2016 Physician Quality Reporting System (PQRS) Group Practice and ACO Web Interface Reporting Mechanism

Web Interface Q&A Session Support Call Program Year 2016

Moderator: Ashley Burrell
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Ashley Burrell: Good afternoon everyone. I am Ashley Burrell from the PQPMI team and I'm your moderator today. I would like to welcome everyone to our Group Practice and ACO Web Interface Question and Answer Session. Today's call will feature brief reminders about Web Interface reporting requirements and helpful hints that can assist during submission. This call will be recorded and made available on the PQRS Web Interface webpage and ACO Portal. Questions will be accepted through the Q&A feature on the right hand side of your screen and will be addressed at the end of the session, as time permits. At this time I would like to turn this call over to Rabia Khan of the Division of Shared Savings Program at CMS. Rabia over to you.

Rabia Khan: Thanks. I'm Rabia Khan from the CMS Division of Shared Savings Program, as Ashley noted, and I want to welcome all of you to our CMS support call for 2016 PQRS Group Practice and ACO GPRO Web Interface reporting. Following our presentation, we will host a Q&A session where our experts on the call will answer your questions. Ah, just to note, some questions may be specific to your organization, so we may suggest that you contact the QualityNet Help Desk for further assistance.

Slide 2

Rabia Khan: Today's slides will be available on the GPRO Web Interface webpage. Ah and in addition, for Shared Savings program ACO's, it is on the ACO portal under the program announcement titled 2017 Web Interface Q&A Support Call Slides and Recordings, and in addition they've been posted on the Next Generation and Pioneer connect sites, for those ACOs.

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During this support call, Pioneer, Next Generation, Shared Savings Program ACOs, and PQRS group practices will all be collectively referred to as organizations.

As a reminder, the Web Interface measure specifications and supporting documents are located on the GPRO Web Interface page of the CMS website. We strongly recommend you use these measure specifications and supporting documents as a resource when you're reporting your quality data. Please use the 2016 measure documents for 2016 reporting. In addition, there's a really helpful Q&A document, uh, that is available on the Web Interface webpage that helps, um, and answers a lot of your frequently asked questions.

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As you know the Web Interface is open for data entry and submission. Users access the Web Interface through the PQRS portal and the Web Interface will be closing March 17th at 8:00 PM Eastern time. We strongly encourage your organization not wait until the last day to submit data and we really urge you to do it before 8:00 PM Eastern Time to ensure that everything is fully submitted before the Web Interface closes.

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To provide helpful information and answer your questions, we do have our weekly Web Interface submission support calls. So please mark your calendars with the remaining dates and times for these calls. We will be hosting a Web Interface lessons learned session shortly after the Web Interface closes, where, ah, will take an opportunity to go over your feedback on 2016 reporting. More information will be provided to you as we get closer to the close of the Web Interface.

Next Slide please; thanks: **Slide 6**

So there are some scheduled outages and maintenance weekends for the PQRS portal and that means that the Web Interface will not be accessible during these dates and times so please mark your calendars with this information. The Web Interface is not accessible:
- Every Tuesday starting at 8:00PM Eastern Time through Wednesday at 6:00AM Eastern Time
- Every Thursday at 8:00PM through Friday at 6:00AM Eastern Time
- And then there is one last maintenance weekend during this submission period and it is actually this coming weekend- so from February 24th through the 27th.

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Uh, as ah *[Pause]* so just as a reminder, um, satisfactorily reporting, all Web Interface, eighteen of the Web Interface measures, will allow PQRS group practices. I think we may have skipped a slide, yes, thank you.

So as a reminder, to meet satisfactory reporting requirements all organizations must completely report a minimum of 248 consecutively confirmed and completed beneficiaries in each module OR 100 percent of beneficiaries if you have fewer than 248 available in the sample.

Satisfactorily reporting all 18 Web Interface measures will allow PQRS group practices and eligible professionals, participating in an ACO, to avoid the 2018 PQRS payment adjustment.

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In addition, Eligible Professionals participating in an ACO or PQRS group practice will satisfy their CQM reporting for the Medicare EHR Incentive Program, if they use certified EHR technology to abstract the data for reporting through the Web Interface. More specifically:

PQRS group practices are required to use EHR technology, that's certified to the 2014 Edition, to populate the Web Interface.

Eligible Professionals participating in an ACO must be using certified EHR technology and abstracting the data to report to the ACO, in the form and manner that's specified by the ACO. The ACO then must satisfactorily report the Web Interface measures.

EPs still need to individually attest separately to the EHR Incentive Program for other program requirements. When your EPs go to the attestation system and reach the screens for reporting CQM's, these eligible professionals should be selecting option 1, since their reporting through an eReporting option. They can also choose to submit their CQM data instead of selecting that eReporting option that is available to them.

And finally, Shared Savings Programs ACOs who fail to satisfactorily report Web Interface measures will not meet the quality performance standard and then will not be eligible to share in any savings, if earned.

Alright Next Slide Please: **Slide 9**

Now I am going to turn it over to Sue Hanlon to go over more information on the Web Interface.

