

## ECQMS WITH SUBSTANTIVE CHANGES FOR THE 2019 PERFORMANCE YEAR WEBINAR TRANSCRIPT

**PLEASE STAND BY FOR REAL-TIME CAPTIONS.**

---

**Speaker: Derek Mitchell**

Hello everyone, and thank you for attending today's webinar. Before we begin, we would like to cover a few housekeeping items. At the bottom of your audience console are multiple application widgets you can use. You can expand each widget by clicking on the "Maximize" icon at the top right of the widget or dragging the bottom right corner widget of your panel.

This webinar is being recorded, and the recording will be available one day after the webcast in the same audience link. If you have any questions during presenters during the webcast, you can click on the Q&A widget at the bottom to submit your question. We will address as many questions as possible during the event. If a fuller answer is required, or we run out of time, we will answer your question later via e-mail. We do capture all questions. If you have any technical difficulties please click on the "Help" widget. There is a "Question mark" icon that common technical issues. You can also use the Q&A widget for technical issues.

Now I'd like to pass it over to Susan Arday. Susan, you now have the floor.

**Speaker: Susan Arday**

Thank you, Brian. I would like to welcome everyone to today's webinar on electronic clinical quality measures titled, "Eligible Clinician eCQMs with Substantive Changes for the 2019 performance year." This is the fourth in our eCQM series webinars for eligible clinicians.

My name is Susan Arday. I am the CMS contracting officer's representative core for the CMS contract, tasked with maintaining the electronic clinical quality measures, or eCQM, used in the CMS merit-based incentive payment system, abbreviated MIPS. I will be presenting today, along with Gary Rezek from Quality Insights, and Claudia Hall and Theresa Feeley-Summerl from Mathematica Policy Research.

Today we're going to present three measures. The first one will be quality ID 128/CMS 69, which is preventative care and screening, body mass index, BMI, screening, and follow-up plan. Next, we'll present on quality ID 370/CMS 159, which is depression remission at 12 months, and then finally, we will present on quality ID 371/CMS 160, depression utilization of PHQ-9. All three of these measures are in the top-ten reported eCQMs for MIPS, and as such, there are many questions that come in, and today our speakers will review the specifications and address the most common questions that we receive.

Our objectives for today are that you will be familiar with the top quarterly ECQMs with substantive changes for the 2019 performance year. You'll better understand the most frequently-asked questions and answers for each of these eCQMs and how to follow ongoing information about these measures in JIRA through the ONC Project Tracking System. You'll learn about changes to these eCQMs for the 2019 MIPS reporting period, including the new CQL updates.

Please make a note that staff and speakers have no financial arrangements for affiliations with corporate organizations either provide edge educational grant to this program or may be referenced in this activity. Now, it's my pleasure to hand the presentation over to Gary Rezek from Quality Insights to discuss CMS 69, the Preventative Care and Screening Body Mass Index, BMI, Screening and Follow-up Plan. Gary, you have the floor.

---

**QUALITY ID 128 / CMS69: PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP PLAN**

---

**Speaker: Gary Rezek**

Thanks, Susan. Okay, so today I'm going to talk for a little bit about the BMI Screening and Follow-up plan measure, some of the changes that have been made for 2019, and some of the frequently asked questions that we received. So, first, let me briefly go over the measure specifications. The denominator for this measure includes all patients 18 and older on the date of the encounter, with at least one eligible encounter during the measurement period. We exclude patients who are pregnant, those receiving palliative care, patients who refuse the measurement of height or weight.

So, the numerator criteria would be patients who have a documented BMI either during the encounter or within the previous 12 months, and then if BMI is outside of normal range, a follow-up plan is documented, again, either during the encounter or within the previous 12 months.

There are denominator exceptions in the specifications. These would be patients with a documented medical reason for not obtaining a BMI or for having a follow-up plan, also patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health.

So, on to some of the substantive changes for this measure for 2019. The first isn't a change to the measure specification so much as a program change. This measure had been part of the Web Interface reporting. It's been removed for 2019 Web Interface reporting. So, for providers who do report by Web Interface, this should reduce some of the burden. If the measure has been retained for other MIPS reporting methods, so, for claims registry and EHR with a double op clinician to choose this as one of the quality performance category requirements.

Now, as for some changes to the specifications, we have added -- for the Denominator Exception Logic, we've added a medical reason exception for not obtaining a BMI result. This was an expert work group recommendation, and the medical reasons can include patients who are in a wheelchair or have other illnesses or disability where obtaining height and weight may not be possible in the current setting.

