[Classical music plays]

Hello, everyone. Thank you for joining today's Web Interface Support Call Webinar. This series of webinars are for Accountable Care Organizations and Groups that are reporting data for the Quality Performance Category of the Quality Payment Program through the CMS Web Interface for the 2017 Performance Period. These webinars will highlight important information and updates about reporting quality data and provide ACOs and groups with the opportunity to ask CMS subject-matter experts their questions. Please note that these calls will only focus on reporting data for the Quality Performance Category. We will not cover reporting data for the other performance categories during these calls. Now I will turn the call over to Lisa Marie Gomez from the Center for Clinical Standards and Quality at CMS. Please go ahead.

Thank you. Welcome, everyone, and thank you for joining us today as ACOs and MIPS Groups prepare for Quality Reporting via the CMS Web Interface. Again, I'm Lisa Marie Gomez with the CMS Center for Clinical Standards and Quality and an expert on CMS Web Interface. Joining me on this call today are other CMS experts and contractors who will share helpful information on Quality Reporting via the CMS Web Interface and answer your questions during the question-and-answer session after today's brief presentation. As noted earlier, today's focus is on Quality Reporting. If you have questions regarding Advancing Care Information, the Quality Payment Program will be providing more information in the upcoming weeks. Also, you can contact the Quality Payment Program Service Center with any of your questions regarding Advancing Care Information, MIPS, or Quality Reporting in general.

Next slide, please. This is a disclaimer slide about this presentation. Information in this presentation was current at the time it was published, but I urge you to please be sure that you're using the source documents and links that are provided throughout the presentation, and please stay tuned to any communication from the Quality Payment Program, your Shared Savings Program, or Next Generation Program regarding any updated information.

Next slide, please. First, I'd like to remind you that the CMS Web Interface opened for submission this past Monday, January 22nd. It will remain open for eight weeks. It will close at 8 o'clock P.M. Eastern Daylight Time on Friday, March 16th. Please note you do not have to click on a "Submit to CMS" button as was previously done in the previous years. Instead, CMS will automatically take the data that is entered at the end of the submission period, but whatever is entered as of 8:00 P.M. Eastern Daylight Time on March 16th is what will be accepted as your data submission for the 2017 Web Interface Quality Reporting. Again, I just want to emphasize that you do not need to click on any "Submit" buttons to CMS. Again, whatever is submitted at that time of 8:00 P.M. will be your reported data for the 2017 Performance Period.

Next slide, please. Now I'm going to go over just a couple of announcements, so please mark your calendars. The next CMS Web Interface Webinar will be held next week on Wednesday, January 31st, from 1:00 to 2:00 P.M. Eastern Standard Time. This will include a Q&A session. Now I'm going to turn over the presentation to Olivia Berzin, a CMS Contractor, for an ACO announcement.

Thank you, Lisa Marie. So the following slide addresses an issue specific to a subset of Shared Savings Program ACOs. So anyone who is not in that category can ignore the next slide.

Next slide, please. As you may recall, in Quarter 3, beneficiaries participating in the Comprehensive ESRD Care, or CEC Model, were not excluded from assignment. For background on the issue, you can refer to the December 22nd ACO Spotlight Issue, as well as the cover notice that was delivered with your supplemental reports if you received them, and as a result, you may see some of these beneficiaries in your Web Interface sample. Using the patient ranking file, we deliver to Shared Savings Program ACOs via MFT. You can identify who these beneficiaries are using the CEC column and request approval to skip them using a CMS-approved reason, and you can e-mail the Quality Payment Program Service Center, which is qpp@cms.hhs.gov with the measure and rank number associated with each beneficiary. You don't need to provide all of the measure and rank numbers associated with each beneficiary, but at least one, and we'll then confirm that these are, indeed, CEC model beneficiaries and send you a determination. As a reminder, never e-mail a beneficiary's health-insurance claim number, which is also referred to as the HICN or Medicare I.D. With that said, I'll hand it over to Jessica Schumacher to review Frequent Measures Questions.

Thank you, Olivia. Today we want to cover some frequently asked CARE-1 questions, and we do ask folks to stay on the line. We just have a couple slides to go through, because after CARE-1, we want to bring up an important announcement regarding the PREV Coding Document.

