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: Caitlin Reyna
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Caitlin Reyna: Good afternoon, I am Caitlin Reyna from the PQPMI team and I am 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 the Web Interface reporting requirements and helpful hints that may 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 and 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 the call over to Rabia Khan of the Division of Shared Savings Program at CMS. Rabia, over to you.

Rabia Khan: Thank you. And yes, I'm Rabia Khan from the Div– CMS Division of Shared Savings Program and I want to welcome all of you to our CMS support call for 2016 PQRS group practice and ACO GPRO Web Interface reporting. Today's slides are available on the GPRO Web Interface webpage, uh, for Shared Savings Program ACOs it's available under today's event on the event calendar, and it is posted on the Next Generation and Pioneer Connect sites for Next Generation and Pioneer ACOs.
- Next slide, please: **Slide 2**
- Next one: **Slide 3**

All right. So, as– uh, during this support call Pioneer uh, Next Generation Shared Savings Program ACOs as well as PQRS group practices will all be collectively referred to as organizations. Uh, in addition please review the Web Interface spec– measure specifications supporting documents, which are located on the Web Interface page of the CMS website. We strongly recommend you use these resources that are provided to you when you're reporting your quality data. And again, just as a reminder, as I've said in the past, please use the 2016 measure documents for 2016 reporting.
- Next slide, please: **Slide 4**

Uh, as a reminder, the attestation deadline for providers who are participating in the Medicare EHR Incentive Program is Monday, March 13th, at 11:59 p.m. Eastern time. The providers participating in the Medicare EHR Incentive Program must attest to the 2016 program re-requirements by March 13th uh, to avoid the 2018 payment adjustment. If you're participating in the Medicaid EHR Incentive Program, please refer to your state's website for attestation information and deadlines.
- Next slide, please: **Slide 5**

So as a reminder, uh, the Web Interface submission period ends March 17th right at 8 p.m. Eastern time. Uh, we strongly encourage that you do not wait until the last day, uh, to enter and submit data. Please do that well before 8 p.m. Eastern time on the 17th to ensure that your data is fully submitted before the Web Interface closes. Uh, you will still be able to access submission reports, out, um, after the Web Interface closes on the 17th. You'll be able to do so from March 20th through the twent– uh, through April 21st.
- Next slide, please: **Slide 6**

So we do have one remaining Web Interface Q and A session and that's next week, uh, during the final week of Web Interface reporting, so please mark your calendar for that last support call. In addition, we will have a Web Interface Lessons Learned on April 6th. Uh, so, uh, we will provide you with more information, um, shortly about how to submit your feedback on 2016 reporting, uh, that we can– that we'll include in our Web Interface Lessons Learned webinar.
- Next slide, please: **Slide 7**

So, uh, there are outages and maintenance weekends scheduled for the PQRS Portal, which means the Web Interface will not be accessible, or, will be unavailable during this time. Uh, the Web Interface won't be accessible every Tuesday at 8 p.m. Eastern time through Wednesday at 6 a.m. Eastern time and then again every Thursday at 8 p.m. Eastern time through Friday at 6 a.m. Eastern time. There are no remaining maintenance weekends, uh, for this final submission.
- Next slide, please: **Slide 8**

As a reminder, organizations must, uh, satisfactorily report and– to do so, you must completely report a minimum of 248 consecutively confirmed and completed beneficiaries in each module, or 100% of beneficiaries if your organization has fewer than 248 available in the sample. By satisfactorily re– uh, satisfactorily reporting all 18 of the Web Interface measures will allow PQRS group practices and eligible professionals participating in an ACO to avoid the 2018 PQRS payment adjustment.
- Next slide, please: **Slide 9**

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. PQRS group practices are required to use EHR technology certified to the 2014 edition to populate the Web Interface. EPs participating in an ACO must be cer– using certified EHR technology and abstracting the data to report to the ACO in the form and manner specified by the ACO. The ACO must then satisfactorily report the Web Interface measures. Please note, all EPs must still individually attest separately to the EHR Incentive Program for other program requirements. When you– when EPs do go to the attestation registration system and reach the screen for reporting CQMs, EPs should select Option 1 since that's the e-reporting option and eligible profes– but eligible professionals could also choose to submit their CQM data instead of selecting the e-reporting option that is available to them. And finally, ACOs who fail to satisfactorily report the Web Interface measures will not meet the quality performance standards and will then not be eligible to share in any savings earned.
- Next slide, please: **Slide 10**

All right, now I'm gonna turn it over to Sue Hanlon who's gonna cover, uh, helpful information on the Web Interface: **Slide 11**

