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# Eligible Clinician eCQMs with Substantive Changes for the 2019 Performance Year

February 27, 2019  
1:00 – 2:00 p.m. ET



## Agenda

Topic	Speaker
Introduction and Meeting Objectives	Susan Arday CMS
CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Gary Rezek and Katie Magoulick Quality Insights
CMS159: Depression Remission at Twelve Months	Claudia Hall and Theresa Feeley-Summerl Mathematica Policy Research
CMS160: Depression Utilization of the PHQ-9 Tool	Claudia Hall and Theresa Feeley-Summerl Mathematica Policy Research
<b>Questions and Answers</b>	

## Objectives for Today's Call

1. Become familiar with electronic clinical quality measures (eCQMs) with substantive changes for the 2019 performance year
2. Identify how to submit questions for each of these eCQMs, and how to follow ongoing information about these measures through ONC Project Tracking System (JIRA)
3. Learn about substantive changes to these eCQMs for 2019 Merit-based Incentive Payment System (MIPS) reporting, including new CQL updates

# Disclosure Statement

These staff and speakers have disclosed that neither they nor their spouses/partners have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity:

- » Gary Rezek, Quality Insights
- » Katie Magoulick, Quality Insights
- » Claudia Hall, Mathematica Policy Research
- » Theresa Feeley-Summerl, Mathematica Policy Research

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Gary Rezek  
*Quality Insights*

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

- » **Measure Description:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter

Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m<sup>2</sup>

- » **Denominator:** All patients 18 and older on the date of the encounter with at least one eligible encounter during the measurement period
- » **Denominator Exclusions:** Patients who are pregnant, patients receiving palliative care, patients who refuse measurement of height and/or weight or refuse follow-up

## Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

- » **Numerator:** Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter
- » **Denominator Exceptions:** Patients with a documented medical reason, patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status



# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan 2019 Substantive Changes

Removed from Web Interface reporting

- » Reduces provider burden as all measures must be reported under Web Interface
- » Retaining this measure for other MIPS reporting methods (Medicare Part B, eCQM etc.) allows clinicians to choose this as one of the quality performance category requirements

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan 2019 Substantive Changes

## Denominator Exception Logic

- » Added medical reason exception for not obtaining a BMI result
  - Expert work group recommended adding medical reason as a denominator exception
  - A medical reason can include patients who are in a wheelchair or have other illnesses or disabilities where obtaining height and weight may not be possible in the current setting

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## 2019 Substantive Changes

- » Coding updates needed for successful reporting
  - Replaced Logical Observation Identifiers Names and Codes (LOINC) single code value sets with **direct referenced codes**. A direct referenced code is a single concept code that is used to describe a clinical element directly within the logic. The use of direct referenced codes replaces the need for single code value sets. Measures using other code systems in single value sets may optionally transition to direct referenced codes.
  - Body mass index (BMI) ratio now referred to by a LOINC code (no longer an OID)
  - code “Body mass index (BMI) [Ratio]” using “LOINC version 2.63 Code (39156-5)”

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## 2019 Substantive Changes

- » Coding updates needed for successful reporting
  - Coding for 2018 reporting using Value Set for BMI **Data Criteria (QDM Data Elements)**
    - “Physical Exam, Performed: BMI LOINC Value” using “BMI LOINC Value Set (2.16.840.1.113883.3.600.1.681)”
  - Coding for 2019 reporting using Direct Reference Code for BMI **Data Criteria (QDM Data Elements)**
    - “Physical Exam, Performed: Body mass index (BMI) [Ratio]” using “Body mass index (BMI [Ratio] (LOINC version 2.63 code 39156-5))”

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## 2019 Substantive Changes

- » Coding updates needed for successful reporting
  - Use of direct reference codes in CQL