Sue Hanlon: Thanks Rabia. Today we have two new questions.

Um, Next Slide Please: **Slide 10**

Sue Hanlon: Ok our 1st question is, what information am I getting out of the Measure Rates Report? That report lists every measure, along with performance metrics for the measure. The description for each metric column is provided in the footnotes. The report displays data as it existed at the time the report was generated. If your patient data has changed since the last time the report was generated, then you need to generate a new report. Um, and the best way to get an understanding of what's in that report is to look at the Web Interface User Guide.

Our next question is, what could be happening when it appears as if I have lost my patients? You could have your preferences set so that the measures the patient is ranked in are not displaying. So you need to go to your preference screen and you can get there by selecting preferences from the navigation bar. And make sure that all the measures are checked on that way all your patients will display on the patient list. Once you do that you can return to the patient list screen and look for your missing patients. Another thing that may have happened is you may have your, your, filters set on that patient list screen. So there is button on that screen that says clear filters, you click that and that will eliminate all filters and you should see all your patients then as well.

And that does it for me today our next slide and will turn this over to Deb Kaldenberg.

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Deb Kaldenberg: Good afternoon everyone, um, I believe we have two questions as well.

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[Pause]

Deb Kaldenberg: Our first question is on the PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. If the patient has ESRD, is it okay to skip for another CMS Approved Reason? And this wouldn't be an appropriate reason to skip a patient. Um, the Other CMS Approved Reason is really, um, specific to very unique circumstances where denominator exceptions and denominator exclusions are not within a measure. Um, if you were to review the 2016 PREV supporting document data guidance tab you would find guidance on how to report the PREV-13 measure if the patient has ESRD. In this case, you would select No – Denominator Exception – Medical Reason, um, and I won't read through the medical reason. This can be found on the posted supporting document within that data guidance tab.

The second question we have today is on CARE-3: Documentation of Current Medications. When reporting the CARE-3 measure, should we indicate that there is no office visit on the date provided by CMS, which is 30 days after discharge? And this question is coming from the fact that TCM codes are included within the code set of this measure. Medication reconciliation may occur within plus or minus 2 days of the pre-populated visit date. The coding for this measure is in alignment with the corresponding eCQM which is why TCM codes are included. If your records indicate the patient's visit happened more than 2 calendar days before or after the pre-populated visit, it would be appropriate to indicate that you cannot confirm the visit or in this case select visit outside practice. And that is all we have for today, thank you.

Slide 13

Jonathan Ladinsky: Hello thank you Deb, uh, this is Jonathan Ladinsky, uh, I'll be, uh, going over the, an, overview of the available educational resources and help desk resources. And then we will get to our Q&A.

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Jonathan Ladinsky: This slide contains a list of educational, uh, educational resources. It includes website and portal links specific to PQRS, uh, group practices and each of the ACO models.
The Web Interface webpage includes links to:
- The Web Interface Support Call transcripts and presentations
- Assignment and Sampling, sampling documentation
- XML and Measure Specifications
- Supporting documentation and Data Guidance and;
- Question and Answer Documents

In addition there are three Educational Demonstrations posted onto Web Interface page. They include a Web Interface Overview, a Web Interface Measures Demonstration, and EIDM for Web Interface. We strongly encourage our organizations to review the step by step instructions provided in the educational demonstrations. Included are instructions on how to access the Web Interface, as well as how to utilize the documentation listed on this slide.

Next Slide Please: **Slide 15**

Jonathan Ladinsky: Uh, this provides a list of available help desk contacts for the PQRS Group Practice and ACO Models. Um, for any PQRS EIDM Web Interface questions, please contact the QualityNet Help Desk. Note that the CAHPS for PQRS Survey Project Team help desk is applicable to PQRS group practices only.

Next Slide Please: **Slide 16**

Jonathan Ladinsky: Here we provide a list of acronyms, which you may find useful during the reporting period.

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Jonathan Ladinsky: Uh, at this time we will begin the question and answer portion of today's support call. Um, attendees, please submit your questions in writing via the Q&A box, located at the top of the web screen. That is you may need to click question mark Q&A at the top right of your web screen. When submitting questions, we ask that you please identify if you are PQRS group practice or the type of ACO that you are.

If your question concern measures please identify the measures number. User specific questions must be sent to the Quality Net Help Desk so a representative may research your organization's unique questions on case by case basis and provide an appropriate resolution.

We will not be responding to MIPS policy related questions during today's Q&A.

Finally, in an effort to read as many questions as possible, we will not read repeat questions.

Question and Answers

Question Moderator: Jonathan Ladinsky

Jonathan Ladinsky: So for our first question, um, this has to do with XML submission.
Question: We have submitted, ah, we have submitted ah via file via XML and we sent more records then we intended to, is there a way to remove these records?

Sue Hanlon: This is Sue Hanlon from DECC. If you want to remove the data from those patients, you have to use the user interface. Um, and you just need to set the data so that the patient now, um, is incomplete. And you might want to consider the fact that if you wanna have your first 248 patients, um, that are consecutively confirmed and completed to stop at 248, then all you need to do is set your patient 249 to incomplete.