Sue Hanlon: Thanks, Rabia. Today we're gonna review the Web Interface reports. Oh– here we are. Um, to find the eight reports available on the Web Interface, um, you select the reports

menu item on the Global Navig– Navigation Bar and there's a little picture and it contains the listing of all the reports. Also, remember that the Web Interface user guide contains a lot of information on each report, and it's extremely useful if you can't figure out what data you're looking at on your report.
Next slide, please: **Slide 12**

OK, the first report we're gonna review is the totals report. This report provides a status of your patient abstraction as of the date and time the report was generated. It contains a Summary level as well as a Detail level, which displays a drill-down of the selected row from the Summary level, and that Detail level is a patient listing. Um, the totals are reported by measure.
- Next slide, or– yeah: **Slide 13**

And here is an example of, um, the report, it's for just CARE-2, and it's, um, as you can see you have a, um, a section called All Ranked Patients and then that is broken down, um, and then beneath that there's a Consecutively Completed or Skipped section and then there's a breakout there. And the details, to get down to the Detail level, is a link on each line. If you click that link you will see, um, the Detail level and that, again, is a listing of the patients.
- Next slide: **Slide 14**

We, um, we included this slide because we know that you are concerned about your Consecutively Confirmed and Completed patients. Here's how to determine your first Incomplete patient. And that is where your– the counting of your Consecutively Completed, um, and Confirmed patients ends, is– is your first incomplete patient. So, if you select the Details link for the All Incomplete, um, row on your, um, Summary level report, the system will return with all your Incomplete patients in order by rank, so that very first patient will be your first Incomplete patient. And again, that is where the counting of your Consecutively Confirmed and Completed patients ends, is that first Incomplete patient.
- Next slide: **Slide 15**

Um, the Check Entries Report. This report contains errors, warnings, and informational messages for all patients in your organization. It provides the same information as the Check Entries button or the Save button on the patient status, except it displays all your patients in the organization. The report is filterable in order to limit the volume of data displayed.
- And the next slide will show you an example of the Check Entries report: **Slide 16**

All right. Next slide? **Slide 17**

We have the Measure Rates Report. This report lists every measure along with the performance metrics for the measure. The descriptions for the performance metrics are provided in the footnotes. So, that– the footnote tells you how each column in the report is defined. Um, it– the report contains a Summary level as well as a Detail level, which displays the patient information for the selected cell.
- Next slide, and that's in– will show us an example of the report: **Slide 18**

This is a Summary level report, and um, once again, if you look at the footnotes and also in the user guide it exp– it describes or defines how each column has been, um, calculated.
- Next slide: **Slide 19**

OK, and here are our five remaining Web Interface reports. There's a Patient Summary Report, which contains the current database data listed for the patient selected. There's a Comments Report, which provides user comments for all the patients in selected measure modules. Um, an

Activity Log, and that's a comprehensive audit trail of all user activities performed for the organization during this submission period. The Pre-filled Elements Report is a display of the original data value and the current data value for the pre-filled elements. And finally, there's the Submission Report, which contains the submission status from the last time you submitted your data to CMS.
- And that completes, um, the Web Interface reports review for today: **Slide 20**
- Our next presenter is Deb Kaldenberg.

Deb Kaldenberg: *[Throat clearing]* Hi everyone, this is Deb Kaldenberg from the PQMM team.
- Next slide, please: **Slide 21**

And we have a couple of questions today. The first question is regarding the HF-6 measure. Can you please confirm that documentation of a pacemaker is considered a Denominator Exception – Medical Reason for the heart failure measure? Um, and this following information has been provided by the measure developer: A pacemaker alone is not a reason to not have prescribed a beta blocker. One of the Denominator Exceptions – Medical Reasons identified in the Data Guidance tab of the HF Supporting Document is to exclude a patient from performance calculation if a patient does not have a permanent pacemaker (along with an AV Block). If diagnosis of Heart Failure is confirmed, LVSD is confirmed, and the patient has a permanent pacemaker, look for prescription of a beta blocker or a documented medical, patient, or system reason the patient was not prescribed a beta blocker. As long as documentation can be found in the medical record for a Denominator Exception (medical, patient, or system) for not prescribing a beta blocker, it would be appropriate to select the applicable option. The measure does allow for physician judgment and specific patient cases in the 'Medical Reason' exception. Another thing that you can review is the coding that's provided in the Evaluation Codes tab of the HF supporting document, as well as the Heart Failure Exclusion and Exception codes tab. Um, again, these are in the supporting document where you would find information and– and additional clarity within the Data Guidance tab as well. If the patient has a permanent pacemaker, and there is not documentation to substantiate a Denominator Exception, medical, patient, or system reason, select no to prescribed beta blocker. This would be the same guidance provided for patients with an implantable cardio– cardioverter defib– defibrillator, an ICD.
- Next slide, please: **Slide 22**

