	457
Number of Patients with Counseling for Pregnancy	419	77	7	503
Number of Patients with Contraception and Pregnancy	419	21	6	446
Rate for Contraceptive Counseling	69.3%	4.8%	21.2%	38.2%
Rates for Pregnancy Counseling	69.1%	14.3%	13.5%	42.1%
Rates for Contraceptive <u>and</u> Pregnancy Counseling	69.1%	3.9%	11.5%	37.3%

Other Medical Reasons for Not Counseling Patients	Clinic A	Clinic B	Clinic C	Total
Number of Patients Submitted	751	581	59	1391
Number of Patients with "Other Medical Reason"	122	156	6	446
Percentage of Patients with "Other Medical Reason"	16.2%	26.9%	10.2%	20.4%

Please note: The following rate re-calculation is for analytical purposes only; removing all patients that had "Other Medical Reason Documented". MNCM does not recommend reporting this rate. Please see Limitations Section

Rates for Contraceptive <u>and</u> Pregnancy Counseling if these patients are also removed from the denominator	86.6%	5.5%	13.0%	49.0%
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Validation Results / Audit Results

MNCM completed validation of the data in a three-step process: 1) denominator certification, 2) data file quality checks, and 3) validation audit. Details of this validation are described in this report.

Denominator Certification

Denominator certification is an essential step in the process to obtaining valid and accurate data. It requires each participant to attest that they will submit accurate data and follow the measure specifications exactly how they are written. It also ensures that each participant is querying the correct:

- Diagnosis codes (*i.e.* 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.70, 345.71, 345.90, 345.91)
- Encounter codes (*i.e.* 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245)
- Date of birth ranges (*i.e.* 01/01/1968-01/01/2000)
- Date of service ranges (*i.e.* 01/01/2012- 12/31/2012)

MNCM did not identify any major flaws or issues during the review of each medical group's denominator forms and therefore each medical group passed denominator certification within the given timeframe. There were a few corrections and clarifications that required MNMCM to send a follow-up email to the respective group; however, each issue was resolved in a timely manner. The list below documents the issues that were identified and required additional follow-up based on the information received on the denominator certification forms:

- Incorrect diagnosis codes included in data query
- Group did not indicate if they would be submitting a sample or full population for the measure
- Incorrect encounter codes included in data query

Data File Quality Checks

After each medical group submitted their data file to MNMCM, quality checks of the files were completed. Each column in the data file represented a field of data for each patient row; the following checks were completed:

- Number of patients/rows submitted were reasonable/expected
- Necessary data fields (columns) were included and completed appropriately
- Patient date of birth spanned the expected range
- Zip codes were 5-digit and primarily within MN and other bordering states as expected
- Race field(s) were included and populated appropriately
- Provider NPI field was included and number of providers expected
- Insurance information was included and was reasonable
- Office visit dates and counseling dates spanned the expected range
- Diagnoses were included and spanned the entire list of expected codes
- Medical reasons for NOT counseling were applied correctly; were not misused

Issues identified through the data file quality checks were generally minor, requiring no corrections. Other mentionable items include:

1. All three groups did not have patients with diagnosis codes 345.70 (Epilepsia partialis continua, without mention of intractable epilepsy) or 345.71 (Epilepsia partialis continua, with intractable epilepsy). These are rare diagnoses and did not come up in the population.
2. Medical groups B and C listed many neurological or congenital conditions as reasons for the patient to NOT receive counseling. These were verified during audit.
3. Medical group C did not include their entire population in first submission, excluding patients whose date of birth was between January thru June 1968. They queried their system again, this time using the specific dates of birth (rather than “age” values) and included the additional patients in their denominator.

Validation Audit

After the data file checks were completed, MNCM completed audits of the patient records to verify the submitted clinical data. We also verified the diagnosis of epilepsy and other demographic data (e.g., race).

