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

**Support Contractor**

## Eligible Clinician Electronic Clinical Quality Measures (eCQMs) with Substantive Changes for the 2019 Performance Year

## Questions and Answers


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

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

**Question 1:** **The guidance indicates that the most recent BMI is used - however, does a follow up plan have to be documented at each encounter - for example, if a patient has a BMI of 30 on 1/1/2019 and is provided a follow up plan, and then has another visit on 2/1/2019 and the BMI is recorded again as 30, does the patient still meet the measure since the follow up was provided at an earlier visit?**

A follow-up plan for a BMI outside of normal range (low or high) should be documented on the date of the eligible encounter or within the past 12 months prior to the eligible encounter. Documentation of the follow-up plan may occur at a different encounter than the most recent BMI including an earlier encounter. The follow-up plan should be appropriate for the most recently documented BMI.

**Question 2:** **Is the updated value set currently available on VSAC?**

Yes, the most recent value sets can be obtained on the Value Set Authority Center (VSAC) website.

**Question 3:** **Why does the height need to be recorded within the last 12 months? Most adult patients' heights aren't changing. Every 96 months seems more reasonable.**

The measure guidance states that height and weight must be documented at least every 12 months. This guidance is based on a clinical practice guideline indicating best practice and should be followed, however documentation of height and weight within 12 months is not required to pass the measure. The measure logic only looks at the calculated BMI value to determine if the patient has a BMI in the normal range or is out of range and requires a follow-up plan. As we conduct annual measure maintenance, we will review any new published clinical practice guidelines and update the measure guidance as necessary in accordance with feedback from an expert work group.

**Question 4:** **How do we report that the patient was not able to be measured for the BMI? Is this with diagnosis? Does this depend on our EMR and Registry?**

Denominator exclusion criteria include pregnancy, patients receiving palliative or hospice care and patients who refuse measurement of height and/or weight. Documentation of those conditions in a structured field in your EMR or Registry using the value sets indicated by the measure specifications should exclude the patient from the measure. In addition, patients may have a medical reason for not obtaining a BMI. Those denominator exceptions should also be documented in a structured field that indicates a reason for why the BMI was not documented.

**Question 5:** **Can you please strictly and concisely define "eligible encounter"?**

Eligible encounters are those patient visits that occur during the measurement period and are defined by encounter coding (i.e. CPT, HCPCS, or SNOMED CT or other terminologies as deemed relevant) that can be found in the value set indicated in the measure specifications and found on the Value Set Authority Center (VSAC) website.

**Question 6:** **Does the BMI documented within 12 months have to be documented by the present provider? Example: patient has had BMI calculated by primary physician. Within 5 months, they are seen by an Occupational Therapist (OT) for hand injury. Can the OT report this measure as completed due to BMI obtained from primary physician?**

Yes, the BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. Since OT is eligible to report the measure and the BMI was documented within the previous twelve months, the OT can report the BMI obtained from the primary provider.

**Question 7:** **I thought BM look-back is only 30 days on the OASIS. How does this calculate with this requirement of 12 months prior?**

The measure specifications include a 12-month look-back period, but this is not a requirement to meet measure intent. The measure looks back up to 12 months and therefore different clinical settings can include a look-back period as appropriate for their specific reporting requirements and/or measurement programs.

**Question 8:** **Is the look back period for CMS69 12 months from the first eligible encounter during the measurement period or the last eligible encounter during the measurement period?**

Measure performance may be calculated using any eligible encounter during the measurement period.

**Question 9:** **Does BMI documentation have to occur in the calendar year, or just in a 12 month period?**

BMI documentation may occur in the previous calendar year if it is within 12 months prior to an eligible encounter during the measurement period.

**Question 10:** **Would you say the biggest change to the BMI measure is the 12-month look back?**

In 2018, the look back was changed from 6 months to 12 months. In 2019, there were denominator exceptions added to capture a medical reason for not obtaining a BMI and an expansion of denominator coding to include nursing home and other types of assisted living and medical counseling visits.