And the second question, we just are starting to get, um, an increased number of these so we wanted to ensure that– that individuals knew how to, um, submit the CMS Approved Reason. So, is a CMS Approved Reason an appropriate option for a p– patient who is deceased during the measurement period? Is it an– an option for MH-1 depression remission for 12 months if the patient was not seen during the index period?" And in these cases, neither of these would be appropriate reasons to request a CMS Approved Reason to skip. If a patient died during the measurement period, please follow the guidance provided in the Patient Confirmation tab of the supporting document. For MH-1, if the patient was not seen during the index period and you cannot confirm diagnosis, select Not Confirmed – Diagnosis. If you can confirm diagnosis, but you do not have a PHQ-9 screening, select No. Select this option if the patient did not have a PHQ-9 administered during the denominator identification measurement period. And in both of these cases, well, in the first case for, um, the patient being deceased, this would actually remove the patient from any of the measures they had been attributed to. In the case of MH-1, when you are selecting that they, you can't confirm for diagnosis or a PHQ-9 screening was not used, this will also skip the patient and replace them.
- Next slide, please: **Slide 23**

And I will hand it over to Michael at this time. Thank you.

Michael Kerachsky: K, thank you Deb. Uh, my name is Michael Kerachsky from the PQPMI team and I will be presenting on available educational and help desk resources prior to moving on to the question and answer portion of today's presentation.
- Next slide, please: **Slide 24**

K, this slide contains a list of educational resources we've presented, um, in all the support calls this year. Um, here we have Web Interface webpage links to, um, support call transcripts or presentations. Uh, the support call presentation for today is posted as well as the transcript from last week's March 2nd call. Uh, there's assignment methodology as well as a sampling document, XML and measures specifications, as well as supporting documentation and data guidance. There's also a question and answer document. *[Pause]* The Web Interface webpage, we have three educational demonstrations posted including the Web Interface overview, the Web Interface measures, and EIDM for Web Interface. Again, we strongly encourage organizations to review these educational demonstrations. Um, included are instructions on how to access the Web Interface and how to utilize the documentation which appears here on this slide.
- Next slide, please: **Slide 25**

All right, this slide contains a list of help desk contacts for the PQRS group practice and ACO models. For any PQRS EIDM Web Interface questions, please contact the QualityNet help desk. Of note, the CAHPS for PQRS Survey Project Team help desk is applicable to PQRS group practices only.
- Next slide, please: **Slide 26**

[Pause] K, this slide contains a list of acronyms that you may find useful during the reporting period. Again, this is posted on every presentation.
- Next slide: **Slide 27**

K, at this time we will begin the question and answer portion of today's support call. Couple of requests: please submit your questions in writing via the Q and A chat box located at the top of the webinar screen. When submitting questions, it's helpful if you identify if you're a PQRS group practice or the type of ACO you are, Shared Savings Program, Pioneer, or Next Generation. If your question concerns measures, please identify the measure number if possible. Um, user-specific questions must be sent to the QualityNet help desk. And we will not be responding to MIPS policy questions today. And finally, in an effort to read as many questions as possible, we will not go over repeat questions. So, let's take our first question. *[Pause]*

Michael Kerachsky [question]: For DM-7, if a PCP note mentions a dilated or retinal eye exam, normally retinopathy and the name of the doctor, but just the name and not that he/she is an eye care professional, but we can confirm that the doctor is eye care professional, is this OK?

Carol Noyes [answer]**:** Hey, this is Carol. It would be OK if that professional you've identified is an ophthalmologist or an optometrist. *[Pause]* Thanks.

Michael Kerachsky [question]**:** K, next question. Regarding PREV-9. If a patient's BMI has been measured and is abnormal and the patient has a follow-up plan associated with obesity or weight management instructing the patient to engage in diet or exercise, is this numerator-compliant?

Deb Kaldenberg [answer]**:** This is Deb, um, it would be numerator compliant as long as that documented recommended follow up is um, documented on the same day as the abnormal BMI.

[Pause]

Michael Kerachsky [question]**:** For PREV-13 statins, if LDL labs cannot be found, do we answer no to the LDLC greater than equal to 190 for risk category 2, and also no for the LDLC between 70 to 189 for risk category 3?

Deb Kaldenberg [answer]**:** Yes, if you can't find LDLC values um for risk category 2, that would be a LDLC value anytime within the patient's medical history, and for risk category 3 that would be, um, an LDL during the measurement period or two years prior to the beginning of the measurement period. But again, if you are unable to verify LDLC values at all, you would have to select "no" in both of those cases.