MNCM uses a validation process developed by the NCQA – National Committee for Quality Assurance, known as the “8 and 30” process. In this process, the first eight records are verified for accuracy and if no errors are identified, the data is considered to be 100% compliant. If errors in the first eight records are identified, we continue reviewing the total 30 records to identify any error patterns and or issues that may need correction.

The audits revealed some data errors, requiring one medical group to make corrections and resubmit data. Individual medical group results were as follows:

Medical group	Audit details	Follow-up action
A	<p>8 records reviewed, 8 records compliant (100%)</p> <p>3 additional records were reviewed for “other” reason patient was not counseled</p> <ul style="list-style-type: none"> o 2 records were compliant o 1 record indicated patient had functional seizures and not epilepsy, but should have been counted as no counseling provided 	No further action necessary
B	<p>30 records reviewed, 26 compliant (87%)</p> <ul style="list-style-type: none"> o Errors: three records had code “2” for no counseling due to intellectual disability, however, we could not verify the diagnosis in the record; one record reported as “1” counseling given could not be verified <p>3 additional records were reviewed whose patients were listed as “cognitively impaired” as a reason for not receiving counseling; verified that these patients had mild retardation; medical group staff corroborated that all 115 patients with this designation also had mild retardation</p>	Group verified patients they submitted who were “surgically sterile” or who had “intellectual disability”; resubmitted data with corrections
C	<p>8 records reviewed, 8 records compliant (100%)</p> <p>We identified one record in the eight reviewed in which the patient could have been flagged for a medical reason to NOT receive counseling (99 “other), but because the reasons were not either type (surgically sterile, intellectual disability), it was appropriate that these patients could have been counseled; these were not counted as errors</p>	No further action necessary

Validation/ Audit Conclusion

The validation process was successful in identifying errors (with subsequent corrections) and verifying the accuracy of the data submitted by medical groups A, B, and C. Finding no significant flaws or errors with the data MNCM is confident the rate calculation and any additional data analysis can be completed using validated and reliable data.

Additionally, during a review of the National Quality Forum’s feedback to the American Academy of Neurology for this measure, it was noted that there was a concern that this may simply be a “check-the-box” measure. During the validation audit, it was noted on several occasions that the practices provided excellent, personalized progress notes about the counseling that was being provided, that were above and beyond a “check the box”.

Limitations

The main limitation that MNMCM identified during the testing of the Counseling for Women with Epilepsy measure is related to the denominator of included and excluded patients. The measure specifications offered two different options for excluding patients from the measure:

1. Patient was surgically sterile (tubal ligation, hysterectomy)
2. Patient has an intellectual disability as defined by ICD-9 codes
 - a. 318.0 moderate intellectual disabilities; IQ 35 to 48
 - b. 318.1 severe intellectual disabilities; IQ 20 to 34
 - c. 318.2 profound intellectual disabilities; IQ under 20

Groups submitted these patients and indicated which reason applied. Additionally, if they felt that there was another medical reason for not providing counseling, they indicated this by a code and accompanying description. These reasons were not used to exclude patients from the measure; rather the purpose was to provide additional information about the population of patients included in the measure.

Reasons Provided by Medical Groups for Not Providing Counseling:

Reason by Frequency	Count	Valid	Thoughts
cognitive impairment/ deficit	138	Maybe	subjective and may still be at risk
cerebral palsy	45	Yes	need to quantify by code
neurodevelopmental disorder	18	Yes	need to quantify by code
encephalopathy	15	Yes	need to quantify by code
developmental delay	14	No	may still be at risk
hydrocephalus	8	Yes	need to quantify by code
brain injury	8	Yes	need to quantify by code
pregnancy	7	No	still needs counseling
pre-menarche	7	No	may still be at risk
autism	4	No	may still be at risk
downs syndrome	3	Maybe	may still be at risk
aspergers	2	No	spectrum of functioning; at risk
birth control- IUD	2	No	may still be at risk
learning disability	2	No	spectrum of functioning; at risk
menopause	1	Yes	need to quantify by code
no menses	1	Maybe	
multiple sclerosis	1	No	Spectrum of functioning; at risk