**Question 11:** **For adults, must the height be measured each visit or can it be carried forward?**

The measure guidance states that height and weight must be documented at least every 12 months. This guidance is based on a clinical practice guideline indicating best practice and should be followed, however documentation of height and weight within 12 months is not required to pass the measure. The measure logic only looks at the calculated BMI value to determine if the patient has a BMI in the normal range or is out of range which requires a follow-up plan. In the future we will review the guidance regarding documentation of height and weight with an expert work group to ensure that it is in line with current clinical guidelines.

**Question 12:** **Given the change in initial population eligible encounter, do you anticipate that the number of denominators will increase?**

For 2019, there has been an expansion of denominator coding to include nursing home and other types of assisted living and medical counseling visits, which could potentially result in more cases being reported.

**Question 13:** **Can you provide an example of how to document an appropriate "Plan" for a high BMI- what elements are you looking for? Diet, exercise, weight loss.... Thank you very much!**

Value sets are included in the measure specifications that define various interventions that meet the intent of the measure in constituting a follow-up plan. In general the follow-up plan would be a proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to: documentation of education, referral (for example a registered dietitian nutritionist (RDN), occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling and/or nutrition counseling.

**Question 14:** **If there was an eligible encounter where BMI was above normal, but no follow up documented, but subsequent BMI is normal, would that meet the measure?**

If the normal BMI is the most recently documented BMI (in relation to an eligible encounter during the measurement period) a follow-up plan would not be necessary to meet the measure's intent.

**Question 15:** **Does the BMI apply to a patient whose weight is muscle mass and not fat?**

For the purposes of this measure, Body Mass Index (BMI) is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories.

**Question 16:** **When a Nurse Practioner (NP) has a visit with a person in a nursing home, do they need to list the BMI and where do I find the CPT codes to go with nursing homes?**

Eligible encounters include some nursing home visits. The full set of eligible encounters are detailed in the value set included with the measure specifications and can be found in the Value Set Authority Center (VSAC)

website. The relevant value set in this case is "BMI Encounter Code Set" OID: 2.16.840.1.113883.3.600.1.1751.

For nursing home patients their BMI would need to be documented in the medical record.

**Question 17:** **So BMI can be documented in January 2019 and follow-up done in December 2018? Is this a good example**?

If there was an eligible encounter and BMI documented in January 2019 and documentation of a follow-up (as appropriate) in December 2018; this would be within 12 months of the eligible encounter and would meet the intent of the measure.

A follow-up plan may include, but is not limited to: documentation of education, referral (for example a Registered Dietitian Nutritionist (RDN), occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling and/or nutrition counseling.

**Question 18:** **In a shared patient chart (shared between primary care and specialty providers) , if a Primary Care Provider documents a follow-up plan for an elevated BMI and the patient is seen by a specialist within 12 months of the PCP visit, would the specialist get credit?**

Yes, if the patient falls into the measure for a provider and the numerator is satisfied, the patient passes the measure. If the patient has a qualifying encounter with a different reporting provider, they would be counted in the denominator for that provider.

The full set of eligible encounters are detailed in the value set included with the measure specifications and can be found in the Value Set Authority Center (VSAC) website. The relevant value set in this case is "BMI Encounter Code Set" OID: 2.16.840.1.113883.3.600.1.1751.

**Question 19:** **Most of our patients 65 and older are a pound or 2 above or below the parameters for BMI normal limits but are at a healthy weight and do not need intervention. Would you please tell us how to code and document this?**

For any patient, a valid medical reason for not performing an intervention can be documented at the provider's discretion.
The Medical Reason exception can include, but is not limited to, the following patients as deemed appropriate by the health care provider:
Elderly patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
* Illness or physical disability
* Mental illness, dementia, confusion
* Nutritional deficiency such as vitamin/mineral deficiency

**Question 20:** **It has been a goal across the nation to integrate behavioral health into medical care. In your talk today you focused on BMI, with Psychologists doing much of the care and research in obesity, and other eating disorders related to BMI but still struggling to be recognized for E/M codes, how can this be measured without them?**

Eligible encounters include some psychiatric, psychotherapy and health and behavior assessment visits.

The full set of eligible encounters are detailed in the value set included with the measure specifications and can be found in the Value Set Authority Center (VSAC) website. The relevant value set in this case is "BMI Encounter Code Set" OID: 2.16.840.1.113883.3.600.1.1751.