Next slide. On Slide 8, we're going to start talking about CARE-1, and before we get into some of the frequent questions that we've received, we'd like to just provide a quick reminder that CARE-1 is new. It's actually reintroduced to the CMS Web Interface for Program Year 2017, and in Program Year 2015 and 2016, the Web Interface used to have CARE-3. So we just want to call attention to abstract just to let them know that this year in 2017, we'll be working with CARE-1, which is medication reconciliation post-discharge as opposed to CARE-3, which is documentation of current medication. Those CARE-1 and CARE-3 have very different requirements. So we strongly want to encourage people to review the CARE-1 measures. In fact, that's available on the QPP website. Just a reminder, CARE-1 is for prescribing practitioners, clinical pharmacists, and registered nurses to reconcile the discharge medications without patient medication on or within 30 days of discharge. And, again, this measure's being reintroduced into the Web Interface after it had a couple years off. And the Measure Spec, you'll find -- We mentioned this during the previous support call, but we just want to really, really beat this in because with every question that you guys submit, this is the checklist that we go through before we provide an answer. So Medication Reconciliation, again, is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. Documentation in the outpatient medical record must include evidence of medication reconciliation and the date on which it was performed, and any one of the following requirements will meet the definition of medication reconciliation, and the first item is documentation of the current medications with a notation that references the discharge medication. So, for example, there could be a comment stating no changes in meds since discharge or same medications at discharge, or discontinue all discharge medication. So if you're looking at your chart, and the notes that you see don't match number one, then you move on to

number two. So do you have evidence of documentation of the patient's current medication with a notation that the discharge medications were reviewed? So if you don't see that type of notation, then move on to item number three -- Is there any documentation the provider reconciled the current or discharged meds? And if there's no documentation that meds are reconciled, moving on to number four -- Is there documentation of a current medication list, a documentation of the discharge medication list and notation that the appropriate practitioner type, which is mentioned in the definition above, reviewed both lists on the same date of service? And if that information is not available, then move on to number five -- If there's notation of no medications were prescribed or ordered upon discharge, that last item will also count as confirmation that the medications were reconciled.

Now, before we move into the Q&A, as I know a lot of you are using EMRs are wondering -- You know, there's a caveat that we have been telling people. If you have an EMR, and you have a policy in place at your organization that indicates if they check a box indicating medication reconciliation defined as one of these five things, so if you have policy in place that supports the setup of your EMR for meeting the intent of this measure, then that will count, as well. And we'll go into a Q&A on one of the next slides about that. Next slide. So, on Slide 9, we're going to start Frequent Questions About CARE-1, and we have a couple slides, and then we'll move on to the important announcement regarding the PREV Coding Documents. So the first frequent question that we come across is, "If we had a policy in place to specify how our EMR functionality worked for medication reconciliation, could we reference that policy in the case of an audit?" If there is a policy in place that the clinician is aware of and agrees with the medication reconciliation completed and is taking responsibility for this information, that would suffice as long as someone somewhere in the chart, you could find evidence that supports one of the five requirements that were listed on the previous slide. And I believe that's an error. We'll have to update that. Instead of referring to Slide 7, we'll refer to Slide 8. The second frequent question is, "During the office visit, the provider documents 'Discontinued multiple discharge medication with specific reasons.' Will this meet the measure?" So if there is documentation of the current medications with a notation that references the discharge medication -- for example, discontinue all discharge meds -- then this would meet the first requirement listed on the medication reconciliation definition that was on the previous slide. The third frequent question that we're getting is, "Does the drug frequency route and dosage -- is that required? Or is just the comment 'medication reconciled' sufficient?" So this measure does not specify what a drug frequency route or dosage required. However, these characteristics may be included when the provider makes notation of the medication usage. A note of "medication reconciled" does not meet the requirements listed in the definition of medication reconciliation that was listed on the previous slide. However, other information in the medical record may help support that comment, and in combination, that could meet the recommendation -- or the requirement for the definition of medication reconciliation.