Future Measure Implementation

During the analysis of this data and also as a byproduct of the validation audit in reviewing medical records, MNMCM staff has some concerns regarding the denominator and intent of the measure. There may need to be a consideration for adding a component of indicating that the patient is sexually active or has the potential to be sexually active, and not

physically handicapped. AAN could refer to the NCQA specifications for the Chlamydia Screening in Women measure (NQF# 0033/ CMS 153v1) for reference tables indicating how to identify potentially sexually active women via pharmacy codes, CPTs, ICD-9, UB Revenue and LOINC codes. Rather than trying to capture/ code every possible exclusion; this may be an option. MNMCM would not recommend having a general type exclusions code, like one that is stated as “any documented medical reason, because providers will use this to their advantage and exclude patients that are at risk for pregnancy and truly belong in the denominator. Having this type of exclusion weakens the measure, and can impact the validity and reliability of the results.

Appendix A: Denominator Certification Form

What information do I submit to MNMCM?

The instructions in this document will guide you in creating the necessary documentation for Denominator Certification. Using the following steps, you will construct a Word document. Your document must describe the process you use to identify eligible patients, including source code and screen shots of your query. After you submit your document to the MNMCM, MNMCM will review your document and respond within two business days. **Please note:** MNMCM will review your denominator method, however, you are ultimately responsible for interpreting and applying the measure specifications correctly in your query.

Please submit your denominator document to support@mncm.org

****Please do not submit patient data along with your denominator document****

What is denominator certification?

Denominator Certification is the process by which medical groups submit a document that explains the process they use to identify patients for the measure. MNMCM then reviews the documentation to verify the measure specifications for the denominator were followed.

What are the denominator criteria?

All females of childbearing potential (12 to 44 years old) with a diagnosis of epilepsy are in the denominator. Please refer to the data collection guide for the complete measure specifications.

Complete this table and provide additional details

Denominator document instructions	Your response
1. Medical group information <i>Supply the following information:</i>	<i>Measure: Enter measure name</i> <i>Medical group name: Enter medical group name</i> <i>Your name: [Enter your name]</i> <i>Your phone number: Enter your phone number</i> <i>Your email address: Enter your email</i> <i>Name of your medical director, administrator or lead: Enter name of medical director, administrator or lead</i>
2. Date of birth range:	<i>We will use the following date range to identify patients age 12 to 44:</i> <i>Enter the date range,</i>
3. Date of service range:	<i>We will use the following date range to identify patients with one or more face-to-face office visits with a provider:</i> <i>Enter the date range,</i>
4. ICD-9 diagnosis codes (epilepsy):	<i>We will use the following ICD-9 diagnosis codes to identify patients with epilepsy:</i>

Denominator document instructions	Your response
<p>5. Exceptions: Please indicate how you will identify exceptions for the denominator.</p>	<p>We will identify exceptions as follows:</p> <p>Patients who are <u>surgically sterile</u>:</p> <ul style="list-style-type: none"> <input type="checkbox"/> we will identify through manual data abstraction <input type="checkbox"/> other, please describe: <u>Enter here</u> <p>Patients with <u>intellectual disabilities</u>:</p> <ul style="list-style-type: none"> <input type="checkbox"/> we will remove upfront using ICD-9 codes 318.0, 318.1 and 318.2 <input type="checkbox"/> we will identify through manual data abstraction
<p>6. Attestations <u>Read each attestation carefully.</u> You must agree to all attestations before you submit your denominator. By submitting this document, you are indicating that you agree with these attestations.</p> <p>Please contact MNCM if you have any questions.</p>	<ol style="list-style-type: none"> 1. We agree to follow the denominator criteria outlined in the measure specifications when searching for eligible patients, and we are ultimately responsible for interpreting and applying the measure specifications correctly in our query. 2. We agree to include patients who are not active patients if they are eligible based on the measure criteria (i.e., we will include patients whose status is “inactive” or patients who transferred care). 3. We agree to identify exceptions for surgically sterile or intellectual disability only. All other patients that meet the denominator criteria will be included in the denominator. 4. Include <u>one</u> of the following attestations: <ol style="list-style-type: none"> a. We agree to submit our full population of eligible patients b. We agree to use one of the sampling methods described in the data collection guide to randomly select patients 5. We agree to identify and remove any duplicate patients. 6. Our medical director, administrator or other lead attests that the measure specifications will be followed and all eligible patients included in the denominator.

