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Speaker: Derek Mitchell

Hello everyone, thank you for attending today's Webinar. Before we begin, we want to cover a few housekeeping items. At the bottom of your screen, you can expand each widget by clicking on the maximize icon on the top right of the widget or by dragging the bottom right corner of the widget panel. This Webinar is being recorded. The recording will be available one day after the webcast both at the same audience link used for today's webcast. If you have any questions for presenters, you can click on the Q&A widget at the bottom and submit your question. We will try to answer as many questions as possible during today's event. But if a fuller answer is required or we run out of time, they shall be answered later via email. we will capture all questions. If you have technical difficulties, click on the help widget; it has a question mark icon and covers common technical issues and you can use the Q&A widget for technical issues. Now I would like to pass it over to Susan, and Susan you have the floor.

Speaker: Susan Arday

Thank you. I'd like to welcome everyone to today's Webinar on electronic quality measures eligible clinician eCQM Diabetes Measures. This is the third in our eCQM-series Webinar for eligible conditions. My name is Susan Arday, the CMS Contracting Officer Representative for the CMS contract for maintaining the electronic goal eCQMs that are used in the CMS Merit-based Incentive Payments System, abbreviated MIPS. I will be presenting today with Dan Roman from the National Committee for Quality Assurance or NCQA. Today we will present three measures. The first will be quality ID number one, CMS 122, diabetes Hemo claimant A1c for control greater than 9%. The second measure will be quality ID 117, also known as CMS 131, diabetes eye exam. And the third measure will be quality ID 119, CMS 134, diabetes medical attention for nephropathy. All three of these measures are in the top 10 reported eCQMs for MIPS and as such there are many questions. Today our speaker will review the specifications and address the most common questions that are received.

At the end of today's session, you will be able to be familiar with the top reported diabetes eCQMs. You will better understand the frequently asked questions for the eCQMs and how to follow the ongoing measures through the project tracking system. You will also learn about changes to the eCQMs for program year 2019 MIPS reporting including new secret CQL updates. I'd like to note that the staff speakers have no with corporate organizations that either provide educational grants to the program or may be referenced in this particular activity. At this time I will hand the presentation over to Dan Roman from NCQA to discuss CMS 122, diabetes measure, hemoglobin A1c poor control greater than nine percent. Daniel, you have the floor.

QUALITY ID 1 / CMS122 DIABETES: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (> 9%)

Speaker: Dan Roman

Thank you, Susan, this is Dan Roman. I'm a senior research associate at NCQA and I work on cardiovascular diabetes care. As Susan said, I'll provide an overview of these measures and

answer your questions today. The first measure is hemoglobin A1c poor control greater than nine percent. Based on guidelines from the American Diabetes Association that recommends lower goals -- of less than eight percent for most individuals with diabetes and less than seven percent for some, we know that HbA1c test results can vary by like 5% and what they're telling us and with that in mind, a result of greater than nine percent is problematic and not representative of what is considered good care has a measure name for control. Diving into the measure components, the measure description is a percentage of patients 18 to 75 years of age with diabetes who have hemoglobin A1c greater than nine percent during the measurement period. The denominator will be all patients 18 to 75 with the diagnosis of diabetes during the measurement period. A visit is intended to make sure that the patient is actually currently seeing the provider who is reporting the measure. We exclude patients who are in hospice during the measurement period. That's because the evidence supporting this measure is intended for the more general healthy population of individuals with diabetes and not those within more complex frail condition and we will see the same exclusion in the next two measures for the same reason.

The numerator is focused on patients with the denominator whose A1c result was greater than nine percent. There is no denominator sessions for this measure. In the improvement notation, a lower score indicates better quality. That's because I mentioned earlier, this measure looked for an indication of a poor HbA1c result greater than nine percent and the score should be low.

Moving to some frequently asked questions. What qualifies for reporting the numerator? Obviously, an HbA1c result greater than nine percent is what we are looking for. But since we are also looking for indications of poor care, we also count situations where we see a test ordered without any result present in the record. Or cases where there has been no test during the year when we would expect to see at least one test with a result during the year for any individual diabetes. If we don't see that, it may potentially mean no one is monitoring that particular individual's diabetes care.