[Pause]

Michael Kerachsky [question]**:** Thank you Deb. We have a lot of patients ranked in both HTM and PREV-11. Is this correct? They're mutually exclusive. Was there an issue with the data pull?

Catherine Hersey [answer]**:** So, this is Catherine from, uh, ACO PAC and it actually can happen that you have a beneficiary who's in both PREV-11 and the hypertension measure. And the reason that can happen is the two measures, um, have different code sets for hypertension. Um, that there are slight differences in those coding sets on how they define the diagnosis. The other, um, main reason that can happen is the time frames associated with those two measures are different. So when we look at the hypertension measure we are looking um, through the first 6 months of 2016, and for the PREV-11 measure we're looking at that exclusion in the year prior to the measurement period so it would be 2015 in this case. So there's that 6 months in 2016 where we're looking for a hypertension diagnosis for the hypertension measure, but that's outside the timeframe that we look for, um, a diagnosis of hypertension for the purposes of the PREV-11 exclusion. Um, so it can happen because of differences in the way the measure is specified. Uh, if you think there's something particularly unusual or inconsistent with what you've seen in the past, you can feel free to send a Help Desk ticket and we can look into it for you.

[Pause]

Michael Kerachsky [question]**:** OK thank you. Our Shared Savings Program ACO states: "I noticed on the total summary report that the thresholds are not appearing. "Medial records not found, not qualified for sample" etcetera, as they have in year's past. I've already hit submit and still no thresholds. Is there a problem?

Sue Hanlon [answer]: Uh, this is Sue Hanlon, um I believe you're referring to the "skip" thresholds, and they were removed upon CMS request. So they were there last year, they are not there this year.

[Pause]

Michael Kerachsky [question]**:** OK for PREV-7, some of our patients are in a skilled nursing facility, would the sign consent, sign consent form flu vaccine in the timeframe be sufficient for documentation of flu vaccine?

Deb Kaldenberg [answer]**:** And this is Deb, no, that would not be sufficient. As, um, the signed consent form does not confirm that the patient received the flu vaccine, and that is what the measure is looking for, is whether or not the patient received the flu vaccine.

[Pause]

Michael Kerachsky [question]**:** OK next question regarding the mental health measure. If a patient has depression with anxiety on their active problem list, would the measure be met if the patient is treated for depression with pharmacological interventions in the progress notes?

Deb Kaldenberg [answer]**:** And this is Deb, the MH-1 depression remission at 12 months. Um, meeting the intent of that measure means that you have confirmed diagnoses of major depression or dysthymia, you've found a PHQ-9 greater than 9 during the index period. The very first PHQ-9 greater than 9 that's found during the index period starts, um, the, the timing for looking for remission which is what you're going to use to show, um, compliance and remission is identified as the PHQ-9 less than 5 at 12 months greater, plus or minus 30 days. Um, from that index date the PHQ-9 greater than 9. So I'm not sure, um, that maybe you haven't, you didn't intend to ask a question about PREV-12, the depression screening measure, if you did I would request that you either resubmit here in the Q & A or open up a QualityNet Help Desk ticket and we can answer that particular question at that time. Thank you.

Michael Kerachsky [question]**:** OK, if the provider indicates in their dictation "smoking cessation education, yes" is that sufficient to answer "yes" for the tobacco prevention measure, "education provided"?

Deb Kaldenberg [answer]**:** Um, that that would be sufficient as long as that smoking cessation education occurred during the measurement period or the year prior to the measurement period.

[Pause]

Michael Kerachsky [question]**:** If a patient is on a nicotine patch, does this pass the measure for both screening and education?

Deb Kaldenberg [answer]: And this is Deb again. For the PREV-10 measure, no this would not pass the measure for both screening and education. You do need to find screening having occurred during that measurement period or the year prior.

[Pause]

Michael Kerachsky [question]**:** OK next question, please show the steps for how we can pull the reports into an application such as Excel or Word

Sue Hanlong [answer]: OK so there's a "view printable report" um, button that you can select. And then you can, *[pause]* hold on one minute. *[pause]* OK so you can use the button to get the report and you can use your browser to save it or print it or whatever.

[Pause]

Michael Kerachsky [question]**:** OK, um next question regarding CARE-3. Would it be OK if the provider documented all routes for prescription medications, but did not document OTC vitamins?