Slide 10, please. The fourth frequently asked question that we received is, "What do we do if the discharge date listed is actually a transfer to another inpatient facility, such as an inpatient rehab facility, and then 15 days later, they are discharged from rehab, which is prefilled as another eligible encounter?" So the good news is, as stated on Page 8 of the Measure Spec in the denominator guidance that states that the measures you report

each time that a patient was discharged from an inpatient facility and had an office visit within 30 days of discharge during the measurement period. So both discharges would count. However, if an office visit overlaps two separate hospital discharges, that office visit can be used to meet the intent of the measure for both discharges if one of the medication reconciliation requirements listed on Slide 5 are met for both visits. And the last frequent CARE-1 question we've been receiving -- "So for those groups that have integrated EMRs, where the hospital and ambulatory settings are on the same EMR, the discharge meds would already be in the med list when the patient presents in the ambulatory setting. If the provider then notes 'medications reconciled,' it would be the discharge list that was reconciled. Would that meet the intent of the measure?" So if the current medication lists that it's updated in your EHR system is based on the hospital discharge medications and shows the start date for the medication, then you would be able to discern which medications were started or stopped during the hospital stay and which ones were the discharge medication. So if "medications reconciled" means to your providers that they performed a review of the medications for appropriateness, then they are meeting the intent of the measure. It's strongly recommended that you have a written procedure in place that automatically defines what this process is and have that on hand in case of an audit.

Next slide. So Slide 11, we're going to talk about the PREV Coding Document. We just want to announce that there was a slight error in coding, and these are some of the questions that have been coming across. The first one is, "There is a coding discrepancy between the 2017 PREV Coding Document and the 2017 Web Interface Release Note. Will code 442333005 qualify for the numerator for PREV-7?" Similarly, people are asking, "There is a coding discrepancy between the 2017 PREV Coding Document and the 2017 Web Interface Release Notes. Will code 90839 qualify as an encounter for PREV-12?" And the third question we're receiving is, "There is a coding discrepancy between 2017 DM Coding Document and 2017 Web Interface Release Notes. Denominator Code E10.3412 is added twice. The code should be E10.3413." So in response to these comments regarding the Coding Document, we just want everyone to know that there was an error within the 2017 Web Interface PREV Coding Document that was inadvertently included in the zip file that's currently posted on the QPP Resource Library with a posting date of December 20, 2017. For PREV-7 influenza immunization, SNOMED Code 442333005 would not qualify for the numerator. For PREV-12, Screening for Depression and Follow-Up Plan, CPT code 90839 would not qualify as a valid encounter. And lastly, for diabetes, Denominator Code E10.3413 should have been added instead. Denominator Code E10.3412 and E10.3413 are valid coding for submission. Next slide, please. And we'll move on. We just want to remind folks that resources are available on the QPP website. Next slide. On Slide 13, you'll see a list of available website resources starting with the QPP Help and Support Website. This site provides videos, webinars, online courses, learning network information, in-person assistance requests and developer tools and APM learning systems. And then down below, there's a long list of materials that are currently available on the QPP Website regarding CMS Web Interface, and at the bottom, we have our new instructional videos, as well, and those are quick videos on YouTube that will allow you to kind of walk through the system and plan abstraction.

Next slide. And Slide 14 are Resources for ACOs. Medicare Shared Savings Program ACOs can visit the website or log on to the portal, and, also, Net Gen ACOs, there's a website and the portal links for you, as well. Next slide. And that is the end of the presentation. This is going to be our

standing slide. If you guys have any additional questions, these will be the contacts that you can reach out to for additional help, and at this time, I'll hand it over to Rabia Khan.

Hi. Thank you. I just want to make a quick announcement because we've received a number of questions from Shared Savings Program and Next Generation ACOs asking about differences and the number of [Indistinct] associated with each of the top NPIs that are identified in the file that we delivered through MFT or EFT versus the Excel that you downloaded from the Web Interface. So, to help clarify, the Excel from the Web Interface provides you with the top three NPIs for each beneficiary, but they're not in order of the care that was provided. So they're not ranked in order. So the file that you received via MFT or EFT does rank the NPIs by the most care provided. So NPI 1 in that file is the provider who provided the most care. NPI 2 is the second-most care, and third is the third-most care. So if you're comparing the two files, you'll need to filter all three NPI columns in the Excel template that you downloaded from the Web Interface to actually see all of the beneficiaries who received care from that provider. So if you're trying to compare, like, the column that says NPI 1 with the MFT file for those listed as the number-one NPI, they're not going to sync up because they're not in the same order. So to confirm, you should look at all three columns in the Excel template version that you downloaded from the Web Interface, but, again, the MFT and EFT version already has them in order of the most care that was provided. So now I will turn it back to Ketchum for the Q&A.