So, of course, all of the measure has been converted to CQL. In addition to that conversion to CQL, we've also added the ability to express value sets with a single code as a direct reference code. So, for 2019, any LOINC value set contains a single code has been converted to a direct referenced code. And what this means is instead of the value set with an OID, which contains that single code, the measure logic now just has a direct reference to that single code, and I'll

explain that a little bit more maybe in the next four slides. But for this measure in particular, the value set, which represented the body mass index ratio, which was a LOINC single code, is now represented by the single LOINC code.

So, what that looks like in your specifications and the data criteria of the eCQM specifications, you'll see a description of all the data elements and the value sets that they are represented by. In 2018, the BMI, the physical exam performed data elements and it was represented by the LOINC value set, that big long string of numbers, which is the OID. For 2019, what it looks like is the same data element of the form with the code description, which is body mass index BMI ratio, and then you'll see the reference to LOINC, the version of LOINC, and the actual code value. So, in the CQL logic, it's a subtle change from the value set reference, but instead of the value set name, the logic now simply refers to the code description. For example, the highlighted portion is an example of how we now refer to the BMI and the CQL logic.

We've made some additional coding updates. We've added some CPT and HCPCS coding to the eligible encounters value set, and those codes were added to address nursing home and other assisted-living-type encounters and several codes for medical counseling.

On to some of the frequently asked questions we received, a lot of the questions we received are in regard to the distinction between exceptions versus exclusions. And, of course, this would apply to any measure which includes exceptions and exclusions, but I'll talk briefly about that distinction. So, a denominator exclusion, it is, of course, evaluated prior to looking at the numerator criteria, so if the patient needs the denominator exclusions, they're removed from the measure and not considered for the numerator.

The nominator exceptions are evaluated after the numerator criteria are evaluated, and if the patient does not meet numerator criteria, then we would look at the denominator exceptions, so if there's then a valid reason why they did not meet numerator criteria, that can be documented and that patient would, at that point, be removed from the denominator.

Okay. So, one of the specific questions we receive frequently, how do we document a BMI not being done for patients with a disability, such as though in a wheelchair, exceeds scale? And, again, so, previously, we had not had medical reason exceptions for obtaining that BMI. We've added that for 2019, so now an exception can be used where the height or weight cannot be obtained for physical disability.

Okay, next question, is it okay to include any encounter in the previous 12 months with a BMI screening and follow up plan for the numerator? So, yes. So, as long as there is one eligible encounter during the measurement period, assuming that the BMI and follow-up plan are not documented during that eligible encounter, you look back 12 months, and as long as that BMI and follow up is appropriate, and are documented in the previous 12 months, that would be appropriate to meet the numerator.

So, for example, we have a patient with an encounter on 6-1-2019. Their most recent BMI was below normal, at 16, and was documented 6-2-2018, so just within that 12-month period look back, and the appropriate follow-up plan was also document on that date. That case would meet

the numerator criteria. Documentation of that BMI and follow-up plan does not necessarily need to have occurred during any particular type of encounter.

Okay, next question, does the follow-up plan, if the BMI is outside of normal limits need to be documented during the same encounter as the BMI screening? No. The required intervention for an abnormal reading must be documented during that same period of either during the eligible encounter or within the previous 12 months. It does not necessarily need to be documented on the same encounter as the BMI screening. So, for example, if you have a patient with an eligible encounter on 11-15, their most recent documented BMI was above normal, 27, and it was several months prior, on 5-1. However, in an appropriate follow-up plan was documented at an earlier encounter on 1-12. So, as long as the most recent BMI and follow-up plan, as appropriate, are documented within that 12-month period, the case does meet the numerator criteria. That's all I have. I'll turn it over for the question portion of the presentation.

---

## Q & A

---

Thank you, Gary. This is Susan Arday again, and at this time, I would like to turn this floor over to Anita to see if there are questions that have come in through the chat. Anita, you have the floor.

Thank you, Susan. Yes, we've had a few questions come in here. Gary, can you please help folks understand what is meant by an eligible encounter?