Another frequently asked question we get about this measure, blood specific lab has counts for the measure and that might seem obvious, but the language used in the medical records and in the code description for A1c test can vary. Samad and we see things listed on the screen here like A1c, HbA1c, glycohemoglobin, and glycated hemoglobin. The answer is that all these counts in general the best rule to follow is that it's i.e. measure stick to what provided the value setting you will not use any test result that is inappropriate.

Speaking about value sets, we did have some changes from the last reporting year to this reporting year. We removed some codes that we decided were inappropriate for identifying people with type I and type II diabetes from the diabetes values set. We also added the office visit value set, in home healthcare services values set, and that is because we decided the face-to-face interaction values that was obsolete that the values that we used to identify encounters for this measure and we decided that it really was a represent how cares be delivered so we removed it and replaced it with our office visit in-home healthcare value home healthcare services values set. As far as terminology in this measure, we as ICD-10 CPT, [Indiscernible] couple reference codes which are essentially attributes in the measure logic that references a single code this measure we have direct reference goes for discharges to healthcare facilities for

hospice care and discharges to home for hospice care those would be used in identifying patients for the exclusion in this measure. And this slide 13 we are have a screenshot of the CQ are logic for the measure this is covering the initial patient population denominator exclusions and numerator, with that I would turn it over for questions and answers about the diabetes hemoglobin A1c poor control measure.

Q & A

Thank you Dan. This is Susan, I would turn it to Anita to see if there's questions that came in through the chat. Anita?

Hello Susan and Dan, you are very popular today. The first question 92012 and 92014 which are both ophthalmology codes been removed from quality ID measure number one in error?

That is a good question and without digging into the values that a little more I might be able to do this on the call, I cannot answer it off the top of my head but I can take a look at it and would you mind saying the codes one more time?

92012, and 92014 and those are ophthalmology codes. >> So for this particular I will say this for this particular measure those codes would not be counted because we would expect PHP once he is being measured monitored at an ophthalmologist with an ophthalmologist so I wonder if maybe that question is geared towards the eye exam measure which will be discussing next but for this measure those codes you would not expect the ophthalmologist is monitoring HbA1c and I'm not sure why they would be to begin with.

A question is I haven't been able four foot exams for a provider practice are you aware of one thank you? >> So for foot exams that is not a measure that is no longer a measure that was part of the ePCQM program previously. I believe it was drive for this reporting year it is no longer part of the set clinicians will report for 2019 and the national benchmark there is no national benchmark as far as I'm aware and we have a Edith measure at the physician level it is used in an CQAs provider program and diabetes recognition program NCQA at the physician level that see only place and where we might be able it is not part of this set of E measures any longer

Okay, thank you, Dan. The next one is clarification on the denominator age. Is 18 to 75 during any time and the reporting period or 18 to 75 during the visit that happens within that reporting period?

I would believe the way that human choices anybody 18 to 75 during the measurement year the way the logic works out is looking for the overlap of anybody who is diabetic who meets the criteria of the 18 to 75 during the measurement year and has a visit during the measurement year so all of those things need to happen and overlap with the measurement year for them to count for this measure and for actually any of these measures. >> Take you down the next one. Is there consideration for denominator exclusion for residents of long-term care facilities?

So for right now that is not part of the measure. As we saw, we do actually consider we are looking at that for other measures outside of this program and that might be something that gets

worked into the E measure in the future so it is something that is being considered. So I guess to answer the question briefly, yes there is some consideration for adding that to the measure. It is something we would exclude; however, to be clear, that is not part of the measure currently. It may be part of the future though.

Our next question is what if application has a 9.1 in June but is 7.0 on September; will they still be considered poor control?

That is a great question because I probably did not say that clearly when I was reading through the specification earlier. The measure is specifically looking for the most recent result. In that case that person would not count for the measure because their most recent result was a seven, which would be a good result and again this measure is looking for kind of bad. We are seeing a patient whose results are too high and out of the range of what is recommended by the clinical guidelines and since for this measure we have to decide to look for one result, not look at all them across-the-board throughout the year. We are focusing on one result. We look at the most recent that ends up being the last one of the of the year. In that case the person will not qualify for the numerator again the lower scores better.

NICU for clarification done the next question is. Can the value be reported by the patient or just a provider has to obtain the A1c? >> For this particular measure we have not started allowing patient reported results. These should come from a provider ordering lab results and then coming back to the provider and have them in the record. We have some concerns about patient reported results. Using measures in general about validity of them and whether or not the recall is correct in what is coming from and the variety of factors that we are looking over and considering for whether or not to include patient reported for any measure, for this one in particular we have not started using patient reported results account for this numerator.