We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, please dial 1-866-452-7887, and if prompted, please provide the conference I.D. number 72087464.

So the first question is regarding CARE-1 medicine reconciliation. "Can we use Health Information Exchange, the admission transfer discharge reports, which is not in patient charts, to confirm that the pre-populated discharge data is within plus or minus two days?"

Hi. This is Jessica from the PIMMS Measures Team, and as long as the A.T. is available at the point of care, you can use it to confirm the date. Thank you.

All right. Thank you. Next question is about PREV-12. "Does a depression screen that is built into an EHR qualify as a standardized screen for this measure?"

This is Jessica from the PIMMS Measures Team. It would be acceptable as long as there's a policy in place that indicates what screening tool it is. It has to be verbatim of the original tool. We understand a lot of times EMRs will have PHQ-2 and/or PHQ-9 embedded within the questions in the EMR. So we do understand this is a common situation for some folks. In the event of an audit, again, you will need to be able to provide the name of the screening tool and whether or not the screening tool is considered positive or negative. Thank you.

Thank you. Next question, "If we cannot find any applicable encounter codes for the denominator of a measure within calendar year 2017, do we skip the patient? What reason do we give?"

So this is Deb. From the measures perspective, you would not skip a patient because we don't actually ask you to confirm those encounters occurred, but I would -- I believe, Olivia or others from the ACO PAC Team could specifically speak to the sampling portion.

Hi. This is Sarah Grallert. Yes, we are sampling based on the claims data that show that the beneficiary did, indeed, have an encounter and therefore made it into the sample.

All right. Thank you. Next question, "If a beneficiary is assigned to the wrong clinic and provider in the sample data file, can the updates be uploaded in a bulk data file or does the original sample record need to be modified within the QPP application?"

Ralph, or somebody from SemanticBits, are you on?

Yeah, could you repeat? I'm sorry. We only caught part of it.

Yes. So the question is, "If a beneficiary is assigned to the wrong clinic and provider in the sample data file, can the updates be uploaded in a bulk data file or does the original sample record need to be modified within the QPP application?"

All right. So, in the CMS Web Interface, if the clinic and provider, you wanted to associate it with that beneficiary was not in the original sample, you can go to Managed Clinics or Managed Providers to increase the list of clinics and providers that you have available to you in the CMS Web Interface. Once you have the clinics and providers you want available to you, you can substitute from your list that's available in the CMS Web Interface into the spreadsheet that you're using to upload data for. So, you can't create new ones via the spreadsheet, but you can manage them within the CMS Web Interface and then report against them accordingly or substitute them accordingly in the spreadsheet.

All right. Thank you. Next question, "If a patient transitioned to managed Medicare anytime during 2017, are they removed for the sample?"

Hi. This is Sarah Grallert. Yes. If a patient is in managed Medicare during the measurement year, they would not be sampled.

All right. Thank you, Sarah. And, Stephanie, I think we can take one question from the phone line if anyone's dialed in.

We have a question from Jason Shropshire.

Hi. Can you hear me?

Go ahead.

Yes, I actually have two questions. So my first is, regarding the -- I also have a question about the office visits. So we all know Medicare claims information can be incorrect, so if we look, and there's no record that the patient assigned to us had any type of encounter at all during 2017, you're saying we still have to include them in the measure even though it's probably incorrect. I guess what I don't understand is, then why do we have denominator encounter codes as part of building the measure if we're basically supposed to ignore them?

Hi. This is Sarah Grallert from RTI again. So the way that we pull our sample is looking at claims data. So when we see -- And I'm not sure of the specific measure, but we are looking for encounter codes that are required by that measure to be eligible for the sample. So we are using our claims data to do that.

