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 g-Group Practice and ACO Web Interface Question and Answer Session Support Call series. Today's call will feature brief reminders about the Web Interface reporting requirements and helpful reports that can assist during submission. This call will be recorded and made available on the PQRS Web Interface websi- webpage and ACO Portal. Questions will be accepted through the Q&A feature on right-si- hand of- side hand of your screen as time permits.

At this time, I would like to turn the call over to Rabia Khan of the Division of Shared Saving Program at CMS. Rabia, over to you.
Rabia Khan: Thank you. As Ashley stated I am Rabia Khan from the CMS Division of Shared Saving 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. During the support call our subject matter experts will go over important reminders about key dates, reporting requirements, helpful information on reports, and submission and frequently asked measure questions.

Following our presentation, we will host a Q&A session where our experts on the call will answer your questions. Please note: Some questions may be specific to your organization therefore we may suggest you contact the QualityNet Help Desk for further assistance.

Today's slides will be available on the GPRO Web Interface webpage. Due to some enhancements to the Shared Savings program ACO portal, today's slides are available under the program announcement titled 2017 Web Interface Q&A Support Call Slides and Recordings instead of the Events calendar. In addition, the slides are available on the Next Generation and Pioneer connects sites.
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-and to the next one: **Slide 3**

Thanks.

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

The Web Interface measure specifications and supporting documents are located on the GPRO Web Interface webpage of the CMS website. We strongly recommend you use those measure specifications and supporting documents as a resource when you're reporting your quality data.

Next slide please: **Slide 4**

As you know, the GPRO web interface is open for data entry and submission. Users access the web interface through the PQRS portal. The web interface closes March 17 right at 8:00 PM Eastern Time, so we strongly encourage that your organization not wait until the last day and to submit data well before that 8:00 PM Eastern Time deadline to ensure that everything has been fully submitted before the web interface closes.

Next slide please: **Slide 5**

To provide helpful information and answer your questions we have weekly web interface, *[repeats]* web interface data submission support calls so please mark your calendars with the dates and times for each of these calls. In addition, we will be hosting a web interface lessons learned session shortly after the web interface closes, where we'll go over your feedback on the 2016 web interface reporting. More information will be provided to you on the Lessons Learned Webinar as we get closer to the close of the web interface.

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K.
There will be some scheduled outages and maintenance weekends for the PQRS portal, which means the web interface will not be accessible during these dates and times. So again, please mark your calendars with this information. The web interface will not be accessible:

- Every Tuesday starting at 8:00PM Eastern through Wednesday at 6:00AM Eastern Time
- Every Thursday starting at 8:00PM Eastern Time through Friday at 6:00AM
- And every third weekend of each month starting at Friday at 8:00PM Eastern Time through Monday at 6:00AM.

The remaining maintenance weekend during the submission period is actually February 24th through the 27th. Although this is the fourth week of the month we had to move that from the third week to the fourth because of a federal holiday.

Next Slide Please: **Slide 7**

As a reminder to meet the 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 your organization has fewer than 248 beneficiaries available in the sample.

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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.

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

For PQR- *[repeats]* for PQRS group practices you are required to use EHR technology 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 specified by the ACO. The ACO must then satisfactorily report the Web Interface measures.

Please note, EPs must still individually attest separately to the EHR Incentive Program for all other program requirements. When you do go to the at, when your EPs do go to the attestation system and reach the screens for reporting CQMs, eligible professionals should select option 1 if they're reporting through an eReporting option. Eligible professionals can also choose to submit their CQM data instead of selecting the eReporting option.

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

Next Slide Please: **Slide 9**

And now I'll turn it over to Sue Hanlon to go over helpful information about Web Interface data submission.

Sue Hanlon: Thanks Rabia. Um, today we're going to review Web Interface Report - oh, jumped ahead of me. Okay.

Slide 10

Um, the Web Interface has eight reports to help ensure that you enter your data completely and correctly. They're listed here we have a:

- Patient Summary Report
- a Check Entries Report
- a Totals Report
- Measure Rates Report
- Pre-field– Pre-filled Elements Report
- Um, an Activity Log
- a Submit Status Report, and a Comments Report. Um, we're going to focus on the Totals reports and the Measure Rates reports today.