**Question 21:** **Is an end date for a medication intervention required?**

There are no medication interventions required for CMS159.

**Question 22:** **I downloaded the 2019 eCQM Value Sets, by CMS ID. For various eCQMs there appear to be entire missing value set name categories. For example, for CMS-177 Child and Adolescent Major Depression Disorder: Suicide Risk Assessment, I don't see the Intervention, Performed: Suicide Risk Assessment section with the corresponding SNOMED codes. Another is CMS-82. I don't see the Assessment, Performed: Maternal Post-Partum Depression Screening SNOMED codes. There are various other instances where I see missing assessments in other eCQMs. What am I not seeing?**

Value sets containing one code have been replaced with the use of direct reference codes. Direct reference codes are single codes that can be

referenced directly in the CQL logic, similar to value sets. For example, in CMS177, the Suicide Risk Assessment uses a direct reference code, which is listed in the Terminology and Data Criteria sections of the measure. The Value Set Authority Center (VSAC) provides a downloadable file of direct reference codes used in all measures.

**Question 23:** **If patients does not return for follow appointments during the reporting periods why are providers still impacted with results of performances not met? Are there any exclusions in this case?**

The denominator identification period has been extended to a total of 14 months to allow for a remission assessment to occur over a 4 month time frame (12 months +/- 60 days after the index event date). The numerator does not require another visit for the follow up assessment to occur, just that the depression assessment is documented during the follow-up assessment period. There is no specific exclusion for patients that do not return for follow up appointments.

The denominator exclusions in this measure are as follows:
1: Patients who died
2: Patients who received hospice or palliative care services
3: Patients who were permanent nursing home residents
4: Patients with a diagnosis of bipolar disorder
5: Patients with a diagnosis of personality disorder
6: Patients with a diagnosis of schizophrenia or psychotic disorder
7: Patients with a diagnosis of pervasive developmental disorder

This target based measure can be described as an intent to treat measure. If the patient is not assessed at least once during the four month window they are not meeting the target of remission demonstrated by a PHQ-9 or PHQ-9M less than 5.

**Question 24:** **Is PHQ-9M same as PHQ-9A for adolescents?**

No, not exactly but there is some confusion in the community about the name of the 9 question PHQ tool that was modified for adolescents. The actual PHQ-A is an 80+ questionnaire that is no longer available today. Years ago it was on the www.phq-screeners website, but has been removed. This original PHQ-A assessed for depression, anxiety, substance abuse, eating disorders, etc. It is not a 9-question tool. We have found valid

version of the PHQ-9M labeled PHQ-A. What we are looking for is the PHQ-9M approved by the PHQ-9 developer contained within the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit at http://www.glad-pc.org/. The tool is found on page 63 of the toolkit.

**Question 25:** **Can we use the 2015 PHQ-9 that starts with the 2 questions and if positive will go to the 9 question one?**

Abbreviated formats of the PHQ-9, such as the PHQ-2, are intended to be used for screening purposes, and not for monitoring ongoing depression. The intent of this measure is to use the PHQ9 as a depression monitoring tool.

**Question 26:** **Are patients with a positive screen (PHQ-9 above 9) but not *positive screen* (i.e. no response of 2 or higher on #1 or 2) included?**

All patients with a PHQ-9 or PHQ-9M summary score greater than 9 and a diagnosis of major depression (see value set list of codes) are included in the denominator. There is no additional condition for a certain number of responses being a certain level. An elevated PHQ-9 score alone (without the confirming diagnosis of major depression) does not meet the index event criteria.

**Question 27:** **May we use the PHQ-9 for cancer patients that are going through depression due to their disease?**

Yes, you may use the PHQ-9 for cancer patients that are going through depression due to their disease. A cancer diagnosis is not an exclusion for this measure. However, patients receiving hospice or palliative care services are excluded from this measure.

**Question 28:** **How is this documented in the patient visit to count?**

The Index Visit Assessment must have a PHQ-9 Total Score documented in the EHR at the time of the initial depression encounter. The numerator must have a PHQ-9 Total Score documented in the EHR during the follow up assessment period, which does not require an additional visit.