Carol Noyes [answer]: Hey this is Carol. To comply with this measure, the EP is attesting documentation and updating or reviewing the patient's current medications using all available resources available on the date of the encounter. This includes documentation of medications the patient is presently taking, including all prescriptions, over the counters, herbals and vitamins, mineral and dietary nutritional supplements, with each medication's name, dosage, frequency and administered route. Um, the EP is to use their best effort to review a current, complete and accurate list of medications at each encounter. For example, if an EP is unable to verify a route, they would still meet performance as long as they are using all immediate resources available on the date of that encounter. So if there are missing components, documentation that substan- substantiates the information available was to the best of the EP's ability on the date of that encounter would suffice. Um. Thank you.

Michael Kerachsky [question]**:** OK next question from the Shared Savings ACO. I want to submit the measures that are ready. The submit screen shows all measures will be submitted. May I submit more than one time on the measures?

Sue Hanlon [answer]: You can submit as often as you want to.

[Pause]

Michael Kerachsky [question]: OK regarding MH-1. We have a very high number of skips. However, on further review we are finding PHQ-9 has been done. Is it prudent to continue a manual chart review on the entire population? I have reviewed 400 charts thus far.

Deb Kaldenberg [answer]: This is Deb. I can answer just from, um, the measure perspective, not necessarily from whether or not you should continue a manual chart review. In regards to, um, the MH-1 measure the denominator criteria is a confirmation of diagnosis and then the PQRS group practice or the ACO should be also looking for, um, a PHQ-9 screening to have occurred during the measures, uh, the index period. The index period is from 12/1 of 2014 to 11/30 of 2015. If you're finding that there is a PHQ-9 screening done between those dates, you should be looking for a PHQ-9 greater than 9 during those index dates. And if you find a PHQ-9 greater than 9, the first PHQ-9 greater than 9 between the dates of 12/1 of 2014 and 11/30 of 2015 would start your, uh, would basically start the clock your 12 months plus or minus 30 days to achieve remission. Um, as far as whether you should continue to do a manual chart review, um, there maybe someone else on the call who can better answer that part of the question.

Sherry Grund [answer]: Uh, this is Sherry from ACO PAC. You will want to, just make sure you have consecutively completed your 248, and if you can't get to that number, um, that you have completed all of them that you do not skip, um, but um, you'll just have to look at you totals report to determine that whether or not you've got the consecutively completed number, um, done. Um, and that is 248.

[Pause]

Michael Kerachsky [question]: OK, thank you. We are experiencing a 30% skip rate, for PREV-11 blood pressure screening. This is extremely high as compared to prior years and we have reviewed multiple times to ensure accuracy. Has there been any issues with the sample methodology for this measure?

Catherine Hersey [answer]**:** So this is Catherine from ACO PAC. We are not aware of any issues with the hypertension measure. I know a question I answered previously explained that you can sometimes find um, patients with hypertension in your PREV-11 sample even though we do exclude them in sampling because of those differing timeframes. Um, and again, sampling uses claims, um, you know we do to the best of our ability try to and pull as much claim data as possible, um, but it's not always a complete picture of what's happening to a patient so there are also cases were you may find, uh, a diagnose of hypertension that just wasn't available to us, um, in claims at the time we were doing sampling. So it's not unusual to have some beneficiaries that have to be skipped, and that's why you have so many beneficiaries uh, beyond what the reporting requirement is. Um, but you know, if you ever are experiencing a particular measure that you think is problematic, you are welcome to submit a Help Desk ticket and um, we can look into a couple of cases for you.

[Pause]

Michael Kerachsky [question]: Is it possible to reset all the data for the patients from the Interface? If no, is there anyone that I can ask to wipe all the data stored?

Sue Hanlon [answer]: No, you cannot wipe out all the data, um, but please go ahead and open a Help Desk ticket and we can probably assist you with some options.

Michael Kerachsky [question]: OK, next question, if we cannot find the death date but the patient is marked as deceased in 2016 in the medical records, what default date should we use?

Deb Kaldenberg [answer]: So if you look at the patient confirmation tab of the supporting document, any one of the supporting documents, if you know the patient is deceased in 2016, but you don't know the exact date, it would be appropriate to use December 31st of 2016 as the date. Thank you.

[Pause]

Michael Kerachsky [question]: OK, does the quality score across all submitted patients or just those which are counted for the minimum ranking, as an …

Olivia Berzin [answer]: Sure this is Olivia, oops sorry go ahead Michael …

Michael Kerachsky [question]: OK I just, quickly as an example, I submitted all 616 for all measures, is my quality score scored for all submitted 616 or just for the consecutive 248?

Olivia Berzin [answer]: Sure, so this is Olivia Berzin from ACO PAC an this answer applies to both ACOs and group practices but the performance rates for each measure are calculated based on all consecutively confirmed and completed patients in, um, each module.