Next Slide Please: **Slide 11**

Okay the Totals Report contains completeness information by measure. Um, the summary section, so there's two sections of the report, a Summary and a Detail. The Summary section contains completeness information in a number of categories, and on our next slide we're going to show you an example of the report, um, but the Summary section has completeness counts really by um, a number of categories; and then the Detail section is a drill-down to patient, the specific patients for each, um, completeness category, so if you pick the category and you drill-down and you can see the patients that apply to that category.

Um Next Slide: **Slide 12**

Okay. Here is an example of the patients report. This is just one measure, and th- you can see the same data for every measure um, in your practice, and um, in the upper left-hand corner you can see the measure, it says CARE-2. And each row is a category of completeness information and as an example, right underneath report title you'll see something that says All Ranked Patients and you'll see the total number of patients that, um, that criteria, and then there is the detail. If you click on that detail, it will show you all the patients. So th- that would be the detail level of the report.

Um, and I think that covers it

So, next slide please: **Slide 13**

We also have a repor, - a report called the Measure Rates Report and this has performance information. So the Total Report gives you all the completeness information and then from there you might want to see your performance information. Um, this too has a summary level and a detail level. The summary level contains a list of the number of patients in um, what I call components of the performance equation, and once we get to the report example you'll see what those things are. Um, it also contains the measure rate. ***[cough in background]*** The detail level contains the specific patients, um, that make up that, that particular component.

Next page please or next slide: **Slide 14**

Okay, this is an example of the Summary level, and you can see that there is a row for each measure. And th- various um, performance components that we have are, the:

- Total Eligible,
- the Denominator Exceptions
- the Denominator
- um, the Number of Patients where the measure is not met
- the meas- the um the Number of Patients where the Measure is Met
- and there's the column for um Measure Rate
- and then there is some completeness information.

So if you're not complete, you're really not seeing the accurate um performance data. If you're complete then you have a pretty good idea of what your performance is.

And once again, you can get to the detail level by clicking on one of those cells.

Next Slide Please: **Slide 15**

Okay very briefly I'm just going to review the other reports that are available:

- There's a Check Entries report, and that will show you all your errors in the data that you have at the time you, you know you run the report.
- Um, we have a Submission Status. You can see the status of your submission. Uh there's a Patient Summary Report, and that's a report that allows you to see all of your patient data um, as it exists in the database when you, when you, you generate the report.
- Pre-filled Elements is a display of the original data value and the current data value for pre-filled elements.
- And we have a Comments Report and that provides all the user comments for all patients in the selected measures.

- And then finally there is an Activity Log, and that shows an audit trail of all the user activities um performed for the that organization or your organization during the submission period.

And that concludes our review of the Web Interface reports.

Slide 16

Deb Kaldenberg: Good afternoon. This is Deborah Kaldenberg, and I'll be going over a couple of frequently asked measures questions.

Next slide please: **Slide 17**

And we have two questions for today. The first question is: For one of our patients we have visit dates elected by CMS ***[clears throat]*** but these visits were only for lab work, the patient did not see a doctor. Should we be using option, "Patient seen on this date," Yes or No – visit outside the practice? And this question is specific to the CARE-3 measure.

In this case you're going to look for a visit within one to two days of the lab visit, as a visit was found in claims to pre-populate the Web Interface. "No – visit outside of practice" should only be selected if the patient was not seen at the office or clinic visit on that date, plus or minus two days.

The Evaluation Codes tab of the CARE Supporting document includes the visits used to attribute patients to the CARE-3 measure. The supporting documents can be found on the CMS website and we've included the link.

From the posted Q&A there's also the following guidance:
The CARE-3 measure is not intended to be limited to providers listed in the three PCP locations in the Web Interface, so you should abstract these patients, seen by other providers. Keep in mind all pre-populated visits were taken from claims billed by one of your group's participating TINs or at your group practice.

The second question is: For the measure PREV-9, BMI Screening and follow-up plan, if a patient has a chronic condition such as diabetes or hypertension, along with an abnormal BMI, and the provider counsels them to watch their diet or exercise, would this satisfy the measure?

And the answer to this question is: If an abnormal BMI was calculated during an encounter when a patient's diagnosis was being addressed - for example, diabetes - and the documented recommended follow up plan addresses both conditions, this would be acceptable. And we've provided the link to the data guidance in this case as well.

