Using the Ardens EMIS case finder searches (Nov 2020)

Disclaimer

Our Case Finder searches identify potential coding errors in patient records.
The data within these reports should be used by clinicians to help them make a judgement on whether the clinical codes in a patient's record are correct.

Specifically, Ardens (EMIS Web) is only identifying clinical records where they may be an error. It is up to clinicians within the practice to decide whether a clinical code requires changing, after careful review of the medical record.
Responsibility for updating a clinical record lies with the clinician making the change. Ardens (EMIS Web) will never update a patient record as we only offer advice for clinicians to consider.

We therefore accept no liability for any mistakes in the data contained within our Case Finder searches.

Calculating the value of a QOF point (2020-21)

The Value of a QOF point is calculated using the national formula: £194.83 x CPI x APDF
Contractor Population Index (CPI) for a Practice is registered list size / 8,799
Adjusted Practice Disease Factor (APDF) is the ratio of the Practice's prevalence of a disease in an individual domain to the national prevalence of the disease.

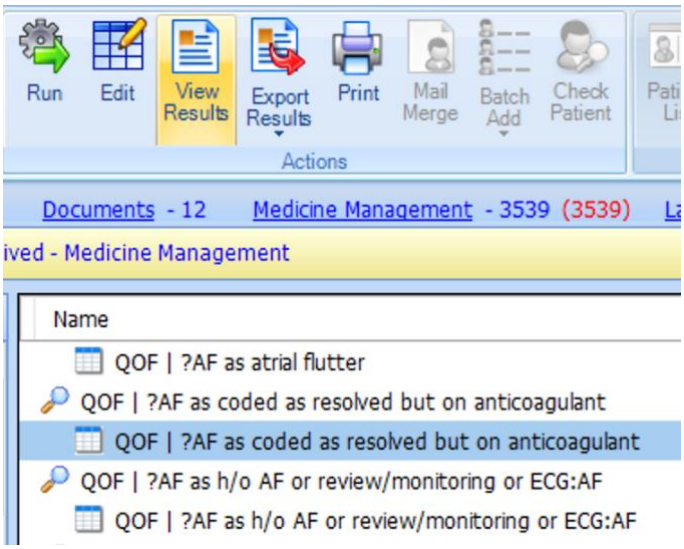
QOF

Our Case Finding searches identify missing and incorrect codes in clinical records that are affecting chronic disease prevalence and therefore practice income. No patients need to be contacted or reviewed before these codes are corrected. You are already doing the work to manage these chronic diseases.

How to use the searches

The searches give you numbers of patients who may be 'missing' from the QOF register within each category. Each search has a report beneath it, which will help to identify which code has been picked up to place the patient within the search, and what date it was recorded on.

Latest AF Resolved Code		Current Anticoagulant Courses				
Date	Code Term	Name, Dosage and Quantity	Dose	Quantity	Quantity Unit	Most Recent Issue Date in Course
07-Sep-2018	Atrial fibrillation resolved	Rivaroxaban 10mg tablets	One To Be Taken Each Day	30	tablet	30-Sep-2020
11-Jul-2019	Atrial fibrillation resolved	Apixaban 5mg tablets	One To Be Taken Twice A Day (for AF)	56	tablet	05-Oct-2020



Changing Clinical Codes

Searching for a clinical code

The reports connected to each search will help you to identify the date on which a code was recorded. To find a clinical code in a patient's records, do the following:

- Load the patient record
- Navigate to "Care History"
- Select "Text search"
- Enter the clinical code or term you are looking for – e.g. "Asthma Resolved"

You can delete a code by right-clicking and selecting "Delete". (**Please note:** you should avoid deleting codes unless you are 100% sure the code is wrong. Deletion of a code is an audit-controlled activity.)
Please note – the Edit option only allows the date and description to be changed, if the code had been originally recorded outside of a consultation. If the code had been originally entered in a consultation, when you Edit this it will take you to this consultation.

Changing a Problem code

Problem codes can be directly changed:

- Load the patient record
- Navigate to "Problems"
- Right-click on the incorrectly coded Problem, then select "Replace"

Appropriate QOF codes

In order for patients to be picked up on the QOF register, they need to have an appropriate code on their record.
These codes are found within the QOF Business Rules, which are issued around twice a year, although the diagnosis codes do not change often.
We have created a document 'QOF Diagnosis codes, based on v45 QOF Business Rules' which will help you to identify the appropriate codes to put a patient on to each QOF register. You could also use our Chronic Disease templates to enter this data if you prefer.