[Pause]

Michael Kerachsky [question]: OK for next year's GPRO Web Interface reporting, would it be possible to open the Interface for testing at an earlier time and for a longer period?

[Pause]

Sue Hanlon [answer]: Uh, this is Sue Hanlon, that's a, that's a program decision.

Rabia Khan [answer]: Sorry this is Rabia, could you repeat the question again?

Michael Kerachsky [question]: Sure thing. For next year's GPRO Web Interface reporting, would it be possible to open the Interface for testing at an earlier time and for a longer period?

Rabia Khan [answer]: Uh, we appreciate that feedback it was really helpful, um, we will take that into consideration and, um, we would also appreciate your feedback when we request, uh, and your feedback for our lessons learned webinar so, um, we'll take that obviously into our consideration for next year's reporting.

Michael Kerachsky [question]: Thank you. When will reports be available for export? After the Web Interface closes when will we have, when will all data be available for download and storage?

[Pause]

Sue Hanlon [answer]: So the reports, the- the period of time were just reports are available starts right after the submission period ends, but those reports cannot be exported. *[pause]* But they can be printed.

Michael Kerachsky [question]: OK we have questions from Shared Savings Program and Next Generation ACO. Please advise why the presence of a cardiac pacemaker was listed on the exclusions exception tab for HF-6 if it is not an exclusion.

Carol Noyes [answer]: Hey this is Carol. Um, so *[clears throat]* the mapping column for HF is what should be utilized to help guide you towards, I guess the coding that is within the evaluations tab, so if you go down to the column that's in the downloadable resource mapping, there is, um, documentation that does state that without permanent pacemaker codes, um, is the acceptable [pause] um and, and guidance about the AB block is also within this column. So you kinda have to use the mapping column with the evaluation coding, but it is present within that mapping column.

[Pause]

Michael Kerachsky [question]: OK for heart failure, the supporting document states if you answer no to determine if the patient has LVSD, the measure is complete. When I submitted this measure using the Web Interface, they counted these patients as skipped. Is there a problem with this one?

Carol Noyes [answer]: No, that would be correct. The patient would be skipped and replaced with another patient.

Deb Kaldenberg [answer]: That, that LVSD component is part of the denominator criteria which is why that patient is being skipped.

Sherry Grund [answer]: This is Sherry from ACO PAC, that patient is compete. It just isn't, um for in, counted for analysis, so therefore it's skipped and, uh, that makes it, um, not concluded in those cases or patients for analysis.

[Pause]

Michael Kerachsky [question]: OK next question is for PREV-5 breast cancer screening. If a patient had a mammogram performed within the 27 months prior, prior to the measurement end date, but that mammogram was done before she was 50 years old, would she be in the numerator or denominator?

Deb Kaldenberg [answer]**:** So for, um, if the, within the inclusions synonyms column of the data guidance, there is a note for the PREV-5 measure, um the, and for 2016, the measure's 27-month look-back period applies to women age 52 to 74. The numerator looks for a mammogram anytime on or between October 1st, 27 months prior to the measurement period, and December 31st of the measurement period, in order to capture women who have had a mammogram every 24 months per clinical guidelines with a 3-month grace period. Therefore, women ages 50-52 are included in the measure if they had a visit and a mammogram since age 50, but the 27-month look-back period only applies to patients aged 52 to 74. For patients that are 51 years of age during the measurement period, look back only to age 50 for the mammogram.

[Pause]

Michael Kerachsky [question]**:** OK, we have a question from a Shared Savings Program ACO. Remind us if the LVL cannot be calculated, do we answer the question around LVL as 'no' for both risk categories requiring LVL?

Deb Kaldenberg [answer]**:** That would be correct. If you cannot confirm the LDL value, as identified in the PREV-13 measure, that, that LDL value for risk category 2 and risk category 3 is part of determining the denominator eligibility, prior to looking for numerator compliance. So if you are unable to determine if the LDL fee values are present in the medical record, you would have to answer no to those questions.

[Pause]

Michael Kerachsky [question]**:** Thank you. Next question. If patients are diagnosed at any time in 2016 for the first time with HTN, they should be excluded from PREV-11, correct?**Deb Kaldenberg** [answer]**:** Correct.

Michael Kerachsky [question]**:** OK, for Shared Savings Program, Next Generation ACO, ah for PREV-12, if we see a PHQ-2 listed but the question varies slightly, is that acceptable? It displays in the past month instead of over the past 2 weeks.

Deb Kaldenberg [answer]**:** So we have been told we are able to accept PHQ-2 questions, that are identified as PHQ-2 questions without documentation specifically that it was a PHQ-2 tool that was utilized. However, if you have modified those questions, um, as- as far as we understand, that should not be used. You would need to document what screening tool's being used. However, there may be as an MSSP or Next Gen ACO, there might be some additional confirmation that someone can provide.