Jonathan Ladinsky: Thank you. Next question.
Question: Can you tell us how to go in an update an individual record. The specific example given here is 'Need to change the date of birth'?

Sue Hanlon: This is Sue Hanlon again. The only way you can change the date of birth is through the user interface. It can't be changed through the, um, XML.

Jonathan Ladinsky: Thank you again Sue. Hopefully we'll give you a break right now.
Question: Do all exception reasons, that is allergies, intolerances, other medical reasons, system reasons, need to be documented in the EMR during the measures year?

Deb Kaldenberg: This is Deb, from the PQMM team. Um, in most cases if you're looking at the denominator exceptions, especially the medical reasons, patient reasons, and system reasons, you would want documentation during the measurement year that those are still applicable. Um, however, I believe there are some cases, such as in the CAD measure, where an allergy to a beta-blocker, uh, oh sorry that's HF, that an allergy to a beta-blocker, um, could be anytime in the patient's medical history.

If you have a specific question though about whether or not a denominator exception, um, meets the intent of the measure, if it's not documented during the measurement year, we would suggest that you open up a QualityNet help desk ticket, so that we can address a specific scenario.

Jonathan Ladinsky: Thank you Deb. Um, next question is another measure question.
Question: For PREV-12: Depression Screening, can the screening occur in an inpatient setting and if the questions are almost exactly the same as PHQ-2, is that okay?

Deb Kaldenberg: Okay I'm going to start with the second question first. If the questions are almost exactly the same as the PHQ-2, then this would not be acceptable. Um, we have gotten questions that if the name of the PHQ-2 tool is not identified, but the questions are exactly the same as the PHQ-2, would it be okay to just use those questions as identifying the screening tool used and in that case it would be acceptable. Um, I-I would not say that though if they are almost the same, it would be acceptable. You really do need to have documentation of the screening tool that has been used for the depression screening and it needs to meet the intent of the measure as identified in the data guidance tab of the supporting document.

In regards to your first question, which is whether or not the screening in an inpatient setting can be used, you certainly can use that screening, um, as long as it's part of your medical records and meets all of the other components that are required of that measure. Um, I would assume, you know, you're not going to find that is what we would call an eligible encounter, um, however, it if that screening is done and its done and documented, we would allow it to be used.

Jonathan Ladinsky: Thank you again Deb, we are going to keep you busy now. Um, next is a CARE-3 question.
Question: Medication Received CARE-3, if a patient is on an over the counter medication where instructions are clearly on the label, such as once per day multiple vitamin or OTC Calcium Carbonate, is it necessary to have the daily dose and route specified?

Carol Noyes: Hi this is Carol with PQMM. For Medication Reconciliation, if the Physician or Eligible Professional is attesting to all of those medications being accurate on that date of service, then this would be acceptable. Um, also this was one of the measures where if you have additional questions, there have been a lot of questions related to CARE-3, please send those to the help desk, um, where we can individually, I guess, speak to you related to this measure. Thank you.

Jonathan Ladinsky: Ok thank you. Um, now we have a PREV-9 measure.
Question: For PREV-9 patient seen in our clinic in November, in December they were seen an outside podiatrist and the note was scanned in. This note has a BMI. Should we use the BMI from our clinic or from the outside clinic?

Deb Kaldenberg: This is Deb. If that BMI is part of your medical record you can certainly use that calculated BMI to report the measure. If for some reason within that BMI, if it's an abnormal

BMI and you don't find that there is a recommended follow-up that is attached to that, you can certainly look to your November BMI, um, to confirm that you know what with that BMI if abnormal is there a recommended follow-up. Basically this measure allows a six month look back period from the most recent encounter and and to be perfectly honest your most recent encounter would be your November visit, um, but but part of that medical record documentation from the December visit is included, so you know you can utilize that as well.

Jonathan Ladinsky: Uh thank you. Uh the next question.
Question: For, uh, Hypertension-2, if hypertension is confirmed at a PCP in the MSSP ACO, but not on the problem list or otherwise confirmable in a specialist medical record in the MSSP ACO, but the latest reading is at the specialist, do we use that one for the measure?

Carol Noyes: For this measure you would utilize the most recent blood pressure that you can find.

Jonathan Ladinsky: Ok thank you. Um, another measure question.
Question: For PREV-11, if the most recent was a nursing only visit for chemo infusion, should we use this blood pressure?

Deb Kaldenberg: So our suggestion would be you go ahead and look at the supporting document, the PREV supporting document posted on the CMS website. Look at the evaluation code tab to confirm whether or not that was, um, an eligible. If it's not considered an eligible encounter, you don't need to use that blood pressure and can look for the next most recent blood pressure documented in the medical record.

Jonathan Ladinsky: Uh thank you.
Question: For Heart Failure, if the patient has asthma can this be used as, uh, as a medical exception for no beta-blocker or does a provider need to explicitly state "No Beta-Blocker due to Asthma"? Please clarify.

Carol Noyes: For this, hi this is Carol again, for this measure, um, with heart failure, *[clears throat]* so if the medication is not prescribed due to beta-blocker, um, due to having asthma, there needs to be some link related to I guess the beta-blocker and to asthma, so that documentation would be necessary.