Next slide please: **Slide 18**

And I'll hand it over to Michael. Thank you.

Michael Kerachsky: Great, thank you Deb and good afternoon to all the attendees. I will briefly touch on the available educational and help desk resources, uh, prior to moving to the question and answer today's presentation.

Next slide: **Slide 19**

Okay, slide 19 contains a list of educational resources. Uh, website and portal links are specific to PQRS Group Practices as well as each of the ACO models.

Included on the Web Interface page are:

- Links to past support call presentations, specific uh specification and supporting documentation, as well as question and answer document. I'd like to add that uh today's uh presentation has already been posted to the Web Interface website. As well as last week's transcription, so that's January 26th.

We strongly encourage organizations to review the step-by-step instructions provided in the educational demonstration, of which there are three. There's the:

- Web Interface Overview
- Web Interface Measures
- as well as EIDM for Web Interface.

Included in these educational demonstrations 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 20**

Okay, slide 20 provides a list of available help desk contacts for the PQR- PQRS group practice and ACO models. Of note, for any PQRS EIDM Web Interface questions, please contact the QualityNet Help Desk.

Next Slide Please: **Slide 21**

And again for your reference, slide 21 includes a list of frequently used acronyms, and this list will be included in each of the support call presentations.

Next slide please: **Slide 22**

Ok, at this time we will begin the question and answer portion of today's support call.

A couple of quick requests for attendees, if you could please submit your questions in writing via the Q&A box located at the top of the webinar screen that would be appreciated. You may need to click the Q&A tab at the top of your screen to access this feature. When submitting questions if you could, please identify if you are a PQRS group practice, Shared Savings Program ACO, Pioneer ACO, or Next Generation ACO.

Um, if your question concerns measures, it would be helpful if you could identify the measure number. User specific questions must be sent to the QualityNet Help Desk.

And, on today's support call we will not be responding to any MIPS or policy questions.

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

Question and Answers:

Question Moderator: Michael Kerachsky

Question: Ok, first question: If I had no record of whether a patient got a flu shot, but called them and they tell me they didn't get it because they didn't want one, and I documented that in their record today, does that meet the intent of the measure? Can I then select no denominator?

Presenter: So in this case I guess I would say, if there was um, if this phone call was made in 2017, you're making it now, then the answer to that would be no. The only way a phone call would be acceptable is if you called during the measurement year, 2016, and documented within the medical record that the patient had refused a flu shot ***[clears throat]*** for the flu season being measured. So, for the flu season where the previous receipt can be August 1st of 2015 all the way through March 31st of 2016. In that case that documentation would be acceptable, but again if you're making those phone calls now and documenting um, patient refusal in the medical record this would not, um, meet the - the denominator exception patient reason, you should select "no," that the patient did not receive the flu shot.

Michael Kerachsky: Okay the next question relates to measure CARE-3; CARE-3 date consisted of an order placement for an MRI. Why was this date selected if there was no real visit and just an order placed? Should we mark "No – Outside of Practice" or is this a "No – No Medications were documented" visit?

Presenter: Hi, um can you go back to slide 17?

Many of the claims or many of the um, visits were actually from your ACO and/or your group. Um, you should look for another visit, an- an inpatient visit, or, I'm sorry not an inpatient visit but for a visit at your um group, within one to two days um, of the lab or of the MRI visit so that um, ***[aside]*** oh I totally went blank, so you can um determine if the med- reconciliation had occurred within one of those visits, that you can find hopefully within those one to two days.

Deb Kaldenberg: Right. I mean it certainly is possible that you have an MRI visit that's been um, during that period of time but what we're trying to say is that if you were to look at the code sets provided in the CARE document, one of those appropriate visits was pulled at your group or ACO um, so you should look for potentially other visits within one to two days of, of that visit. If you can't find it then yes, you should select "No - Visit Outside Practice" something certainly could've occurred um, and the visit was outside of your practice but just make sure you're looking um around that visit date for an appropriate encounter.

Michael Kerachsky: Okay, next question: for PREV-6 we have patients who have hemocculs times 3 CPT 82270. This is not a listed CPT under the narrative specifications for this measure. Only FIT and Cologuard are listed here; is this acceptable or does this count for a CMS ticket number?

