Electronic Clinical Quality Measures (eCQM) Development and Maintenance for Eligible Professionals

Support Contractor

Eligible Clinician New Electronic Clinical Quality Measures (eCQMs) Finalized for 2019

Questions and Answers

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The following document provides actual questions from audience participants. Webinar attendees submitted the following questions and subject-matter experts provided the responses during and after the live webinar. The questions and answers may have been edited for grammar.

Question 1: **For CMS249, if the patient is referred to an orthopedic by a primary care physician (PCP) and the orthopedic refers a DXA and the PCP failed to order either FRAX, how would that scenario be reported? Is that still numerator eligible for the PCP? If so, what if the PCP was in a different appointment after the ortho appointment and orders FRAX, will that patient not be numerator complaint?**

The FRAX does not have to be completed for a patient to be excluded from this measure. Patients can be excluded from the measure if they meet the combination or independent risk factors. The PCP would only be reporting on a patient referred to an orthopedic clinician if the PCP had information about the DXA in the patient's primary care electronic health record (her). In this case, the patient would be classified as having an appropriate DXA if they did not have any of the combination or independent risk factors. For a FRAX score to be used to exclude a patient from the measure it must be present before the start of the measurement year, so a FRAX conducted after the DXA cannot be used to exclude the patient.

Question 2: **If the HIV screening is part of an obstetric (OB) panel, will this meet the intent?**

Yes, an HIV screening as part of an OB panel would meet the measure intent.

Question 3: **Can we discuss the financial implications of HIV testing? HIV tests may not be covered if there is no justification and then the cost will fall on the patient. I have personally witnessed patients receive $500+ bill because of the screening. What about the stigma in relation to this testing?**

United States Preventive Services Task Force (USPSTF) has recommended once in lifetime screening for HIV, and since this measure is intended to capture lifetime screening, there should not be financial implications for the patient. Regarding stigma, this is an important question. Screening everyone without concern for risk is a stigma-reducing strategy.

Question 4: **Do you know what the confirmatory test is once a patient has a positive screening test for HIV?**

Clinics and health care facilities should follow the current CDC recommendation for laboratory testing https://www.cdc.gov/hiv/testing/laboratorytests.html

Question 5: **HIV testing is not coded and billed as routine care?**

Facilities would need to work with their medical coders to ensure that this testing is being accurately coded. More information about providing HIV testing in clinical settings can be found on CDC's website https://www.cdc.gov/hiv/testing/clinical/index.html. CDC is aware of several sites, including emergency departments that have implemented routine HIV screening in their facilities. Additionally, CMS has provided coding guidance for HIV testing: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9980.pdf

Question 6: **Should automatic screening for HIV be suggested depending upon patient's lifestyle or past medical history?**

This screening measure is recommended for all patients without regard for perceived risk or medical history.

Question 7: **I feel really horrible because I have not been screening for HIV. Is there a place to document screening and results in your EHR?**

It is not too late to begin screening your patients for HIV! We encourage you to talk to your EHR/EMR vendor to ensure these results can be documented.

Question 8: **Could this be one of those improvement initiatives? For the quality reporting? This would be the MIPS?**

Currently there is no HIV related improvement activities (IA) in the inventory. You can visit the CMS Quality Payment Program (QPP) website to look up the current IAs. The site is key word searchable. There is currently a "Call for IAs", where you could submit a proposal using the submission form. All proposals must go through a review process after the call closes on July 1. All information about the Call for IAs can be found in the QPP Resource Library: https://qpp.cms.gov/about/resource-library

Question 9: **What is the frequency of testing recommended? To clarify, there are no exclusions, regardless of how recent the previous negative test was resulted?**

This is a measure for ever screening for HIV with documentation of no previous test. If no previous test can be documented, it is recommended to screen the patient. If the patient has had a previous negative test that was documented in some way (not self-report) then they would not be eligible for an HIV test.

Question 10: **Is this measure to be used in the clinic setting? My providers are in the hospital, urgent care settings. Will they be required to meet this measure?**

This measure can be used in any clinical setting, as HIV screening recommendations are not limited to ambulatory or non-emergent care settings. In fact, available evidence indicates that screening in emergency departments and inpatient settings presents an important opportunity to identify undiagnosed infections. Ultimately, however, selection and use of the measure is optional.