Yeah, absolutely. So, we provide a particular dissect containing the eligible encounter, which are -- and it can be any -- if you have any encounter during the measurement period that meets that criteria, if it matches one of the encounter codings that we provide. For the denominator criteria, that would be an eligible encounter. There is a wide variety of general sort of E&M, and, again, as I'll refer to, we've added some nursing homes. I would refer you to the encounter value set that's provided with the measure specifications to get sort of a complete list. But any encounter that matches one of the codes we've provided for the denominator criteria would be ineligible.

Thanks, Gary. The next question is, the guidance indicate that is the most recent BMI is used; however, does a follow-up plan have to be documented at each encounter; for example, if the patient has a BMI of 30 on January 1st, and is provided a follow-up plan, and then has another visit on February 1st, and the BMI is recorded again in 30, does the patient still meet the measures since the follow up was provided at an earlier visit?

Yes. And that was one of the examples I talked about. Absolutely, there's the follow up plan, that we do reference the most recent BMI; however, if a follow up plan has been documented, even if it was an earlier date, that would meet [inaudible].

Thanks. Gary. The next question is, why does the height need to be recorded within the last 12 months? Most adult patients' heights aren't changing? So, I don't know if that's something you've discussed with your experts or not, Gary, or if you can provide a response to that.

Okay. Well, technically the height, we don't actually look for height and weight. We look for the BMI. So, as long as the BMI can be accurately calculated, that meets the requirements.

Thanks. Folks want to know is the updated value set currently available on [VSAC]. Yes. The value sets that apply to 2019 reporting are on published on VSAC; right.

I believe you answered this question, but a few people sent it in. How do we report that the patient was not able to be measured for the BMI? Is this with a diagnosis or does it depend on our EHR and registry?

Yeah, so it kind of does depend. So what we provide are some coding that are really broad descriptions of medical reasons or contraindications or things like that that can be applied to a number of criteria. So those would need to be documented with the medical reason codes we provided with the denominator exception. So, you know, if a patient, say, is in a wheelchair, these are examples we hear a lot, the reasons why height and are unable to be obtained, you would want to document using one of the [inaudible] codes we provide for the denominator exceptions as a reason why the BMI was not obtained.

Thanks, Gary. The next one is very common and comes in. Does the BMI documented within 12 months have to be documented by the present provider; for example, the patient had a BMI calculated by a primary care physician. They are seen by OT for hand injury. Can the OT report this measure is completed due to the BMI previously being obtained?

So, if the clinician who is in charge of that eligible encounter has access to the BMI, it's in the patient's medical record, that would meet the intent of the measure, so it doesn't necessarily have to have been documented by that particular clinician. So, yeah, as long as it has been integrated into the patient's medical record in a way that's accessible by the current provider, then that would.

Thanks, Gary. The next question relates to the new edition of home health codes. They are saying that they thought that the BMI look-back period is only 30 days on the Oasis. How does this calculate with the requirement of 12 months?

Okay, I think for an Oasis question, I'm going to have to defer, or we'll have to provide that guidance offline, like, at least take note of that question and we can provide further information later. But I'm not sure how to answer that at this point. So, for MIPS reporting, it's a 12-month look back. That may not be in accordance with Oasis, and we can look into that and find more information.

Okay. And I do want to let folks know that all questions, while we don't have time now to take them and answer them live, we will provide the answers and responses to all questions that we receive, and they will get posted on the Resource Center, the eCQI Resource Center. I think that we have time for one more question, and that is, the look-back period for this measure is 12 months from the first eligible encounter during the measurement period or is it the last eligible encounter during the measurement period?

Yeah, so that's a good question, and, actually, it's from any eligible encounter during the measurement period at that point, so, it's basically a meet the measure once during the measurement period, and we've met the measurement.

Thanks, Gary. At this time, I'm going to turn back to Susan. And, again, to reiterate, we will get the responses to the other questions out to all of you.

Thank you, Anita and Gary. Next, Claudia Hall will present CMS 159, depression remission at 12 months. Claudia, you have the floor.

---

**ID 370 / CMS159: DEPRESSION REMISSION AT TWELVE MONTHS**

---

**Speaker: Claudia Hall**

Sure. Hello everyone. Okay, well, we're going to start by looking at depression remission at 12 months. This measure looks at the percentage of 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 after an index event date, and that's 12 months plus or minus 60.