Okay and the next one is how do you account for the new onset diabetic shoes A1c may very likely be above nine? >> That would depend, I suppose, on when the results come in during the year. So there are very likely might be some patients whose results only have one result at the end of the year and it is not going to look at because they have not got it under control and we would think that overall that's a small percentage of the population being included. It likely would be a wash across providers reported in the measure so it would be very difficult for us to work in that caveat into the measure of who to ask good and you'd also not want to necessarily exclude; you want to shine a light on the situation because that person their first HB1c will come and they are not under control. They are not getting or receiving the care yet that they will get but you need to show that and know that and yes they may get it under control within the next several months. That would be outside of the measurement year but for any individual who is new to diagnosed with diabetes and has a high results through the rest of your HB1c test should in theory be done almost every three months because that's about what they will show you as far as blood sugar and being under control is about three months. So at least one a year if not more and so again that would really only count or really only be a problem for someone newly diagnosed at the end of the year whether my only have the first test for getting a sense of what their HB1c values are and again you want to know that so it is not something you want to hide or exclude from the measure.

Dan we need to move on to your next presentation. We do still have a number of questions and we want to let participants know we will get answers out to all the questions that we receive but right now, Susan I'm turning back over to you. >>

Thank you Anita, and next Dan will present on CMS 131, the eye exam and Dan, you have the floor.

QUALITY ID 117 / CMS131 DIABETES: EYE EXAM

Thank you, Susan. So, as you heard we will talk about our diabetes eye exam measure. This measure will be guidance from the American Diabetes Association and recommends annualized for individuals with diabetes to look for retinopathy. That guidance also indicates that retinopathy is found in one particular and exam every other year may be appropriate and see how this plays out in the numerator once we get ahead a couple slides. A measure description is the percentage of patients 18 to 75 with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period. For a negative retinal exam and other was no evidence retinopathy was found in the 12 months prior to the measurement period. We have the same denominator as the previous measure which is patients 18 to 75 with diabetes and we have the same exclusion for patients who are in hospice care during the measurement period.

Numerator for this measure, we are looking for patient to receive an exotic samurai screening for diabetic retinal disease. We look specifically for exams performed by an eye care professional during the measurement year that indicate the retina was examined or we look for those same type of exams during the previous year performed by an eye care professional where there was a negative finding or no evidence of retinopathy. There's no denominator exceptions and this is a measure where higher is better. The higher the score the better the performance on the measure and that's because here we are looking for good quality care as opposed to what we are talking about in the previous measure.

As far as frequently asked questions go, what counts again for the measure when we report the numerator. So as I said, we are looking for exams during the measurement year that indicate the retina was examined or want to see there was an exam in the previous year was no evidence of retinopathy found. An exam during the measurement year will count and not be concerned about the result during the measurement where you we want to see there's an exam you'll exam if there was no exam you'll exam want to see in the previous year the was an annual exam but no evidence of retinopathy was found that means that the exam happened patient eyes looked healthy and that next year they get a pass for having an exam. Then again we want to see there's an exam the next shifter wasn't one during the measurement year.

Another question we often get is what counts as evidence of an exam. So first of all we want to see that the exam was performed by an eye care professional that includes an optometrist or an ophthalmologist. We allow charts or images taken outside of the eye care professional offices lines or some indication that an eye care professional reviewed the image and provided an interpretation that is based on the current guidance that we have from the American Diabetes Association that requires that an eye care professional is the one doing the examining or interpreting the images or charts that come out of the exam. Another piece of this of what counts as an exam is types of values that we use includes a wide variety of codes and they are

all proxies for exams that took place where the retina had to have been examined. So if you look in the code said there's a large group of codes that some don't necessarily intuitively say or don't straightforwardly say there was an eye exam but there's things that are procedures that are performed that somebody had to look at the retina in order to have done what his qualifying and in the code description it is a proxy for an eye exam being performed again where we know that the retina had to be examined.