Supply source code or screen shots of your query in a Word document

1. Generate a query of your record system (e.g., electronic medical record, practice management system, billing system); maintain the source code and/or screen shots of the steps you take to search for eligible patients. Copy and paste 1) the source code or 2) the screen shots of your steps into the Word document
2. Highlight details for the MNMCM reviewer:
 - Date of birth range**
 - Date of service range**
 - ICD-9 diagnosis codes (epilepsy)**
 - Exceptions (e.g., ICD-9 codes for intellectual disability)**

Screen shots: If you cannot include data source code, you can instead copy and paste screen shots of your process in your Word document. Please only include screen shots that will demonstrate to the MNMCM reviewer that you have used the correct criteria for querying your system for eligible patients. For example, the following criteria must be clearly shown in the screen shot: correct date of birth range, correct dates of service, correct diagnosis codes if applicable. Do not include screen shots with blank codes, dates, etc. (this will not demonstrate to the MNMCM review that the criteria used are correct).

****Please do not submit patient data along with your denominator document****

Appendix B: File Quality Checks & Validation

Counseling for Women with Epilepsy measure | File Quality Checks & Validation

File Quality Checks | to verify the data submitted is complete and in the correct format

1. **Clinic name** is entered consistently for each record
2. **Patient IDs** are not duplicated
3. **Date of birth** is between = 01/01/2000 to 01/01/1968; full range is covered in data set
4. **Zip codes** are 5 digits and primarily MN zip codes
5. **Race** was entered in one or more fields with valid codes
6. **Provider NPI** fields are all populated with 10-digit values
7. **Insurance product name** fields are all populated with valid entries
8. **Primary payer type** fields are all populated with valid codes
9. **Office visit date** is between 01/01/2012 and 12/31/2012; full range is covered in data set
10. **Diagnosis code** was entered with valid code; expect to see more than one type of code entered
11. **Date of contraception counseling** is between 01/01/2012 and 12/31/2012; full range is covered in data set
12. **Contraception counseling received?** fields are all populated with valid codes
13. **Date of pregnancy counseling** is between 01/01/2012 and 12/31/2012; full range is covered in data set
14. **Pregnancy counseling received?** fields are all populated with valid codes
15. **Medical reason for not receiving counseling** fields that are populated contain valid code
16. **Medical reason for not receiving counseling "other"** fields that are populated contain valid reasons (review each reason given)
17. "Medical Reason" fields are populated minimally
18. "Medical Reason" fields (columns S and T) that are populated must not have counseling dates or values entered
19. Number of rows of patients matches what was expected

Appendix C: MNCM Audit Strategy

The validation process is conducted to verify that the submitted data matches the source data in the medical record. After the clinical data file is successfully transferred to MNCM and passes the initial quality checks, MNCM will contact the medical group about the validation process.

