Stage 1 Meaningful EHR Use via RevolutionEHR
Core 10 – Clinical Quality Measures

Overview

Providers are expected to use EHR technology to track their quality care of patients, and to then report clinical quality measures (CQM) to CMS. This objective tracks a variety of PQRS analytics that the provider chooses to comply with. *IMPORTANT NOTE: the ongoing use of PQRS codes outside of the purview of EHR MU is expected to continue, despite the perception that the CQM process which references PQRS terminology might be the same reporting activity.*

Beginning in 2013, this objective is no longer a separate MU measure. CMS removed the standalone nature of the objective that required providers to attest that they plan to report on CQMs because it was redundant.

MU Calculation

Successfully report CMS clinical quality measures to CMS during the attestation process, using output data from the EHR. The provider will submit during completed clinical quality measure information that is output from RevolutionEHR. The numerators, denominators, and exclusions for each CQM will be submitted.

Meaningful Use Discussion

In recent years, CMS has asked Medicare providers to voluntarily submit PQRS codes that were developed to demonstrate the level of patient quality care that was delivered at each office visit. That system serves the purpose of giving CMS information about patient care actions and results, which are not obvious when a provider is only submitting CPT (procedure) and ICD-9 (diagnosis) codes.

CMS anticipates that this CQM reporting system will be effective because of the automated calculations that occur as a result of information that the doctor enters in the certified EHR. The results of CQM will not show up on the Coding screen of an encounter like the PQRS coding. Instead, this will be automatically calculated by RevolutionEHR. It is also important to understand that the CQM calculations are made for all patient care, not just those with Medicare coverage.

In 2013, some vendors provided the capability to automatically submit CQM data using a QRDA file as part of a pilot program to automate data submission. Doctors who participate in that program do not need to file standard PQRS codes. This is not available in RevolutionEHR.

The provider will be deciding which of the CQM items they will be measured against. There are three core CQM items and three alternate core measures, in addition to three additional measures which each software vendor has been certified based upon the vendor's belief of what will be valued by the software users.

RevolutionEHR is certified for the automatic measure of the CQM measures, which optometrists will need to contemplate for compliance. The core set is: Hypertension: blood pressure

measurement; Tobacco use assessment and cessation advice; Adult weight screening and follow-up. The alternate core set is: Influenza immunization, Childhood weight assessment and counseling, and Childhood immunization status.

The calculations of the Core and Alternative Set are as follows:
1a) BMI aged over 65
Denominator:

- 1 approved encounter with a CPT in (90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350)
- Age >= 65 at the start of the report period

Numerator

- BMI is between 22 and 30

1b) BMI aged 18 to 64
Denominator:

- 1 approved encounter with a CPT in (90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350)
- Age 18 to 64 at the start of the report period

Numerator

- BMI is between 18.5 and 25

2) Hypertension
Denominator:

- 2 approved encounters during the report period with a CPT in (99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350)
- Age >= 18 at the start of the report period
- A diagnosis of Hypertension (401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93)

Numerator

- Recorded BP

3a) Tobacco Use
Denominator:

- **Either** 2 approved encounters with a CPT in (99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215) or 1 approved encounter with CPT in (96150, 96152, 97003, 97004, 99411, 99412, 99420, 99429, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862)
- Age >= 18 at the start of the report period

Numerator:

- **Either** Indication of Tobacco Use or Smoking Status in (Current some day smoker, Current every day smoker)

3b) Tobacco Cessation
Denominator:

- **Either** 2 approved encounters with a CPT in (99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215) or 1 approved encounter with CPT in (96150, 96152, 97003, 97004, 99411, 99412, 99420, 99429, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862)
- Age >= 18 at the start of the report period
- **Either** Indication of Tobacco Use or Smoking Status in (Current some day smoker, Current every day smoker)

Numerator:

- Numerator: Either CPT code for cessation of tobacco: 99406 (Smoking and tobacco-use cessation counseling visit, 3-10 minutes), 99407 (Smoking and tobacco-use cessation counseling visit, 10+ minutes)

