PARKINSON’S DISEASE MEASURES GROUP OVERVIEW

2014 PQRS OPTIONS FOR MEASURES GROUPS:

2014 PQRS MEASURES IN PARKINSON’S DISEASE MEASURES GROUP:
#289. Parkinson’s Disease: Annual Parkinson’s Disease Diagnosis Review
#290. Parkinson’s Disease: Psychiatric Disorders or Disturbances Assessment
#291. Parkinson’s Disease: Cognitive Impairment or Dysfunction Assessment
#292. Parkinson’s Disease: Querying about Sleep Disturbances
#293. Parkinson’s Disease: Rehabilitative Therapy Options
#294. Parkinson’s Disease: Parkinson’s Disease Medical and Surgical Treatment Options Reviewed

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

  G8903: I intend to report the Parkinson’s Disease Measures Group

- Report the patient sample method:
  20 Patient Sample Method: 20 unique patients (a majority of which must be Medicare Part B FFS [fee for service] patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2014 OR July 1 through December 31, 2014).

- Patient sample criteria for the Parkinson’s Disease Measures Group are patients aged 18 years and older with a specific diagnosis of Parkinson’s Disease accompanied by a specific patient encounter:

  The following diagnosis code indicating Parkinson’s disease:
  ICD-9-CM [for use 1/1/2014 – 9/30/2014]: 332.0
  ICD-10-CM [for use 10/1/2014 - 12/31/2014]: G20

  Accompanied by:

  One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310

- Report a numerator option on all measures within the Parkinson’s Disease Measures Group for each patient within the eligible professional’s patient sample.

- Instructions for qualifying numerator option reporting for each of the measures within the Parkinson’s Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

  Composite QDC G8762: All quality actions for the applicable measures in the Parkinson’s Disease Measures Group have been performed for this patient

- To report satisfactorily the Parkinson’s Disease Measures Group it requires all measures for each patient within the eligible professional’s patient sample to be reported a minimum of once during the reporting period.
• Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting.

• **NOTE**: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option.
**Measure #289: Parkinson’s Disease: Annual Parkinson's Disease Diagnosis Review**

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's disease who had an annual assessment including a review of current medications (e.g., medications that can produce Parkinson-like signs or symptoms) and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually.

**NUMERATOR:**
All patients who had an annual assessment including a review of current medications and for the presence of atypical features.

**Numerator Options:**
- Parkinson’s disease diagnosis reviewed *(1400F)*
- Parkinson’s disease diagnosis was not reviewed, reason not otherwise specified *(1400F with 8P)*
Measure #290: Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment

DESCRIPTION:
All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually

NUMERATOR:
Patients who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually

Numerator Options:
- Psychiatric disorders or disturbances assessed (3700F)
- Psychiatric disorders or disturbances not assessed, reason not otherwise specified (3700F with 8P)
Measure #291: Parkinson’s Disease: Cognitive Impairment or Dysfunction Assessment

DESCRIPTION:
All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually.

NUMERATOR:
Patients who were assessed for cognitive impairment or dysfunction at least annually.

Numerator Options:
- Cognitive impairment or dysfunction assessed (3720F)
- Cognitive impairment or dysfunction was not assessed, reason not otherwise specified (3720F with 8P)
**Measure #292: Parkinson’s Disease: Querying about Sleep Disturbances**

**DESCRIPTION:**
All patients with a diagnosis of Parkinson’s disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually

**NUMERATOR:**
Patients (or caregiver(s), as appropriate) who were queried about sleep disturbances at least annually

**Numerator Options:**
- Patient (or caregiver) queried about sleep disturbances *(4328F)*
- OR
- Documentation of medical reason(s) for not querying about sleep disturbances *(4328F with 1P)*
- OR
- Patient (or caregiver) **not** queried about sleep disturbances, reason not otherwise specified *(4328F with 8P)*
Measure #293: Parkinson’s Disease: Rehabilitative Therapy Options

DESCRIPTION:
All patients with a diagnosis of Parkinson’s Disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually

NUMERATOR:
Patients (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually

Numerator Options:
Rehabilitative therapy options discussed with patient (or caregiver) (4400F)

OR
Documentation of medical reason(s) for not discussing rehabilitative therapy options with patient (or caregiver) (4400F with 1P)

OR
Rehabilitative therapy options not discussed with patient (or caregiver), reason not otherwise specified (4400F with 8P)
Measure #294: Parkinson’s Disease: Parkinson’s Disease Medical and Surgical Treatment Options Reviewed

DESCRIPTION:
All patients with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) who had the Parkinson’s disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually.

NUMERATOR:
Patients (or caregiver(s), as appropriate) who had the Parkinson’s disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually.

