2016 Physician Quality Reporting System [PQRS] Group Practice and ACO Web Interface Reporting Mechanism

Web Interface Q&A Session Support Call
Program Year 2016

Moderator: Ashley Burrell
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Ashley Burrell: Good afternoon everyone. I am Ashley Burrell from the PQPMI team and I'm your moderator today. I would like to welcome everyone to our Group Practice and ACO Web Interface Question and Answer Session. Today's call will feature brief reminders about Web Interface reporting requirements and helpful tips during submission. This call will be recorded and made available on the PQRS Web Interface webpage. Questions will be accepted through the Q&A feature on the right hand side of your screen and will be addressed at the end of the session as time permits.

At this time, I would like to turn the call over to Rabia Khan of the Division of Shared Savings Program at CMS. Rabia, over to you.

Rabia Khan: Thank you, Ashley. I'm Rabia Khan from the CMS Division of Shared Savings Program.

Slide 2

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, and helpful information on data entry and submission, and, uh, frequently asked questions about our quality measures.

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

Today's slides will be available on the GPRO Web Interface webpage. Due to some recen-recent enhancements to the Shared Savings program ACO portal, the slides for today 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 posted on the Next Generation and Pioneer connect slides-sites.
-next slide please:
-Sorry, slide 3 please: **Slide 3**

OK, thanks.

Now for some important announcements and reminders. During this support call, Pioneer Model ACOs, Next Generation A-ACOs, Shared Savings Program ACOs, as well as PQRS group practices will all be collectively referred to as organizations.

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

Next slide please: **Slide 4**

So, OK.

As you know, the Web Interface is open for data entry and submission. Users access the Web Interface through the PQRS portal. And, the Web Interface closes March 17, right at 8:00 PM Eastern Time. We strongly encourage your organization does not wait until the last day and to submit data well before 8:00 PM Eastern Time on the 17th to ensure that it's fully submitted before the Web Interface closes.

Next slide please: **Slide 5**

To provide helpful information and answer your questions we do have weekly Web Interface support calls so please mark your calendars with all of the upcoming dates and times for each of these calls. In addition, we'll 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. So, more information will be provided to you on that Lessons Learned webinar as we get closer to the close of the Web Interface.

Next Slide Please: **Slide 6** *[pause]*

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

Please note that the remaining, uh, maintenance weekend occurring during the submission period is actually scheduled for February 24th through the 27th. We do understand that that is the fourth week of the month instead of the third, but that's because it's a federal holiday during the third week.

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 available in the sample.

Next Slide Please: **Slide 8**

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

More specifically, for PQRS group practices, you are required to use EHR technology certified to the 2014 Edition to populate the Web Interface.

For EPs participating in an ACO, you 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 these Web Interface measures on your behalf.

Please note, EPs eh-must still individually attest separately to the EHR Incentive Program for other program requirements. When you go to the attestation system and reach the screens for reporting CQMs, EPs should select option 1 if they're reporting through an eReporting option. EPs can also choose to submit their CQM data instead of selecting that eReporting option available to them in the system.

And finally, Shared Savings Program ACOs who satisfactorily-who fail to satisfactorily report Web Interface measures will not meet the quality performance standard and will therefore not be eligible to share in savings they've earned.

Next Slide Please: **Slide 9**

And now I'll turn it over to Sue Hanlon who's going to go over helpful information about the Web Interface.

Sue Hanlon: Thank you. Today we're going to review 2 frequently asked questions about the Web Interface.

Next slide please: **Slide 10** *[pause]*

Okay, our first question is, can the submission of a new XML file overwrite existing data values in the Web Interface? And, I'm going to point out right away that our answer is incorrectly stated on the slide, and I apologize. We have an answer of no. That is not right. And, um, once again I apologize for the error. So, please ignore the no or cross it out on your slide and we'll have that corrected, um-and-um-have an updated presentation put out on the GPRO webpage.

The answer really depends on the scenarios listed. So, the first bullet: an XML element which contains a value (anything other than a NULL) will replace the value for that same element in the database. So on that, the answer is really yes. The new XML file will overwrite the existing value in the database.