**Question 29:** **What is an "index event"?**

The index event includes the first instance of an elevated PHQ-9 or PHQ-9M greater than nine, documented during a depression encounter during the denominator identification measurement period, where the patient has a diagnosis of depression or dysthymia.

**Question 30:** **Does the PHQ-9 qualify as a follow-up?**

Yes, the follow up consists of the total PHQ-9 or PHQ-9M assessment score less than five during the follow-up assessment period.

**Question 31:** **We use the PHQ-9 A for adolescents. I've never heard of a PHQ9M.**

It has been our experience that the PHQ-9 modified for adolescents has actually been mislabeled in versions in the internet and in the community. The actual PHQ-A is an 80+ questionnaire that is no longer available today. Years ago it was on the www.phq-screeners website, but has been removed. This original PHQ-A assessed for depression, anxiety, substance abuse, eating disorders, etc. It is not a 9-question tool. We have found valid version of the PHQ-9M labeled PHQ-A. What we are looking for is the PHQ-9M approved by the PHQ-9 developer contained within the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit at http://www.glad-pc.org/. The tool is found on page 63 of the toolkit.

**Question 32:** **Is the PHQ-M referring to the PHQ-9 modified for teens?**

Yes, PHQ-9M refers to the version approved by the developers of the PHQ-9 for use in adolescents contained within the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit at http://www.glad-pc.org/. The tool is found on page 63 of the toolkit.

**Question 33:** **I am wondering how they track the numerator instances if a PCP provides an AOD diagnosis and refers the patient to a specialist.**

Diagnoses of alcohol and drug disorders are not excluded from the measure. The numerator requirement does not require another visit, only that the total PHQ-9 or PHQ-9M score is assessed and documented as less than 5 in the record during the follow-up assessment period. The index and

follow up depression assessments do not need to be performed by the same individual.

**Question 34:** **How is the PCP's EHR going to capture the patient receiving additional treatment (twice) within 30 days?**

There is only one index event captured for CMS159. It is the date in which the first instance of elevated PHQ-9 or PHQ-9M greater than nine and diagnosis of depression or dysthymia occurs during the denominator identification measurement period. A PHQ-9 documented 30 days after the index event would not need to be reported for this measure as it occurs before the follow up assessment period. If this question is instead meant to be directed toward CMS160, then if a patient has 2 PHQ-9 assessments in the four month measurement period, they are counted once as meeting the numerator.

**Question 35:** **Is this for patients with a score greater than 9 again?**

The intent of this measure is look for the presence of a documented PHQ-9 or PHQ-9M score at least once during the four month period. A specific value of the score is not required. This is a paired supportive process measure that helps support frequent Patient Reported Outcome (PRO) tool use for assessment to move towards the goal of remission.

**Question 36:** **How is denominator exclusion different from denominator exception?**

Denominator exclusion criteria are evaluated before checking if a patient meets the numerator criteria. A patient who qualifies for the denominator exclusion would be removed from the denominator.
Denominator exception criteria are only evaluated if the patient does not meet the numerator criteria. Patients who do not meet numerator criteria and also meet denominator exception criteria would be removed from the denominator. This measure does not have denominator exceptions.

**Question 37:** **Does diagnosis of Major Depression include any other Depression diagnoses, such as Adjustment Disorder, or Reactive Depression, Situational depression or mixed anxiety/depression? Ex. are there certain ICD10 diagnosis codes? Or just Major Depression Disorder or Dysthymia?**

The intent of this measure is to include dysthymia and major depression diagnosis codes. The diagnoses of Major Depression or Dysthymia in this measure do not include other diagnosis such as adjustment disorder, reactive depression, situational depression, or mixed anxiety/depression. The relevant diagnoses codes are included in the measure value sets.

**Question 38:** **Does this measure apply to only those patients who have Medicare?**

This measure can be applied to patients with or without Medicare. The application of this measure depends on the selected reporting program. We support and encourage the application of this measure to all patients without restriction by insurance type.

**Question 39:** **Can clinicians who do NOT provide the diagnosis for disorders etc. for the age of 18 and older report this measure?**

Yes, this measure can be reported by clinicians who do not provide the diagnosis. The depression diagnosis just needs to overlap the encounter. This means the patient could have been diagnosed prior to the encounter, but the diagnosis must be documented before the end of the encounter.