Right, but we did not bill any of those codes, so that's my question. You're saying we're not allowed --

I mean -- This is Olivia. I'll just step in and say if you could submit a QPP Service Center Inquiry on this, and we can pull the specific -- We may be able to pull the specific claim that got identified there.

Okay. So my next question is, for the Preventive-9 Measure for BMI, I want to make sure we are allowed to accept -- not exclude, but accept the patient if they have a diagnosis of dementia?

So, Jason, this is Deb. When you say "accept for PREV-9 BMI because they have dementia," I don't think that measure has any exceptions for a diagnosis of dementia. Is that what you're asking about?

Correct. Because if you read the specs, it says, "Denominator exception. Patient has mental illness or dementia."

You don't have to use that. Those are there in the event because there are certain situations where, based on a patient's diagnosis of dementia, maybe there is absolutely no way to provide a recommended follow-up, but, certainly, depending on the stage of the disease, there are times -- Even -- I mean, if you even look at the PREV-12 Measure as a depression screen, you're not going to exclude those patients automatically because, depending on where they are in their disease, there would be reasons to go ahead and give the screen. Same with the BMI. There would be reasons to go ahead and provide a recommended follow-up, and there might come a time where the provider documents it -- you know, a recommended follow-up is no longer something that can be provided.

Okay. Thanks.

Mm-hmm.

All right. We're going to go back to some chat questions now. So the next question, "Under the definition section of PREV-9, what is the current encounter referring to?"

Hi. This is Angie Stevenson with the PIMMS Measures Team, and it is referring to the most recent encounter, or -- Yeah, the most recent. You can find that on Page 10 under Numerator Reporting that it does refer to the most recent.

All right. Thank you. Next question, this person says, "Several of our staff still cannot access the portal to submit data. When will this issue be fixed?"

Hi. This is Lisa Marie. So we're working diligently to work through these different issues that folks are experiencing, and we're hoping to get everything resolved as soon as possible. Also, we found that issues aren't

necessarily overarching to the portal itself. Usually it's with an individual user account. So we're working through to get actually several tickets on a daily basis to ensure that folks are able to access the Web Interface.

And this is Rabia. Just to add for the person who has this question. If you do not have a ticket open about this, could you send that to the QPP Service Center? And that will help us address your specific issue.

All right. Next question, "Is there any advantage to submitting more than the required 248 consecutive patients this year?"

Olivia, can you take that question, please?

Sure. So I think I heard this question correctly. If you submit more than the 248 required beneficiaries, then all consecutively concerned and completed beneficiaries will be used in your performance rates. Does that answer the question?

I think so. So, next question, "The criteria for PREV-5 states the patients need a visit during the measurement year. Are you referring to a mammo visit or an office visit? Please clarify."

This is Deb Kaldenberg from the Measures Team, and the visits, again, kind of using your PREV Coding Document in combination with the Sampling Document, you'll see that the coding that was used to attribute a patient was based on the encounter codes that are identified as for CMS sampling only within the PREV Coding Document if you store it to PREV-5. So it could be any one of those types of office visits that occurred. It would not be specific to an encounter for a mammogram, because, of course, with your mammogram, you are looking back, typically, to see if the mammogram is compliant within a 27-month time period, which would include the measurement year, the year [Indistinct] Thank you.

Thank you. And, Stephanie, I think we can take one more phone question at this time.

Certainly. Our next question comes from the line of Diana Hamidi.

Hi, there. Thank you so much, and my question has to do with the use of Heparin on the exclusion for IVD, and I'm finding that there are a lot of patients that are on Heparin in the hospital, and it's using the appropriate and allowed amount that's listed in the measures specs, but upon discharge, these patients would not be going home on Heparin, though what is the appropriate use of Heparin for this measure to exclude patients when they're not being discharged on Heparin and remaining on Heparin?

Hi. This is Angie Stevenson with the PIMMS Measures Team. If they are actually prescribed the Heparin, then it would count as a denominator exclusion, but it was just used to -- What is the word? -- heparinize a line, an I.V. line, then that would not count for the exclusion.