Question 11: **How often do you recommend re-testing for low-risk patients?**

CDCs current recommendation is to rescreen high risk persons for HIV at least yearly. Patients not part of these risk groups are not recommended for rescreening.
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm;
https://www.cdc.gov/hiv/testing/clinical/index.html

Question 12: **Do you know if health plans are following the recommendation and covering the cost of screening?**

Because of the Affordable Care Act (ACA), most private health insurers are required to cover the cost of screening. Additionally, the ACA authorized Medicare to expand its existing coverage to include this screening. Through the National Coverage Determination process, Medicare made the determination to cover this screening. Finally, the ACA requires Medicaid to cover the screening for beneficiaries covered through Medicaid expansion, and many states have chosen to extend this coverage for their beneficiaries covered through traditional Medicaid.

For more information visit the National Coverage Determination (NCD) for Screening for the Human Immunodeficiency Virus (HIV) Infection (210.7): https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=335&ncdver=2&bc=AAAAgAAAAAAA&

Question 13: **As this is a proportion measure does this mean more screenings is good for PCP? And why is only the age limited to 65?**

Data from CDC's HIV Surveillance System were used to support the USPSTF recommendations. Because HIV prevalence markedly decreases after age 65 years, routine screening may not be necessary in older patients. However, as more recent data become available, CDC and USPSTF will review and reevaluate whether this upper limit is still appropriate.

The age limit of 65 is based on a systematic literature review. For more information see link: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening

Question 14: **Since the HIV Screening measure is an eCQM measure but not yet endorsed by NQF, does the NQF endorsement makes a difference in implementing the eCQM? If so, what values added does the endorsement status make if the measure is already an eCQM measure?**

MIPS measures do not need to have NQF endorsement to be included in the program. eCQMs are not tied to endorsement and are just one type of measure that NQF endorses.

Question 15: **Can give free screenings for every young people in DC area?**

There are many screening programs in the Washington DC area that may provide frequent tests for young people. The purpose of this measure is to screen all persons.

Question 16: **After a negative result, how long before you screen again?**

This measure is recommended for all persons age 15-65; see link https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening. There is not a recommendation at this time for a subsequent HIV test unless the patient is engaged in behaviors that put them at higher risk. See CDC

recommendations:
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm and
https://www.cdc.gov/mmwr/volumes/66/wr/mm6631a3.htm

Question 17: **Can CVS and Walgreens provide free Screen HIV testing in the future?**

Most drugstores carry over the counter HIV tests for a fee. Some health departments collaborate to provide these tests for free to residents in their jurisdiction.

Question 18: **What is the recommended age to start testing?**

These recommendations are for persons age 15-65.

Question 19: **So should a patient be asked while having any blood work done if they would like the HIV test? Is that the goal to ask all patients to obtain as many patients tested as possible?**

The goal is to screen more persons for HIV in their lifetime. CDC recommends opt out HIV testing, meaning the patient should be told they will be offered an HIV test unless they decline it. This is to routinize HIV screening into other types of routine screening and decrease stigma.

Question 20: **What if the patient declines the screening? Is that a denominator exclusion?**

There are no denominator exclusions. When providers routinize opt-out HIV testing in a manner consistent with CDC guidelines, we believe the refusal rate to be low enough to not have a meaningful effect on scores. Additionally, exclusions for other forms of prevention are not common, and allowing them for HIV would contribute to stigma regarding HIV testing.

Question 21: **What is the reimbursement for HIV screening and what code should providers use?**

The amount that a provider would be reimbursed for performing HIV screening is determined through negotiations with providers and payers. More information about providing HIV testing in clinical settings can be found on CDC's website https://www.cdc.gov/hiv/testing/clinical/index.html. We also recommend

checking the most recent coding guidance published in The Machine Learning Network (MLN) Matters: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9980.pdf

Question 22: **If refusal is not an exclusion for the HIV measure, how will the provider's percentage reflect positively?**

When providers routinize opt-out HIV testing in a manner consistent with CDC guidelines, we believe the refusal rate to be low enough to not create a discernable impact on providers' percentage.

Question 23: **Is there a timeline for a Negative screen to be considered valid for the purpose of the measure?**

If documentation of an HIV test with a negative test result exists, that would satisfy the measurement.