The second bullet says an XML element contains a value (anything other than a NULL) will replace a NULL value for that same element in the database. So on that scenario, the answer is yes, your XML file will replace what's in the database or what's in the Web Interface. And then

finally, our last bullet – an XML element which contains a NULL value will NOT replace the value for that same element in the Web Interface. So, in that scenario, the answer is no. Once again, I apologize for the error at the top of the screen where it says the answer is no.

Um- moving on to our second and final question. What is the difference between uploading an XML file or manual data entry versus submitting my data to CMS? Uploading data via XML saves your data in the Web Interface. Likewise, doing manual data entry and then saving the patient, saves your data in the Web Interface. The data submission makes your data available for CMS to do the official scoring and reporting. And that completes our frequently asked questions this week.

Thank you.

Slide 11

Deb Kaldenberg: Good afternoon everyone. This is Deb Kaldenberg and I will be going over a couple of frequently ma-measures questions.

Next Slide Please: **Slide 12**

So, our first question has to do with MH-1: Depression Remission at Twelve Months. In our EMR, we have implemented the PHQ-9 Depression Screen in a 2 step process as follows when reporting the numerator: The first step is to answer the first 2 questions, or in this case it is the PH-2, and if positive then the entire PHQ-9 is completed. If the PHQ-2 is negative, then we do not complete the entire PHQ-9. Does this count as a PHQ-9?

And the answer to this is no, it-it doesn't count. The follow up PHQ-9 is required for this measure. The only way to show remission is to complete a full PHQ-9 screening. So in this case, you would choose no, select this option as the patient did not have a PHQ-9 less than 5 during the follow-up measurement period.

The second question we have on here is for PREV-12, the Depression Screening Measure. Would mental retardation be an exclusion for this measure? Would Dementia be an exclusion?

And for PREV-12, if the physician decides that in these situations the patient's functional capacity or motivation to improve may impact the accuracy of the results of the standardized depression assessment tool, then you would select "No – Denominator Exception – Medical Reasons". This would be up to the physician's discretion and should be documented in the patient's medical record. So in other words, the Mental Retardation or Dementia are not considered automatic exclusions or automatic denominator exceptions.

We did want to go over a couple of things I had said on last week's call that I would try and get an answer for you on MH-1 and in the last 2 days I did get a response from the measure owner. So, I'm going to go ahead and read it and I will also post it in the Q&A for next week. The question was, if a patient has a diagnosis of major depression during the index period but then later during the index period it is annotated in the medical record that the diagnosis of major depression is resolved, should the patient be considered eligible based on diagnosis or not?

And the following response we received from Minnesota Community Measurement. This patient would be considered eligible for the measure. During the index period, an index event is the first instance of diagnosis, an elevated PHQ-9. The index then starts at 13-month measure

assessment period that is held constant. Everything that comes after it is an opportunity to assess, monitor, and change treatment plan, if needed. Patients' depression symptoms, symptoms can start to resolve or can get worse. So in other words, if you have a diagnosis of major depression or dysthymia during that index period, for the diagnosis component, that patient would be denominator eligible.

And then there was one other question we have received a lot in the last 48 hours, we're assuming it may be because groups are starting to abstract for the CAD-7 measure. Um- there's a lot of questions regarding, um, medications that are not a part of the medication list for that measure. But within the data guidance tab of the supporting document, the measure developer has provided direction that the drugs are not considered to be all inclusive. So, if you find documentation of an ACE or an ARB, that is not included in the drug code tab or the data guidance tab, you may use that ACE or ARB to show compliance for that measure. Um, I hope that's helpful and we will certainly include the MH-1, um, question response on next week's slide deck.

Thank you.

Slide 13

Michael Kerachsky: Okay, thank you Deb. I'm going to briefly go over the educational resources, as well as the help desk resources and then we'll move on to the question and answer portion of the call.

Next please: **Slide 14**

Okay, slide 14 contains a list of educational resources. Um, this slide includes website and portal links 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, uh, specification and supporting documentation, as well as question and answer uh documentation. Please note, that the support call from last week and all previous support calls are posted to this website, as well as the transcription.

We strongly encourage organizations to review the step-by-step instructions provided in the educational demonstrations, also posted to the Web Interface. There are three education demonstrations:

- One is the Web Interface Overview
- The Web Interface Measures
- And finally, 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 15**

This slide includes a list of help desk contacts for the PQRS group practice and ACO models. For any PQRS EIDM Web Interface questions, we ask that you please contact the QualityNet Help Desk.