Deb Kaldenberg: So, you would not want to request a CMS approved reason to skip this patient. Um, from a couple of support calls ago we did provide the following information; you can also find this in the posted Q&A document on the CMS website, um, based on the updated USP STF guidelines: um, NCQA - the measure developer of the PREV-6 Colorectal Cancer Screen measure – is accepting CT Colonography and the FIT DNA testing. However, the coding has not been added to the measure specifications at this point in time, so you would just want to make sure you had medical record documentation to show that one of those two types of testing was performed. And, if you want the specifics or written documentation of those um, tests again, that information can be found in the posted Q&A document on the CMS website.

Michael Kerachsky: Thank you. Um, for PREV-9, the patient was evaluated by the RN for the annual Medicare Wellness Exam. As part of the exam, the RN documents detailed diet modifications, plans, and discusses healthy eating options. Does this meet the measure intent since it is an RN?

Presenter: Yes as long as the BMI was calculated, um, documented as abnormal at that encounter and a recommended follow-up has also been documented, this would meet the intent of the measure.

[pause]

Michael Kerachsky: Ok next question: A DM measure, if the documentation says the patient had a retinal scan done, but I cannot find the actual results, does that qualify as a yes to the retinal scan question?

Presenter: No it would not. According to the data guidance, um within DM-7, patient reported requirements are the date, which is the year, and then the results and findings. So, you would need to have those results in order to report yes.

Michael Kerachsky: Okay, next question: PREV-11, in order for a BP to be classified as normal, must it be less than 120, must it be less than 120 and less than 80? For example, I have a patient whose blood pressure was 120/70.

Presenter: So, a blood pressure of 120/70 would be classified as a pre-hypertensive blood pressure reading.

Michael Kerachsky: Okay: For PREV-9, similar to a previous question; our after-visit summary auto-populates diet instructions, and/or links to diet plans based on the current BMI. Will this meet the intent of the follow-up plan?

Deb Kaldenberg: So, this is Deb from the PQMM team. We would appreciate it if you would go ahead and open up a QualityNet Help Desk ticket so we have some time to kind of dig into that a little bit. Um, my concern is an auto-populated diet instruction um would be, is the patient then receiving that and taking it home, in which case certainly this would be acceptable as long as you have that documentation that it was provided. Um, but t-to really give you an appropriate answer it may be best if you open up a ticket.

[pause]

Michael Kerachsky: Okay. Um, next question: What percentage of organizations submit their entire population? Is there any drawback to doing this?

Rabia Khan: Sorry Mike, can you repeat that one again?

Michael Kerachsky: Yea, certainly. Um, what percentage of organizations submit their entire population? Is there any drawback to doing this?

Rabia Khan: So this is Rabia. Um, so I can't share how many organizations on average um, complete the entire population because it will vary by um, their sample, um and depending on if they have the complete 248 or uh they reported on all that they had available. But, um just to share some organizations may choose to report more than the minim- minimum number of

beneficiaries, so if you enter the beneficiaries consecutively, the first 248 consecutively confirmed and completed patients will be used in the completeness determination. But all consecutively confirmed and completed beneficiaries reported on, will be used in measure rate calculations. So for example, if you complete 310 consecutively confirmed beneficiaries, then all 310 would be used in the measure rate cal-calculations.

So um, I hope that helps sort of address the question in terms of reporting, you must though - in terms of meeting our satisfactory reporting requirements – report on 248 consecutively confirmed beni's or uh, 100 percent of your sample if you have fewer than 248 available.

Michael Kerachsky: Okay. PREV-13: how should we address this measure when the triglyceride measure is too high to measure the LDL?

Deb Kaldenberg: So with the PREV-13 measure, you definitely want to and need to start with risk category one where you are selecting "yes or no" to the diagnosis of ASCVD. If you have said "no" to ASCVD and you're into risk category two and the patient - you can't find that the patient has ever had a fasting or direct LDLC of greater than or equal to 190 um, so you're looking back into the patient history and if all you can find is um, high triglyceride, there's no results; in that case you would select no here as well. Move into risk category three, and if you didn't have an LDLC that you could report in risk category two, that's obviously going to be the same in risk category three, so when you get to that point you would select "No- Select this option if the patient does not have an LDLC 70-189," you would stop abstraction for that measure for that patient they would be replaced with the next patient. They would be skipped. Um, there's no way to provide - if you can't find the LDLC value, um there's no way to report the LDLC within the measure.