Sherry Grund [answer]: No, that's correct, Deb. Um, you were correct if the ah PHQ2 questions are verbatim um as they are in the PHQ2 tool, um, we will take that, ah even though it may not be labeled as the PHQ-2, um but they have listed verbatim as those 2 questions.

[Pause]

Michael Kerachsky [question]**:** Alright, next question. Are the measures that are dependent on patient age based on the patient age of the particular visit or the patient age at start of measurement period?

Catherine Hersey [answer]: This is Catherine from ACO PAC, ah, when we look at sampling we determine patient age ranges as of the first day of the measurement period.

[Pause]

Michael Kerachsky [question]**:** For CARE-3, if medications are only documented under the planned section of the note, would this be acceptable to consider as medication is being documented, updated, or reviewed at the office visit?

[Pause]

Carol Noyes [answer]: So if the plan section is, is the physician signing off on that visit, and it's applicable to that visit then yes. As long as it meets all of the components of the measure.

[Pause]

Michael Kerachsky [question]**:** OK. Next question. GPRO PREV-12 - can you use a skilled nursing facility MDS resident PHQ-9 assessment to show that a screening took place in the measurement year?

Deb Kaldenberg [answer]**:** So as long as what you have documented in the medical record, um, meets that measure, yes, you can use that screening. So the name of the standardized screening tool must be documented in the medical records, the results must be reviewed and verified, documented by the eligible professional in the medical record on the date of the encounter to meet the screening portion of the measure. Um, if there is, you- you would also need documentation if the screening results were considered positive or negative and if they were considered positive on the date of that screening, of that positive screen, there would also need to be documentation of a recommended follow-up.

[Pause]

Michael Kerachsky: OK, at this time, we do not have any more questions in the chat box. Um, why don't we give it a minute or two, and if you have any questions, please write in. OK, we've got one here.

Michael Kerachsky [question]**:** Can you clarify, Shared Savings Program ACO, the GPRO seems to not be taking the diagnosis of diabetes, the age for the risk category of diabetes seems to be excluding patients who turned 76 during 2016. Is this correct?

Deb Kaldenberg [answer]**:** So, I do, I do believe this is correct, um basically what's occurring is for, um, oh maybe I'm speaking out of turn, is, can you clarify if you are asking about the DM composite or if you are asking about the diabetes component within risk category 3 of PREV-13?

Michael Kerachsky: OK, looks like the DM component within PREV-13.

Deb Kaldenberg [answer]**:** OK, thank you. That's what I thought. And, um yes, this would be happening because the system knows, that, that narrower age range for risk category 3, um if you look at risk category 1 and risk category 2, the age range is patients aged 21 years and older; however, for risk category 3, that age range is 40 to 75. So the patient has to be 75 years of age all the way through 12/31 of 2016. Otherwise they will not be considered eligible based on age for risk category 3. The system knows that, and they will automatically skip them for that reason.

Catherine Hersey [answer]: And this is Catherine from ACO PAC, just to clarify my previous answer. When we look at age ranges for any measure, um, we do look at age as of the beginning of the measurement period, for lower age limits, but for the few measures that have an upper age limit like this one we look at the age as of the end of the measurement period. So just like Deb said, um, you have to be in that upper age limit of 75 as of the last day of the measurement period. So if you turn an age during the year that brings you outside of that limit, um, you're not including for sampling purposes um, and if the web interface realizes that the patient has turned that age, it will also remove them.

[Long pause]

Michael Kerachsky [question]**:** In the check entry report, if the patient has informational warning listed, is this patient skipped? Is the patient considered complete?

Sue Hanlon [answer]: That patient is skipped.

[Pause]

Michael Kerachsky [question]**:** If the provider indicates 'never smoker' but does not specifically mention or ask the member about smokeless tobacco use, should we mark the member as' no screens identified/non-user' or 'not screened/unknown' as smokeless tobacco use is not addressed?

Deb Kaldenberg [answer]**:** So, for the PREV-10 measure, PREV-10 is looking for all tobacco use. If the only thing you're aware of is whether or not the patient is a smoker and there's no indication whether or not the patient has been screened for smokeless tobacco, it would appear as if the most appropriate answer would be 'not screened/unknown' as smokeless tobacco use is not addressed. However, you may find in um doing some some medical record review, you can find that potentially your, your question about smoking encompassed smokeless tobacco, um but if you're not able to identify that um, again, not screened/unknown as smokeless tobacco use is not addressed, seems to be the most appropriate.