The denominator looks at adolescent patients 12 to 17 years of age older with a diagnosis of major depression or dysthymia, with an initial PHQ-9 or PHQ-9M score greater than nine during the index event. When we looked at the denominator exclusions, they exclude patients who died, patients who received hospice or palliative care services, patients who were permanent nursing home residents, patients with a diagnosis of bipolar disorder or personality disorder or schizophrenia or psychotic disorder or pervasive developmental disorder. And the numerator looked at the patient population aged 12 to 17 years of age, and adult patients 18 years of age and older who achieved remission at 12 months, as demonstrated by 12 months, plus or minus 60 days, PHQ-9 or PHQ-9M score of less than five. There are no denominator exceptions for this measure.

Okay, the first substantive change that we're going to look at is denominator exclusions. On the left-hand side, we have the previous denominator exclusion for the measure, and on the right-hand side we have the current 2019 denominator exclusions. We've highlighted in red the additions of patients with a diagnosis of schizophrenia or psychotic disorder and patients with a diagnosis of pervasive developmental disorder.

So, adding these diagnoses as exclusions negates the need to use the principle diagnosis attribute in the measure logic. The concept of principle diagnosis or primary diagnosis is not regularly recorded in ambulatory electronic health record; therefore, patients were inadvertently excluded from the measure. This change allows for more accurate identification of the patient population.

Okay, where does the show up in the CQL logic? First, we look at the denominator exclusions definition, and I have this listed here. And you can see in red there's reference to diagnosis of disorder diagnoses. And when we further look into that definition, disorder diagnoses, you can see highlighted in red the new diagnoses of schizophrenia or psychotic disorder or and pervasive developmental disorder. The coding updates needed for successful reporting of this measure

include the new value set for basic developmental disorder and the new value set schizophrenia for psychotic disorder.

Next, we'll look at age range. The previous age range in this measure included adult patients age 18 and older. The current age range now includes adolescent patients 12 to 17 years of age, and adult patients of 18 years of age and older. And the rationale is because depression assessment is a clinically relevant and important topic to address among adolescents. As a change age range does not require any value set changes but is reflected in the logic. And when we look at the initial population definition, we can see the reference to the age has now changed, as highlighted in red, greater or equal to 12 at the time of the depression assessment.

There are additional changes of the age range in the stratifications of the measure. The first stratification is looking at adolescent patients, so greater than or equal to 12 and less than 18 at the time of the index assessment, and the second stratification looks at adult patients greater than or equal to 18.

The next change for this measure is allowing the ability to allow the PHQ-9M. The previous measure allowed the depression assessment to be the PHQ-9, and then currently, the measure now includes PHQ-9 and the PHQ-9M, and the PHQ-9M is an appropriate tool to evaluate depression in adolescents, which is appropriate for the newly-added age group.

Okay, when we look at where we see this in CQL logic, first we look at the initial population, and you can see that there is a reference to the index depression assessment. And when we further take a deeper dive into that index depression assessment definition, we see the reference to the first assessment performed, the PHQ-9 total reported score. Another place that we see reference to PHQ-9 performance scores is in the numerator.

Now the produced value that was removed and replaced with the direct reference code, as Gary identified earlier in this talk, to more accurately reflect use of the total reported score. And the PHQ-9M did not have a specific code available when it was added to the measure; therefore, the only changes to the measure was specifying a direct reference code for total reporting score.

The next thing that we're going to look at is the expanded timeframe demonstrating the person's remission at 12 months. The previous index visit looked at the percentage of patients 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire PHQ-9 score greater than nine who demonstrated remission at 12 months, plus or minus 30 days after an index visit, defined as PHQ-9 score less than five. The new updated project now allows the depression assessment remission period be at 12 months plus or minus 60 days after an index event date. The rationale is because the follow up with adolescent and adult patients can be challenging, and the expert workgroup members felt an increased assessment window would be prudent.

Okay, where is this timeframe reflected in the logic? We can look at the follow-up assessment period definition and see that the plus or minus 60 days has been added to the 12-month depression assessment period, and these are highlighted in red. Another change that was made was to revise the value set to define encounters. The measure previously used only office visits

or face-to-face encounters, not including Emergency Department visits. The new version of the measure that uses the new value set named contact or office visit, it includes codes for office, telephone, internet, and e-visits, which represents the types of encounters that will typically occur with the index event. And the rationale for this is that restricting visits to face-to-face encounters does not accurately identify encounters with patients being treated for depression. The measure now includes these codes for evaluation and management of a patient by telephone or online interactions to value set. Okay, and when we look at coding updates, we remove the value sets, remove the face-to-face interaction, and office visit, replaced it with a new value set called contact or office visit.