### ▲ Most Recent Documented BMI

Direct Reference Code

```
Last(["Physical Exam, Performed": "Body mass index (BMI) [Ratio]" LastBMI  
  with "Qualifying Encounters During the Measurement Period" QualifyingEncounter  
    such that(LastBMI.relevantPeriod starts 12 months or less on or before start of QualifyingEncounter.relevantPeriod  
              or LastBMI.relevantPeriod starts during QualifyingEncounter.relevantPeriod  
            )  
    and LastBMI.result is not null  
  sort by authorDatetime  
)
```

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan 2019 Substantive Changes

- » Coding updates needed for successful reporting
  - Value set BMI Encounter Code Set (2.16.840.1.113883.3.600.1.1751): Added 24 Current Procedural Terminology (CPT) codes and one Healthcare Common Procedure Coding System (HCPCS) code. These codes address nursing home and other assisted living type encounters and several codes for medical counseling visits.

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## Frequently Asked Questions

- » Denominator Exceptions vs. Denominator Exclusions
  - Denominator exclusion criteria are evaluated before checking if a patient meets the numerator criteria
  - A patient who qualifies for the denominator exclusion would be removed from the denominator
  - Denominator exception criteria are only evaluated if the patient does not meet the numerator criteria
  - Patients who do not meet numerator criteria and also meet denominator exception criteria (e.g. medical reason for not performing a BMI) would be removed from the denominator



# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## Frequently Asked Questions

- » Q: How do we document BMI not being done for patients with a physical disability (ex. wheelchair bound, exceeds scale)?
  
- » A: A denominator exception may be documented where a medical reason prevents the documentation of height and/or weight
  - 4 broad codes available in value set "Medical or Other reason not done" (2.16.840.1.113883.3.600.1.1502) to identify a medical reason for why a BMI could not be obtained
  - The measure logic cannot account for every reason of why/how a patient may fit into a measure
  - Denominator exceptions allows the provider more discretion to assess if a patient is appropriate for measure inclusion



# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## Frequently Asked Questions

Numerator: documentation of BMI and follow-up if abnormal (timing)

- » Q: Is it OK to include any encounter in the previous 12 months with a BMI screening and follow-up plan for the numerator?
- » A: Yes. There must be at least one eligible encounter during the measurement period but the BMI and follow-up plan can be documented either during that eligible encounter or anytime within the previous 12 months.

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## Frequently Asked Questions

Numerator: documentation of BMI and follow-up if abnormal (timing)

### » Example

A patient has an eligible encounter on 6/1/2019. Their most recent BMI (16 kg/m<sup>2</sup>) was documented on 6/2/2018 along with an appropriate follow-up plan. This case would meet the numerator criteria.

# Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

## Frequently Asked Questions

Numerator: documentation of BMI and follow-up if abnormal (timing)

- » Q: Does the follow-up plan (if BMI is outside normal limits) need to be documented during the same encounter as the BMI screening?
- » A: No. Required follow-up interventions for an abnormal reading must be documented during the eligible encounter or within the previous 12 months. If within the past 12 months, it is not necessary that follow-up interventions be documented on the same encounter as the BMI screening.

## **Quality ID 128 / CMS69: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan Frequently Asked Questions**

Numerator: documentation of BMI and follow-up if abnormal (timing)

### » Example

A patient has an eligible encounter on 11/15/2019. The most recently documented BMI (27 kg/m<sup>2</sup>) was on 5/1/2019. However, an appropriate follow-up plan was documented at an earlier encounter on 1/12/2019. As long as the most recent BMI and a follow –up plan (as appropriate) are documented within 12 months prior to the eligible encounter (or at the eligible encounter) the case meets the numerator criteria.

# Questions?



# Quality ID 370 / CMS159: Depression Remission at Twelve Months

Claudia Hall and Theresa Feeley-Summerl  
*Mathematica Policy Research*

## Quality ID 370 / CMS159: Depression Remission at Twelve Months

- » **Measure Description:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with major depression or dysthymia who reach remission 12 months (+/- 60 days) after an index event date.
- » **Denominator:** Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event.