Sherry Grund: Carol I believe asthma is one of the listed codes.

Carol Noyes: It is one of the listed codes but wouldn't, wouldn't, they need documentation? Why *[Multiple voices]* beta-blocker?

Sherry Grund: No we just need to have asthma documented *[Multiple voices]* for audit purposes we just need to have asthma documented.

Jonathan Ladinsky: Thank you both. The next question
Question: For Fall Risk Assessment, do the following count? Timed up and go test, documentation of patient environment, and gait assessment.

Carol Noyes: This is Carol again. No, you would need documentation of, I guess, history of falls, um, injury within the measurement year, um, but some documentation related to the fall and a specific tool used is not necessary.

Jonathan Ladinsky: Thank you Carol.

Question: As I note, as I, as I know it's the Influenza vaccine was received PREV-7, the information will be pre-populated by CMS from documentation. Can you please let me know which dates that file and which column I can find this information?

[Pause]

Sherry Grund: Um, this is Sherry from, um, ACO PAC, and I'm not certain what the questioner is asking, but if they are asking about, um, what the pre-populated information is, um, that pre-populated information will be visualized through the user interface or that, what you see when you go into the GPRO Web Interface as a 'Yes' answer. So you don't need to do anything with that, nor do you have to have supporting documentation in the event of an audit.

Jonathan Ladinsky: Uh, thank you. The next question is, uh.

Question: We are experiencing an abnormally high number of skips for IVD measure, and I'm sorry I don't remember which measure that is. CMS did confirm an issue resulting in high skips for CAD previously. Is there a known issue with IVD as well?

Deb Kaldenberg: So from the perspective of the measures team, so this is Carol and Deb, we would say the only thing we might be able to attribute a higher skip to is we are seeing an increase number of requests for CMS approved reason to skip due to patients being on an antithrombotic. Um, but that would be the only thing we would be aware of.

Olivia Berzin: Hi this is Olivia, I can confirm that there's no known issue with the IVD sample.

Jonathan Ladinsky: Thank you. The next question.

Question: Can I clear all the values entered in the Web Interface?

Sue Hanlon: Um, the only way you can do that is to do it through the user interface.

[Pause]

Jonathan Ladinsky: Thank you.

Question: For measure requiring patient diagnosis confirmation, but you can't find confirmation after looking through most of the medical records from various ACO participants, but not all of them, do you record confirmed and no if not all records are viewed?

[Pause]

Debra Kaldenberg: So this is the measures team again, Deb and Carol. The only thing we would say is, uh, we certainly would provide guidance that if you are unable to confirm diagnosis, you would select No- unable to confirm or you, uh, diagnosis not confirmed. As far as whether or not you should select that without going through all of your records, um, that's not a part a your question that we can address.

Jonathan Ladinsky: Ok thank you. Uh, PREV-13, for group practice question.

Question: We seem to have a fair number of beneficiaries who do not meet any of the three denominators for this measure, is this a trend for others?

Deb Kaldenberg: So this is Deb from the measures team, again we would anticipate that there would be higher skips occurring with PREV-13. There are three different samples of patients

that has been, um, done to get your patient sample set, um, and and some of them can only be confirmed based on information that you can locate. So while some of the patients that have been sampled have a diagnosis of ASCVD, of course if you can't confirm diagnosis of ASCVD, you would go on to Risk Category II, which is just an LDL-C value. Um, that is totally up to the ACO or the group practice to locate that LDL-C value. Um, if you're unable to find and confirm the LDL-C value for Risk Category II, you would go ahead and move into Risk Category III. Again, a certain percentage of your, um, patient set was identified as having a diagnosis of diabetes, however if you cannot confirm diabetes, um, you would, that patient would be skipped and and basically in Risk Category III, they would be placed at that point. If you can confirm a diagnosis of diabetes you would then be looking for again an LDL-C value. If you cannot confirm that LDL-C value for Risk Category III, that patient would be skipped and replaced.

So as you can see, it is one of those measures that have a higher skip threshold, due to the fact that you really are confirming part of that denominator eligibility.

Jonathan Ladinsky: Thank you. Ah, next question is for PREV-10-Tobacco.
Question: Um, if the EMR has a template with smokeless options if the patient is a user, but not a non-smokeless user option, is it okay if the record itself is silent on the smokeless question as long as it is clear the screening was performed?

Deb Kaldenberg: As long as it's clear that the screening that was performed includes both screening of smoking and smokeless tobacco, this would be sufficient. But the measure, the intent of the measure is not just to screen whether or not a patient is a smoker, but it is to include smokeless tobacco as well. So if that doesn't specifically answer your question, you can go ahead and open up a help desk ticket and we can look at that further, um, however, just be aware that you're screening what you need to have documented and be able to support is that that patient was screened for both smoking and for smokeless tobacco.

Jonathan Ladinsky: Uh, thank you. New one.
Question: Can you report on a patient who died during 2016?