Excluding patients from case finder searches

If, on reviewing the patient record, you feel that they are not appropriate for the relevant register, some searches allow for you to add a code to remove them from the case finder list.

The code remains on the record and any subsequent use of the case finder searches will only include patients with new activity subsequent to that entry. Thus if you review the list of *?AF as Atrial Flutter*, decide that a patient is not appropriate for a code of Atrial Fibrillation ,you can add the code for 'Atrial Fibrillation Excluded' and this will remove the patient from the case finder list UNLESS a subsequent code of Atrial Flutter is added.
Each of the available 'excluded' codes is listed below:

Condition	'Excluded' codes	
Atrial fibrillation	Atrial fibrillation excluded	816401000000105
CHD	Coronary arteriosclerosis excluded	473146006
	Coronary artery disease absent	699196002
Dementia	Memory function normal	247602005
Depression	Depression resolved	196381000000100
Diabetes	Diabetes resolved	315051004
	Diabetes mellitus excluded	315216001
Heart failure	Heart failure excluded	394927997
Learning disability	Learning disability excluded	984051000000100
Mental health	No thought disorder	1897941000006106
	Psychosis, schizophrenia and bipolar affective disorder resolved	200951000000109

Atrial Fibrillation

The correct code is *Atrial Fibrillation (49436004).* For additional diagnosis codes please see here.

QOF | ?AF as atrial flutter	The patients in this report have a code of 'Atrial Flutter' on their record. The report will show you the date on which this was recorded. Consider whether this code needs to be replaced with the code above.
QOF | ?AF as coded as resolved but on anticoagulant	These patients may need to have the 'AF Resolved' code removed from their record if they still have Atrial Fibrillation (they are prescribed an anti-coagulant). The report will show you the date on which the "AS Resolved" code was recorded and their current medication.
QOF | ?AF as h/o AF or review/monitoring or ECG:AF	These patients have had a code added to their record which indicated that they have had monitoring or recall for AF OR they have had an ECG which shows AF, but they have not had a diagnosis made. The report shows the dates of any such events and the record should be reviewed and a diagnosis code added if relevant.
QOF | ?AF as on anticoagulant (no DVT/PE/Thrombus/Thrombophilia)	These patients are being prescribed an anticoagulant with no obvious other indication, so it is worth reviewing the record to check why they are on it, adding an appropriate QOF AF code if appropriate.
QOF | ?AF as on digoxin (and no heart failure)	These patients are being prescribed digoxin with no obvious other indication, so it is worth reviewing the record to check why they are on it, adding an appropriate QOF AF code if appropriate.

Asthma

Commonly used codes for asthma which count for the register are these:
Mild asthma (370218001)
Moderate asthma (370219009)
Occasional asthma (370220003)
Severe asthma (370221004)
Allergic asthma (389145006)

For additional diagnosis codes please see here.

QOF | ?Asthma as coded as resolved but inhaler in last 1y	It looks as though Asthma resolved has been coded in error. This code needs deleting from the record if the Usual GP feels this code has been added incorrectly. The report will show you the date of the resolved code and the recent medication.
QOF | ?Asthma as FEV1/FVC <0.7 + inhaler in last 1y	These patients have results and medication which indicate that they may be asthmatic. The record needs to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.
QOF | ?Asthma as h/o or exac/review/plan + inhaler in last 1y	These patients have a code which indicates they may have asthma and they have had an inhaler prescribed in the past 12 months. The patients' records need to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.
QOF | ?Asthma as PEFR variability >20% + inhaler in last 1y	These patients have results and medication which indicate that they may be asthmatic. Patients' records need to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.
QOF | ?Asthma as positive reversibility + inhaler in last 1y	These patients have results and medication which indicate that they may be asthmatic. The record needs to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.

Cancer

The only codes that are recognised by QOF are “Malignant tumour of ...”.
“Transitional cell carcinoma NOS”, for example, should be coded as “Malignant tumour of urinary bladder”.

For QOF diagnosis codes please see here.

QOF | ?Cancer as carcinoma in situ and had cancer treatment	These patients have a non-QOF cancer code on their record and a code of cancer treatment. Please use the report to view the non-QOF code and consider whether a QOF cancer code should be added.
QOF | ?Cancer as tumour histology	These patients have a histology result which indicates they may have cancer. The details of the histology are shown on the report - please use the report to view the non-QOF code and consider whether a QOF cancer code should be added.

CHD

For diagnosis codes please see here.

