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

Support Contractor

Eligible Clinician Electronic Clinical Quality Measure (eCQM) Preventive Care and Screening Measures

Questions and Answers

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January 15, 2019
1:00 p.m. ET

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

Question 1: **How would we show exception?**

Acceptable exception criteria include patient refusal and urgent medical conditions. These reasons would need to be documented in the medical record as a reason why either the blood pressure was not taken or that the follow-up was not performed. To report, these reasons would need to be mapped to the appropriate codes in the "Patient Reason refused" (2.16.840.1.113883.3.600.791) or "Medical or Other reason not done" (2.16.840.1.113883.3.600.1.1502) value sets.

Question 2: **So, if a patient has 4 encounters and only 3 of 4 yield a measurement the patient would 'fail' 1 of 4 encounters?**

No, that is incorrect. The measure is calculated based on the most recent encounter during the measurement period where a blood pressure was taken. There can be subsequent encounters where no blood pressure was taken or previous encounters where the numerator criteria are not met. As long as the most recent encounter with the blood pressure taken passes the numerator criteria, the patient would pass.

Question 3: **When we are being audited to check this specific quality measure, can the auditor take any BP measure reported during the reporting period or do they have to take last BP reported?**

The measure uses the most recent encounter in the measurement period where a blood pressure was taken.

Question 4: **So if a provider stops taking BP readings mid-way through the year, we just take that last BP? Seems like that would encourage not taking BP's after you get 1 controlled reading.**

The measure's intent aligns with the U.S. Preventive Services Task Force recommendation for screening for high blood pressure in adults age 18 and

older and to encourage appropriate follow up for patients who are screened as hypertensive. We cannot comment on clinicians' choices for care delivery.

Question 5: **Can the follow-up be a nurse visit?**

99211 is not an eligible encounter code for this measure, and would not meet the intent of the measure.

Question 6: **In regards to nurse visit and BP, am I correct that as long as the nurse visit is assigned a 99211 visit code then this BP and visit does qualify as an eligible encounter?**

99211 is not an eligible encounter code for this measure.

Question 7: **Clarify what an eligible encounter is? Nurse visit?**

An eligible encounter is defined within the codes of the value set provided in the initial population as "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)."

Question 8: **If hypertension is a visit diagnosis in an office or ED visit and is the only record of that diagnosis, should the patient still be in the denominator?**

That would depend on how it is documented in the patient record. If there is a record of that patient's having a diagnosis of hypertension and it is documented in their record, they would be excluded. In order to qualify for the denominator exclusion criteria, the diagnosis of hypertension would include any patient with a past or active diagnosis documented prior to or during the measurement period AND before the end of the measurement period. We only look that the diagnosis starts before the end of the measurement period.

Question 9: **We are a multi-specialty clinic so our physicians treat patients on the same day, if a physician meets the measure and then an OT treats the same patient, do the measures count for the OT as well?**

Any patient seen during the measurement period at a qualifying encounter, as outlined in the value set "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)," and meets numerator intent, such as having a documented blood pressure screen, could be reported by multiple providers if the patient was seen on the same day and again during a separate eligible encounter.

Question 10: **Do these recommendations have to be recorded as structure data?**

In order to report eCQM measure data, the required measure data must be recorded and reported electronically. Chart abstracted data would not meet the eCQM measure intent.

Question 11: **Why were direct reference codes removed from the value sets? This makes interpreting into SQL difficult. Can we move back to including them in "normal" value sets?**

Direct reference codes were not removed from value sets. Direct reference codes replaced LOINC single-code value sets. A direct reference code is a single concept code that is used to describe a clinical element directly within the logic. Diastolic and systolic blood pressure are now referred to by LOINC codes (no longer OIDs).

Question 12: **She gave an example where the patient had 4 encounters and encounters 1, 2, 3 had a BP measure but encounter 4 didn't. Why didn't encounter 4 be used for the logic?**

If a patient has 4 eligible encounters during the measurement period, and the BP was taken at the 1st, 2nd and 3rd encounters, but not on the 4th, the measure would look at the 3rd encounter. The most recent eligible encounter with a BP screening result is considered to meet measure intent and as this 4th encounter did not included a BP screen, it would not be included.

Question 13: **For the criteria, what is the "normal" BP range?**

Normal BP, as outlined in the definition section of the measure specification, is systolic BP < 120 mmHg AND diastolic BP <80 mmHg.

Question 14: **For pain management do we require CPT code for the blood pressure?**

Would need clarification as to what CPT code is being referred to and the relevance of pain management. In order for any clinician to report the measure, the documentation of blood pressure would require diastolic and systolic blood pressure ("Diastolic blood pressure" using "LOINC version 2.63 Code (8462-4)" and "Systolic blood pressure" using "LOINC version 2.63 Code (8480-6)").

Question 15: **Please repeat the numerator comment about the 24 hours follow up.**

The follow up cannot occur prior to the eligible encounter. Also, the follow up must be ordered within 24 hours after the start of the eligible encounter to meet numerator intent.

Question 16: **Can you explain more about direct reference codes?**

Measure specifications can now use what are called "direct reference codes," meaning that instead of a value set, which contains a list of codes, criteria can be specified through reference to a single code within the logic statements. The use of direct referenced codes replaces the need for single-code value sets. Diastolic and systolic blood pressure now are referred to by LOINC codes (no longer OIDs).

Question 17: **Are there medicine IDs that we can use in the documentation?**

The medication value sets contain specific medication codes used in the measure. These codes can be used to map content in the EHR.

Question 18: **For CMS 22 - once a patient has a documented Denominator Exception at any point in the reporting period, will that patient always be excluded for that reporting year even if they had subsequent visits and had follow-up documented?**

No. Denominator exceptions to not carry over to subsequent eligible encounters, even within the same measurement period.