So when you say "prescribed," I think there needs to be some clarification on that, and the heparin injection versus I.V. So those are two different routes. So you've got a Heparin injection, which is a shot, and then they're not technically prescribed that on discharge. That is being used during the treatment phase of their hospital stay, not for them to be treated outside

of the four walls of the hospital where they have been prescribed a medication. Does that make sense?

Yes. The exclusion actually is -- It would be any Heparin use during the measurement period at all. So it would include the inpatient stay.

There's going to be a lot of patients that will be excluded from the measure in my sample because they were using Heparin injection shots in the hospital stay, and they were then discharged on a completely different medication for the purpose of IVD.

Sure. This is Sherry from the ACO PAC Team. This may be an issue we'll discuss internally with CMS, but we may wish to go back to the measure on the Web. So we'll take this back to our team and discuss it and certainly get back with everyone if there's a change.

That'd be great. And just so you guys are aware from a CMS perspective that, at least from my perspective, that we have everything built out within our electronic record based off of the CMS specifications, so if this change is going to be something that they are going to say, "No, a hospital Heparin injection, a shot, is not going to be considered allowed," then that needs to be relayed to us sooner than later because then we have to do some massive changes within our electronic record to then submit the correct data.

Diana, this is Deb from the Measures Team. I would ask if you go ahead and open up a Service Now Inquiry, because I think -- I completely understand what you're referring to, and if my understanding of that measure is correct, the use of those denominator exclusions is intended to be for those patients that are prescribed [Indistinct]

You're breaking up.

Okay. If you could just open up a Service Now Inquiry, I think that will help [Indistinct] the requirement.

I already did that, and I have not heard anything, and it's probably been about three weeks.

Could you give me the Inquiry Number, please?

I will have to pull it up into my e-mail, so if there's another way for me to communicate the number with you, I will gladly do that.

If you put it into -- Yeah, if you put it in the Q&A, I will look that up and start doing the research on that, as well, and we will use that to further our research for you.

Thank you so much. Appreciate it.

You bet.

This is Rabia. Just to add for the last individual who was asking about the Heparin issue. If you do have a ticket number, and you're an ACO, from an ACO, you can send your ticket number to your Regional Coordinator, and they can escalate that to us so we can help identify your question.

All right. Back to some of the chat questions. "Are there issues with DM Measure? We are entering information into the Web Interface, and beneficiaries are showing Incomplete."

Hi. So for a beneficiary to be marked Complete, if you're doing it by the Excel upload, please make sure you're also filling out the Patient Confirmation section of the Excel template. So it asks some questions about is the patient qualified, and you have to answer those questions for any of your measure answers to be counted as complete.

All right. This next question pertains to HTN-2. "If a patient is receiving palliative chemotherapy, would that be a reason to say 'Not Qualified for Sample, Patient Entered Hospice Care'?"

Yes. Palliative chemotherapy and palliative care would be viewed the same.

All right. Thank you. Next question, "Is anyone else having issues entering data for HTN? The values disappear once entered into the Web Interface."

Okay, if you could please report that, we'll investigate that issue. If you don't have a Help Desk ticket, please create one. If you do, we'll be answering those as soon as we can.

All right. Thank you. Next question, "Is Warfarin use a denominator exclusion for IVD-2, too?"

Hi. This is Angie Stevenson again with PIMMS, and, yes. Warfarin is a denominator exclusion. They do list some examples of anticoagulants on Page 6 under the Denominator Exclusion Medications, and you can also look in the Coding Document for denominator exclusion codes for medications, as well.

All right. Thank you. Next question, "How do we report data on patients whose physician expired and we are unable to take custody of the patient's records?"

This is Olivia from ACO PAC. I can take that one. If you are truly not able to look at and access the patient's medical record, then and only then would it be appropriate to select "Medical Record Not Found" for that beneficiary in the Web Interface.

All right. Thank you. And, Stephanie, I think we can take one question from the phone.

Our next question comes from Samantha Brumsickle.

Hi. I'm just wondering if there is any kind of document that can provide information for coding for the Statin Measure?