Deb Kaldenberg: This is Deb from the measures team. You should look at the patient confirmation tab and any one of the supporting documents. It shows you how to report if a patient has died during the measurement year, um, and if you know the date you should enter the date that they have passed and that patient will be skipped from all measures in which they've been attributed and replaced. Um, you should not be reporting on a patient who has, who is deceased in 2016.

Jonathan Ladinsky: K, um the next one is a CARE-2 uh falls measure question.
Question: Does the actual falls history query need to be in the medical record, that is - the question that was asked or, is it sufficient that an answer like "no recent falls" or "no falls" is in the record without the question asked?

Carol Noyes: Hi this is Carol. As long as there is documentation of no falls or, uh what ki- what does it say "no falls" or "no recent falls," this would acceptable.

Jonathan Ladinsky: Ok, here's a question that tries to kill more than two birds with one stone.
Question: For CARE-3, PREV-9, PREV-10 and PREV-te 12 where exceptions are allowed for emerge- urgent/emergent situations, please detail what information needs to be documented in the chart to qualify for this situation.

Deb Kaldenberg: So this is Deb from the measure perspective. There isn't any one specific detail we can give you *[Background Voices]* that's really on a case by case scenario basis. I mean, you might have a situation where what you have is-is the patient was in a provider's office and was immediately, um, sent to the ER or was sent to the ER and then ended up in inpatient status. That, that would really be identified as um, an urgent or emergent situation. Um, so that is really specific to what you are finding in your medical record and if you have questions about a scenario, um, my recommendation would be to go ahead and open up a help desk ticket um, and, and we can respond in in that manner.

Jonathan Ladinsky: Uh, thank you. Next question is PQRS GPRO on PREV-13.
Question: If a patient has a – has 443.9 Peripheral Artery Disease unspecified on problem list, does this confirm ASCVD? It isn't on the list of inclusion codes but data guidance says Peripheral Artery Disease of atherosclerotic uh, origin is included.

Debra Kaldenberg: [*Background Voices*] So this is Deb. This would be another one of those cases where um, that the, coding for PREV-13 is considered to be all inclusive. However, that code set can be used if you're finding medical record documentation that supports a diagnosis of ASCVD, you can certainly use that to confirm ASCVD. Um, but you would want to ensure that that what you are using to confirm does match um, not a specific code necessarily, but the intent of the coding that is part of the PREV-13 code set.

Carol Noyes: Also, the unspecified portion of this may be the reason that it was not included within the measure so, may need to look for additional details within your medical record.

Jonathan Ladinsky: Uh, thank you. Now we have a PREV-5 question.
Question: If we cannot tell from the mammogram report if a 2-D or 3-D technique was used, can we say "mammogram was done" if we have the date and result?

Debra Kaldenberg: This is Deb from the PQMM team. If your, if you just have documentation that the mammogram was completed and, you have the date and the results, you can certainly use that to confirm that the 3-D mam - or that the mammography was completed. Um, we're not asking you to dig into the measure to confirm that it was a 3-D mammography. It's just if you happen to know that it was a 3-D mammography, you would want to report or request a CMS approved reason to skip that patient, as the measure developer, um, has provided guidance that in in their view, the 3-D mammography is not considered numerator compliant for this particular measure.

Jonathan Ladinsky: Thank you. Uh, now a mental health measure question.
Question: If we do not use the codes in the Group Practice Reporting Option Supporting Document but a provider says the patient has depression or codes 311 on the problem list, do we confirm or skip this patient?

Deb Kaldenberg: This is Deb from the PQMM team. You would need to not confirm this patient for a diagnosis. Minnesota Community Measurement has been very specific about this code set not including, um, ICD-9 311, and they do not want that particular code being used to confirm diagnosis of major depression.

[Pause]

Jonathan Ladinsky: Ok, sorry for the pause there.

Question: Um, for PREV-6, we need a confirmation of the results, negative or positive, in our EHR. Would having the colonoscopy report in our EHR count as acceptable for the measure?

[Long Pause]

Rabia Khan: I'm sorry, um, Jonathan could you repeat that one again?

Jonathan Ladinsky: Sure, not a problem. So this is for PREV-6. Um, we need a confirmation of the results in our EHR, would having the colonoscopy report in our EHR count as acceptable for the measure?

Sherry Grund: Yes, of course i- it would. Um, the entire report would be acceptable. Um, what this question doesn't tell us, is any reference to the timing of the colonoscopy, um, so we would want to make sure it is within either the measurement year or the nine years prior to the measurement year.

Jonathan Ladinsky: Thank you.
Question: Okay, for PREV-11, does a diagnosis of hypertension need to be documented – documented in the last visit in 2016, or can it be anytime in 2016?

[*Pause*]

Sherry Grund: Could you say that question again? I'm wondering if- if Deb and Carol are having trouble with their microphone.

Jonathan Ladinsky: Sure. K, for PREV-11, does a diagnosis of hypertension need to be documented at the last visit in 2016, or can it by any time in 2016?

Sherry Grund: As long as it is prior to the most recent visit, so that they've - they've had that diagnosis prior to the- to the most recent visit in the measurement period where you're looking for that blood pressure.