Frequently asked questions on this measure includes something along the lines of this question, the eCQM specification indicates visits during the January through December timeframe 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 the encounter itself, does the PHQ-9 score need to be remission? Essentially 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. And I just wanted to clarify that the denominator identification period is the period in which eligible patients can have this index event. This denominator identification period occurs prior to the measurement period and is defined as 14 months to 2 months prior to the start of the measurement period. So, for patients with an index event, there needs to be enough time following the index for patients to have the opportunity to reach remission at 12 months, plus or minus 60 days after the index event. And so showing the numerator criteria does not require an additional encounter, just the assessment score of less than five.

---

## **Q & A**

---

Okay, at this time, I'm going to pass it off for questions.

Thank you, Claudia, this is Susan Arday. I'd like to turn it over to Anita to see if there are questions that have come in through the chat session. Anita, you have the floor.

Thanks, Susan. Yeah, we do have a few questions for you. You have it in the one slide, but I think the question is, if PHQ-9M is the same as PHQ-9A for adolescents?

Thank you, Anita. I think I'll actually have to defer and double check with our steward on that.

Okay. Again, we will get all of these answers out. The next question is, it has been a goal across the nation to integration behavioral health into medical care. Oh, this one, I'm sorry, it came in for you and said it was psychologists, BMI. I'm going to remove that one. Okay, the next question is can we use this 2016 PHQ-9 that starts with the two questions, and if positive, we'll go to the nine-question version? So, in other words, they're starting with the PHQ-2 and then if it's positive, going to the next.



The PHQ-9 has to be the total reported for. But that LOINC code, I believe, is for all the sections. But we can double check and provide a written response to that one as well.

The next one is, may we use PHQ-9 for cancer patients that are going through depression due to their disease?

I don't necessarily think that a cancer patient will be excluded based on that diagnosis alone. However, if they do need any of the other exclusions, they would be excluded from the measure, such as hospice or palliative care or nursing home care, or any of the diagnosis decisions. So, the answer would be, yes, unless they qualify for the exclusions on the measure.

Thanks, Claudia. The next question is, can you please explain what an in-depth event is?

Sure. The in-depth event is the date in which the first instance of the elevated PHQ-9 or PHQ-9M is greater than nine, with the diagnosis of depression or dysthymia occurring in that denominator identification measurement period.

Great. The next question is, does the PHQ-9 qualify as a follow up? The PHQ-9 four that falls within that last PHQ-9 four that is reported and documented within the follow-up assessment period qualifies.

There was a question that folks are Googling PHQ-9M, and they are not seeing anything. Is it possible it is known by some other name?

It is possible. We will have to take a look at that further.

And then the last question that we have time for is, they're asking, how is this documented in the patient visit so that it counts? Okay, so is that referring to -- I guess the question is, is that referring to the initial PHQ-9 or the follow-up, the numerator criteria? So, the initial PHQ-9 is documented during an encounter where the patient also meets the diagnosis criteria. And then the follow-up PHQ-9 has to be done in that follow-up assessment timeframe but does not have to occur in an encounter.

Thank you. Next, Claudia Hall will present on CMS 160, Depression Utilization. Susan, at this time, I'm going to return it back to you for the next presentation. Thank you. Next, Claudia Hall will present on CMS 160, depression utilization of the PHQ-9 tool. Claudia, you have the floor.

---

## **QUALITY ID 371 / CMS160: DEPRESSION UTILIZATION OF THE PHQ-9 TOOL**

### **Speaker: Claudia Hall**

Okay. So, we're going to continue on our depression journey and talk about the next measure, and this is looking at the depression utilization of the PHQ-9 tool. So, this measure looks at 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 completed a PHQ-9 during each applicable four-month period in which there was a qualifying depression encounter. And the denominator is set, again, adolescent patients 12 to 17 years of age and adult patients 18 and

older, with the diagnosis of major depression or dysthymia during PHQ-9 during a four-month period.

One thing to note is that there are three populations in this measure. So, there's one population for each four-month period. Population one is September through December, population two is made for August, and population three is January.

Okay, you'll note that the denominator exclusions are very similar to the last measure, so looking at patients who died, patients with hospice or palliative care, patients who were nursing home residents, and patients with a diagnosis of bipolar disorder or personality disorder or schizophrenia or psychotic disorder or pervasive developmental disorder. And the numerator is looking at the patient population 12 to 17 years of age and adults 18 and up who have a PHQ-9 or PHQ-9M tool administered at least once during each four-month period. And there are no denominator exceptions in the measure.