Michael Kerachsky: Okay. Um, next question: If we c- if we can find record of pneumonia vaccination, in the statewide registry, does that qualify as meeting the measure - ACO 15 - or does that record need to be transferred into an EMR to qualify?

Deb Kaldenberg: So this is the PREV-8 measure and as long as you have access to that information, that would meet the intent of the measure. It doesn't have to be transferred, but you would have to provide that information in the event that you were selected for an audit.

Michael Kerachsky: Okay, next question: Regarding MH-1 Depression Remission at 12 months, does a PHQ-9 form have to be physically present in the chart to be included? Or, is documentation of only a score acceptable to be included in the denominator?

Deb Kaldenberg: Documentation of the score would be sufficient. ***[pauses]*** And – and to add to that, certainly you would want to show that the date of that PHQ-9 score um, for the denominator eligibility was during the index period and for the um, remission component that it's during the appropriate timeframe.

Michael Kerachsky: Okay. For the PREV-5 measure requirements um, a pa- sorry, the PREV-5 measure requires a patient to be in the age range and have an office visit. If an EMR shows the correct age and a mam- and a mammography report but no office visit, is this patient still eligible for the measure?

Deb Kaldenberg: Yes, if you can show that the patient is eligible based on age, and they had a mammography done during the appropriate time period and you have that documented, um, that would be sufficient. Just know that the documentation and the reco- medical record must

include both of the following: a note indicating the date the breast cancer screening was performed and the results or findings. Documentation of “normal” or “abnormal” is acceptable. Um, for “Patient Reported” you would want the date and type of test, as well as the results or findings.

Michael Kerachsky: Okay, I have a Web Interface question: If when loading an XML an individual data element of an individual patient has a ‘null’ value, will this overwrite manually entered data?

Sue Hanlon: Ah, this is Sue Hanlon from DECC. No it will not.

Michael Kerachsky: Okay, next question: For PREV-6, can diagnostic surveillance screenings be counted for diagnoses other than cancer?

Deb Kaldenberg: So, where you would want to look for what would count for the PREV-6 Colorectal Cancer Screening measure is within the 2016 PREV Supporting document, which is located on the CMS website. Um, noted in there is the FOBT, the flexible sig, and the colonoscopy, it gives timing components of those testings that can be- screenings that can be considered compliant. As well in the posted um, Q&A document - which we went over earlier - that you can do now a CT or a FIT DNA testing to meet, um the measure intent. And again the Q&A document includes the lookback period for those two added screenings.

Michael Kerachsky: Okay. For CARE-2, if the encounter reason is to examine the patient for injury due to “the patient fell from a bicycle” does that count as “history of a fall”?

Presenter: Yes, it would as long as it occurred within the measurement period, so the report in the documentation is present.

Michael Kerachsky: Okay, next question: At most recent visit it was identified that a patient was a smoker. Cessation was not provided at that visit but it was within the past 24 months. Can this be used or does it have to be on the most recent visit?

Deb Kaldenberg: So for the PREV-10 measure, the um identification of whether or not somebody is a tobacco user, and the cessation intervention, can occur within the 24 months, so the measurement period or the year prior. They do not have to occur on the same visit. If, however, there is more than one screening for tobacco use, you do need to use the most recent screen for tobacco use. Um, but again the cessation intervention can happen during the measurement period or the year prior.

Michael Kerachsky: Okay, we have a Web Interface question: So, for portal issue after ensuring that the browser setting is set per user guide for GPRO, many abstractors experienced portal freezing and inability to save changes to some patient records. Please advise how to resolve these portal issues.

Sue Hanlon: This is Sue Hanlon again. Please open a help desk ticket number for those types of issues.

Michael Kerachsky: K, Next question: For PREV-8 measure, if a claim tells the type of vaccine administered and the patient’s medical record doesn’t include this information due to a patient getting vaccine at pharmacy, will this satisfy the measure?

Deb Kaldenberg: It appears that what you're asking - and again this might be one you want to get um confirmation by opening up a QualityNet Help Desk ticket – it sounds like you have documentation that the patient did receive the vaccine but within that documentation you don't have the vaccine type, but you do have the vaccine type within a claim. Um, this appears to be something that would meet the intent of the measure but again because of the different components um, it may be best to open up a QualityNet Help Desk ticket. We certainly don't take the claims level data on its own, but again, you have medical record documentation that the patient received the vaccine at the pharmacy, so this would probably be sufficient.