**Question 40:** **Does the visit have to be related to Depression (ex. "Depression encounter")?**

The visit does not have to be related to depression, but the patient must have the diagnosis prior to or before the end of the visit.

**Question 41:** **What are the three populations?**

Population 1 includes patients who meet the age and diagnosis criteria and have a depression encounter in September through December.

Population 2 includes patients who meet the age and diagnosis criteria and have a depression encounter in May through August.

Population 3 includes patients who meet the age and diagnosis criteria and have a depression encounter in January through April.

**Question 42:** **As we know the PHQ-9 is just a screening tool that can be used to demonstrate the briefest of snapshots of some patient symptoms in time. Are you saying that to participate in quality ID 371 there are certain months/periods of months when the PHQ-9 must be administered? I believe p.51 made that clearer if so do you have a chart please?**

If a patient has a qualifying diagnosis and encounter in more than one of the 4 month periods within the measurement year, the patient must be counted (denominator and numerator) in each qualifying 4 month period. For example, a patient could be counted in the first and third 4 month periods.

**Question 43:** **Does the adolescent population have to be assessed using PHQ-9M or can they be assessed using the same PHQ-9 as adults?**

Either the PHQ-9 or PHQ-9M score can be used for this measure. The PHQ-9 is validated for ages 13 and older, but it is up to the clinician to decide if they want to use the PHQ-9 for age 12.

**Question 44:** **Will these encounters count if they are "Nurse only" (CPT 99211)? This could occur with post hospitalization follow up calls, or chronic care management.**

Yes, CPT 99211 is included in the eligible encounters.

**Question 45:** **What if during the 4 month period you diagnosed them with depression and then gave them the assessment at an eligible encounter?**

The depression diagnosis just needs to overlap the encounter. This means the patient could have been diagnosed prior to the encounter, but the diagnosis must be documented before the end of the encounter.

**Question 46:** **Does the full PHQ-9 need to be answered in order to count in the numerator?**

Yes, the intent of this measure is to use the PHQ-9 as a depression monitoring tool therefore report the total score which contains the combined score of all the PHQ-9 questions.

**Question 47:** **I'm confused. Is there a value set for the assessment performed PHQ-9? I do not see that on the VSAC by CMS ID.**

The previous value set was removed and replaced with a direct reference code to more accurately reflect use of the total reported score. Value sets containing one code have been replaced with the use of direct reference codes. Direct reference codes are single codes that can be referenced directly in the CQL logic, similar to value sets. The specific codes are listed in the Terminology and Data Criteria sections of the measure. This measure uses LOINC code (44261-6). The Value Set Authority Center (VSAC) provides a downloadable file of direct reference codes used in all measures.

**Question 48:** **Is there a cross walk for the ICD-10 codes to the HCC codes?**

We are not aware of an available cross walk for ICD-10 codes to HCC codes.

**Question 49:** **Will there ever be a cognitive impairment/delay exclusion or exception?**

Patients with cognitive impairment are not excluded from the depression measure. There are no plans to incorporate cognitive impairment as an exclusion for this measure as it is not a population based screening measure, rather a measure with a denominator of diagnosed major depression. If a clinician determines it is not appropriate to administer a tool, then they should not administer the tool. In family practice, internal medicine and behavioral clinics this should not have a significant impact on the rate for this measure. Additionally, for measure CMS159 not administering the PHQ-9 to a patient who cannot complete it prevents them from inclusion in the denominator for remission outcome at twelve months.

**Question 50:** **Since all reporting is done on PHQ-9, then is the PHQ-2 being eliminated?**

No, the PHQ-2 serves a purpose as a screening tool, however it is important to understand that the denominator for this measure is patients with the diagnosis of major depression or dysthymia, not the general population. It is not a screening measure. The PHQ-9 is validated both for determining a diagnosis of major depression and for evaluating progress and outcomes over time.

**Question 51:** **Can you tell me where to find "Direct Reference code"?**

Direct reference codes are single codes that can be referenced directly in the CQL logic, similar to value sets. The specific codes for this measure are listed in the Terminology and Data Criteria sections. For example, this measure uses LOINC code (44261-6). The Value Set Authority Center (VSAC) provides a downloadable file of direct reference codes used in all measures.