## Quality ID 370 / CMS159: Depression Remission at Twelve Months

### » Denominator Exclusions:

1. Patients who died
2. Patients who received hospice or palliative care services
3. Patients who were permanent nursing home residents
4. Patients with a diagnosis of bipolar disorder
5. Patients with a diagnosis of personality disorder
6. Patients with a diagnosis of schizophrenia or psychotic disorder
7. Patients with a diagnosis of pervasive developmental disorder

» **Numerator:** Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five

» **Denominator Exceptions:** None





# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

Previous Denominator Exclusions	Current Denominator Exclusions
1. Patients who died	1. Patients who died
2. Patients who received hospice or palliative care services	2. Patients who received hospice or palliative care services
3. Patients who were permanent nursing home residents	3. Patients who were permanent nursing home residents
4. Patients with a diagnosis of bipolar disorder	4. Patients with a diagnosis of bipolar disorder
5. Patients with a diagnosis of personality disorder	5. Patients with a diagnosis of personality disorder
	<i>6. Patients with a diagnosis of schizophrenia or psychotic disorder</i>
	<i>7. Patients with a diagnosis of pervasive developmental disorder</i>

# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

- » Rationale for adding Denominator Exclusions:
  - *6. Patients with a diagnosis of schizophrenia or psychotic disorder*
  - *7. Patients with a diagnosis of pervasive developmental disorder*
  
- » To allow for more accurate identification of the patient population, the 'Principal Diagnosis' attribute was removed and the following exclusions were added: diagnosis of schizophrenia or psychiatric disorder and pervasive developmental disorder. The concept of "principal diagnosis" or "primary diagnosis" is not regularly recorded in ambulatory electronic health records (EHRs). Therefore, patients were inadvertently excluded from the measure population. Adding these diagnoses as exclusions will negate the need to use the "Principal Diagnosis" attribute in the measure logic.

# Quality ID 370 / CMS159: Depression Remission at Twelve Months



## 2019 Substantive Changes

### » CQL logic updates – Denominator Exclusions

#### – Denominator Exclusions

- exists ( "Palliative Care Order" )  
or exists ( "Encounter Palliative Care" )  
or exists ( "Long Term Care" )  
or exists ( "Expired" )  
or exists ( "*Disorder Diagnoses*" )

#### – Disorder Diagnoses

- ( ["Diagnosis": "Bipolar Disorder"]  
union ["Diagnosis": "Personality Disorder"]  
 union [ "*Diagnosis*": "*Schizophrenia or Psychotic Disorder*" ]  
 union [ "*Diagnosis*": "*Pervasive Developmental Disorder*" ] )  
DisorderDiagnoses  
where DisorderDiagnoses.prevalencePeriod starts before end of  
"Follow-Up Assessment Period"

# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

- » Coding updates needed for successful reporting
  - Added Data Criteria
    - "Diagnosis: Pervasive Developmental Disorder" using "Pervasive Developmental Disorder (2.16.840.1.113883.3.464.1003.105.12.1152)"
    - "Diagnosis: Schizophrenia or Psychotic Disorder" using "Schizophrenia or Psychotic Disorder (2.16.840.1.113883.3.464.1003.105.12.1104)"

## Quality ID 370 / CMS159: Depression Remission at Twelve Months 2019 Substantive Changes

- » **Previous age range:** Adult patients age 18 and older
- » **Current age range:** *Adolescent patients 12 to 17 years of age* and adult patients 18 years of age and older
  - **Rationale:** Depression assessment is a clinically relevant and important topic to address among adolescents.

# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

» CQL logic updates - Age Range

- **Initial Population**

- exists ( ["Patient Characteristic Birthdate"] Birthdate with "Index Depression Assessment" IndexAssessment such that
- Global. "CalendarAgeInYearsAt"(Birthdate.birthDatetime, IndexAssessment.authorDatetime) **>= 12**

# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

### » CQL logic updates - Age Range

#### ○ Stratification 1

- ["Patient Characteristic Birthdate"] Birthdate with "Index Depression Assessment" IndexAssessment such that  
Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime, IndexAssessment.authorDatetime) **>= 12**  
and  
Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime, IndexAssessment.authorDatetime) **< 18**

#### ○ Stratification 2

- ["Patient Characteristic Birthdate"] Birthdate with "Index Depression Assessment" IndexAssessment such that  
Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime, IndexAssessment.authorDatetime) **>= 18**

## Quality ID 370 / CMS159: Depression Remission at Twelve Months 2019 Substantive Changes

- » Previous diagnosis tool: PHQ-9
- » Current diagnosis tool: PHQ-9 and *PHQ-9M*
- » **Rationale:** PHQ-9M is an appropriate tool to evaluate depression in adolescents, a newly added age group.



# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

- » CQL logic updates - Depression Assessment
  - **Initial Population**
    - exists ( ["Patient Characteristic Birthdate"] Birthdate  
with  
*"Index Depression Assessment"* IndexAssessment  
such that
    - Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime,  
IndexAssessment.authorDatetime)>= 12
  - **Index Depression Assessment**
    - ( First (*"Assessment, Performed": "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]"*) DepressionAssessment  
with
    - "Depression Encounter" DepressionEncounter  
such that
    - DepressionAssessment.authorDatetime during  
DepressionEncounter.relevantPeriod  
where
    - DepressionAssessment.result > 9  
and DepressionAssessment.authorDatetime is not null  
sort by authorDatetime

# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

- » CQL logic updates – Depression Assessment
  - Numerator
    - Last (*[“Assessment, Performed”: “Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]”*)  
DepressionAssessment  
where
    - Global.“ToDate“ (DepressionAssessment.authorDatetime) in  
“Follow-Up Assessment Period“sort by  
authorDatetime).result < 5

# Quality ID 370 / CMS159: Depression Remission at Twelve Months

## 2019 Substantive Changes

- » CQL logic updates – Terminology
  - Update uses Direct Referenced Code (DRC) instead of value set
  
- » **Terminology**
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]" using "LOINC version 2.63 Code (*44261-6*)"

## Quality ID 370 / CMS159: Depression Remission at Twelve Months 2019 Substantive Changes

- » **Previous index visit:** The percentage of patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months *(+/- 30 days after an index visit)* defined as a PHQ-9 score less than five.
  
- » **Current index visit:** The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with major depression or dysthymia who reach remission at twelve months *(+/- 60 days)* after an index event date.
  - **Rationale:** Follow up with adolescent and adult patients can be challenging, and the expert workgroup members felt an increased assessment window would be prudent.

## Quality ID 370 / CMS159: Depression Remission at Twelve Months 2019 Substantive Changes

» CQL logic updates - Increased Time frame

### – Follow-Up Assessment Period

- "Index Depression Assessment"  
FirstIndexAssessment
- return  
Interval[Global."ToDate"(FirstIndexAssessment.auth  
orDatetime)+ 12 months - **60 days**,  
Global."ToDate"(FirstIndexAssessment.authorDateti  
me)+ 12 months + **60 days**]

## Quality ID 370 / CMS159: Depression Remission at Twelve Months

- » **Previous office visits:** The measure included only office visits for face-to-face encounters (not including emergency department visits)
  
- » **Current office visits:** The measure uses a new value set named "Contact or Office Visit" to include codes for office, *telephone and internet/e-visits*, which represent the types of encounters that will typically occur with the index event
  - **Rationale:** Restricting visits to face-to-face encounters did not accurately identify encounters with patients being treated for depression. The measure now includes codes for evaluation and management of a patient by telephone or on-line interaction to the value set.

## Quality ID 370 / CMS159: Depression Remission at Twelve Months

- » Coding updates needed for successful reporting
  - Value Sets Removed
    - valueset "Face to Face Interaction - No ED" using "2.16.840.1.113762.1.4.1080.1"
    - valueset "Office Visit" using "2.16.840.1.113883.3.464.1003.101.12.1001"
  - Value Sets Added
    - valueset "Contact or Office Visit" using "2.16.840.1.113762.1.4.1080.5 "

## Quality ID 370 / CMS159: Depression Remission at Twelve Months

### Frequently Asked Questions

- » Q: The eCQM specification indicates visits during the Jan-Dec time frame only and does not capture an encounter during the performance period of the following year. Should the encounter codes used during the index period be used during the performance period too and on this encounter itself, does the PHQ-9 score need to be <5 (remission)?
  