Sherry Grund: Um, this is Sherry from the ACO PAC program, and we would take that um, if this is an ACO and you would be audited on that particular patient's record.

Deb Kaldenberg: Thanks Sherry.

Michael Kerachsky: Okay next question: For CARE-3, if the chart for the patient visit includes the medication name and administered route but not the dosage and frequency, does it still meet the requirement for patient medication to have been updated, documen- documented and reviewed?

Presenter: Yes, um, if you are missing components documentation that shows the information available with the best of the EPs ability, at that date, on that encounter, that would suffice.

Michael Kerachsky: Okay, if a practice uses an EMR that does not allow faxes to be scanned into the EMR, but keeps records of services like, eye exam, colerector – colorectal cancer screening, breast cancer screening in paper files in the practice, can these paper files be used to report?

Deb Kaldenberg: As long as your files are part of your rec- medical record documentation, and they support what you're reporting within the measures that you are referring to, this would be acceptable.

Michael Kerachsky: Okay, for the screening for depression PREV-12, in order to qualify for this measure, does the patient have to be screened on every encounter or just once in the measurement period?

Deb Kaldenberg: The patient would only need to be screened once during the measurement period. If however, they have been screened more than once, you would want to use the most recent,

[pause] [muffled voices]

Michael Kerachsky: For PREV-5, can diagnostic screenings be counted?

Deb Kaldenberg: So um, we would recommend that you go ahead and look at the information from the PREV-5 um, data guidance. 3-D mammography, MRI, and ultrasound are not considered breast cancer screening for the measure. Um, screening does include: breast x-ray, diagnostic mammography, mammogram screening mammography; the other place that would um, possibly assist you is looking within the code set of that particular measure, and that code set can be found in that supporting document as well, within the Evaluation Codes tab.

Michael Kerachsky: Okay next question: Uh,for- CAD measure still seems to have an issue with a lot of patients not being confirmed. I doubt if we would be able to submit 248 consecutive patients due to this issue. How can you resolve this?

Rabia Khan: Right, um so this is Rabia. Um, so some organizations have reported that they're skipping a higher than expected number of beneficiaries in CAD s- in the CAD-7 sample, due to not being able to confirm the diagnosis. Um, we did investigate this issue and determined that due to recent upgrades to our programming processes that it had affected the sampling criteria for this measure. So this may result in more cases in which a CAD diagnosis cannot be confirmed. However, we do provide an oversample of 616 beneficiaries for reporting. As with all measures, organizations are required to consecutively confirm and complete 248 beneficiaries, or as many as possible until the sample is exhausted. So um, just as I said so, specifically for your question I read this response in case others had questions about their CAD sample, but yes, as long as you exhaust your oversample and can report on as many beneficiaries as you can completely and accurately, um that will meet the requirements.

Michael Kerachsky: Okay, next question: For PREV-9 if a patient's height was taken in 2015, with weight in 2016, would this be acceptable to use ***[background clinking]*** even if height was taken in 2015, with none in 2016?

Deb Kaldenberg: So this would be acceptable in a very specific scenario. Um, you're determining if the patient had a BMI documented during the most recent visit or in the last 6 months prior to the most recent visit. So if you're most recent visit, looking back 6 months, goes into 2015, and that 2015 height and the 2016 weight are within that 6-month timeframe, then you can use those even though the height is from 2015. What you have to make sure of is first of all, those the height and weight are within the same 6-month period, and that you have determined that the BMI documented, is documented during the most recent visit or in the last 6 months prior to the most recent visit.

Michael Kerachsky: If a patient had a PT visit listed for CARE-3 measure, and the PT note has the medications from the hospital listed, but does not specifically state "reconciled" can we count this as met?

Presenter: If the medications are not reconciled, um that would be a no. But if the physician or if someone has reviewed those medications um, on that visit then that would actually count.

Michael Kerachsky: Okay next question uh: For CAD, does current listed documentation of ACE/ARB therapy qualify if it is only documented in an outside visit note and not in a – and not an office visit, by the primary care physician?