Next Slide: **Slide 16**

Slide 16 contains a list of acronyms, uh, we're going to include this slide in each of the presentations and it may be a useful resource during the report period.

Next slide: **Slide 17**

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

A couple of quick requests for attendees today: Please submit your questions in writing via the Q&A box located at the top of the webinar screen. 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.

If your question concerns measures, it's also helpful to identify the measure uh number. User specific questions must be sent to the QualityNet Help Desk.

And, uh, also we will not be responding to any MIPS or policy questions during today's Q&A.

And finally, in an effort to read as many questions as possible we will not go over repeat questions. So let's begin.

Question and Answers:

Question Moderator: Michael Kerachsky

Michael Kerachsky [question]**:** Okay, first question: On mental health, on the question was PHQ-9 test performed. If the answer is 1 no, does this mean that the patient is skipped for this measure?

Deb Kaldenberg [answer]**:** And this is Deb Kaldenberg, um, yes, it does mean the patient is skipped. A visual representation of this can be found in the measure calculation [*repeat*] flow on the CMS website. This particular measure has 3 denominator criteria, actually 4: That you are the correct, the correct age; you have the diagnosis of major depressive or dysthymia; you use a PHQ-9; and there is a PHQ-9 greater than 9. All of these things have to be pertinent during the index period, um, in order for the patient to be considered denominator eligible. So, if you don't confirm diagnosis, or you do not use a PHQ-9 or you do not have a PHQ-9 greater than 9 during the index period, um, any one of those reasons would end up being a skip because that patient would not be considered denominator eligible. Thank you.

Michael Kerachsky [question]**:** Thank you. Next question. PREV-9 EMI 2016 XML Specification indicates pregnancy may be used as a denominator exclusion, but indicates no other exclusions. The 2016 Data Guidance indicates patient refused is a denominator exclusion as well as pregnancy. Could you clarify?

Deb Kaldenberg [answer]: This is Deb from the PQMM team and-and you are correct. Within the denominator exclusion for PREV-9, um, you would select that option if there's an exclusion for patient disqualification from the measure for pregnancy or if the BMI measurement was not performed for medical reasons or patient reasons, and there's some additional information in the exclusion exceptions column of the data guidance tab. I'm not sure if anyone wants to speak

to the XML spec indicating pregnancy. The answer I provided is strictly based on the Data Guidance.

[pause]

Sue Hanlon [answer]**:** This is Sue Hanlon from DECC. Um, so we would always advise that you use the um the measure supporting documentation as your primary source of guidance.

Michael Kerachsky [question]**:** Okay, next question. Um, regarding the Web Interface. We uploaded our data to the GPRO Web Interface. Many incomplete records for heart failure and mental health due to not confirmed additional denominator criteria. No denominator, no denominator displaying for these two measures. Can we review charts and confirm heart failure diagnosis and confirm to confirm diagnosis, and convert to confirm diagnosis?

Sue Hanlon [answer]**:** Okay, this is, once again this is Sue Hanlon from DECC. Um I think that you need to look at these patients in the Web Interface. They should be skipped patients. And, if by chance they're not, please enter a, um, help desk ticket for for this scenario.

[long pause]

Michael Kerachsky [question]**:** Okay, next question. CARE-3. If the provider imports the medication list into his notes, but doesn't mention that he reviewed the medication list, does this meet the measure?

Carol Noyes [answer]**:** There would need to be documentation. Hi, this is Carol, from the PQMM team. There would need to be documentation of, um, the provider I guess, attesting to those medications. Now if he's signing off on those medications within that note, um, as done then that would count, but if there's, if they're just on the chart and we don't know that they've been reviewed by anyone, then that would not count.

Sherry Grund [answer]**:** Um, this is Sherry from the ACO PAC team, if we could go back just one moment to the question before this last one, um, that Sue answered, um, which was appropriate to the XML, ah however, I think there may be another angle that the um the inquirer is looking at for this question. Um, they're asking about those um people that they might get get back that would be potential skip um people, um, because they are fulfilling one of the additional denominator criteria, um, that they are not, um, going to be in the denominator. I think those people may be people that, um, they're just not able to pick up with their XML upload because their EHR does not have a discrete field for that bit of information, so in that case they can go ah ahead and manually abstract, um, those to add more people ah rightfully to the denominator in some of those measures. So that may be, um, the issue and it may be, um, the way, um, that Sue was answering it. So if that was the intent of your question, um, then I hope I've answered it.