Question 19: **I think it needs to be specified that LOINC codes are different than what you would see in the regular note. You would not see a LOINC code in a note, but you would see the CPT code.**

The view depends on the EHR design. Each EHR may choose to display codes differently, or not at all and map behind the scenes.

Question 20: **How do you document an exception in our EHR, "Nextgen"?**

Please contact your Nextgen representative to verify how exceptions are captured in your electronic medical record.

Question 21: **In order to meet the guidance we need to enter the codes as well? Will this apply for pain management specialist?**

Any eligible clinician may report Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented. Data elements necessary to calculate measure performance would need to use structured fields which capture the codes provided in the value sets supplied in the measure specifications.

Question 22: **How would a referral to Cardiology or Nephrology be designated as hypertension follow-up?**

In order to meet measure intent for recommended follow-up if selecting to make a referral to an alternate provider, such as cardiology or nephrology, please reference the value set and provided codes "Intervention, Order: Referral to Alternative Provider / Primary Care Provider using "Referral to Alternative Provider / Primary Care Provider (2.16.840.1.113883.3.600.1475)." The referral would have to be documented in the patient record to meet intent.

Question 23: **How much advance time before the new reporting period do the changes for measures become available to the software vendors? We repeatedly**

don't receive the updates from our vendors as late as September of each 12 month reporting period. This forces us to go back and document the "new" LOINC code (or whichever code they program) to replace the "old" code we previously documented.

Measure specifications are updated annually. Measure implementation updates begin the May prior to the upcoming performance period, which is January 1 and December 31. Please use the eCQI Reference Center webpage for Eligible Professional / Eligible Clinician eCQMs (https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms) to reference measure implementation release updates for the 2019 reporting period. It is important to note that CMS may publish an addendum to the eCQM updates after the initial implementation release to update value sets (only).

Question 24: **How do Direct Reference Codes affect EHR reporting data? Such as EHR's that have LOINC and SNOMED codes mapped to structured data within the EHR system. Will this affect reporting for eCQM's and workflows?**

An effect of direct reference codes would be the need to review the updated value sets for the measure you are reporting to verify you are reporting the correct codes to meet measure intent. Direct reference codes replaced LOINC single-code value sets. Diastolic and systolic blood pressure are now referred to by LOINC codes (no longer OIDs) for example.

Question 25: **Could you provide some clarification on how we support Brand name drugs which are not listed as part of the value set document or the RXNORM list provided to us?**

Branded drugs are not used in eCQMs for CMS' quality reporting programs. Branded drugs may be mapped to their equivalent generic counterparts, if the route, strength and form match.

Question 26: **What code do we submit that the patient refused BP follow-up?**

There are two codes that would require submission for patient refusal of BP Screening: "Physical Exam, Not Performed: Diastolic blood pressure" using

"Diastolic blood pressure (LOINC version 2.63 Code 8462-4)" and "Physical Exam, Not Performed: Systolic blood pressure" using "Systolic blood pressure (LOINC version 2.63 Code 8480-6)."

Question 27: **How do you convert CQL to SQL?**

There is currently tooling to support authoring, parsing, and validation of CQL. There are open source tools available to evaluate ELM for both the JavaScript and Java platforms. There is also a .NET toolkit for ELM that can support translation and evaluation.

Question 28: **If you have 3 eligible encounters and the patient is hypertensive on the first encounter and is given recommended follow-up, but on the last/3rd eligible encounter BP taken and elevated but the patient was not given the recommended follow-up (since the follow-up was documented on 1st eligible encounter) would this still pass the measure?**

The most recent eligible encounter with a BP screening result is what is considered to meet measure intent. We would need to know the outcome of the second eligible encounter to answer the question because if the second encounter meets measure intent, as the third encounter does not per your explanation, the second encounter could be the most recent eligible encounter with a BP screening result that would be considered.

Question 29: **If there is only one encounter for the year, does that count?**

Any patient seen during the measurement period at least one qualifying encounter, as outlined in the value set "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)," is eligible to be assessed for meeting the numerator.

Question 30: **Are we now able to receive credit for remote BP monitoring?**

Home Blood Pressure Monitoring (HBPM) or Ambulatory Blood Pressure Monitoring (ABPM) is not currently available. It is under consideration for 2020 reporting.

Question 31: **In the scenario where the BP is taken at an encounter, but the encounter code is not directly related to the ones specified in the measures, should the BP still not be considered as valid value?**

An eligible encounter is defined within the codes of the value set provided in the initial population as "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)." Any of the codes from within this value set would be considered an eligible encounter and reported only.

Question 32: **If we send our measures via claims, what would go out on the claim for this exception?**

"The following exception code is listed in Quality ID #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented **Screening or Follow-Up for High Blood Pressure not Completed, Documented Reason

Denominator Exception: G9745: Documented reason for not screening."

Question 33: **Per specifications: If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading?**

Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service, use the most recent as the representative blood pressure, not the lowest readings.

Question 34: **If the provider documents the reason for the exception in the medical record (text format), how is this then reported for MIPs tracking/reporting? Question asked early in discussion was not a meaningful answer.**

In order to meet measure intent for a denominator exception, any of the codes provided within the denominator exception value sets would need to be reported/ documented to meet measure intent. Patients who do not meet numerator criteria and also meet denominator exception criteria (e.g. medical

reason for not performing a screening) would be removed from the denominator. Electronic clinical quality measures do not abstract patient record information for reporting, such as provided in text fields. Value set coding as provided in the measure specification must be reported to meet measure intent.