Michael Kerachsky [question]**:** OK on the GPRO MH, if the patient has diagnosis code for depression with anxiety on their active problem list, but this patient also is being treated for depression only in a progress note, is MH confirmed?

Deb Kaldenberg [answer]**:** So MH-1 depression remission at 12 months, that measures codes set is considered all inclusive. The measure developer has provided coding, that as far as they're concerned is the only coding that would meet the intent of confirming diagnosis. The diagnosis really needs to be major depression or dysthymia, so if you're, if in doing your medical record review, you can't find an applicable code and you can't find documentation of major

depression, then it would seem that the most appropriate response would be to not confirm based on diagnosis.

[Pause]

Michael Kerachsky [question]**:** So, we have found that when I correct an entry, such as patient has LVSD or not, it does not nullify a previous positive answer for beta blocker, for instance. Are there errors in the formula?

Sue Hanlon [answer]: Um, no there's no errors. If you change uh, a previously answered question, it won't blank out um the answers but they'll appear grayed out, but those grayed out answers are not used in any formulas, it that data is ignored.

Michael Kerachsky [question]**:** OK next question. Why are patients above 75 included in PREV-13?

Deb Kaldenberg [answer]**:** So, the measure developer and through their technical expert panel have determined that for diagnoses of ASCVD or for risk category to the LDLC um, of greater than or equal to 190, um in those cases the age range used for that is age 21 years and older, uh, if you have a question about that and it's not answered by reviewing the measure specification, maybe the clinical recommendation statements or the rationale, you could always reach out to the measure developer. The measure developer contact information is included in 2016 GPRO Web Interface Measures List, posted on the CMS website.

[Pause]

Michael Kerachsky [question]**:** For HTN measure, I have patients that have blood pressure value of 140 over 90 that are being counted as met on the measure rate reports. Data guidance says less than those values. If patient has blood pressure 140 over 90, how do they fall in the numerator?

Sue Hanlon [answer]: Could you go ahead and create a help desk ticket number for that, please?

Deb Kaldenberg [answer]**:** Hey, Michael, can I go ahead and read one of the questions that's coming in about MH-1?

Michael Kerachsky: Ah, yes, for sure.

Deb Kaldenberg: OK. Um, for MH-1 we do a PHQ-9 only when the PHQ-2 is positive. So in the follow-up period, it looks like our remission is zero, because for possible remission patients we only have a PHQ-2. Can we use the PHQ-2 score in the follow-up measurement period?

Deb Kaldenberg [answer]: And the answer to this is no. The only way to show remission is if you are using a PHQ-9 screening, and- and you get a result of less than 5. So unfortunately if you have a confirmed diagnosis of major depression or dysthymia, you have a PHQ-9 greater than 9 during the index period and you do not have a PHQ-9 screening less than 5 during the numerator period to show remission, this would be a numerator fail.

[Pause]

Michael Kerachsky [question]**:** OK, next question – for IVD, what option will you choose if patient was prescribed aspirin in measuring period, but currently not taking it?

Carol Noyes [answer]: This is Carol. You would select the patient was taking aspirin during the measurement period.

Michael Kerachsky [question]**: OK,** are we able to skip a patient if they have only been seen at the Coumadin clinic?

Olivia Berzin [answer]: This is Olivia Berzin from ACO PAC. Um, so all beneficiaries sampled in the Web Interface um, have claims evidence of at least two primary care services billed by your organizations to Medicare in 2016, so I don't think it would be appropriate to skip them, and at the same time if you disagree or if there are extenuating circumstances, you can certainly submit a request for a CMS-approved reason.

Michael Kerachsky [question]**:** OK, um, at this point we will take one more question. [pause] For PREV-12, if the provider does not mention depression screening or results in their note, but there is documentation of screening in the EMR from that visit does that meet the requirement for being reviewed, verified, and document- documented by the EP?

Deb Kaldenberg [answer]**:** So, based on this question I would say no, it doesn't. And the rationale for that is I cannot tell by your question what screening tool has been used and whether or not there are actually results documented. So those are two components required by that measure. Um, the PREV supporting documents, the 2016 PREV supporting document data guidance tab um really has a lot of that guidance provided, um, within that tab for what is required for PREV-12.

Michael Kerachsky: OK, thank you for that response. Um, at this point, uh this ends the question and answer portion of this call. Back to you, Caty.

Caitlin Reyna: Thank you, and thank you panelists for that informative session. And thank you to attendees for participating in today's Web Interface Support Call. If you would like further information or feel that your question was not answered on today's call, please contact the QualityNet Help Desk and the appropriate team will be able to assist you. Have a great day, everyone. Presenters, please hold for the sub-conference.