Presenter: If you can find that information, or I guess, show that information um, as being current, um and can actually get that information if needed um let's say for an audit then you can use that. The patient has taken an ACE and an ARB, um,to comply with the measure.

Michael Kerachsky: Okay next question: If a patient was seen in the clinic, on February 24, 2016 for CARE-3 measure and the medications were noted, however, the note was not finalized with reconciliation noted until the note was closed the next day on February 25th, can we mark the measure as met?

Presenter: Yes, the documentation would have occurred within one to two days of that visit, so you would select "yes."

Michael Kerachsky: Okay. For MH-1, does the depression diagnosis have to be active through the end of the denominator identification period, or active at any time during the denominator identification period?

Deb Kaldenberg: Can you repeat that please?

Michael Kerachsky: Absolutely. For MH-1, does the depression diagnosis have to be active through the end of the denominator identification period, or active at any time during the denomina- during the denominator identification period?

Deb Kaldenberg: If, if you don't min- I mean and I'm sorry I'm hesitating because I, typically the term "active diagnosis," defined as on the patient's problem list, diagnosis code listed at the encounter, diagnosed in, documented in the progress notes, all of those things obviously you've had during the identification period. If, though, that diagnosis of major depression or dysthymia, was resolved prior to the end of the identification period, I think th- this would be sufficient as well. Um, however, if- if you don't mind um, opening a QualityNet Help Desk ticket we will research that and we will also add that um to next week's slide deck so others that have heard me stumbling around will have a- a response as well.

Michael Kerachsky: Okay, next question: For PREV-13, is the diabetes diagnosis criteria for the risk category three denominator, active or history of, similar to the ASCVD diagnosis for risk category one?

Deb Kaldenberg: Yes, we have received clarification from the measure developer that the diagnosis of type 1 or type 2 diabetes is history of as well as active; so prior to or during the measurement period.

Michael Kerachsky: Next question: For PREV-12, regarding the screening tool, if the PHQ-2 questions are asked but the tool is not identified as a PHQ-2, would this satisfy the measure?

Deb Kaldenberg: So I'm going to ask, Sherry, I believe that you guys have an answer to this one and I – and I don't want to answer it incorrectly. I believe you would expect that if you can identify those two PHQ-2 questions as a PHQ-2 screen without the name of the screen tool documented, which is the requirement of- of the measure. Is that correct?

Sherry Grund: Yes, those are very um easily identifiable so we do accept those if they are written out um as acceptable to um match uh, what was submitted through the Web Interface. So that would be fine.

Michael Kerachsky: Okay, next uh question: For the mental health measure, if the patient had a PHQ-9 index score of 18 in 2015, in 2016 a PHQ-2 was done and did not signify the need for a PHQ-9, would this be sufficient?

Deb Kaldenberg: No, that- that would not meet the intent of this particular measure, and the rationale for that is if the patient has been identified as meeting the denominator criteria based on diagnosis, a PHQ-9 greater than nine result during the index period, the numerator compliance is to show remission at 12 months plus or minus 30 days using the PHQ-9 screening tool. So the only way to show that the PHQ- that they have achieved remission is by having a less than five result on a PHQ-9.

Michael Kerachsky: Next question: Some providers us a blood test for colorect- colorectal cancer called ColoVantage to screen for colorectal cancer. This is not fecal blood test, but a test drawn from veins. This is not acceptable in the data guidance, correct?

Deb Kaldenberg: So um, NCQA - the measure developer of PREV-6 – does, does not speak to name brand screenings. Um, so what you would want to look at again in the posted Q&A document the additional clarification based on the updated guidelines in the summer of 2016. If ColoVantage is identified as a FIT DNA test, this would be acceptable, um, but- but you would want to confirm that again as the measure developer does not make any- any kind of comment to name brand technologies.

Michael Kerachsky: Okay next question: CAD-7, can an allergy- can allergy or intolerance count towards an exception if it was documented before the measurement period? Or, does the documentation of exception only count if documented on a 2016 office note?

Presenter: Yes, that is correct, it would need to be during the 2016 um, timeframe. So during the measurement period.

Michael Kerachsky: Okay next question, concerns the Web Interface: We would like to do periodic submissions throughout the submission period but have some concerns. If you upload without hitting the 'Submit' button, does each subsequent upload overwrite what was there? Will this affect the original XML files?