Question 35: **CMS138 has everyone a little concerned about the 'most recent encounter' language.**

The measure uses the most recent BP reading from the last eligible encounter during the measurement period. For example and to clarify, if a patient has 4 eligible encounters during the measurement period, and the BP was taken at the 1st, 2nd and 3rd encounters, but not on the 4th, the measure would look at the 3rd encounter. Again, the most recent eligible encounter with a BP screening result is what is considered to meet measure intent.

Question 36: **Can we take the lowest systolic and diastolic from multiple readings, as long as it is on the same date of service? So for example, if 3 readings were taken, we can take the lowest systolic and lowest diastolic even if it is not the same reading?**

The measure uses the most recent BP reading from the last eligible encounter during the measurement period.

Question 37: **If there are two eligible encounters and the most recent encounter has no blood pressure and the first one does, which encounter do you use?**

The measure uses the most recent BP reading from the last eligible encounter during the measurement period. If there are 2 eligible encounters and the most recent encounter has no blood pressure and the first one does, the first encounter would be reported.

Question 38: **Re: follow-up with another provider for pre-hypertension or hypertension, a specialist advising a patient to follow-up with a PCP does not satisfy the measure? There must be an order in the record?**

In order to meet measure intent, recommended follow-up for a pre-hypertensive or hypertensive reading must begin concurrently with, or start

after, the eligible BP screening encounter and ordered within 24 hours after the start of the encounter. Yes, a referral to an alternate provider, such as a PCP, would have to be documented/ordered to meet measure intent.

Question 39: **The MIPS codes themselves are not changing, correct?**

The coding update discussed referred solely to the replacement of LOINC single-code value sets with direct reference codes. Measure specifications can now use what are called "direct-reference codes," meaning that instead of a value set, which contains a list of codes, criteria can be specified that reference a code directly.

Question 40: **Where can healthcare practices download the value sets to compare to what the EMR companies define from the value sets?**

Value sets can be downloaded from the Value Set Authority Center at https://vsac.nlm.nih.gov/.

Question 41: **For a specialty clinic, we take blood pressures but do not provide follow-up. Do we need to make sure we are documenting referral to PCP every time?**

Yes, a referral to an alternate provider would have to be documented to meet measure intent. In order to meet measure intent recommended follow-up for a pre-hypertensive or hypertensive reading must begin concurrently with, or start after, the eligible BP screening encounter and ordered within 24 hours after the start of the encounter.

Question 42: **We check a BP on every patient on every encounter. So is it okay to report the measure every time there is an encounter with the proper E&M code?**

The measure uses the most recent BP reading from the last eligible encounter during the measurement period for reporting only.

Question 43: **Is the FAQ for CMS22 available on the eCQI resource center site?**

No. However, presentation slides are accessible through the eCQI Resource Center website.

Question 44: **How does the measure work if multiple providers see the same patient? Does each provider need to perform the action to put the patient in the numerator?**

Any patient seen during the measurement period at a qualifying encounter, as outlined in the value set "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)," and meets numerator intent, such as having a documented blood pressure screen, could be reported by multiple providers. Each eligible encounter would be reported and would require a documented BP screen.

Question 45: **Why would a nurse visit at later date not be considered as valid since the requirement is that if a patient is pre-hypertensive, then a follow-up rescreen should be done within < 4 weeks?**

An eligible encounter is defined within the codes of the value set provided in the initial population as "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)." Any of the codes from within this value set would be considered an eligible encounter. For example, you may use 99211 for a blood pressure check, but there must be a doctor's order that this must be done.

Question 46: **If you take the blood pressure in an encounter and you add a referral to PCP and edition about exercise for hypertension, will this count?**

Recommended follow-up for a pre-hypertensive or hypertensive reading must begin concurrently with, or start after, the eligible BP screening encounter. Either of the listed follow up interventions (referral to alternate provider or physical activity recommendations) would meet numerator intent as provided in the corresponding value sets within the measure specification.

Question 47: **If diagnosis of hypertension is listed on the day of the encounter, would this remove it from making it into the denominator?**

No. In order to be considered for the exclusion criteria, the diagnosis of hypertension diagnosis must start (be documented in the patient medical record) before the start of the eligible encounter.

Question 48: **We are having scenarios where, the patient sees one of our doctors in the office and takes BP. At this point in time the patient's BP is normal so no follow-up documentation is required. Then on the same day, the patient goes to get chemo in the hospital setting. The patient's vitals are taken at chemo by the RN and they are out of range. Our system is picking up the most recent BP so in the scenario above, it would pick up the BP during the chemo visit. Since the patient already saw the provider, no follow-up plan is document and thus the patient is counting negative for our providers in the numerator.**

Each eligible encounter should be reported separately. Any patient seen during the measurement period at a qualifying encounter, as outlined in the value set "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)," and meets numerator intent, such as having a documented blood pressure screen, could be reported by multiple providers if the patient was seen on the same day and again during a separate eligible encounter.

Question 49: **Regarding nurse visit. If the patient has an encounter with the provider in the first six months and has a diagnosis of HTN, the follow-up visit would be in the next 6 months since the BP is controlled, so if a nurse takes the BP and the patient does not see the doctor would this count?**

Blood pressure control is not considered in this measure. The measure checks that patients are screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive.

Question 50: **Do we have to do CQM's for patients we see in a setting other than "11" office... example 22 outpatient... 21 inpatient if we bill a qualifying E/M code?**

eCQM reporting is completed solely on measures for which your organization chooses to participate. Eligible provider/eligible clinician eCQMs will consider all eligible encounters as defined within the codes provided in the value set(s) of the measure specification for population consideration.