And another question is about patient ported results and this is something received on the E measure question on the E measure and on the parent verse of the measure. As I said earlier we considered the possibility of counting patient reported results across our missions but take it measure by measure and what we think would be reasonable to include or not to include and for this particular measure the answer is yes, we do allow patient reported results but there's criteria that must be met. So first, you must have evidence that the exam was performed during the measurement year or the year previously; that the exam was performed by an eye care professional and ophthalmologist or optometrist; the date of the exam and the results; and the patient would have to be able to provide all those. Information has to get into the chart in some way, some structured field that is reportable by any measure but if it came from and they met the criteria, we would allow it for this measure.

As far as the value sets and changes that may have taken place from last reporting year to this year, the same change for the diabetes that I set remove some calls we felt were inappropriate for identifying individuals with diabetes type I and type II we had that though Sam's and home healthcare services values set to replace face-to-face interaction values set no longer representing the care being delivered currently for individuals with diabetes. Terminology is the same as a previous measure ICD-10 CPT codes and long codes and as far as direct reference codes we have the discharge to healthcare facility for hospice care discharged to home for hospice care and have negative finding direct reference code that direct finding where we look at a what took place in the previous year and no indication of retinopathy was found and that is how that particular attribute that direct reference code of negative finding is used in this measure. And to wrap things up on the exile before go to questions we have a screen capture of semiologic where we cover the initial patient population the denominator and exclusions and numerator. With that I turn it back over to Susan for questions.

Q & A

Thank you, Dan. At this time I'd like to turn it over to Anita to see if there's questions that have come in through the chat. Anita, you have the floor.

Thank you, Susan, and once again, Dan. we have a lot of questions for you and the first is, do you look for providers with a taxonomy indicating eye care professional for compliance for this measure? And community health centers have retinal photography machines that do not require an eye care professional to operate. >> That is a great question and it is one that gets to one of the biggest challenges with this measure for it being used as an electronic clinical quality measuring the program we do not currently one of the challenges is still that we are looking for this is meant to be a measure that it can be used by any provider who is providing the general care for patients with diabetes and so it gets difficult because you want to see that the data from

an ophthalmologist and optometrist got into the provider who is reporting the measure into their record and so currently we don't require that for the measure whoever is reporting the measure that there are an ophthalmologist or optometrist we are however I will say we are looking into ways for improving this since we know that there's a bit of the flow of data issue with this measure for some providers and some vendors of the EHRs for capturing it correctly for making sure that you are getting the results from an optometrist or ophthalmologist into the general care general practitioner reporting measure into their health record and currently no but we are working on that for future versions of the measure.

Clarification the codes we do have in the values that are specific to they should because that are only been used by ophthalmologist and optometrist and we include in their also for any time there's a chart or remote image taken a description I believe includes tribulation that it has been reviewed or interpreted by an eye care professional.

Reported by one provider make sure there we are working on ways to improve this measure for future versions of the specification.

Thank you, Dan, and the next question, are blind patients excluded?

So currently blind patients are not excluded from the measure. This goes back to some coding [Indiscernible - Audio cutting in and out] not able to determine from codes whether someone was legally blind but probably should be getting eye exams versus 100% blind and really no reason to look for retinopathy anymore. That is another thing for this particular specification the version of measure we do not include but that is absolutely on our list of things to try to work into the measure for future specification. Our reminder about the timing for when the specification are updated, it is almost a two-year time period from when we make an update to the spec and when it gets published for use, so there's some lag time where things we are working on for future specs, things talking about now, it takes some time to get them into the specs but the blindness is absolutely something we are working trying to work and using the current version current coding into the measure.

Thank you, Dan, and the next question, what would you consider to be patient reported evidence that the eye exam was done? >> Great question. That's something we wrestle with a lot of our measures were this measure we are looking for the patient to be able to have provided to the provider and it gets into the medical record I think that's a key component it is not you know it has to be there and provider [Indiscernible - Audio cutting in and out] desk it he reported so the information has to get into the record as I said it has to be they have evidence the exam took place but know the dates and results and it was performed by an eye care provider and optometrist or ophthalmologist we know that the -- data isn't always shared between providers. [Indiscernible - Audio cutting in and out] >> A little reassurance it is a valid piece of information and should be acceptable for use in the measure and especially since the provider deems it appropriate input into the medical record and usable and structured feels that a measure will pull that information than we think it is usable.

Okay thanks. Next question is would you quickly repeat if it has to be an optometrist or ophthalmologist required?