QOF | ?CHD as coronary artery op or stent	These patients have details on their record of a procedure which indicates that they may have CHD but without an appropriate QOF code. Review the record to check whether the patient should have a diagnosis of CHD recorded and add a code as required.
QOF | ?CHD as h/o CHD or review/monitoring/plan	These patients have had a code of CHD monitoring or a CHD review on their record but do not have a diagnosis of CHD so should be reviewed to check whether they should have a diagnosis code added.

CKD

CKD codes for QOF include the following:

Chronic kidney disease stage 4 (431857002)
Chronic kidney disease stage 3 (433144002)
Chronic kidney disease stage 5 (433146000)

For additional diagnosis codes please see here.

QOF | ?CKD 3-5 as eGFR <60 (on 2 occasions in last 3yrs)	If patients have had 2 eGFR results below 60 in the past 2 years, the report will show you details of these recent eGFR results so that you can make a decision as to whether CKD should be coded onto the patient record.
QOF | ?CKD - repeat eGFR as <60 1m-1y ago and no repeat done	These patients may need to have a repeat eGFR to check whether they have CKD.
QOF | ?CKD as h/o CKD or review/monitoring	These patients have had a code of CKD monitoring or a CKD review on their record but do not have a diagnosis of CKD so should be reviewed to check whether they should have a diagnosis code added.

COPD

Commonly used COPD QOF codes are as below:

Mild chronic obstructive pulmonary disease (313296004)
Moderate chronic obstructive pulmonary disease (313297008)
Severe chronic obstructive pulmonary disease (313299006)

For additional diagnosis codes please see here.

QOF | ?COPD as FEV1/FVC <0.7 after bronchodilation	These patients have results and medication which indicate that they have COPD. The records needs to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.
QOF | ?COPD as h/o COPD or exacerbation/monitoring/plan	These patients have had a code of COPD monitoring or a COPD review on their record but do not have a diagnosis of COPD so should be reviewed to check whether they should have a diagnosis code added.

CVA/TIA

The correct QOF code is “Transient Ischaemic Attack (syn)” or “CVA unspecified” (or other CVA codes within the same read-code tree).

For additional diagnosis codes please see here.

QOF | ?CVA/TIA as amaurosis fugax	Patients have had amaurosis fugax coded but this has not put them on the Stroke register. Consider whether an additional (QOF) code needs to be added.
QOF | ?CVA/TIA as h/o CVA/TIA or CVA review/monitoring/plan	Review the patient records to check whether they should actually have a diagnosis of Stroke recorded as they have a code which indicates they have had monitoring or been recalled for stroke.

Dementia

There are a number of recognised codes for QOF, including *Dementia (52448006*).

For additional diagnosis codes please see here.

QOF | ?Dementia as h/o dementia or review/monitoring/plan	Review the patient records to check whether they should actually have a diagnosis of dementia recorded and add an appropriate code.
QOF | ?Dementia as on repeat dementia medication	These patients are on medication which is commonly used for the treatment of dementia. Please review to ensure there is not a diagnosis missing and add a code if appropriate.

Depression

For diagnosis codes please see here.

QOF | ?Depression as coded as resolved but antidepressants >3m	The report will show the date on which the Depression Resolved code was added. Consider whether this was added in error (so should be removed) or whether a subsequent diagnosis needs to be added to put them back onto the register.
QOF | ?Depression as h/o depression or review/monitoring	Review the patient records to check whether they should actually have a diagnosis of depression recorded as they have a code which indicates they have had monitoring or been recalled for depression OR have a non-QOF depression code used.
QOF | ?Depression as repeat antidepressants >3m (+ no anxiety)	These patients are on repeat anti-depressants but are not currently diagnosed with a QOF depression code. Consider whether an appropriate code should be added.

Diabetes

For diagnosis codes please see here.

QOF | ?DM as coded as resolved but on diabetic medication	It looks as though Diabetes Resolved has been coded in error. This code needs deleting from the record if the usual GP feels this code has been added incorrectly. The report will show you the date of the resolved code and the recent medication.
QOF | ?DM as coded as resolved but on insulin	It looks as though Diabetes Resolved has been coded in error. This code needs deleting from the record if the Usual GP feels this code has been added incorrectly. The report will show you the date of the resolved code and the recent medication.
QOF | ?DM as h/o Diabetes or review/monitoring/plan	Review the patient records to check whether they should actually have a diagnosis of diabetes recorded as they have a code which indicates they have had monitoring or been recalled for Diabetes but do not have a QOF diabetes code on their record.
QOF | ?DM as HbA1c >=48	Review these patients' records as they have a record of having had a high HbA1c but have no valid QOF diabetes code recorded
QOF | ?DM as on repeat insulin (+ no gestational DM)	These patients have results and medication which indicate that they have Diabetes. The record needs to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.
QOF | ?DM as on repeat oral anti-diabetics (+ no PCOS)	These patients have results and medication which indicate that they have diabetes. The record needs to be reviewed to check whether there is a diagnosis missing and an appropriate code added if needed.