Michael Kerachsky: Okay, thank you for that clarification. [pause]

Michael Kerachsky [question]**:** OK, another question regarding, um, CARE-3. For the CARE-3 medication reconciliation measure; if a patient had a visit on a date for a TCM but the visit date in the measure matches the claim date and not actual date of office visit note, does that count as a visit or not?

Carol Noyes: [answer] Hi, this is Carol again. You know there is TCM coding within that measure um but you would need to look for ah around that timeframe, um, within one or two days of that visit in order to be able to confirm that that visit, um, the medication reconciliation for that particular visit, um, if you do not have that then you would and it's outside of that timeframe then you could select um outside of the provider, no, outside of the provider visit.

Deb Kaldenberg [answer]**:** And basically we realize that apparently there is some the TCM coding ah might be 30 days out but still look for plus or minus two days of the visit date that's been pre-populated and if you cannot find an encounter go ahead and select visit outside practice, um, and move on to the next visit that you have pre-populated.

[long pause]

Michael Kerachsky [question]**:** Thank you. Next question, when we have, when we have found a PHQ-9 screening done between 12/1/2014 and 11/30/2015, very often it is less than 9, very often it is less than 9 months, because… I'm sorry, let me repeat this. When we have found a PHQ-9 screening done between 12/1/2014 and 11/30/2015, very often it is less than 9 because they have been diagnosed so long that their meds therapy are managing their depression. So we answer yes to mental health confirmed since the beneficiary…[inaudible]

Deb Kaldenberg: That's OK Mike, I think I can answer their question. I think I understand what they're getting at.

Michael Kerachsky: Thanks.

Deb Kaldenberg [answer]**:** Um, this is Deb. You're welcome. So, in this case, um, it sounds like you've confirmed diagnosis and, um, you're also confirming that there's a PHQ-9 screening so you've selected yes to the PHQ-9 screen. Um, however, if you are not finding a PHQ-9 greater than 9 during that index period you will select No select this option if the patient did not have a PHQ-9 greater than 9, um, and the rationale for this is the patient is not considered denominator eligible because you're not looking for um the outcome of remission at this point in time. So, for this particular patient you meet two of the three denominator components – the diagnosis, the PHQ-9 screening. However, if you're not finding the PHQ-9 greater than 9, you would select that the patient did not have a PHQ-9 greater than 9 and they would be skipped and replaced. Thank you.

Michael Kerachsky: Okay, thank you.

Michael Kerachsky [question]**:** For CARE-3, the patient had a visit with optometrist or podiatrist and doesn't have a primary care physician visit. Is medication reconciliation required?

Carol Noyes [answer]**:** Hey, this is Carol again and Olivia you may want to ah, um, pop in on this one as well. But, CARE-3 measure is not intended to be limited to primary care providers, so you should continue abstracting on those patients who were seen by specialists.

[click]

[pause]

Michael Kerachsky [question]**:** OK, um next question. There seems to be a high number of skips for the heart failure measure this year. Is this due to the change in the data guidance wording of moderate or severe?

[long pause]

Carol Noyes [answer]**:** Hi, this is Carol, from I guess the measure perspective, no, moderate and severe has, actually, always been part of this measure. Um, there is additional criteria, though, that is necessary and that is confirmation that um the patient has LVSD, um or diabetes… Nope, oops, sorry that's CAD, let me get it straight. Anyway, there's additional denominator criteria and that may be if you are not able to, um, identify that and you need to select No then you would stop reporting on those patients and sometimes that will make your numbers a little bit less.

[pause]

Does anyone else have anything to say related to this measure? For heart failure.

Sherry Grund [answer]**:** Carol this is Sherry. They may be referring to the, um, measure owner decision to remove the synonym list.

Carol Noyes [answer]**:** That could be as well, and yes it is gone. But moderate to, moderate or severe, or looking for the LVEF less than 40 percent at any time in their history is how you would identify and confirm heart failure for this measure.