- » A: The codes used to identify the index encounter return a set of encounters that meet the specified criteria. That set of encounters is carried through the remainder of the measure logic. There is no requirement for this set of encounters to be reassessed for code compliance after identification for inclusion into the Initial Population.



# Questions?



# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

Claudia Hall and Theresa Feeley-Summerl  
*Mathematica Policy Research*

## Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

- » **Measure Description:** The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter
- » **Denominator:** Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with an office visit and the diagnosis of major depression or dysthymia during the four month period

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## » Denominator Exclusions:

1. Patients who died
2. Patients who received hospice or palliative care services
3. Patients who were permanent nursing home residents
4. Patients with a diagnosis of bipolar disorder
5. Patients with a diagnosis of personality disorder
6. Patients with a diagnosis of schizophrenia or psychotic disorder
7. Patients with a diagnosis of pervasive developmental disorder

» **Numerator:** Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who have a PHQ-9 or PHQ-9M tool administered at least once during the four-month period

» **Denominator Exceptions:** None



# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

Previous Denominator Exclusions	Current Denominator Exclusions
1. Patients who died	1. Patients who died
2. Patients who received hospice or palliative care services	2. Patients who received hospice or palliative care services
3. Patients who were permanent nursing home residents	3. Patients who were permanent nursing home residents
4. Patients with a diagnosis of bipolar disorder	4. Patients with a diagnosis of bipolar disorder
5. Patients with a diagnosis of personality disorder	5. Patients with a diagnosis of personality disorder
	<i>6. Patients with a diagnosis of schizophrenia or psychotic disorder</i>
	<i>7. Patients with a diagnosis of pervasive developmental disorder</i>

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

- » Rationale for adding Denominator Exclusions:
  - *6. Patients with a diagnosis of schizophrenia or psychotic disorder*
  - *7. Patients with a diagnosis of pervasive developmental disorder*
  
- » To allow for more accurate identification of the patient population, the 'Principal Diagnosis' attribute was removed and the following exclusions were added: diagnosis of schizophrenia or psychiatric disorder and pervasive developmental disorder. The concept of "principal diagnosis" or "primary diagnosis" is not regularly recorded in ambulatory electronic health records (EHRs). Therefore, patients were inadvertently excluded from the measure population. Adding these diagnoses as exclusions will negate the need to use the "Principal Diagnosis" attribute in the measure logic.

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool



## 2019 Substantive Changes

### » CQL logic updates – Denominator Exclusions

#### – Denominator Exclusions

- exists ( "Palliative Care Order Before End of December" )  
or exists ( "Encounter Palliative Care Overlaps September through December" )  
or exists ( "Long Term Care Overlaps September through December" )  
or exists ( "Expired in September through December" )  
or exists ( "*Disorder Diagnoses Overlaps Depression Encounter in September through December*" )

#### – Disorder Diagnoses Overlaps Depression Encounter in September through December

- ( [ "Diagnosis": "Bipolar Disorder" ]  
union [ "Diagnosis": "Personality Disorder" ]  
 union [*"Diagnosis": "Schizophrenia or Psychotic Disorder"*]  
 union [*"Diagnosis": "Pervasive Developmental Disorder"*] )

Disorder Diagnoses with "Depression Encounter in September through December"

Depression Encounter such that DisorderDiagnoses.prevalencePeriod overlaps  
DepressionEncounter.relevantPeriod

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

- » Coding updates needed for successful reporting
  
- » Added Data Criteria:
  - "Diagnosis: Pervasive Developmental Disorder" using "Pervasive Developmental Disorder (2.16.840.1.113883.3.464.1003.105.12.1152)"
  
  - "Diagnosis: Schizophrenia or Psychotic Disorder" using "Schizophrenia or Psychotic Disorder (2.16.840.1.113883.3.464.1003.105.12.1104)"



## Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool 2019 Substantive Changes

- » Previous age range: Adult patients age 18 and older
- » Current age range: *Adolescent patients 12 to 17 years of age* and adult patients 18 years of age and older
  - Rationale: Depression assessment is a clinically relevant and important topic to address among adolescents.