MNCM Audit Process

MNCM utilizes the NCQA (National Committee for Quality Assurance) “8 and 30” process for validation audits. The following method is used for each measure:

- MNCM randomly selects 33 records for each clinic site for validation. At most, 30 records for each clinic site will be reviewed. The additional three records requested are oversamples to ensure there will be 30 records available on the day of the review.
- MNCM auditor reviews the first eight records of the clinic site’s selected sample to verify that the submitted data matches the source data in the medical record.
- If **all** of the first eight records reviewed are in perfect compliance (100%), the clinic site is determined to be in high compliance, and the MNCM auditor may determine that no further record review for that site is necessary.
- If the first clinic site is in high compliance and the data collection process for all clinic sites within the medical group is identical, further review may be abbreviated at the discretion of the MNCM auditor.
- If clinic sites are not in high compliance after review of the first eight records, the MNCM auditor will continue to review the remaining 22 records. If after review of all 30 records the clinic site is not in high compliance on all factors (less than 90%), the MNCM auditor will review the results with the clinic representative and communicate the results with MNCM. MNCM will then contact the medical group to develop a mutually agreed upon re-submission plan. (Re-submission plans will only be allowed for errors in the numerator portion.)
- Clinic sites that are not in high compliance or have not been in high compliance in a previous MNCM audit may be held to a more rigorous denominator certification and validation audit.

Data Fields for Audit: Counseling for Women of Childbearing Potential with Epilepsy

- Patient ID
- Patient DOB
- Patient is female
- Race 1-5
- Office visit date ?
- Patient has epilepsy
- Date of contraception counseling
- Contraception counseling received
- Date of pregnancy counseling
- Pregnancy counseling received
- Medical reason code – no counseling
- Medical reason “other” – no counseling

Appendix D: Questions and Answers Received During Measure Testing

Q: Does the counseling need to take place during the measurement period (2012). If patient was seen, for example in 2011, and counseling was done then, I would assume that would not count towards meeting the measure. Or can the counseling occur prior to the measurement period.

A: *Counseling does need to take place during the measurement period for it to count towards meeting the measure criteria.*

Q: What about patients who have the diagnoses of epilepsy but who may not be on anti-epileptic medication? Is the presence of anti-epileptic medication being prescribed considered an exclusion from the denominator? Or should the counseling be provided whether they are on medication or not?

A: *The counseling should be provided regardless of whether or not the patient is on medication. A patient who has epilepsy, but is not on anti-epileptic medication still would be included in the measure. Although medication is a common treatment, this is a measure to capture if a female patient with epilepsy was counseled on the disease and treatment (regardless of what type of treatment) and how it may affect contraception and pregnancy.*

Q: We have some patient seen during the measurement period in our clinic for something completely unrelated to their epilepsy diagnosis, example for sleep disturbance. Their epilepsy is not being addressed at all. They carry the diagnosis of epilepsy so they are showing up in the denominator. Some may have also been seen by their regular neurologist but some may not have been. Should these patients be included in the denominator?

A: *These patients should still be included in the denominator as the visits are opportunities to address how epilepsy and its treatment may affect contraception and pregnancy.*

Q: We have patients that are seen by more than one provider during the measurement period with epilepsy diagnosis so we have two entries for them in the denominator. Should I take only the most recent encounter, and just use the provider who saw the patient most recently?

A: *The patient should only be counted one time in the denominator. For "Provider NPI", refer to the data field specs – If both providers saw the patient equally enter the provider NPI who saw the patient most recently. If the patient received counseling from another provider, though, still submit the dates of the counseling.*

Q: Does patient use of birth control (part of medication list ie; birth control pills) provide an exception for receiving contraception counseling?

A: *No – counseling is still an expectation regardless if the patient is using birth control. This is an opportunity for the provider to address how epilepsy treatment may affect contraception.*

Q: Is tubal ligation considered surgical sterilization?

A: *Yes, patients with tubal ligation are excluded because they are considered to be surgically sterile*

Q: Is it appropriate to count Intrauterine Device (IUD) as “other” medical reason for not receiving counseling?

A: *Actually, based on the intent of the measures this does not count as a reason for not receiving counseling because having an IUD does not guarantee pregnancy will not occur for that patient. IUDs are not a permanent procedure and thus it is still appropriate to counsel the about the risks associated with pregnancy. The measure focuses on counseling about medications that may affect pregnancy or fetal malformation which may determine the course of treatment for a patient who is not sterile.*

Q: If a patient does not plan to get pregnant again and her husband had a vasectomy should she still receive counseling?