The eye exam should be performed by an optometrist or an ophthalmologist those are the only two types of eye care professionals we count for the measure so they either perform the exam [Indiscernible - Audio cutting in and out] generated remotely we know that something occurring currently in practice where there is facilities that provide imaging or photography that can be taken or done remotely and as long as it's interpreted by an optometrist or ophthalmologist accounts for the measure. >> Would providers such as a physician assistant or nurse practitioner specializing an eye disease also be an acceptable provider?

Great question, something we should put on our list for considerations for the future. The current specification does not allow for that. It does not allow for it in any version of this measure so even in the parent version of the measure we only count ophthalmologist and optometrist in this current specification but again that should be something we have on our list of things to consider for the future. >>

And prior exam is 2018 will that qualify and count for this reporting period?

Read that beginning again . >> If the result is negative and need date of the prior exam was 2018, will that qualify as counting for this reporting period?

Yes. This reporting period 2019, you are looking at 2018 data and what that is telling us is there was an exam in 2018 with a negative result so we would not require that the results be there for 2018 since it will count for the results report for 2019. It means an exam took place for the future version on the future of the measure what that will then say is the next year that patient if there is no eye exam that is okay because in 2020 was a negative result so for 2019 when the patient is receiving care they can get a pass on getting the eye exam according to the measure and of course in clinical care as a provider in reality the provider what they deem necessary for when the patient gets the eye exam that is completely up to them and up to their clinical judgment for the purposes of the measure a negative result in 2018 would mean that for 2019 they don't necessarily need the eye exam and to be clear though, keep in mind in 2019 the reporting results reporting data from 2018 so the case you are talking about that means there was an eye exam and 2018 and the numerator hits for the measure which is good. >> Okay and Dan that takes us we are out of time to continue answering questions now so I'm going to turn back to Susan.

Thank you, Anita. Next Dan will present on CMS 134, medical attention for nephropathy. Daniel you have the floor.

QUALITY ID 119 / CMS134 DIABETES: MEDICAL ATTENTION FOR NEPHROPATHY

Thank you. So what we are talking about here is diabetes medical attention for nephropathy measure. This measure is based on guidance from American Diabetes Association recommends individual diabetes should ever kidney health assessed once a year and there's variations on how the guidance is discussed and whether or not depending on when diagnosed some kidney values how often they should be assessed and what exactly should be done. This measure in

particular is taking a very high-level look at whether or not patients with diabetes or have their kidney health addressed and we look for variety of things during the measurement year and again we get into these as we dive into the measure component. So the measure description is a percentage of patients 18 to 75 with diabetes who had a nephropathy screening test for evidence of nephropathy during the measurement period. We have the same denominator, we are looking for patients 18 to 75 with diabetes had a visit during the year. The same exclusion for patients with receiving hospice care during the measurement year.

Numerator as I said is patients with a screening for nephropathy or evidence of nephropathy during the measurement year. There's no denominator and similar to last measure the improvement highest score indicates better quality. Again we are looking for good care where there is attention paid to the patient's kidney care at least once during the year. So when you see it as a numerator hit, your score goes up which is what we want to see for this measure.

The main question we get about this and it breaks and can break into a lot of different questions is what accounts for numerator qualifying? For numerator, as I was saying, we are looking for evidence [Indiscernible - Audio cutting in and out] screen or patient was diagnosed with nephropathy and the way we look for that is screening for kidney disease and a variety of tests looking for protein in the urine and there's a value set that covers that and looking for treatment for kidney disease that might come in the form of visit with the nephrologist. But again there's a variety of things we look for in the measure that cover that. I think one of the things we include in this measure is treatment for kidney disease there are some medications like ACE and ours apologize I think something got caught in the slide part of the treatment for kidney disease might see medications like ACE are for used to treat kidney disease that something we look for in this measure as part of the numerator.

As far as changes to the value set, we have the same change for the diabetes value set remove codes we thought were inappropriate and added and removed codes for the nephritis and nephrotic syndrome value set hypertensive chronic kidney disease value set and protein value set where we added some codes that were decided were appropriate to be included in the value set and we removed some codes from the urine protein test value set. As far as terminologies goals wheeze ICD-10 CDT and then have to direct reference codes we use for the hospice exclusion discharge healthcare facility hospice care and discharged to home for hospice care and we will finish up with this before questions with a screenshot of the CQL will recover the initial patient population the denominator exclusions and numerator and you can see in the numerator where we look for an active medications ACE RRs and diagnosis of nephropathy and look for some nephropathy screen. And I'll turn it back over for questions.