Epilepsy

The following patients, who appear to have epilepsy, have been coded with an incorrect code. One correct clinical code for QOF is *Epilepsy (8475700).*

For additional diagnosis codes please see here.

QOF | ?Epilepsy as on anti-epileptics + h/o Epilepsy or plan	These patients have medication which suggests they may have epilepsy but they do not have a QOF epilepsy code. Review the record and add an appropriate code if required.

HF and LVSD

One suitable code for LVSD for QOF is:

Left ventricular systolic dysfunction (134401001)

For additional diagnosis codes please see here.

QOF | ?HF and LVSD as HF diagnosed but no LVSD assessment	These patients have HF but have not yet had an LVSD assessment.

Heart Failure

An example of a suitable code for Heart Failure for QOF is Heart failure (84114007).

For additional diagnosis codes please see here.

QOF | ?HF as BNP >100 or BNP-Pro >400 + on diuretic + no echo	These patients have had a diagnostic tests and are on medication which indicate they may have Heart Failure but do not have a QOF HF code on their record. Consider whether it is appropriate to add one.
QOF | ?HF as BNP >100 or BNP-Pro >400 + on diuretic + no echo	These patients have had a diagnostic test and are on medication which indicate they may have heart failure but do not have a QOF HF code on their record. Consider whether it is appropriate to add one.
QOF | ?HF as cardiomyopathy and breathing difficulty	These patients have codes on their record which indicate that they may have heart failure, but they do not have a QOF heart failure code. Please consider whether it is appropriate to add one.
QOF | ?HF as echocardiogram shows LVD	Please review the results of these patients' Echocardiograms and code LVD as appropriate, and also a QOF heart failure code.
QOF | ?HF as h/o heart failure or plan	These patients have a code of 'history of' heart failure or have a heart failure plan recorded on their record. The report will show you the date of these. Please review the record and add a code if appropriate.
QOF | ?HF as left ejection fraction <45%	These patients have a diagnostic code which indicates possible heart failure but do not have an

	appropriate QOF HF code on their record. Please review the record and add a code if appropriate.
QOF | ?HF as on diuretic + impaired LVF	These patients are on a diuretic and have a code of impaired LVF but do not have a QOF heart failure code. Please review the record and consider whether it is appropriate to add a code.

Hypertension

There are a number of QOF recognised codes for Hypertension, including:
Essential hypertension (59621000).

For additional diagnosis codes please see here.

QOF | ?HTN as ABPM, HBPM or 24hr BP reading >135/85	These patients have had a high BP reading, indicative of hypertension, but have not got a code on their record to put them on the QOF hypertension register
QOF | ?HTN as h/o HTN or review/monitoring/plan	These patients have a code on their record which indicates that they have had some sort of hypertension monitoring, but they do not have a code on their record to put them on the QOF hypertension register
QOF | ?HTN as on antihypertensives + BP >140/90	These patients have a prescription for anti-hypertensive medication and they also have a high BP but they do not have a code on their record to put them on the QOF hypertension register
QOF | ?HTN as resolved but on antihypertensives	These patients have a current prescription for anti-hypertensives, but they are coded as 'hypertension resolved' – review the record and remove the resolved code if appropriate. The report will indicate the date of the resolved code and the most recent medication.

Mental Health

For appropriate diagnosis codes please see here.

QOF | ?Mental Health as H/O schizophrenia	These patients are not on the mental health register but have a code on their record to indicate that they have a history of schizophrenia. The report will show you the date of the code – review the record and code with an appropriate QOF mental health code if required.
QOF | ?Mental Health as lithium or antipsychotics (exc dementia)	These patients are prescribed lithium or anti-psychotics but are not on the mental health register nor the dementia register. Review the notes to decide whether they should be on the QOF mental health register and code them appropriately.
QOF | ?Mental Health as on depot antipsychotics (exc dementia)	These patients are on depot anti-psychotics but are not on the QOF mental health register nor the QOF dementia register. Review the notes to decide whether they should be on the register and code them appropriately.