Question 51: **Does visit 99211 count?**

99211 is an eligible encounter code for this measure. An eligible encounter is defined within the codes of the value set provided in the initial population as "Encounter, Performed: BP Screening Encounter Codes" using "BP Screening Encounter Codes (2.16.840.1.113883.3.600.1920)." Any of the codes from within this value set would be considered an eligible encounter.

Question 52: **How do you suggest we handle when a PCP has the BP under control, but the next visit is a Specialist visit and the BP is high? We are fighting an uphill battle sometime.**

Blood pressure control is not considered in this measure. The measure checks that patients are screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive. Eligible clinicians report this measure independently and again for this measure control is not considered to meet measure intent.

Question 53: **In reference to CMS 22: what if the referral is never fulfilled or never ordered, only documented? Is the performance measured upon completion of the referring action or upon finalization of the referral/returned consult note?**

The fulfillment of the order (or verification that the patient utilized the referral) is not required to meet measure intent. The logic solely seeks to verify that a referral order was documented in the patient medical record.

Question 54: **Going back to CMS22v7: Can you please clarify if the "or" in the numerator to generate a Referral Alternate Provider is for the entire numerator logic, meaning the Follow-up/Interventions if they are not met, then the referral is okay?**

Referral to Alternate Provider" meets the numerator intent for interventions of the assigned BP reading without the completion of the other interventions. "Or" signifies that either of the listed interventions satisfies the logic intent.

Question 55: **Can you please clarify follow-up time frames for Prehypertensive, first hypertensive and second hypertensive visits?**

Prehypertensive readings require a follow-up visit to be ordered within 1 year of the eligible encounter, while first hypertensive reading documentation requires a follow-up visit to be ordered within 4 weeks of the eligible encounter. Specifically, for a second hypertensive BP reading the follow up must include one or more of the following as indicated:

* Anti-Hypertensive Pharmacologic Therapy

* Laboratory Tests

* Electrocardiogram (ECG)

Question 56: **Wondering what is the decision on the performance rate of measure 226 and CMS138 i.e., which performance rate would be considered for scoring?**

Based on the documentation available for the 2018 program year, the second rate, assessing whether tobacco cessation intervention was performed for patients screened and identified as tobacco users, is the stated performance rate. We recommend looking at each program year's documentation to ensure you have the most up-to-date information, which can be found at http://qpp.cms.gov.

Question 57: **Isn't the tobacco measure topped out?**

According to our most recent benchmarks, the tobacco screening measure is not topped out. Average performance rates vary by data submission type and range between 82.7% for EHR reporting up to 97.4% for claims reporting. Benchmark averages and rates are based on the second population, assessing whether tobacco cessation intervention was performed for patients screened and identified as tobacco users.

Question 58: **Does the screening and cessation have to happen at every encounter?**

No, the screening and cessation does not have to happen at every encounter. However, the patient must meet the visit/encounter requirement during the measurement period in order to meet the initial population criteria. A patient should be screened at least once within a 24-month period and, if identified as a tobacco user at the most recent screening, should receive a tobacco cessation intervention.

Question 59: **What about patients who quit smoking? When are they actually considered a non-smoker in measure? For example, last year the patient smoked and this year they quit. Are they considered a non-smoker?**

If during the most recent tobacco use screening the patient indicated they no longer used tobacco, or were an ex-tobacco user, they would be considered a non-user, based on the applicable coding.

Question 60: **If there are multiple providers seeing the patients on the same Electronic Health Record, does each provider need to screen the patient and Counsel or can one provider (most likely the PCP) do this and count for the group?**

This question speaks to attribution, a topic that is currently under review by CMS. However, CMS138 does provide the following guidance: “In order to promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician.”

It is important to note, though, that for the eligible clinician or provider reporting on this measure, it should be expected that provider satisfies the

encounter requirements, as this measure is reportable through the Eligible Clinician/Eligible Professionals.

Question 61: **How does CMS138 work when multiple qualifying encounters with multiple providers occur during the reporting year? Do all providers who saw the patient receive credit if one provider completed screening and follow-up or does each provider need to complete screening and follow-up?**

This question speaks to attribution, a topic that is currently under review by CMS. However, CMS138 does provide the following guidance: "In order to promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician."

It is important to note, though, that for the eligible clinician or provider reporting on this measure, it should be expected that provider satisfies the encounter requirements, as this measure is reportable through the Eligible Clinician/Eligible Professionals.

Question 62: **Do you have to screen for tobacco use for known nonsmoker patients?**

The only way to determine whether a patient is a tobacco user or nonuser is to screen for tobacco use. This result of this screening must be documented in the record.

Question 63: **Could you give some examples for medical reason for not providing Tobacco cessation interventions?**

The PCPI distinguishes between measure exceptions and measure exclusions.

Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (i.e., the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences.

CMS138 only includes denominator exceptions, which are limited to documented medical reasons for either not screening a patient for tobacco use, or for not providing tobacco cessation intervention to those patients who are identified as tobacco users. As noted above, an exception would be open to clinical judgment for a medical reason that clinician deems appropriate for not providing the clinical action described by the numerator of the measure/population. Our expert work group, or technical expert panel, has included an example of a valid medical reason of patients with a terminal illness or who have limited life expectancy.

Question 64: **What are the specific cessation intervention components?**

Cessation intervention is defined within the measure documentation (see Definition field within the eCQM header) as the following: Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy -- Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the value set for the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies are not included in the value set and do not qualify for the numerator.

The eCQM would require that the patient is either ordered tobacco use cessation pharmacotherapy, documented as currently taking the tobacco use cessation pharmacotherapy, or that a tobacco cessation counseling intervention is performed. Applicable coding to satisfy each of these options is available at the National Library of Medicine's (NLM) Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov.