Jonathan Ladinsky: Uh, thank you. Now we have a new one here.
Question: Um, we use paper templates to write down the measure information that we abstract. How long do we have to keep these templates for?

Sherry Grund: I- I think that's up to your um, um, quality department or whoever is running your program. Um, as long as you uh feel it is necessary to, um, I know if you're an ACO and you are selected for audit I know that you would most likely want to keep it uh, at least as long as you have uh audit results back, and are able to, um, have a chance to refer to what you kept uh, during that process. Um, but I think that's an internal, uh, decision as far as I know. Um, you might also want to um, look at your agreement and to determine if there are any restrictions uh, in your agreement with CMS.

Jonathan Ladinsky: Uh, thank you for that answer. Ah, next one's from uh Track One ACO.
Question: Can an XML file be loaded that just includes patient confirmation information and no measure specific columns?

Sherry Grund: Yes, an XML file can be loaded with just the patient confirmation information.

Jonathan Ladinsky: Thank you. Now from a Medicare Shared Savings Program ACO, a PREV-11 question.

Question: If the blood pressure is taken in the primary care physician's office, systolic between 120-139 or diastolic from between 80-89, do we answer the same as last year, which is "no" for normal and "yes" for planned?

Sherry Grund: That is correct. [*Pause*] The fact that you um- that the visit is in the primary care, um, uh – provider's office counts in this case because the blood pressure, um, is in the pre-hypertensive range so it counts, um, as a plan because their primary care physician is going to be monitoring them.

Deb Kaldenberg: Deb and Carol are back from the PQMM team. Thank you so much for Sherry…

Sherry Grund: [*Overlapping*] Okay. [*Laughs*] Okay

Deb Kaldenberg: We got we got kicked out all of a- all of a sudden the phone went dead but we appreciate you covering for us.

Sherry Grund: I realized that when there was a pause so *[Laughs]*.

Jonathan Ladinsky: I thought you just needed to go get a drink, you've been answering so many questions.

[Laughter]

Jonathan Ladinsky: Okay *[Laughs]* Well i- it is perfect timing because we have a follow-up question ah, that specifically asks for Carol or Deb. And this is from um, a Medicare Shared Savings Program ACO.
Question: Just like the asthma exception for beta-blocker previously mentioned for CARE-2, if a patient is non-ambulatory, as long as that is documented in the record somewhere, is that enough to give a "no – other CMS approved reason"?

Debra Kaldenberg: So this is Deb. I'm not sure that that, we- we would need you to open up a help desk ticket for that because it doesn't appear as if, non-ambulatory, I'm assuming you're talking…

Carol Noyes: *[Interjects]* You- that would be for CARE-2, I hope- I hope that's what you had just said. Um, for CARE-2 there is a medical reason exception and ambulatory/non-ambulatory is part of that exception. Um, so I would suggest looking at the- the documentation that is posted on the CMS website. The supporting documents um, have that information included.

Deb Kaldenberg: And I believe non-ambulatory for CARE-2 is non-ambulatory at the most recent encounter.

Carol Noyes: Correct

Deb Kaldenberg: Um, so you want to make sure that that's there and then of course that would be a denominator exception medical reason if it- it is appropriate it would not be a reason to request another CMS approved reason to skip.

Carol Noyes: Perfect.

Jonathan Ladinsky: Uh, thank you very much. Ah, now for the IVD measure.
Question: Could you please clarify what was just said? Um, said a while ago at this point- should we be requesting a CMS "other reason" if patient is on another anti-thrombotic and not on ASA? I thought we just put "no", has this changed from prior years?

Carol Noyes: Hi this is Carol, with PQMM. So, this was actually a part of the slide deck from last week. Um, that is an option. And it's an option for all of the measures if there is not a medical reason, or an I guess, a medical patient or system reason, um, that is an option that you can send in an CMS approved reason request. Um, you would need to have the rank, the reason, and be very specific about the reason you are requesting because we are finding that several of the requests actually have medical patient or system reasons that could address that um actual question. So please refer to the documentation um within the supporting documents and that will help assist you in reporting these measures.

Deb Kaldenberg: And- and the thing with the IVD, basically if you look at the 2017 specifications there's been a major change to that measure; and so what we are finding is that um if you're finding a patient is on an antithrombotic, um, we can't allow that medication as numerator compliant as for 2016 it is not compliant, it's not considered a denominator exclusion, but if you are finding that in your medical record documentation and has been the case in the past and you want CMS to review that as a CMS approved reason to request…

Carol Noyes: *[In Background]* Absolutely can.

Deb Kaldenberg: You can. If you want that in writing as to what that might look like again as Carol said, it is part of, I believe its question one or two from last week's support call slide deck.

Jonathan Ladinsky: Ah, thank you. Okay, um, a documentation question.
Question: Can documentation, added to the EMR during the group practice reporting option process from an outside clinic for something performed in 2016 count towards the closure of a measure ga- of a gap measure or, does this have to be added to the EMR in 2016?

