DLM 275 - Audits incorporating QOF Business Rules v13

Contents

No Change in v13 Business Rules for the following domains

Cancer

CHD

CKD

COPD

Cytology

Dementia

Depression

Epilepsy

Heart Failure

Hypertension

Learning Disabilities

Mental Health

Obesity

Palliative Care

Thyroid

Changes in Business Rules v13

Atrial Fibrillation changes in Business Rules v13

Two additional codes from the 2008 Quarter 3 Read Dictionary are now included in the AF diagnostic criteria:

G5734 Permanent atrial fibrillation

G5735 Persistent atrial fibrillation

Diabetes Mellitus change in Business Rules v13

Additional code from the 2008 Quarter 3 Read Dictionary for peripheral pulses and neuropathy testing (DM9 and DM10):

66Aq. Diabetic foot screen (v13)

Records changes in v13 and Smoking changes in v13

Records 23: The percentage of patients aged over 15 years whose notes record smoking status in the preceding 27 months

Smoking 3: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, asthma, CKD, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months.

Two changes to the smoking business rules in v13.

Patient is ex-smoker if most recent smoking record for an ex-smoker in last 15 months (not 12 months) is ex-smoker.

Patient can count as Never Smoked if the patient is 25 or under and their latest smoking status is recorded as Never Smoked and in the 15 months up to 1st April 2009.

However the rules for recording smoking status that will qualify for QOF from v12 onwards is so complicated that we have produced the guide below to help you.

There are five ways that the Smoking status can be recorded to qualify for Smoking 03 and Records 23. You will reach the targets for any patient if ...

1. The patient's latest smoking status is a Current Smoker code and this has been recorded in the 15 months up to 1st April 2009 (or 27 months in Records 23).
2. The patient is over 25 and their latest smoking status is Never Smoked. (This MUST be recorded as 1371. Never smoked; a record of 137.. Tobacco consumption and a radio button of Never Smoked is NOT acceptable). This also has to be recorded AFTER the patient's earliest diagnosis for inclusion on the Smoking register (not needed for Records 23) but AFTER the patient's 25th birthday in Records 23.

3. If the patient is 25 or under and their latest smoking status is recorded as Never Smoked and in the 15 months up to 1st April 2009. For Smoking 3, a smoking status of 'never smoked' recorded on the date of diagnosis is not ignored.
4. The patient's latest smoking status is an Ex-Smoker record and is recorded in the 15 months up to 1st April 2009
5. The patient's latest smoking status is an Ex-Smoker record and between 12 to 24 months prior to it they also have an Ex-Smoker record. Another record also needs to be recorded between 24 and 36 months prior to the latest Ex-Smoker code. There needs to be 3 consecutive codes; as any Current Smoking code recorded after the earliest of the three Ex-Smoker codes breaks the chain.

In Records 23 patients under 15 are excluded.

Asthma change

This change is confirmed in v13 Business Rules but was actually implemented by system suppliers during conformance testing for v12

Indicator ASTHMA 3: The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months

The smoking codes have been brought in line with those used for Records 23 and Smoking. The latest code before reference date:

137.. - 137D.

137F. - 137H.

137J. – 137T. (v13)

137V. (v13)

137X - 137h

Stroke change

This change is confirmed in v13 Business Rules but was actually implemented by system suppliers during conformance testing of v12

MRI/CT scan codes, and the MRI/CT scan declined codes, are checked against Stroke and TIA codes, and not just Stroke only.

Stroke/TIA codes now correctly include TIA codes.

G65..- G654., G656.- G65zz, F4236

Corrections made in v13 nGMS QOF audit 2008-9

The following lines are corrected in the v13 audit:

AF04 DENOMINATOR correction in the v13 audit – this audit was only looking for ECG read code 3272 in Test SDA. However, some practices have added them as History entries. They have now been added to the search as history entries.

BP05 negative correction in v13 audit – A correction has been made to the line text and reminder text to reflect the fact that this negative line will find the percentage of patients with hypertension who are NOT excepted and in whom the last blood pressure (measured in last 9 months) is greater than 150/90, Or who have NO BP measured in the last 9 months.

CHD11 negative correction in v13 – A correction has been made to the search criteria as there was an error in the search for the percentage of patients with CHD and a history of MI infarction (diagnosed after 1/4/2003) who are NOT excepted and who are NOT currently treated with an ACE inhibitor or A2 antagonist.

COPD 12 Numerator correction in the v13 audit - the spirometry that was being picked up was the first one in the patient's Journal instead of the first one between -3m and +12m of the COPD diagnosis date.

DEP01 EXCEPTION5 correction in the v13 audit – A correction has been made to the text of the audit line to reflect that this exception includes those patients who have a first diagnosis of Diabetes or IHD in the 3 months before 01/04/09 or any patients whose first diagnosis, according to the extraction criteria for the business rules, has been superseded by a resolved code. Even if they have a later confirmed diagnosis, this is ignored by the extraction for the exception reporting.

SMOK03 correction in the V13 audit – A correction has been made so that 137F. is now being picked up as an ex-smoker code. Previously it was not being counted.

SMOK03 EXCEPTION5 correction in the v13 audit – A correction has been made to the text of the audit line to reflect that this exception includes those patients who have a first or only diagnosis of Diabetes, IHD, Stroke/TIA, hypertension, COPD, asthma, CKD or MH in the 3 months before 01/04/09 or any patients whose first diagnosis, according the extraction criteria for the business rules, has been superseded by a resolved code. Even if they have a later confirmed diagnosis, this is ignored by the extraction for the exception reporting.

Data Quality Audits

Corrections made in v13 Data Quality Audits

Data Quality Hypertension correction in the v13 audit - for the line “Pts. with either CHD or DM or CVA or PVD and last BP in last 5 yrs > 150/90, but no diagnosis code for hypertension”. The sub-search was incorrectly searching for patients with BP < 150/90. Changed the sub-search to search for BP > 150/90.

Data Quality Records correction in the v13 audit - "Patients registered within last 6m with notes NOT received". Was picking up notes received and was actually looking at patients not registered in the last 6m with notes received; now fixed.

Data Quality Records correction in v13 audit - "Patients registered in last 6 months with notes received 6-8 weeks ago and notes NOT yet summarised". Search not picking up any patients because coding incorrect on ALL negative lines; now fixed.

Changes to the CKD Data Quality Audits for v13

CKD DQ Audit has been changed at the request of several users to search only for the LATEST eGFR record for the patient which may indicate inclusion in a CKD level.

Additional lines have been written for CKD05 in order to identify patients who have CKD and diagnosis of Hypertension and whose only record, which might indicate Proteinuria and therefore include them in the CKD05 Register, has been entered using the Vision SDA for Urine Protein (467..) and the qualifiers of +, ++, +++, ++++

These patient’s codes should be changed to qualifying Read codes for proteinuria:

4674. Urine protein test =+

4675. Urine protein test =++

4676. Urine protein test =+++

4677. Urine protein test =++++