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

- » CQL logic updates – Age Criteria
  - **Depression Encounter in September through December**
    - ["Encounter, Performed": "Contact or Office Visit"]  
DepressionEncounter  
with "Depression Diagnoses" Depression  
such that DepressionEncounter.relevantPeriod overlaps  
Depression.prevalencePeriod  
with ["Patient Characteristic Birthdate"] BirthDate  
such that  
Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of  
DepressionEncounter.relevantPeriod) **>= 12**  
where DepressionEncounter.relevantPeriod ends during  
"Measurement Period"  
and end of DepressionEncounter.relevantPeriod in  
"September through December of Measurement Period"

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

### ▲ Depression Encounter in January through April

["Encounter, Performed": "Contact or Office Visit"] DepressionEncounter  
with "Depression Diagnoses" Depression  
such that DepressionEncounter.relevantPeriod overlaps Depression.prevalencePeriod  
with ["Patient Characteristic Birthdate"] BirthDate  
such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of DepressionEncounter.relevantPeriod) >= 12  
where DepressionEncounter.relevantPeriod ends during "Measurement Period"  
and end of DepressionEncounter.relevantPeriod in "January through April of Measurement Period"

### ▲ Depression Encounter in May through August

["Encounter, Performed": "Contact or Office Visit"] DepressionEncounter  
with "Depression Diagnoses" Depression  
such that DepressionEncounter.relevantPeriod overlaps Depression.prevalencePeriod  
with ["Patient Characteristic Birthdate"] BirthDate  
such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of DepressionEncounter.relevantPeriod) >= 12  
where DepressionEncounter.relevantPeriod ends during "Measurement Period"  
and end of DepressionEncounter.relevantPeriod in "May through August of Measurement Period"

### ▲ Depression Encounter in September through December

["Encounter, Performed": "Contact or Office Visit"] DepressionEncounter  
with "Depression Diagnoses" Depression  
such that DepressionEncounter.relevantPeriod overlaps Depression.prevalencePeriod  
with ["Patient Characteristic Birthdate"] BirthDate  
such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of DepressionEncounter.relevantPeriod) >= 12  
where DepressionEncounter.relevantPeriod ends during "Measurement Period"  
and end of DepressionEncounter.relevantPeriod in "September through December of Measurement Period"

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

### » CQL logic updates – Age Criteria

#### – Stratification 1

- ["Patient Characteristic Birthdate"] Birthdate  
with "Depression Encounter in September through December"  
DepressionEncounter  
such that

Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime, start of  
DepressionEncounter.relevantPeriod) **>= 12**

and Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime, start of  
DepressionEncounter.relevantPeriod) **< 18**

#### – Stratification 2

- ["Patient Characteristic Birthdate"] Birthdate  
with "Depression Encounter in September through December"  
DepressionEncounter  
such that

Global."CalendarAgeInYearsAt"(Birthdate.birthDatetime, start of  
DepressionEncounter.relevantPeriod) **>= 18**

## Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool 2019 Substantive Changes

- » Previous diagnosis tool: PHQ-9
- » Current diagnosis tool: PHQ-9 and *PHQ-9M*
- » **Rationale:** PHQ-9M is an appropriate tool to evaluate depression in adolescents, a newly added age group.