Deb Kaldenberg: So this is Deb I'll- I'll take it to begin with and Sherry may want to add information to this. Um, basically there's a couple of different things that we're seeing come through QualityNet and- and some concerns people have so I'm going to give you two different scenarios. If you are finding that based on your medical record documentation, you are missing components as you're trying to abstract data, and you want to try and fill in those gaps as you go, this would not be appropriate. If, however, there is a situation where maybe a mammogram or a colorectal cancer screen was done late in the measurement year and your- your provider whether the PCP or the specialist is aware that that occurred and it's just a timing thing where you're getting that information put in in 2017, but- but there is you know, information available that says the provider is aware that that took place; this would be appropriate to use that information even if you received it and scanned it in in 2017. What we are trying to clarify for people is that, it's not appropriate as the GPRO Web Interface is a retrospective reporting mechanism, that you are trying to fill in gaps in 2017 for specific patients, when that information was not available during the measurement year.

Sherry Grund: Yes, and I - this is Sherry I would agree um, that that is um, appropriate guidance. Um, our concern would be that the physician needs to have the full picture of the patient and what's going on with the patient during the year, during that performance year; um,

so you know, adding something um six eight months later that they weren't aware of at the time they were caring for the patient in 2016 um, is- is not our goal. Um, so, um what Deb says is appropriate for um the purposes of an audit if you're an ACO as well.

Jonathan Ladinsky: Thank you. Okay the next question.
Question: You keep telling us to look at the encounter codes. Can you explain the difference between the sampling codes and denominator non-billable services code? Please explain a little bit about how to use this list.

Deb Kaldenberg: So, I think from the measure perspective we- we can answer from, not the sampling code piece, but we can kind of give you an idea of the encounter codes. The encounter codes in the evaluation codes tab of the documents - of the supporting documents for each of the measures within the Web Interface, those are encounter codes that have been provided by the measure developer as instances where they would expect to see, you know, this- this could be a denominator eligible event. Um, and so when we point you to those codes, basically what we're trying to tell you is if you're questioning if a certain encounter is appropriate, you should report uh, uh a blood pressure or BMI, um those encounters will give you a really good indication as to whether or not that visit um, the expectation would be that there is the- the blood pressure or whatever the particular measure is looking for. As far as the sampling piece and- and how those two work together, um I'll hand that off to someone else to address. Oh I'm sorry.

Carol Noyes: Also, the non-billable portion of it, um, those are typically- or you may notice that there are alternative um, visits which might be like phone calls, um emails that some measures actually include within like SNOMED codes within those encounter codes so if you have questions about those they are located there as well. Um, and now I guess off to the sampling folks. Olivia perhaps?

Olivia Berzin: Sure. Um, so I'll just echo what you both have said which is that you know, we look um for those codes in claims submitted by your organization to Medicare um, in order to sample, um sample patients into the Web Interface.

Sherry Grund: And we- we put them in the document for your information only; not so that you um, would try to uh further do any uh sampling checks…

Olivia Berzin: Mhm

Sherry Grund: on your end, so that's why they're greyed and labeled as "for sampling use only." Um, so that it's an indication um to all of you whether you're a GPRO or um one of the types of ACOs, um so that you know that you don't have to do anything with that, that information is just there for your information.

Carol Noyes: Good point. Thank you.

Jonathan Ladinsky: Thank you. Uh let's see next, we are an ACO Medicare Shared Savings Program, track one.
Question: We have a patient who only saw wound care, but the primary care physician is outside our ACO; we do not have the full medical record. How can we skip this patient? Can we exclude if we do not have any eligible encounters?

Olivia Berzin: This is Olivia; I can answer that one. So, all patients sampled into the Web Interface received the plurality of their primary care services codes at your organization. Additionally, your organization billed Medicare for at least two primary care services codes in 2016, so it would not be appropriate to skip this patient um, and you know CMS expects you to work with providers inside and outside the ACO in order to coordinate care for this patient.

Jonathan Ladinsky: Thank you Olivia.

Olivia Berzin: Mhm.

Jonathan Ladinsky: The next question, for PREV-6 for a group practice reporting option
Question: In 2015, we were not required to have results. For 2016 you are requiring results. If the patient had documentation prior to, the 2000- to 2016 of the colonoscopy there would be no medical reason to re-inquire about results. Can we mark them yes?

Deb Kaldenberg: So from the perspective of the measure, the expectation is you would have results; and the rationale for this, even the results are "normal," "abnormal," "polyps present" is basically that assists in determining really when the next colorectal cancer screen should be completed. Um, so from the measure perspective, from NCQA the measure developer, the expectation would be- its results would be part of the documentation

Jonathan Ladinsky: Thank you Deb. K, for PREV-11.
Question: If they had a code of 401.1 in 2014, do we choose denominator exclusion or, does there have to be a mention of a hypertension diagnosis in 2016?

Deb Kaldenberg: So this is Deb from the PQMM team. I believe we were talking PREV-11 and the denominator exclusion language in the supporting document data guidance tab is to select the denominator exclusion for patient disqualification um, it includes active diagnosis of hypertension, so the patient would have to have an active diagnosis of hypertension in 2016 for you to select the denominator exclusion. Um, if you are only finding documentation of hypertension in 2014 and there is nothing available in 2016, then you would want to go ahead and screen that patient.