And here, again, we've outlined the prior denominator exclusions on the left, and the current denominator exclusions on the right, and we have highlighted the new added (inaudible) in red below, so that's patients with schizophrenia or psychotic disorder or pervasive development. And the reason for adding these diagnoses as exclusions, again, it negates the need to use the principle diagnosis attribute, which we found would not be regularly recorded in the EHR, so the patients were inadvertently being excluded from the measure population. This change allowed for more accurate identification of the patient population.

Okay, now if we look at the CQL, where are we going to find this change? First, we're going to look in the denominator this definition, and we see in the pilot in red a definition, the disorder diagnoses overlaps depression encounter in September through December, and as this dives further into that definition, you can see that in the red there is now an added value set of schizophrenia or psychotic disorder and pervasive developmental disorder. This logic is actually repeated for all three populations for the given timeframe.

Okay, when we talk about terminology updates, again, we will add the pervasive developmental disorder and the schizophrenia or psychotic disorder value sets. And now when we talk about the name change, what is the expanded age range. Just like the other measures, the previous measure, looked at adult patients 18 and older, and now have added adolescent patients, 12 to 17 years of age, as well as adult patients 18 and older. Again, that's because depression assessment is clinically relevant and important topic to address among adolescents.

And just like the last measure, this change is not reflected in value sets but is reflected in the logic, and you can see that the patient must be greater than or equal to 12 that the time the depression is encountered. And, again, these definitions are repeated for each population, and I have an example of that in this slide here. So, the age criteria is referenced in the depression encounter for each four-month period. They can see one from January through April. They can see one through September.

There are also age stratifications in this measure. The stratification one looks at that adolescent patient population, which is greater than or equal to 12, less than 18 at the start of the depression

of encounter, and then stratification two looks at age greater than or equal to 18 at the start of that depression encounter.

Okay. And the next change is use of the assessment tool. The previous measure allowed for the PHQ-9 and now it's been expanded to allow the PHQ-9 and the PHQ-9M. And the PHQ-M, again is an appropriate tool to evaluate depression in adolescents for that newly added age group, and it's actually called -- this is just an update, it's called the PHQ-M, meaning modified for teens, modified for adolescents.

Okay, now where do we find this in the logic? So, here is an example of the one of the numerators and that looks at the existence of the total reported for that s, and this is for the September through December measurement period. And, again, since this measure has three different populations, I provided you an example that you'll see the PHQ-it is going to be referencing in each of those three numerators for the four-month period.

Okay. And similar to the other measurements, measures, the previous value set was removed and placed with the direct reference code to more accurately reflect use of total reported score. The PHQ-9M did not have a specific code available when it was added to the measure, so, therefore, the only changes to the measure was specifying a direct reference code for that total reported score. And, just like the other measures, an additional change was made to revise the value set used to define encounters. The previous measure included offices for face-to-face encounters, not including emergency department visits, and this measure uses a new value set called contact or office visit, that includes codes for office, telephone, internet, and e-visits, and represents the types of encounters that will typically occur with the indexed event.

In the end, the change was made because restricting visits to face-to-face encounters did not accurately identify encounters with patients being treated for depression, so now this measure includes codes for evaluation management of the patient by telephone or online interactions for the value set. So, the coding updates needed for this change are removing the face-to-face interaction and office visit value set and adding the new contact or office visit value set.

Okay. So, we receive frequently asked questions regarding denominator exclusions on this measure, and denominator exclusions should have a relationship to the respective encounter, or a four-month follow-up period rather than the measurement period. For example, if we are looking at the major August four-month period timeframe, the current logic will allow a patient to be excluded if the depression assessment occurs in May, and then they are later diagnosed with bipolar disorder in August. The exclusion diagnosis can start at any time on or before the end of the four-month period. Okay. And at this time, I think we can move on to questions.

---

## **Q & A**

Thank you very much, Claudia. I would like to turn it over to Anita to see if there are questions that have come in through the chat. Anita, you have the floor.

Thanks, Susan. And, yes, Claudia, we do have several questions that have come in. Is this for patients with a score greater than nine, again, similar to the other measure?

No. This is looking at did they have the PHQ-9 tool administered at least once during the four-month period. So, while you are recording the score, it is looking for the existence of the score rather than a specific score value. The next question is a very frequent question for all measure developers. How is it the denominator exclusion is different than the denominator exception?