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

» CQL logic updates – Depression Assessment

### – Numerator 1

- exists ( *["Assessment, Performed": "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]"]* )

DepressionAssessment

where

DepressionAssessment.result is not null

and DepressionAssessment.authorDatetime in "September through December of Measurement Period")

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

### » CQL logic updates – Depression Assessment

#### ▲ Numerator 1

```
exists ( ["Assessment, Performed": "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]"] DepressionAssessment
  where DepressionAssessment.result is not null
    and DepressionAssessment.authorDatetime in "September through December of Measurement Period"
)
```

#### ▲ Numerator 2

```
exists ( ["Assessment, Performed": "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]"] DepressionAssessment
  where DepressionAssessment.result is not null
    and DepressionAssessment.authorDatetime in "May through August of Measurement Period"
)
```

#### ▲ Numerator 3

```
exists ( ["Assessment, Performed": "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]"] DepressionAssessment
  where DepressionAssessment.result is not null
    and DepressionAssessment.authorDatetime in "January through April of Measurement Period"
)
```

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

- » CQL logic updates – Terminology
  - Update uses Direct Referenced Code (DRC) instead of value set
  
- » **Terminology**
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]" using "LOINC version 2.63 Code (**44261-6**)"



## Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

- » **Previous office visits:** The measure included only office visits for face-to-face encounters (not including emergency department visits)
  
- » **Current office visits:** The measure uses a new value set named "Contact or Office Visit" to include codes for office, *telephone and internet/e-visits*, which represent the types of encounters that will typically occur with the index event
  - **Rationale:** Restricting visits to face-to-face encounters did not accurately identify encounters with patients being treated for depression. The measure now includes codes for evaluation and management of a patient by telephone or on-line interaction to the value set.

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## 2019 Substantive Changes

- » Coding updates needed for successful reporting
  - Value Sets Removed
    - valueset "Face to Face Interaction - No ED" using "2.16.840.1.113762.1.4.1080.1"
    - valueset "Office Visit" using "2.16.840.1.113883.3.464.1003.101.12.1001"
  - Value Sets Added
    - valueset "Contact or Office Visit" using "2.16.840.1.113762.1.4.1080.5 "

# Quality ID 371 / CMS160: Depression Utilization of the PHQ-9 Tool

## Frequently Asked Questions

- » Q: How do you apply the denominator exclusions?
  
- » A: The denominator exclusions should have a relationship to the respective encounter or 4-month follow-up period rather than to the Measurement Period. For example, if we are looking at the May-August 4-month period, the current logic will allow a patient to be excluded if the depression assessment occurs in May, and then they are diagnosed with Bipolar Disorder in August. The exclusion diagnosis can start any time in or before the end of the 4 month period.

# Questions?



## Slides and all Q&As will be posted to:

- eCQI Resource Center - <https://ecqi.healthit.gov>
- Additional Questions may be submitted to: **Electronic Clinical Quality Measure (eCQM) Issue Tracker in JIRA:**  
<https://oncprojecttracking.healthit.gov/support/projects/CQM/summary>

## How to use ONC JIRA

### Here's how to use ONC JIRA:



- **Create an Account (Optional).** You will need an account to create a new issue or to track (watch) an existing issue, but you don't need one to search for a public issue.
- **Search for an Issue.** Have a question? Search by keyword or project, see if others have submitted the same question, and review the responses.
- **Track an Issue.** Find an issue that you're interested in? Keep track of changes or comments on a ticket by clicking '*Start watching this issue*' on the right-hand side of the issue. You will need to be logged into your JIRA account.



- **Create an Issue.** Can't find your issue? Make sure you're logged in – create an issue by clicking the orange "Create Issue" button at the top of the screen. **Be sure to select the correct project and issue type from the dropdown menu in the form. Reminder: Do not include any Protected Health Information (PHI).**
- **Review your Issue.** Once you create an issue, you will be listed as a reporter of that issue. You can make comments, edits, change, add attachments, and communicate with assigned subject matter experts via the comments feature. Additionally, you will receive an email notification of any status changes to your issue.

### Electronic Clinical Quality Measure (eCQM) Issue Tracker in JIRA:

<https://oncprojecttracking.healthit.gov/support/projects/CQM/summary>

**Thank you!**

The final EC Webinar, *New eCQMs Finalized for 2019*, will be held March 11, 2019 from 1:00 – 2:00 p.m. ET.