Thank you, Dan, it is Susan and at this time I'd like to thank our presenter, Dan Roman, and turn it over to Anita to see if there's final questions that came in the chat. Anita, you have the floor.

Q & A

Hello, Dan, we have more questions in. The first one is if there is a diagnosis, is the diagnosis itself sufficient as a numerator definition or would appropriate medication or other treatment need to be shown also? If so, what are those medications and treatments and other resources?

So as far as if there's a diagnosis, I am taking that as there is a diagnosis of nephropathy that is going to come for the measure that would indicate to us that somebody has paid attention to this patient's kidney and there's lots of other things the measure does not incorporate everything and all things that would be done for somebody who might have kidney disease as a result of their diabetes. This is a very high-level look at if somebody paying attention to the patient's kidneys and seen a diagnosis during the measurement year of nephropathy mean somebody is looked at it and found there is a problem and we do count that and as far as the medications included in this measure, the only things counted are Acer are medications again a host of other things that would potentially be considered and prescribed or recommended for this patient is measure in particular is only looking for Acer are and that on its own would qualify for numerator for this measure we are not looking for a diagnosis of nephropathy medication as well this is an either/or type of thing and again we note there is a variety of things I might shove the medical record and indicate someone is paying attention to the patient's kidneys and the only medications we look for are medications that are active for a CCRs and the next question is does a protein test need to have a numeric value we frequently see a result of positive instead of a numeric result.

We actually for this measure are not looking for the result so that might sound funny but we are not concerned with results specifically it the measure doesn't go further than looking for that there was some test looking for kidney disease. As long as there was a test ordered, that is numerator compliance for this measure or qualifying for the numerator we do not care. We care about the results but the measure does not concerned about whether or not the result was positive or negative or what the number was. We are disliking that there was a test ordered or test performed that falls within the values that we provided that looks for a nephropathy screening. >> The next question is what a diagnosis of security or chronic kidney disease count and the numerator? >> Those are part of the diagnosis weekly for nephropathy value set it is a whole list of kidney disease ranging from mild to severe kidney disease that we count this measure and any evidence that nephropathy or kidney disease has been diagnosed will count for those in those would count. Yes.

And next what a Clinic perform urinalysis qualify as screening for kidney disease?

Providing that the lab test performed is representative as one of the healing codes we provided the value set for the nephropathy screening value set then yes, we do not provide any or have requirements about that specific like location of where it was performed. We are only looking at certain codes that we are counting for the value set in providing the test you mentioned lines up with the code can be billed or coded to fit with the link code that we provide a link code in the value set then yes.

Great. Next question is what evidence of nephropathy should be included in the chart? I think they want to know is it a diagnosis code or something else that needs to be in there? >> For evidence of nephropathy certain diagnosis codes it will be the codes have fallen to the nephropathy diagnoses value set that is things like I diagnosis of chronic kidney disease or ESRD and a decent list but it will be diagnosed codes and they should fit with any value set that is provided.

Next one is is there a list of tests that qualify for this measure? If so, where do we find that list? >> The list of tests will be in the nephropathy screening value set so the tests that qualify will line up and match to the codes we provided in the value set for nephropathy screening. That is the easiest thing to look at. It is already there for you and in the value set and you want to align with that and that way there's no question of is not in the value set. Then it will not count for this current version of the measure and we are, I will say, we are looking for new codes that might be appropriate because we know the terminologies are updated quite often. So we try to add those when we are able to but we do have to stick within the time frames for when we update these measures and there may be codes that are representing a lab test looking for nephropathy that is not part of our value set but for the purposes of qualifying for this measure, you have to use the code sets provided.

Thank you, Dan, the next question: does a prescription of [Indiscernible] for the measure that would indicate the patient has kidney disease? >> I believe now that is not on our list of medications we include for the measure for accounting numerator and so again a reality that might be totally appropriate however what is in the measure specification I currently would not count since it is not in the value sets of things that count the numerator but it is a great question that is something we can put on our list for updates to this back to make sure we include if it's appropriate for future versions.