Sue Hanlon: Okay, each um, successive um XML upload will overwrite what you have in the database at the time. But it's kind of independent of the um, of submitting your data. So you can load successive XML files, and that will overwrite what you had in the database, and then when you want the data to be, you know, seen by CMS is when you submit.

Michael Kerachsky: Okay, I have another CARE-3 question: Does a home health visit count towards an eligible encounter?

Presenter: I'm going to tell you to please take a look at the encounter codes that are specific to this measure. Home health codes are not involved in it, but the evaluations have, contains the coding for the visits that are specific to this measure.

[pause]

Deb Kaldenberg: Michael do you mind if, there seems to be some confusion and- and some questions on the BMI answer that was bo- both posted in the FAQ and then probably followed up, do you mind if I answer a couple of those?

Michael Kerachsky: No, no absolutely go right ahead.

Deb Kaldenberg: Okay so, we have one that says the BMI answer is still not clear. We were told that follow-up plan must refer to abnormal BMI, a follow-up recommended diet changes, in the medical record for a diabetic patient would be acceptable? Or must follow-up be due to diabetes recommended, et cetera?

So what we're trying to say with um, th- that if there are multiple conditions, so let's say you have an abnormal BMI and you have uh a, a diabetes visit, so the provider is really addressing potentially both the abnormal BMI and the diabetes. When you have something like um

“recommend diet and exercise modifications,” that recommended follow-up is- is pertinent to both of those conditions. It’s pertinent to the abnormal BMI as well as the diagnosis of diabetes. We would not expect that a provider would say um, “recommend diet and exercise modifications for diabetes, and for BMI.” Um, they would just make that recommendation, and so we would accept that because it is relevant to both of the conditions on that same encounter. Um I hope that clears it up. If not, I would recommend you open up a QualityNet Help Desk ticket and we can give you um, the answer in writing and maybe tweak it or- or answer it in a bit different way that might um, be of assistance.

Michael Kerachsky: K, next question concerns CARE-3: If a visit was for physical therapy, would this require a medication reconciliation or would you select “Outside of Practice”?

Presenter: Hello. Physical Therapy coding is located within the Evaluations Tab, um, under the CMS sampling use only. If you look there you may see that there are very different encounters um, and PT is one of them so you would select “Yes” or “No” based on, I guess, if you’ve reviewed the medications or not at that visit.

Michael Kerachsky: Okay, next question: If height and weight are documented in the chart, but body mass index is not calculated, does this meet the measures- does this meet the measures despite the calculation itself not be documented in the chart?

Deb Kaldenberg: So for PREV-9 um, I’m just going to look and see exactly what you have to provide. Um, obviously if, if the height and the weight that you have are not patient reported, but have been measured you can certainly do that calculation after the fact. The only thing that you want to be aware of is, if that BMI is abnormal you would still have to have a recommended follow up. As far as the Web Interface is concerned, um, you are just answering whether they had a BMI documented or not, you are not having to provide that documented BMI. So again, you can calculate it after the fact, um and if it’s considered normal, they meet the measure. If it’s considered abnormal, and there’s no recommended follow up, then you would um, select as appropriate.

Michael Kerachsky: Thank you.

Um, at this point we will take one more question, um: In 2015 Q&A document, there was a mention of accepting mix and match of lowest systolic and diastolic on last visit date, however that question was removed in 2016. Does that mean it is no longer accepted?

Deb Kaldenberg: Um, no that doesn’t mean it’s no longer accepted. So, I’m assuming that what you’re referring to is not the PREV-11 measure, but to the Hypertension-2 and the reason it is not in the Q&A document is, that information is included in the supporting documents posted on the CMS website. Um, we try and minimize the repetition as much as we can so that things don’t get confusing. So, the fact that you can mix and match the systolic and diastolic blood pressures on the same encounter is relevant to Hypertension-2 and it is included in the Data Guidance tab of that supporting document.

Michael Kerachsky: Thank you. So that concludes the question and answer portion of today’s call. Um, back to you Ashley.

Ashley Burrell: Thank you Mike. Thank you to all of our panelists for that informative session. I’d like to thank all of our attendees for participating in today’s web interface support call. Everyone have a great day and presenters, please hold for the subconference.

*Bolded words – Non-spoken