This is Deb Kaldenberg from the Measures Team. The coding documents for all of the measures are included on the CMS Resources Page. The Statin Measure PREV-13 Coding would be included in the PREV Excel Coding Document.

Okay, great. And for the BMI Measure, if a patient is wheelchair-bound or it's unsafe for them to get on a scale in our practices, can we exclude them from taking their BMI, or the exclusions are only for the follow-up portion?

The exclusions are only for the follow-up portion. That's been confirmed with the Measure Developer.

Okay, thank you.

You're welcome.

All right. Next question, "Were the beneficiaries in OCM excluded in Shared Savings Program, and will the ranking list be re-sent due to this error?"

This is Olivia Berzin. We definitely would like to look into that one, so if you could submit a question to the Quality Payment Program Service Center, that would be wonderful.

All right. Next question, "Is pulmonary HTN a qualifying diagnosis for HTN-2 Measure?"

This is Deb from the Measures Team. The hypertension diagnosis is defined within the coding document for the HTN-2 Measure. I would look at the diagnosis codes that are included to determine whether or not the diagnosis you're finding meets the parameters for that particular measure. If you have additional questions after reviewing that document, please feel free to open up a Service Now Help Desk Inquiry, and we should be able to help you through that.

Thank you. Next question. This person says, "I have Web Submitter Interface Role for a few ACOs, and I do not see Web Interface Screen when I log in to QPP. I have contacted QPP several times and have not been able to resolve this. What option do I have?"

Hi. This is Rabia. So, yes, we do have a few tickets related to that that we are investigating about why, if you have the correct role, you can't log in. We have noticed that there are issues with the user names in relation to you having symbols within your user name that is affecting some access for some users, so if you are working with an ACO, and you have a ticket number, could you work with your ACO to make sure that they can communicate to their coordinator the ticket number that you have? That way we can escalate it and try to resolve it as fast as we can.

All right. Thank you. For this next question, this person says, "We have a few patients that have only been in our clinic one time, which was urgent care. We've tried to get them in for other visits, but they refuse. How do we report on these when we have no data?"

Hi. This is Sarah Grallert. I can answer a piece of that question, I believe. So, in order to be sampled into any measure, a beneficiary needs to be seen two times during the measurement year to be eligible, and then, depending on the measure, another time during the measurement year, and the place of service, in and of itself, is not necessarily going to exclude the beneficiary from the sample, so what we're looking for is primary care services that are provided. [Indistinct] Yeah.

Thank you. And, Stephanie, I think we can take one question from the phone.

Certainly. The next question is from William Martin.

Hello. I had a question concerning the Place of Service Code Exclusion. It was noted earlier that a Place of Service Code of 32, 33, 34, 54, or 56 would garner some exclusions. I was wondering if that was on the patient confirmation side, so you would label it as Not Qualified for Sample for any measure, or if that was just on specific measures such as a PREV-6?

So that would be specific to the measures where that's identified, and I believe that's PREV-5, PREV-6, and Hypertension 2. This is Deb from the Measures Team.

Okay, thank you. I also had another quick question concerning the IVD-2 Measure. Is it possible to get an exclusion for a patient who is allergic to aspirin?

So, basically, if you find that you don't have documentation of the denominator exclusion, and the patient's not... [Indistinct] all you're signing is documentation that the patient is not receiving the medication due to an allergy to aspirin. One option you do have is to open up a CMS Help Desk ticket requesting a CMS-approved reason to skip. Those requests need to include the patient rank, the measure in question, and the reason for the request, and they always ask please do not include any PHI or PII. Then those requests are reviewed by [Indistinct] We'll say not, but I've seen it become an issue, but in previous years, just simply having an allergy to aspirin has not always been approved by CMS because there are so many other medications that can be prescribed, but having said that, [Indistinct] and maybe what other information you find in the medical records [Indistinct]

Deb, you're breaking up. Can you please repeat?

Long story short, that is -- Yes?

You're breaking up. Do you mind repeating your last statement?

I'm not sure what the last statement was, but, basically, if you make this request to CMS, it may not be approved, but it is your one option if you feel like there is a reason the patient was not prescribed an applicable medication for the numerator or a denominator exclusion medication.

Okay. Thank you very much.