Great, next question is what if a system prescriber -- screen for nephropathy as may not be clinically appropriate? >> That makes total sense, the situation not necessarily appropriate for everyone with kidney disease. The measure again is not looking to see there's both that's an either/or type situation, so we would look for ACR are and look for nephropathy diagnoses anything that fits within the list we provided such as kidney disease the ESRD different stages of chronic kidney disease or nephropathy screening test ordered and in this case if they order the test during the measurement year that would count for the measure they is no order the test and prescribed something is not how the numerator works we are looking for one of those three things the ACR medication diagnoses or nephropathy screening.

Next question, if the result or exam documentation is located in the EHR, that allows for viewing actual results. Will this suffice for the exam portion of the evidence for patient reported? >> In other words they are able to look at the results that others had in the EHR.

I believe the answer is yes. I need more detail required to answer that question if the results are viewable by the EHR can be reported for this program than there is no reason why they would be allowed. There some mention in that question of patient reported. Patient reported results are not generally allowed for this measure so we don't specifically have anything that kicks out patient reported results in a measure of logic so potentially the measure of its implementer were

picks up results like that they would end up counting but the guys generally run this measure as patient reported results are not we have not started to count patient is reported results from nephropathy measures and would probably need more detail about the question about specific set up they are talking about comment to answer the best I can but if it is something that is picked up in the EHR and mapped appropriately so the E measure can report automatically it probably will end up counting if they have a field that says patient reported results that should not be included for this measure for how the measure is implemented in the EHR currently we don't allow patient reported results for medical [Indiscernible] >> Great. A question that came in a few times, does the test need to be completed or just ordered?

That is a good question. We would like to say that there has to be a completion of some sort but I believe the way the logic works is we are just looking for a test to be performed so I want to say that might be one we should follow up on after this meeting and I can make sure the logic is -- I believe we are looking for test to be ordered or performed during the year if there's anything about the logic that says it isn't completed there's no result that's the part I need to dig into more and my quick half answers I believe as long as it's ordered it is fine but that should be something we should include as a follow-up to this presentation discussion to be sure that we are answering it completely and correctly. >> The next question are you looking at pharmacy claims for a's arm in other words are you receiving information on pharmacy claims to make that determination?

That is another good question. I think if there is access to pharmacy claims they could be used in the HR the EHR's don't have the ability to look at pharmacy claims this measure is looking to see -- we are looking for an active prescription active medication it should be a status within the EHR of what is ordered or being prescribed . We are not looking specifically for there being a dispensing event which is often what we need to use pharmacy claims for so there's no wants is there but for this measure we are not requiring that at all we are looking for what's available in the HR as far as being prescribed or ordered.

The measure looks the quality of care ordering test should make the spirit of the measure correct?

Repeat that please.

This measure looks at quality of care. Just ordering the test should make the spirit of the measure correct?

Correct, yes, we are looking the logic itself is looking for the test to be performed and [Indiscernible - Audio cutting in and out] I believe the logic looking for cases where the results there is a result it is not known but the measure logic and looking for test to be performed and there is a result we are not worried about what the result is but I think it is because if there's a test order but no result that potentially is an issue you don't really know anything about what's happening to me that kind of higher bar of quality we are saying we want the test to be order and there should be a result that is an the guts of the logic of the E measure logic to see that we are not worried about results for the measure but there should be a result and that's how we

consider the test actually performed glad we had that follow-up question so I could answer it better.

The next question may be for Susan and have several questions on where they can find the value sets for this measure.

This is Susan, our day the value sets to find this is on the ECQ I. held what I quality improvement web source website available >>

Susan at this time I'm going to turn it back to you so we can wrap up today's program.

CONCLUSION

Thank you, Anita. The Q&A from today's Webinar will be accessible through the electronic Quality Resource Center website, ECQ I.Health IT.gov. I mentioned and the resource center contains information on the Diabetes Measures as well as measure specifications for 2019 reporting program, your and additional questions and issues can be submitted at any time to the eCQM easy tracker in the project tracking system which is on Health IT.gov and I like to quickly go over how you use the project tracker. You submit questions on the tracking system and follow instructions on the slide to create account if you don't have one in follow-up with an issue ticket.

I'd like to thank everybody for joining us today and give a thanks to our presenter, Dan Roman, and next EC eCQM Webinar will focus on eCQMs with substantive changes for the 2019 program year and will be held February 27, 2019 from 1:00 to 2:00PM Eastern time. Registration has been distributed and is available on the ECQ I Resource Center website. Thank you for attending today, goodbye.

[Event Concluded]