Jonathan Ladinsky: Uh, thank you.
Question: Okay, can you please clarify PREV-10? Per the Q&A, it says, if a patient quit smoking in the last three months, then they are considered a non-tobacco user. No smokeless tobacco mentioned.

Deb Kaldenberg: So if your most recent, um documentation is the patient is a non-tobacco user, you can certainly use that. If the only thing you have is whether or not they're a smoker, then you would want to screen for smokeless tobacco. Um, again you would want to look at the- the measure specification or the data guidance tab of the PREV Supporting Document. PREV-10 is looking for all tobacco use, not simply cigarettes, or cigars, or pipes.

Jonathan Ladinsky: Okay, thank you. Ok now we have a uh follow-up question on mental health measure.
Question: If the provider notes reference depression, but no applicable code is on the chart or has been billed that we can tell, should we confirm depression for the mental health measure? Even if there is 311 on the problem list, or skip for me- mental health?

Deb Kaldenberg: Okay so, I thought this one was going to be a little difficult at first. Um, I'll try to answer maybe in two different lines of thought. First of all, if you can find that the diagnosis of depression is tied to the ICD-9 code 311, then that is an absolute you do not want to confirm diagnosis based on that code. The measure developer is adamant about that code not being part of the um, diagnosis confirmation. If you are finding no coding at all and all your finding is depression, then our suggestion would *[Cough in Background]* be you really want to kind of go back to your provider and find out i-is this major depression because the- the MH-1: depression remission at twelve months is pretty specific to major depression or dysthymia. So, whatever you're using to confirm that diagnosis should be in alignment with the coding that is provided. Um, if you have some specific questions this might be one you want to go ahead and open up a QualityNet Help Desk ticket.

Jonathan Ladinsky: Uh, uh. Thank you Deb. Next question.
Question: Do you have to a copy of the colonoscopy in your chart, or do you just need to have it noted that the scope was done?

Deb Kaldenberg: *[Background Shuffling]* You do not need a copy of the report. What you need for PREV-6 is very similar to what you need for PREV-5. Um, you- you're going to want the type of test and- and the reason for the type of test is to ensure that its meeting um, the timing component required for the colorectal cancer screening. And then, you're going to want the results or the findings, um, so your- your date, the type of test that was done, the results or the findings is what's necessary and that's just to ensure that what you're reporting is compliant with what the measure is looking for but, as is the case with PREV-5, PREV-6 does not require that you have the actual report, um available. It just requires that you have documentation that the components are being met if you're reporting compliant.

Jonathan Ladinsky: Uh, okay, so uh we have a question which I think is a follow-up from earlier.
Question: For the IVD-2, um, they were asked to submit a ticket. Should the other CMS approved reasons be submitted separately, or both together in a single ticket?

Carol Noyes: If you have- Hi, this is Carol again. If you have um, similar I guess um, requests it would be okay to lump them all together as long as you have each individual rank, each individual reason, um, as specific as possible, that would be acceptable.

Jonathan Ladinsky: K, um, well we have time for one more question.
Question: And it's a PREV-5: Breast Cancer Screening. Is the answer "yes" for confirmation and "no" or "not done" for a patient who has a 3-D mammogram performed?

Debra Kaldenberg: No. Um, in this case, if you are finding that the patient has a 3-D mammography, you would need to um, request a CMS approved reason to skip. And the way you would do this is you'll open up a help desk ticket, provide the patient rank or patient ranks, um the measure in question. So, if we're just talking about PREV-5, you'd open up a QualityNet Help Desk ticket: "request a CMS approved reason to skip the following patients from the PREV-5 measure due to 3-D mammography." You can have several patients in one request, we ask that you do not supply any PHI information. Truly, the only thing we need is the reason for your request, so in this case the 3-D mammography, the fact that it is being requested for patients ranked and whatever their rank happens to be, um, and identify that it's PREV-5. And then we will, as in any other-other CMS approved reason request, when you receive the resolution, the resolution is either going to state "approved" or "denied". If it's approved, then you would select the "No-other CMS approved reason" within the Web Interface. It will prompt

you to have a ticket number, to enter a ticket number and that ticket number would be the inquiry number of the- the ticket that you've opened up and have the response. Um, and then you would just move on and- and you know if there's several patients within the same um, ticket, that same ticket number can be used for each one that you, um, select that "No-other CMS approved reason." And just so you know those patients will be skipped and replaced, as what is basically happening is we're saying that patient is not considered denominator eligible for that particular measure.

Jonathan Ladinsky: Uh, thank you Deb. And, that concludes our Q&A. Back to you, Ashley.

Ashley Burrell: Thank you, Jonathan. Thank you to our panelists for that informative session, and thank you to our attendees for participating in today's call. If you would like further information, or feel your question was not addressed on today's call, please contact the QualityNet Help Desk and the appropriate team will be able to assist you. Everyone have a great day and presenters please hold for the sub-conference.

*Bolded Words – Non-spoken