A: *While it may be true she does not plan on becoming pregnant at this time it is still appropriate for the patient to be counseled about the risks associated with using some epilepsy medications that can negatively affect a pregnancy or may limit the effectiveness of certain contraceptive medications. Unplanned pregnancies are extremely common.*

Q: We reviewed several patients who were on the young side of the age included who did not received counseling. Yet we wondered about the cultural appropriateness of discussing contraceptives and pregnancy with 12-14 year old patients from conservative religious environments.

A: *The measure specifications establishes 12 as the lowest age for receiving counseling so in the example above these patients will not be excluded from the numerator. The measure development work group discussed this issue quite extensively. The decision to use 12 as the minimum age came from the fact that the average age that girls have their first experience menstruation is 12. This has been cited by numerous different research studies and peer reviewed papers.*

Q: We found that the ICD-9 codes for intellectual disability (318.0, 318.1, or 318.2) were not sufficiently inclusive. One of our patients with ICD-9 code of 315.9 Developmental Delay Mental, would definitely not have been able to understand counseling. Another patient had Developmental Delay Global 783.42, lives at group home, Family Medicine started Oral Contraceptives to help with menses, and father makes the decisions for patient. We coded both case as did not receive counseling for “other” medical reasons.

A: *AAN understands that this is a retrospective chart review and that most clinicians and clinics are not familiar with the use of CPT-II exclusion codes or that they would need to document why something was not done. The AAN is not looking for specific codes to justify a medical exception or exclusion. Rather we are looking for something that is written in the medical record that would justify why the measure wasn't done. So my response is that if the clinician and/or abstractor looking at what is documented by the clinician feels that the patient would have a medical exclusion/exception that was appropriate based upon what is written in the medical record that we accept that. So in the first case where the patient couldn't understand any counseling it would be appropriate to exclude this patient with a medical exclusion. Given the details provided for the 2nd individual (with the inappropriate description of the code 783.42) who lives at a group home, is on*

contraception, etc. I would leave it up to the clinician/abstractor to make the decision whether or not she should be excluded since we do not know all the details of her cognitive impairment. In short, exclusions are primarily a judgment call by the physician; however, there should be documentation in the record explaining why the counseling was not appropriate. However, the codes you referenced will not be added to the exclusion list for the following reasons:

315.9 is actually "Unspecified delay in development" and the definition includes developmental disorder not otherwise specified and learning disorder not otherwise specified. This code is way too general and could be used for so many other things besides intellectual disabilities. Thus, MNMCM recommends not including it.

783.42 is actually "Lack of normal physiological development in childhood; delayed milestones" and the definition includes late talker and late walker. Again, we would not recommend adding this code to define intellectual disability, it would be inappropriate.

Q: If an oral contraceptive is on the active medication list, does the patient need further counseling?

A: *Yes, it is still appropriate to counsel the about the risks associated with pregnancy because the patient may still become pregnant in the future.*

Q: What should be done in cases with an initial diagnosis of epilepsy but found to have non-epileptic events upon further investigation?

A: *Since this patient met the denominator for the current measurement year they should be included. However, in future reporting years this patient would not be included in the denominator according to your example above. This issue will likely be a random and somewhat rare occurrence and thus performance results would likely not be significantly affected. At the time/visit that the retrospective chart review was being done if the patient had a diagnosis of epilepsy the measure should have been done. If the diagnosis changes in the future they would not be eligible for the measure and shouldn't have the counseling at that future date.*

Appendix E: Post Measure Survey Results: Resource Use and Data Burden

1. Were you able to prepare the data from this measure using ONLY an electronic medical record (EMR)?		Create Chart	Download
		Response Percent	Response Count
Yes (all data was extracted from our EMR)		33.3%	1
No (we are on paper charts only)		0.0%	0
Hybrid-(EMR was used but manual chart reviews were also required)		66.7%	2
		answered question	3
		skipped question	0