Thank you.

All right. Our next question is, "What are the diagnoses acceptable for the denominator IVD-2 Measure?"

Hi. This is Angie with PIMMS Measures Group. You can refer to the IVD Coding Document under Denominator Codes for Acceptable Diagnoses, and I wanted to mention these codes are considered all-inclusive for eCQM mapping. The measure specifications are -- I wanted to remind you they are available in the CMS Resource Library. You can access that link on the QPP site under Resource Library.

Our next question is, "Please confirm that we should send other CMS-approved reasons to this e-mail, qpp@cms.hhs.gov."

Hi. This is Kayte Moore from the PIMMS --

Go ahead, Kayte.

...from the PIMMS Measures Team. Yeah, you can go ahead and send those to the QPP Service Center, and if you can, please include the patient rank and measure along with your justification as to why you are submitting that request, and then we'll get those processed.

Our next question is, "For HTN-2, are patient-reported home readings accepted for the most recent BP reading?"

And this is Deb from the PIMMS Measures Team. No. If you look at the measure specification, it actually calls out the fact that home readings are not acceptable for this measure. Thank you.

Our next question is, "Where are the coding documents located?"

Hi. This is Jessica from the PIMMS Measures Team, and I can provide steps to accessing those documents. So if you're on the QPP website, which is https://qpp.cms.gov, go to the upper -- There's like a toolbar sort of, and there's a drop-down with the word "About," and when you drop down, there's a link to the Resource Library, and there's information about the Resource Library that says, "To make it easier for your search and find what you're looking for year by year, go to the Resource Library at cms.gov." So there's a redirect. You go to that redirect. You click on that redirect to resourcelibrary@cms.gov, and you'll get to a landing page that asks if you want to go to the 2017 or 2018 resources, and I recommend that you select that first link. It's in large font. It says, "Find 2017 resources by provider type or topic," and when you click that, you come to the 2017 Resource Library, and it's a large website that's filled with all the supporting documents for QPP. So it's not just CMS Web Interface documents. You'll find documents for other reporting mechanisms, as well, but if you scroll down, under the section titled MIPS Group Participation -- I'm sorry. I'm lying to you. No, no. If you scroll down to MIPS, and the subcategory is "Quality," there's a long list of claims registry measures, and below that, there's a link that reads, "Web Interface Measures and Supporting Documents," and it was posted on December 20th of 2017. When you click that link, you'll get a pop-up, and it's asking if you want to allow a file to be opened. Click "Open," and that will lead you to the zipped file that contains all of the 2017 Web Interface Measures, and then the supporting documents are the spreadsheets that are included in that zipped file, and the spreadsheets are the coding documents, and there will also be release note and other supporting documents, as well. Thank you.

Our next question is, "When uploading the deceased patients, we enter the 'Not Qualified for Sample,' but what shows up on the main form is, 'No medical record. Not found.' Is this something to be concerned about?"

Could you repeat the question?

Sure. So the question is, "When uploading the deceased patients, we enter the 'Not Qualified for Sample,' but what shows up on the main form is, 'No medical record. Not found.' Is this something to be concerned about?"

We'll look into that. Thank you for reporting it.

Yeah, and could you directly send that to the QPP Service Center and open a ticket? And if you have any frame shots or anything, that would be really helpful.

Okay. And we'll take one more question for today's session. And our last question is, "What is the purpose of the QPP Service Center Ticket Number and how do we obtain the number?"

This is Deb from the PIMMS Team.

Hi. This is Kayte --

Go ahead, Kayte.

Okay. [Laughs] So those Service Center case numbers are going to be your validation for your approved CMS skip reason. So if you send in a request, and your request is approved, you'll want to say that and enter it in when entering your skip request.

All right. Great. Thank you so much. I believe that concludes the Q&A portion, and I'll turn it back over to Lisa Marie to close the call.

I just want to thank everyone for joining today and asking really great questions. I know we weren't able to get to every single question, particularly all the ones that were sent via the chat, but if you do have other questions that you do want us to address, please submit them to the Service Center, and we will be able to address those questions. Again, thank you all for joining, and we hope you enjoy the rest of your day and have a good week.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.