Question 65: **Is it correct that the tobacco cessation needs to be performed any time the tobacco screening is performed and the patient is a documented tobacco user?**

Yes, that is correct.

Question 66: **With the recent boom of patients converting to vaping, will these measures pertain to them? Specifically, if they achieve cessation via conversion to vaping.**

Vaping, or the use of electronic nicotine delivery systems (ENDS), is not currently included in the measure. ENDS are not currently classified as tobacco in the recent evidence used by the USPSTF since the devices do not burn or use tobacco leaves, nor are ENDS included as a tobacco cessation aid in current evidence and guidelines.

Question 67: **2018 requires patients who are marked as non-tobacco users to have a follow-up. Will we need a follow-up for those who are not tobacco users in 2019?**

This measure requires that patients are screened for tobacco use, and if identified as a tobacco user was provided a tobacco cessation intervention, at least once within 24 months. The decision to screen patients on a more frequent basis is up to the individual clinician or institution.

Question 68: **Does the Tobacco Screening Counseling clock get reset if the patient was screened again?**

Yes, the most recent tobacco screening during the 24 month timeframe is what is used to satisfy the various numerator components of each population for this measure.

Question 69: **For the denominator exception of terminal illness, is it sufficient to have this documented in a note in the medical record, or does the SNOMEDCT code from the value set for the exception have to be present?**

In order to satisfy the denominator exception, it must reported by a SNOMED code - either from the 'Medical Reason' value set or the 'Limited Life Expectancy' value set. One of these codes must be linked to not performing one of the numerator actions, but how that is built into the electronic system is not prescriptively defined.

Question 70: **In the example on Slide 42, should the denominator exclusion for the third example be '10' still since both examples 1 and 2 had '10' for a denominator exclusion? Why are these values added together to be 20 if the population is the same?**

It is important to note that this measure does not have denominator exclusions, which are absolute meaning a patient with that condition would never be assessed for the numerator, but rather denominator exceptions, which are included in a measure when there may be reason for which the numerator action is not performed.

That being said, population 1's denominator exception is applicable for not screening a patient. Population 2 includes patients who are already screened but allow denominator exception for not providing the cessation intervention. Because population 3 assess both screening and cessation interventions, you would need to combine the denominator exceptions for not screening and not performing a cessation intervention, because they would not have any overlapping patients due to the additional denominator criteria for population 2.

Question 71: **If a patient is seen more than one time during the 24 month time frame, however, screening was done but no other documentation was done, will that disqualify that patient if screening, cessation and documentation was done on a previous visit?**

The most recent tobacco use screening documented during the 24-month timeframe will be used to assess the three populations. If a screening was performed after a previous screening with documentation, the last screening during the 24-month timeframe would still be used, regardless of what was completed at the previous screening.

Additionally, there is guidance in the eCQM header that may prove helpful for these situations, where we state: If tobacco use status of a patient is

unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure.

Question 72: **So if the patient, a tobacco user, is given cessation intervention during 10/01/18, then another eligible visit on 12/15/18 identified them as a tobacco user and no cessation information was given, do they fail any of the measures since no cessation information was given on the last eligible encounter?**

Based on the information provided, this scenario would pass population 1, but would fail populations 2 and 3 on account of the fact that the cessation intervention must occur at the same time as or after the most recent screening during which the patient was identified as a tobacco user. This is similar to the scenario described within the slide deck, so please feel free to review that documentation for a written example.

Question 73: **Just to confirm, if the patient was seen January 10 and identified as a tobacco user and cessation was given, and then the patient was seen March 10 and marked as a tobacco user and cessation was not given, the measure would be evaluated on the March visit only?**

Correct, the measure and each population would be evaluated on the March visit only.

Question 74: **Can you recommend a single best place to learn of CQM changes each year? A resource that would call out changes only to make it easier for us to know what behaviors must be changed?**

The eCQI Resource Center (https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms) provides a list of the year-to-year changes in the technical release notes published with each update.

Question 75: **Where can I find all CPT codes for these to meet the measures?**

The National Library of Medicine's (NLM) Value Set Authority Center (VSAC) has downloadable files with all applicable coding for each eCQM: https://vsac.nlm.nih.gov/.

Question 76: **What if the patient was screened for tobacco use 4 times during the performance period and each time was identified as a tobacco user, but only received cessation counseling once after the second time they were screened as a tobacco user? Do they meet or fail the measure?**

Based on the information provided, this scenario would pass population 1, but would fail populations 2 and 3 on account of the fact that the cessation intervention must occur at the same time as or after the most recent screening during which the patient was identified as a tobacco user. This is similar to the scenario described within the slide deck, so please feel free to review that documentation for a written example.

Question 77: **Patient sees their PCP on 3/1 and documentation of tobacco use and screening is performed. Then the patient sees a specialist using the same EHR who does not document screening. Does the PCP receive credit for all three measure populations?**

The PCP would report on all three populations for the measure, as the patient was identified as a tobacco user. If the patient did not receive tobacco cessation intervention after being identified as a tobacco user and before the end of the measurement period, then performance on populations 2 and 3 would not be met.

Question 78: **Vaping is not considered tobacco use, correct?**

Vaping, or the use of electronic nicotine delivery systems (ENDS), is not currently included in the measure. ENDS are not currently classified as tobacco in the recent evidence used by the USPSTF since the devices do not burn or use tobacco leaves, nor are ENDS included as a tobacco cessation aid in current evidence and guidelines.

Question 79: **If a physician provides smoking cessation, do we satisfy the measure for 24 months?**

The measure requires that a patient be screened at least once every 24 months, but they must also meet the age and encounter requirements within the initial population. If 2018 is the measurement period, the patient can be

screened anytime between January 2017 and December 2018. It is important to note, as clarified during the presentation, that the most recent tobacco screening is the one used to determine if performance was met across all applicable populations.