2. Please estimate the percentage of time spent MANUALLY abstracting data for the Counseling for Women with Epilepsy Measure?		Create Chart	Download
		Response Percent	Response Count
0%- all items extracted from EHR electronically		0.0%	0
1-20%		0.0%	0
21-40%		33.3%	1
41-60%		33.3%	1
61-80%		0.0%	0
81-100%		33.3%	1
		Other (please specify) Show Responses	1
		answered question	3
		skipped question	0

3. MNMCM always takes into account the burden associated with data collection and submission, however, this can be difficult to gauge. This question will help MNMCM better understand the scope of burden associated with extracting the data elements specific to the Counseling Women with Epilepsy measure. How difficult was it to extract the following data elements? [Create Chart](#) [Download](#)

	Very Easy (fully extractable data element, "as is")	Easy (extractable, but needs alteration)	Difficult (in EMR, but not extractable, manual look-up)	Very Difficult (manual abstraction, paper record)	Rating Count
Zip Code	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)	3
Race/Ethnicity	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)	3
Provider NPI	100.0% (3)	0.0% (0)	0.0% (0)	0.0% (0)	3
Primary Payer (e.g. commercial, Medicaid, Medicare, uninsured/self pay)	66.7% (2)	33.3% (1)	0.0% (0)	0.0% (0)	3
Date of Contraception Counseling	0.0% (0)	0.0% (0)	100.0% (3)	0.0% (0)	3
Contraception Counseling Received?	0.0% (0)	33.3% (1)	66.7% (2)	0.0% (0)	3
Date of Pregnancy Counseling	0.0% (0)	0.0% (0)	100.0% (3)	0.0% (0)	3
Pregnancy Counseling Received?	0.0% (0)	33.3% (1)	66.7% (2)	0.0% (0)	3
Medical Reason for Not Receiving Counseling	0.0% (0)	33.3% (1)	66.7% (2)	0.0% (0)	3
Medical Reason for Not Receiving Counseling "Other" Description	0.0% (0)	0.0% (0)	100.0% (3)	0.0% (0)	3
answered question					3

Q4: Respondent Comments on the Data Elements:

“Some items were extremely time consuming and required me to look through the majority of charts to find data. I would expect that it will get easier with time as more information is put into our structured data fields that were created mid-year in 2012, hence the need to manually go through charts in EMR”

5. Please estimate the amount of time it took to PROGRAM and ABSTRACT the data.

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		Response Percent	Response Count
Less than 20 hours total		33.3%	1
21-40 hours		33.3%	1
41-60 hours		33.3%	1
61-80 hours		0.0%	0
81-100 hours		0.0%	0
101 hours or more		0.0%	0
		answered question	3
		skipped question	0

6. Beyond the time spent on programming and abstracting the data, please estimate the amount of additional time your medical group spent preparing for the data submission (e.g. file preparation, surveying, quality checks, submitting data file):

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		Response Percent	Response Count
1-10 hours		100.0%	3
11-20 hours		0.0%	0
21-30 hours		0.0%	0
31-40 hours		0.0%	0
41-50 hours		0.0%	0
51+ hours		0.0%	0
		answered question	3
		skipped question	0

7. How many people in your medical group were involved in collecting and preparing the data for the pilot?

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		Response Percent	Response Count
1		33.3%	1
2		0.0%	0
3		33.3%	1
4		0.0%	0
5 or more		33.3%	1
		answered question	3
		skipped question	0

Q8: Comments/Suggestions about your experience

“Difficult to put items in your excel spreadsheet format. For example, our insurance extraction pulls what the name of the insurance is, it doesn't automatically group them into medicaid, medicare, commercial, etc. So it took some time as some plans can be both. Pulling dates that education was received was difficult as patients may have been seen more than once in a year, and I can tell by the data extraction that the patient was educated sometime in that year, but then I have to go through the chart manually to find which visit it took place in.”