Obesity

QOF | ?Obesity as ht + wt but no BMI this fiscal year + BMI >30 in last 5y	To be on the obesity register, patients need to have a coded BMI > 30 in this fiscal year. These patients have had a high BMI in the last 5 years but have not had a BMI calculated this year (but do have a recent weight and height) *Please note that an "Obesity" diagnosis code is NOT required.*

Osteoporosis

For osteoporosis, 50-74 year olds need to have all 3 of the following codes:

- **Fragility fracture** Fragility fracture (306171000000106)
- **Code of osteoporosis** (Osteoporosis (64859006))
- **Dexa scan** (codes below):
  Hip dual X-ray absorptiometry scan result osteoporotic (391070005)
  Lumbar dual energy X-ray photon absorptiometry scan result osteoporotic (391075000)
  Femoral neck dual energy X-ray photon absorptiometry scan result osteoporotic 440100002)
  Lumbar spine dual energy X-ray photon absorptiometry scan T score (1083701000000107)
  Hip dual energy X-ray photon absorptiometry scan T score (391068001)
  Lumbar spine dual energy X-ray photon absorptiometry scan T score (391073007)
  Femoral neck dual energy X-ray photon absorptiometry scan T score (440050006)

Those over 75 need just the following 2 codes:

- **Fragility fracture**
- **Code of osteoporosis**

QOF | ?Osteoporosis as 50-74y, DXA + fracture = ?Fragility # + ?Osteoporosis	These patients have had a fracture and a dexa but neither a fragility fracture nor osteoporosis is coded. Please review the record and consider whether it is appropriate to add these codes.
QOF | ?Osteoporosis as 50-74y, DXA + fragility # = ?Osteoporosis	These patients have had a dexa, have a fragility fracture coded but do not have a code of osteoporosis. Please review the record and consider whether it is appropriate to add the "osteoporosis" code.
QOF | ?Osteoporosis as 50-74y, DXA, osteoporosis + fracture = ?Fragility #	These patients have had a dexa, have a fracture coded, and have osteoporosis coded but do not have a fragility fracture coded. Please review the record and consider whether it is appropriate to add the "fragility fracture" code.
QOF | ?Osteoporosis as 50-74y, Fragility # + Osteoporosis = ?DXA	These patients have a fragility fracture coded and have osteoporosis coded but do not have a dexa scan coded. Please review the record and consider whether they have had a dexa and whether it is appropriate to add the code.
QOF | ?Osteoporosis as >75y + fracture = ?Fragility # + ?Osteoporosis	These patients have had a fracture coded but neither fragility fracture or osteoporosis codes. Please review the record and, if the fracture was a fragility fracture consider adding the appropriate code. If appropriate, also add the osteoporosis code.

QOF | ?Osteoporosis as >75y + fragility # = ?Osteoporosis	These patients have a fragility fracture coded but do not have a code of osteoporosis.
QOF | ?Osteoporosis as >75y, osteoporosis + fracture = ?Fragility #	These patients have a fracture coded and have osteoporosis coded but do not have a fragility fracture coded.

PAD

An example of a code for QOF is *Peripheral vascular disease (400047006)*

For additional diagnosis codes please see here.

QOF | ?PAD as ABPI <90%	Patient has ABPI under 90% but no code on record to put them on the QOF PAD register.
QOF | ?PAD as arterial operation	Patient has had an arterial operation but does not have a code on record to put them on the QOF PAD register.
QOF | ?PAD as h/o PAD or review/monitoring	These patients have a code on their record which indicates that they have had some sort of PAD monitoring, but they do not have a code on their record to put them on the QOF PAD register.

Rheumatoid Arthritis

One suitable code for QOF is Rheumatoid arthritis (69896004)

For additional diagnosis codes please see here.

QOF | ?RA as on DMARD (+ no IBD, psoriasis, SLE, SS, Sjogren's, JIA)	Patients in this list are on a DMARD but have no clear indication for it so may need to have a diagnosis code entered to put them on the QOF RA register.

Individual Patient Values per QOF Domain (2020/21)

(approximate)

Domain	Patient value
Atrial Fibrillation	£31
Asthma	£15
Cancer	£8
Coronary Heart Disease	£30
Chronic Kidney Disease	£4
COPD	£36
Dementia	£122
Diabetes	£30
Epilepsy	£4
Heart Failure	£71
Hypertension	£4
Mental Health	£44
Osteoporosis	£22
Rheumatoid Arthritis	£22
TIA/Stroke	£16
Obesity	£2
Learning Disabilities	£18
Peripheral Arterial Disease	£7
Depression	£2