Question 80: **Many patients have an immunization in a pharmacy. What is the minimum documentation needed to meet the numerator? The patient says he had the vaccine with the date of immunization, and with fax or electronic verification from the pharmacy.**

In order for a patient to meet the numerator, a patient must have an influenza immunization administered during the current flu season of the measurement period, (October-March), or from August-September of the year prior. If a patient is seen for a visit during the measurement period and verbally tells their provider that they have received an influenza vaccination elsewhere, such as at pharmacy, and the applicable influenza vaccination code is not known, then this should be documented using the SNOMED CT "Previous Receipt of Influenza Vaccine" value set (OID: 2.16.840.1.113883.3.526.3.1185), or could be documented using the "Influenza Vaccine" value set which includes CVX codes identifying specific formulations, as well as CVX 88 for "unspecified formulation," to ensure that the measure is appropriately met.

Question 81: **So do you get dinged if the patient refused this vaccine?**

If a patient refuses the influenza immunization, this will be considered a "patient exception" and can be documented using the "Patient Reason" value set (OID: 2.16.840.1.113883.3.526.3.1008).

Question 82: **If a provider does not immunize, is the shot record the best way to satisfy this measure?**

If a provider doesn't provide immunizations, then this does not seem like an appropriate measure to report on. The intent is that the provider would report on measures for which they would conduct the clinical action(s) identified in the numerator.

Question 83: **Are we expected to be giving influenza vaccinations for ED visits?**

Emergency department visit codes are not included in the qualifying encounters for the measure, so would not be included.

Question 84: **Has any thought been given to changing the October 1 date since the recommendation to start getting the vaccine has changed to August and September?**

As part of the annual maintenance process, we convene a technical expert panel who reviews the updated guidance and recommendations. Although, within the specifications, the influenza season is October through March, patients will still meet the measure if they receive the influenza vaccination in August or September.

Question 85: **Can you satisfy both the denominator and numerator during a single visit?**

For a patient to meet the initial population requirements, they must have an encounter during the measurement period. For a patient to meet denominator criteria, they must have an encounter during the current influenza season.

In some instances, the patient could have an encounter during the current influenza season and the provider administers an influenza vaccine during this encounter. This would meet the initial population requirements because the visit is during the measurement period, would fulfill denominator requirements because the encounter is during the influenza season, and the numerator requirements are met because the provider administered an influenza vaccine.

Question 86: **What is meant by the Denominator Exception requirement stating for example: Patient has allergy to eggs whose prevalence must start AFTER influenza season? What does this mean?**

The denominator exception timing requires that a diagnosis of allergy to eggs must ""overlap after"" the influenza season. This means that diagnosis must be active through the end of the influenza season. For instance, the allergy diagnosis must be active after March 31st and be active on April 1st,

but the measure logic does not require that the allergy diagnosis be active after April 1st.

Question 87: **How can you effectively report on this measure if the logic crosses reporting years? What if you report in January? You would be 'missing' 60 or more days of data.**

The eCQM only assesses the flu season that ends during the measurement period. This is noted within the measure's guidance field but is important to note: "To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year." As an example, if the measurement period is January 1, 2018 through December 31, 2018, the influenza season included in the measure would be from August 1, 2017 through March 31, 2018. So, if a provider recorded an influenza vaccine on January 3, 2018, this would effectively meet the numerator requirement for the measure if the measurement period is 2018.

Question 88: **If the patient reports they received the vaccine from another provider in August, do these count toward the numerator?**

In order for a patient to meet the numerator, a patient must have an influenza immunization administered during the current flu season of the measurement period, (October-March), or from August-September of the year prior. If a patient is seen for a visit during the measurement period and verbally tells their provider that they have received an influenza vaccination elsewhere, such as at pharmacy or from another provider, and the applicable influenza vaccination code is not known, then this should be documented using the SNOMED CT "Previous Receipt of Influenza Vaccine" value set (OID: 2.16.840.1.113883.3.526.3.1185), or could be documented using the "Influenza Vaccine" value set which includes CVX codes identifying specific formulations, as well as CVX 88 for "unspecified formulation," to ensure that the measure is appropriately met.

Question 89: **If a patient refuses to have an influenza immunization, and it is documented that the patient refuses, this does not meet our measure, correct?**

If a patient refuses an influenza immunization, this would qualify as a valid patient exception and should be reported using the "Patient Reason" value set (OID: 2.16.840.1.113883.3.526.3.1008).

Question 90: **This is a calendar year measure, why are we looking retroactively? We as a specialist ask if the patient had previous receipt. This makes it confusing and hard to track.**

The eCQM measurement period corresponds to a calendar year (Jan. 1 – Dec. 31), as indicated in the "Measurement Period" field in the measure header. For an eCQM, data is queried retrospectively and the information is aggregated at the end of the measurement period (i.e., December 31) in accordance with the program reporting guidelines.

Question 91: **So, in order for this measure to count for 2019, patients must have their flu shot by March 31, 2019, correct?**

The eCQM only assesses the flu season that ends during the measurement period. This is noted within the measure's guidance field but is important to note: "To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year." So, if reporting on this measure for 2019, that is correct, patients must have flu shots administered by March 31, 2019.

Question 92: **I highly recommend a visual slide(s) to represent the timing for the influenza vaccine measure.**

Thank you, we will note this for future presentations.