4) Influenza Immunization for patients 50+ years old (only for physicians administering immunizations)
Denominator: always 0
Numerator: always 0

5) Child Weight Assessment and Counseling (only for primary care physicians and OB/GYN)
Denominator: always 0
Numerator: always 0

6) Childhood Immunization Status (only for physicians administering immunizations)
Denominator: always 0
Numerator: always 0

RevolutionEHR is certified for automatic measures of the three additional set measures that were deemed most appropriate for the delivery of primary eye care services: POAG: optic nerve assessment, Diabetic Retinopathy: documentation of macular edema and severity of retinopathy, and Diabetic Retinopathy: communication to diabetic care provider.

For information purposes, the method of calculation of the three eye care measures are described here:

1) POAG – optic nerve assessment
Denominator:

- 2 approved encounters with a CPT in (99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 92002, 92004, 92012, 92014)

- Age >= 18 at the start of the report period
- A diagnosis of POAG (365.10, 365.11, 365.12, 365.15)

Numerator:

- Optic Nerve Test entry

Additional information: For any encounter with two visits within the reporting period, with 99xxx coding, that has been signed by the provider, and where the diagnosis code is 365.10, 365.11, 365.12, or 365.15, the Numerator will be "1" if there is any field completed in the Optic Nerve Test, and "0" if not, while the Denominator will be "1"

2) Diabetic Retinopathy – macular edema and severity of retinopathy

Denominator:

- 2 approved encounters with a CPT in (99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 92002, 92004, 92012, 92014)
- Age >= 18 at the start of the report period
- A diagnosis of Diabetic Retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, 362.06)

Numerator:

- Entry in the DME field of the Fundus test
- A diagnosis in (362.04, 362.05, 362.06)

Additional information: For any encounter with two visits within the reporting period, with 99xxx coding, that has been signed by the provider, and where the diagnosis code is 362.02, 362.03, 362.04, 362.05, or 362.06, the Numerator will be "1" if there is a Y/N entry in the DME (diabetic macular edema) dropdown of the Fundus test and a Problem List diagnosis code of 362.04, 362.05, or 362.06, and "0" if not, while the Denominator will be "1"

3) Diabetic Retinopathy – communication to diabetic care provider

- 2 approved encounters with a CPT in (99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 92002, 92004, 92012, 92014)
- Age >= 18 at the start of the report period
- A diagnosis of Diabetic Retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, 362.06)
- An entry in the Fundus test

Numerator:

Generating the communication template "Diabetes Encounter Summary for PCP" for an external provider

Additional information: For any encounter with two visits within the reporting period, with 99xxx coding, that has been signed by the provider, and where the diagnosis code is 362.02, 362.03, 362.04, 362.05, or 362.06, the Numerator will be "1" if there is a Communication letter generated from the "Diabetes Encounter Summary for PCP" for an external provider, and "0" if not, while the Denominator will be "1"

RevolutionEHR will not prompt doctors to provide certain levels of care or to deliver particular services in order to satisfy the CQM objectives. The doctor is encouraged to consider the professional clinical practice guidelines in delivery of care, and to use RevolutionEHR to document their care.

To get a report of the CQM compliance that has been documented, RevolutionEHR providers can go to the Administration module, and open the Employees/Users section to find the Reports section. There will be found the Clinical Quality Measures reporting tool. To run the CQM report, select a provider and a date range for evaluation, and generate the report. The numerators and denominators of documented care will be shown. Please export this grid to an Excel sheet using the F8 function, and retain a copy for your records. You will need the data from this grid for Attestation, although CMS will not judge the ratio of numerators and denominators to pass this objective; you simply need to document the data.

Conclusion

The CQM process is related to the documentation of care delivered for key patient conditions. Many of the core measures are related to public health matters, while the alternates that can are specialty-specific also deal with critical health topics. It is obvious that eye care providers are being analyzed for the cautious care of two vision-impacting diseases in glaucoma and diabetic retinopathy.

Meeting this objective is moderately challenging in that there are particular documentation activities that the provider must make for the automatic calculations to be registered.