Numerator Options:
Medical and surgical treatment options reviewed with patient (or caregiver) (4325F)

OR
Medical and surgical treatment options not reviewed with patient (or caregiver) for medical reasons (e.g., patient is unable to respond and no informant is available) (4325F with 1P)

OR
Medical and surgical treatment options not reviewed with patient (or caregiver), reasons not specified (4325F with 8P)
Measure #289 - Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review

RATIONALE:
Because the diagnosis of Parkinson's disease is clinical with no confirmatory laboratory or imaging study, it is important to review the diagnosis periodically in order to ensure that no atypical features emerge. The emergence of atypical features in a patient previously thought to have Parkinson's disease will influence prognosis and medical treatment. It has been demonstrated that in the course of caring for patients with suspected Parkinson's disease, 10-15% will ultimately have a different pathologic diagnosis. This measure will alert the clinician to the emergence of atypical features in Parkinson's disease and suggest alternate diagnostic possibilities.


CLINICAL RECOMMENDATION STATEMENTS:
The diagnosis of PD should be reviewed regularly (6-12 month intervals seen to review diagnosis) and re-considered if atypical clinical features develop. (Level D (DS)) NICE GL35 (June 2006)

Determining the presence of the following clinical features in early stages of disease should be considered to distinguish PD from other parkinsonian syndromes: 1) falls at presentation and early in the disease course, 2) poor response to levodopa, 3) symmetry at onset, 4) rapid progression (to Hoehn and Yahr stage 3 in 3 years), 5) lack of tremor, and 6) dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension) (Level B). AAN QSS PD (April 2006)

All veterans with the suspected diagnosis of PD who are also receiving medications known to cause parkinsonism (e.g., neuroleptics) should have a trial of withdrawal of these medications, a trial of low-potency neuroleptic, or documentation in the medical record that the medication could not be withdrawn before making the diagnosis of PD. Cheng #1 (Assessment of medication-induced PD) 2004


Cheng Eric, Siderowf Andrew, Swartztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson’s disease

Measure #290 - Parkinson’s Disease: Psychiatric Disorders or Disturbances Assessment

RATIONALE:
Parkinson’s disease is associated with a wide range of psychiatric disorders. Some of these problems are related to the disease itself and some are related to the medications used to treat the disease. These disorders range from
anxiety and depression to psychosis and impulse control disorder. It has been demonstrated that depression, in particular, has been often overlooked as a diagnostic possibility in patients with Parkinson’s disease. In fact, it has been demonstrated that depression and other psychiatric disorders are often overlooked in the general medical population. This measure will ensure that the clinician remembers to evaluate the patient for the basis of these psychiatric disorders on a yearly basis.


Galpern WR, Stacy M. Management of impulse control disorders in Parkinson's disease. Curr Treat Options Neurol. 2007 May;9(3):189-97


**CLINICAL RECOMMENDATION STATEMENTS:**

Clinicians should be aware of dopamine dysregulation syndrome, an uncommon disorder in which dopaminergic medication misuse is associated with abnormal behaviors, including hypersexuality, pathological gambling and stereotypic motor acts. This syndrome may be difficult to manage. (Level D) NICE GL35 (Jun 2006).

If a veteran with PD presents with new onset of one of the following symptoms: sad mood, feeling down; insomnia or difficulties with sleep; apathy or loss of interest in pleasurable activities; complains of memory loss; unexplained weight loss of greater than 5% in the past month or 10% over one year; or unexplained fatigue or low energy, then the patient should be asked about or treated for depression, or referred to a mental health professional within two weeks of presentation. (Outcomes Impact 5; Room for Improvement 4; Overall utility rating 4) Cheng 2004

Clinicians should have a low threshold for diagnosing depression in PD. (Level D) NICE GL35 (Jun 2006) All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004

All people with PD and psychosis should receive a general medical evaluation and treatment for any precipitating condition. (Level D) NICE GL35 (Jun 2006)


**Measure #291 - Parkinson’s Disease: Cognitive Impairment or Dysfunction Assessment**

**RATIONALE:**

Parkinson’s disease is associated with cognitive impairment. It is important to assess patients with Parkinson’s disease on an annual basis with regard to their cognitive abilities. Clinically significant cognitive difficulties may be present early on in the disease course, but dementia may emerge and be diagnosed later in the course of the disease. However, the insidious onset of cognitive impairment/dementia often occurs over a prolonged period of time.
Emerging cognitive impairment has limited treatment, but is important to identify in terms of the patient’s care and responsibilities within the home, socially, or in the work place.

Factor, S. Weiner, W. Parkinson’s Disease: Diagnosis and Clinical Management . 2002

**CLINICAL RECOMMENDATION STATEMENTS:**

The Mini-Mental State Examination (MMSE) and the Cambridge Cognitive Examination (CAM Cog) should be considered as screening tools for dementia in patients with PD (Level B). AAN QSS (April 2006)

All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004


Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson’s disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)This measure may be used as an accountability measure.