Question 93: **So encounters that occur after March 31 of the current measurement CY year wouldn't qualify the patient in the denominator because they don't have an encounter DURING the flu season?**

For a patient to meet the initial population requirements, they must have an encounter during the measurement period. For a patient to meet denominator criteria, they must have an encounter during the current influenza season. If the measurement period is 2019, a patient must have an encounter in 2019 to be included in the initial population. They must also have an encounter during the current influenza season to be included in the denominator. If a patient has an encounter after March 31st of the Measurement Period, this would count towards the initial population requirements, but it would not count towards the denominator requirements of the measure because they did not have an encounter during the influenza season.

Question 94: **So the only encounters that will count are for everything happening from August to March?**

For a patient to meet the initial population requirements, they must have an encounter during the measurement period. For a patient to meet denominator criteria, they must have an encounter during the current influenza season. If the measurement period is 2019, a patient must have an encounter during 2019 to be included in the initial population. They must also have an encounter during the current influenza season to be included in the denominator. In some instances, the encounter during the measurement period and the encounter during the influenza season may be the same encounter. In order for a patient to meet the numerator, a patient must have an influenza immunization administered during the current flu season of the measurement period, (October-March), or from August-September of the year prior.

Question 95: **So just to clarify if we administer the Flu Vaccination after the March 31 date, but within the reporting year, we would be able to meet the measure?**

If an influenza vaccine is not given during the influenza season, but within the reporting year, the numerator requirements for the measure would not be met. This measure requires that the influenza vaccine is administered during

the current influenza season or during August and September prior to the current influenza season.

Question 96: **It is my impression that the eCQM is generated by the practice's EHR. The variable is really how the provider is entering the required data. Is this correct?**

CMS 147 is specified according to federal standards for eCQMs and follows all recommended terminology standards for coding. The eCQM should be able to generate data from a practice's EHR, but we cannot speak to the variability among EHRs.

Question 97: **If the patient screened has not received a flu vaccine and the specialty practice does not administer, can the encounter qualify based on the screening only?**

If a provider doesn't provide immunizations, then this does not seem like an appropriate measure to report on. The intent is that the provider would report on measures for which they would conduct the clinical action(s) identified in the numerator.

Question 98: **Why would an egg allergy end prior to the end of the flu season? Once a patient has an egg allergy it doesn't go away.**

In some instances, an allergy to eggs may not remain active in a patient's chart. To account for this, the measure logic is structured to ensure that a patient's allergy "overlaps after,' or in other words, is active throughout the entire influenza season.

Question 99: **So if this is a new patient with an egg allergy how would you document this? Is there a medical reason refusal for a valid exception to this measure?**

If a patient has a new allergy to egg, this could be documented using QDM data type: Diagnosis and captured using the "Allergy to Eggs" value set (OID: 2.16.840.1.113883.3.526.3.1253). The measure also has a medical

reason which can be reported using the "Medical Reason" value set, (OID: 2.16.840.1.113883.3.526.3.1007).

Question 100: **A few EPs in the Medicaid PI program may use a 90 day reporting period. If the EP is using a period outside the flu season, he would report zero over zero? Right?**

The eCQM measurement period corresponds to a calendar year (Jan. 1 – Dec. 31), as indicated in the "Measurement Period" field in the measure header. For an eCQM, data is queried retrospectively and the information is aggregated at the end of the measurement period (i.e., December 31) in accordance with the program reporting guidelines.

Question 101: **Has annual wellness been added to the value sets?**

Yes, the Annual Wellness Visit value set (OID: 2.16.840.1.113883.3.526.3.1240) is included in the measure as an initial qualifying encounter.

Question 102: **How are docs/systems capturing flu immunization and submitting them electronically?**

The administration of an influenza immunization may be captured electronically using the QDM datatype "Immunization, Administered" and recorded using the Influenza Vaccine value set (OID: 2.16.840.1.113883.3.526.3.1254). The administration of an influenza immunization may also be captured electronically using the QDM datatype "Procedure, Performed" and recorded using the Influenza Vaccination value set (OID: 2.16.840.1.113883.3.526.3.402).

Question 103: **Can a provider give the vaccine during a home visit?**

Home Healthcare Services are included as qualifying encounters for the measure and may be documented using the "Home Health Care Services" value set (OID: 2.16.840.1.113883.3.464.1003.101.12.1016).

Question 104: **Why was the face to face visit value set removed from CMS147?**

As a part of the annual maintenance process, the Face-to-Face interaction value set, which was stewarded by NCQA, was removed from the program. To account for the codes in the value set, PCPI kept the "Encounter-Influenza" grouping value set (OID: 2.16.840.1.113883.3.526.3.1252) to account for the encounters which would meet the measure.

Question 105: **How does this work when multiple providers have a qualifying encounter during the flu season? Do all providers receive credit or only the provider who documents an immunization?**

Any provider who has a qualifying encounter with the patient during the measurement period, as well as a qualifying encounter during the influenza season, can report on this measure if they would administer the influenza vaccination. The provider who actually administered the vaccination may receive numerator credit through one option to capture the numerator action, while any other provider may use a different option as the patient would have documented previous receipt of the influenza vaccination.

Question 106: **Where can you find the CPT codes for the new value sets for reporting?**

The National Library of Medicine's (NLM) Value Set Authority Center (VSAC) has downloadable files with all applicable coding for each eCQM: https://vsac.nlm.nih.gov/.

Question 107: **What is the difference between a denominator exclusion and a denominator exception?**

The PCPI distinguishes between measure exceptions and measure exclusions.

Exclusions arise when the intervention required by the numerator is not appropriate for a group of patients who are otherwise included in the initial patient or eligible population of a measure (i.e., the denominator). Exclusions are absolute and are to be removed from the denominator of a measure and therefore clinical judgment does not enter the decision.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences.

For CMS147, this measure only includes denominator exceptions.