I think Gary actually had a slide on that earlier in the presentation. So, he said -- I think he had it well laid out there. Let me just find his slide. The denominator exception occurs when -- hold on. So, the denominator exclusion criteria are evaluated before checking if a patient meets the numerator criteria. So, a patient that qualifies for the denominator exclusion would be removed from the denominator. Denominator traction criteria are only evaluated if the patient does not meet the numerator criteria. So, in these two measures there are no denominator exceptions.

Thanks, Claudia. The next question is, does diagnosis of major depression include any other depression diagnoses, such as adjustment disorder, reactive depression, situational depression, or mixed anxiety and depression? Are there specific ICD-10 codes for these diagnoses, or is it just major depression disorder or dysthymia.

So, the codes used are specified in the value set. I don't know specifically if those codes are included, so we'll have to respond to that written after we look at that.

The next question is, does this measure apply only to patients with Medicare? I don't believe so.

Go ahead.

Go ahead. That's all I have. Next question.

Okay. Can clinicians who do not provide the diagnosis for the disorders for the age of 18 and older still report this measure? So, in other words, they're not the diagnosing physician and they want to know if they can report it?

Right. So the answer to that one is, yes, as long as they have that diagnosis documented actively in the EHR.

Okay, the next question is, does a visit have to be related to depression; for example, does it have to be a depression encounter? The depression encounter has to include the types of encounters specified in the value set contractor office, so, it's based off of those visits. It is not necessarily a depression encounter as long as it meets those criteria and they have the diagnosis of depression.

Thank, Claudia. The next one is, what if during a four-month period you diagnose them with depression, and then gave them the assessment, and an ineligible encounter?

Say that one again.

What if the four-month period you diagnose with depression and then gave them the assessment at an eligible encounter? So, they're saying that during a four-month period, you had diagnosed with them depression and then a following eligible encounter, you gave them the assessment.

Yes, the depression diagnosis has to be present at the time of the encounter.

Thanks. Claudia, the next one is, does the full PHQ-9 need to be answered in order to count in the numerator? So, I'm going to say, yes, just like the last question, because it's looking at the total reported score code, so I believe that total reported score has all of the PHQ-9 questions.

The next question is, have you considered cognitive impairment or delay as an exclusion or exception?

We could check back with the steward on that one.

Okay, thanks. And then the last question I believe we have time for before we turn it back to close it out says, I'm confused. Is there a value set for the assessment performed PHQ-9? I do not see that on the VSAC.

Yes. So the reason why there's no value set for the PHQ-9, is us it is now a direct reference code, which is listed in the terminology section, so it's not a value set, it's a direct reference code. And those district reference codes, there is a downloadable spread sheet from the VSAC for just referencing out direct reference codes, similar to other managers, such as Gary mentioned one in the BMI measure.

Okay, great. Thank you. The last question is, could all reporting done on PHQ-9 that is a PH-2 being eliminated?

So, the total score of the PHQ-9 is what's used or this measure. I'm not sure that the PHQ-2 was, but we can check back with the steward regarding more information about PHQ-2.

Great. And one was a clarification, could we spell out what VSAC means? Sometimes we use acronyms and folks don't understand them. That is the Value Set Authority Center.

At this time, I'm going to turn it back to you to be able to explain to folks how they will get these slides and next steps.

---

## **CONCLUSION**

### **Speaker: Susan Arday**

I would like to thank you, Anita, and I'd like to thank all of our presenters today. The slide deck and all of the Q&A's from today's webinar will be available as shown on this slide right here, and accessible through the Electronic Clinical Quality Improvement Resource Center. The Resource Center contains information on eCQMs, with substantive changes for the 2019 performance year, as well as the measure specification for 2019 reporting. Additional questions or issues may be

submitted to the eCQM issue tracker in JIRA and the ONC project tracking system. You're probably wondering how do I use this.

So, if you would like to submit questions through JIRA in the on-project tracking system, please follow the instructions outlined on the slide to create account, then follow it up with an issue ticket. And I'd like to thank, again, all of today's presenters. The final EC, eCQM webinar will focus on new eCQMs finalized for 2019, and it will be held on March 11th, 2019, from 1:00 to 2:00 p.m. Eastern Time. Registration has been distributed and is also available on the eCQI Resource Center. Thank you for attending today's webinar, and goodbye.