**Measure #292 - Parkinson’s Disease: Querying about Sleep Disturbances**

**RATIONALE:**

Sleep disorders are common in Parkinson's disease and most commonly include sleep fragmentation (80%), restless legs syndrome (20%), REM behavior sleep disorder (>40%), and excessive daytime sleepiness (~50%). Sleep fragmentation could relate to motor symptoms such as tremor and dystonia, restless legs syndrome, depression, anxiety, agitation, urinary frequency, or medication (most notably selegiline but also dopamine agonists). Several approaches to effective therapy are available. Excessive daytime sleepiness could result in sleep attacks or unintended sleep episodes. Such episodes have been described in various situations, including while driving a car. Excessive daytime sleepiness may result from medication (dopamine agonists), dementia, psychosis, or poor nocturnal sleep hygiene and is generally more common in advanced Parkinson's disease.

Medication adjustment and the use of stimulants may be warranted. REM behavior disorder is defined by the patient acting out dreams. The result could be either the patient or spouse moving to a different bedroom. This syndrome is treated with benzodiazepines and other medications. Assessing sleep would be expected to lead to improved morbidity and function.


**CLINICAL RECOMMENDATION STATEMENTS:**

A full sleep history should be taken from people with PD who report sleep disturbance (Level D) NICE GL35 (Jun 2006)

Good sleep hygiene should be advised in people with PD with any sleep disturbance and includes: avoidance of stimulants (for example, coffee, tea, caffeine) in the evening; establishment of a regular pattern of sleep; comfortable
bedding and temperature; provision of assistive devices, such as a bed lever or rails to aid with moving and turning, allowing the person to get more comfortable; restriction of daytime siestas; advice about taking regular and appropriate exercise to induce better sleep; a review of all medication and avoidance of any drugs that may affect sleep or alertness, or may interact with other medication (for example, selegiline, antihistamines, H2 antagonists, antipsychotics and sedatives). NICE GL35 (June 2006)

All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004


Measure #293 - Parkinson’s Disease: Rehabilitative Therapy Options

RATIONALE:
For those patients with Parkinson’s disease who have impaired activities of daily living, therapy options such as physical, occupational, and speech therapy should be offered. Rehabilitative therapies play an important role in improving function and quality of life for these patients. Symptomatic therapy can provide benefit for many years. Patients with Parkinson’s disease commonly develop dysarthria.


Factor, S. Weiner, W. Parkinson’s Disease: Diagnosis and Clinical Management, 2002

CLINICAL RECOMMENDATION STATEMENTS:
Physiotherapy should be available for people with PD. Particular consideration should be given to: gait re-education, improvement of balance and flexibility; enhancement of aerobic capacity; improvement of movement initiation; improvement of functional independence, including mobility and activities of daily living; provision of advice regarding safety in the home environment. (Level B) NICE GL35 (Jun 2006)

Occupational therapy should be available for people with PD. Particular consideration should be given to: maintenance of work and family roles, home care and leisure activities; improvement and maintenance of transfers and mobility; improvement of personal self-care activities, such as eating, drinking, washing, and dressing; cognitive assessment and appropriate intervention. (Level D) NICE GL35 (Jun 2006)

Speech and language therapy should be available for people with PD. Particular consideration should be given to: Improvement of vocal loudness and pitch range, including speech therapy programs such as Lee Silverman Voice Treatment (LSVT) (Level B) NICE GL35 (Jun 2006)

All veterans with PD who have impairment of ADLs or in walking ability should be referred for physical therapy. Cheng et al. #9 (Referral for physical therapy) 2004
For patients with Parkinson’s disease complicated by dysarthria, speech therapy may be considered to improve speech volume (Level C). Different exercise modalities, including multidisciplinary rehabilitation, active music therapy, treadmill training, balance training, and "cued" exercise training are probably effective in improving functional outcomes for patients with Parkinson’s disease. For patients with Parkinson’s disease, exercise therapy may be considered to improve function (Level C). AAN QSS Neuro Alt (April 2006)


Measure #294 - Parkinson’s Disease: Parkinson’s Disease Medical and Surgical Treatment Options Reviewed

RATIONALE:
There are many different pharmacological, non-pharmacological, and surgical treatment options available for patients diagnosed with Parkinson’s disease. Within each type of treatment, there are also multiple factors to be considered when deciding whether a patient with Parkinson’s disease is a candidate for the treatment option.

With the advent of newly available pharmacological treatments from many different ongoing clinical trials and studies, the patient’s current medication treatment should be reviewed as therapy-based reviews are updated.


CLINICAL RECOMMENDATION STATEMENTS:
People with PD should have regular access to the following: clinical monitoring and medication adjustment; a continuing point of contact for support, including home visits when appropriate; a reliable source of information about clinical and social matters of concern to people with PD and their careers which may be provided by a Parkinson’s disease nurse specialist. NICE GL35. (June 2006)

With the current evidence it is not possible to decide if the subthalamic nucleus or globus pallidus interna is the preferred target for deep brain stimulation for people with PD, or whether one form of surgery is more effective or safer than the other. In considering the type of surgery, account should be taken of: clinical and lifestyle characteristics of the person with PD; patient preference, after the patient has been informed of the potential benefits and; drawbacks of the different surgical procedures. (Level D) NICE GL35 (June 2006)