Question 108: **In terms of what counts for a system exception, is this something like a national shortage, or could it also be the local clinic site running out of its vaccine supply? Either temporarily or for the rest of the season.**

Applicable coding for system reason exceptions may be found in the "System Reason" value set (OID: 2.16.840.1.113883.3.526.3.1009).

Question 109: **Regarding allergies, the specifications don't have the details about having to have the allergy for full year. Is this new? Will specifications be updated stating this?**

The denominator exception timing requires that a diagnosis of allergy to eggs must "overlap after" the Influenza Season. This means that diagnosis must be active through the end of the Influenza Season.

Question 110: **Would this be required in the chart for a Behavioral Health client?**

Behavioral health encounters are not included as "Initial Qualifying Encounters" so would not be included in the initial population or denominator for the measure.

For a list of applicable encounters, we recommend visiting the eCQM Resource Center at https://ecqi.healthit.gov/ and reviewing the specifications for CMS147.

Question 111: **Can you clarify “overlaps after” the influenza season for an allergy? Would it have to be active after April 1st?**

The denominator exception timing requires that a diagnosis of allergy to eggs must "overlap after" the Influenza Season. This means that diagnosis must be active through the end of the Influenza Season or March 31st and must be active at least through April 1st. The allergy could be active after April 1st, but this is not required for an allergy to be a valid exception.

Question 112: **I am the immunization consultant for the QIN-QIO in Maryland and my challenge has been getting providers to document refusals. I am finding that a lot of EHR's do not have a field to document so meeting the measure is difficult.**

Thank you for your feedback and comments.

PCPI notes that this may be more appropriate to discuss this issue with vendors.

Question 113: **Do you have to satisfy all 3 denominator exceptions to use this measure if the patient denies the immunization?**

In order to qualify as a valid denominator exception, all three types of denominator exceptions do not have to be met, only one has to be met. If a patient denies the immunization, this would qualify as a "patient reason" and could be recorded using the "patient reason" value set (OID: 2.16.840.1.113883.3.526.3.1008).

Question 114: **We receive MANY notifications from outside pharmacies and facilities. What is the best way to document and do we need to keep the form we receive from pharmacy to prove this was performed?**

In order for a patient to meet the numerator, a patient must have an influenza immunization administered during the current flu season of the measurement period (October-March) or from August-September of the year prior. If a patient is seen for a visit during the measurement period and verbally tells their provider that they have received an influenza vaccination elsewhere, such as at pharmacy, and the applicable influenza vaccination code is not known, then this should be documented using the SNOMED CT “Previous Receipt of Influenza Vaccine” value set (OID: 2.16.840.1.113883.3.526.3.1185), or could be documented using the

"Influenza Vaccine" value set which includes CVX codes identifying specific formulations, as well as CVX 88 for "unspecified formulation," to ensure that the measure is appropriately met.

Question 115: **What is the downfall to using this measure if the practice never immunizes patients?**

If a provider doesn't provide immunizations, then this does not seem like an appropriate measure to report on. The intent is that the provide would report on measures for which they would conduct the clinical action(s) identified in the numerator.

Question 116: **If the flu shot is patient reported, is the record from the performing pharmacy or provider required to be in the patient's chart?**

In order for a patient to meet the numerator, a patient must have an influenza immunization administered during the current flu season of the measurement period (October-March) or from August-September of the year prior. If a patient is seen for a visit during the measurement period and verbally tells their provider that they have received an influenza vaccination elsewhere, such as at pharmacy, and the applicable influenza vaccination code is not known, then this should be documented using the SNOMED CT "Previous Receipt of Influenza Vaccine" value set (OID: 2.16.840.1.113883.3.526.3.1185), or could be documented using the "Influenza Vaccine" value set which includes CVX codes identifying specific formulations, as well as CVX 88 for "unspecified formulation," to ensure that the measure is appropriately met.

Question 117: **Please clarify, if a patient has received a flu immunization at their pharmacy, will documenting that the patient reported they received the vaccine count?**

In order for a patient to meet the numerator, a patient must have an influenza immunization administered during the current flu season of the measurement period (October-March) or from August-September of the year prior. If a patient is seen for a visit during the measurement period and verbally tells their provider that they have received an influenza vaccination elsewhere, such as at pharmacy, and the applicable influenza vaccination code is not

known, then this should be documented using the SNOMED CT "Previous Receipt of Influenza Vaccine" value set (OID: 2.16.840.1.113883.3.526.3.1185), or could be documented using the "Influenza Vaccine" value set which includes CVX codes identifying specific formulations, as well as CVX 88 for "unspecified formulation," to ensure that the measure is appropriately met.

Question 118: **We are not the administering physician for influenza. We are a specialist practice. Can we report the measure if previously received by another physician?**

If a specialist practice is not administering influenza vaccines, this is not an applicable measure to that practice, because as indicated, there will never be an influenza immunization administered by these specialists.

Question 119: **Please clarify. If we do not give flu shots but record the data in our charts are you saying we should NOT report on this measure?**

Yes, if the influenza immunization would never be administered by an eligible provider, this measure does not seem appropriate to report.

Question 120: **Quality measures are reported for a full calendar year. So if the visit is January 4, 2018, but the immunization was given in December 2017, would that count?**

If the measurement period is 2018, the patient has a visit on January 4, 2018, but the influenza vaccine is administered in December 2017, this would meet the measure because the vaccine was administered during the current influenza season and the patient had an encounter during the measurement period.

Question 121: **The receipt (of proof of immunization). Does the documentation indicating the immunization occurred during the same time periods, indicate if you were to immunize yourself?**

Yes, if a patient tells a provider that they have already received an immunization, this would have to be during the current influenza season.