Sherry Grund [answer]**:** And that is not a change…

Carol Noyes [answer]**:** Nope…

Sherry Grund [answer]**:** …that's always…

Carol Noyes [answer]**:** Thank you, Sherry, for that.

[pause]

Michael Kerachsky [question]**:** OK next question. My question is about MH-1 and PREV-12. What is the exact number score that is considered positive for the PHQ-9 screening tool? The data guidance gives numbers for mild, moderate, and severe, but no exact qualifying number.

Deb Kaldenberg [answer]**:** This is Deb from the PQMM team. So these two measures are extracted very differently. The MH-1 has very specific scores that the measure is looking for. So for denominator criteria it's the PHQ-9 greater than 9. For the numerator criteria it's PHQ-9 less than 5. Your PREV-12 depression screening measure does not give any guidance, um, for what is considered positive and what is considered negative. That is up to the provider to document, as it could be, um, based really individually patient by patient, as what would be considered positive or negative, um, so that would be something you would want to find within the medical record, if they documented it as positive or negative. That screening tool does not have a definitive number that is considered positive or negative for the depression screening measure, um, or the PREV-12 measure.

[pause]

Michael Kerachsky [question]**:** Okay, the next question concerns patient ranking. What if you uploaded data…I'm sorry, this is already answered here.

[pause]

Michael Kerachsky [question]**:** Okay, sorry, next question. For heart failure, the patient declines listed ED due to cost, does this have to be documented annually or only when first discussed with the patient?

Carol Noyes [answer]**:** Um, for this measure within the denominator exception, um, you can have documentation [inaudible, looking for]…you can have documentation, um, if you have documentation, um, if you have documentation anywhere in your chart, you can use that documentation, um, to select no denominator exception… *[inaudible]…* what am I looking for here], due to cost, oh due to cost. Sorry, I was re-reading the ah question again. And there's a denominator, you can select denominator exception for this measure if it is something that is due to cost but that it is also something that I guess providers can also work with their patients with as well. Um..

Deb Kaldenberg [answer]**:** It may not be a bad idea, um, to open up a ticket on this one…

Carol Noyes [answer]**:** …might need to know more about the situation…

Deb Kaldenberg [answer]**:** Yeah, how long ago did the patient decline. Um, it may be something that additional details would be helpful in order to give you a complete answer.

Michael Kerachsky: Thank you.

Michael Kerachsky [question]**:** The next question concerns the IVD measure exclusion. Why is there no exclusion for medical reason, such as patient is on warfarin and provider documented that patient has been instructed not to take aspirin while on anti-coagulation therapy?

Carol Noyes [answer]**:** For this measure in 2016 there is not a-an exclusion or exception for Coumadin or warfarin use. So in those cases you would select no. Um, however if you would like your situation reviewed and it is unusual and you would like CMS to review it for CMS approved reason, you may submit that to the Help Desk – um with the patient's rank, and what the reason may be why this patient um is not taking another type of an anti-platelet medication, um. So the recommendation I suppose is that you could submit a CMS approved reason.

Deb Kaldenberg [answer]**:** This just happens to be one of those situations where, um, the measure developer, in this case NCQA, did not include a denominator exclusion or a denominator exception within the measure, um, but in cases where you have an unusual circumstance and you want CMS to review the situation, um, for a possible skip, as another CMS approved reason request, you can always make that request by opening up a QualityNet Help Desk ticket and adding those components that Carol went over.

[click]

[pause]

Michael Kerachsky [question]**:** Okay. Next question is regarding PREV-7. What are the patient reported requirements for flu immunization? If a patient asked a, if a patient is asked a question, have you received the flu immunization during the flu season, October 1 through March 31, and that encounter was during the flu season November 2015, would this be acceptable?

Deb Kaldenberg [answer]**:** This would be acceptable. Basically what you're looking for is documentation to support in the event you're selected for an audit that the patient received a flu vaccine for the flu season being measured. So, in in some cases if all you have is flu vaccine

received 2016, this wouldn't be appropriate because there's no way to tell which flu season that is attached to. But if you had, um, flu shot received at Walgreens, um, last month, and the encounter is during the flu season, you've made that connection between the flu season being measured and when the flu immunization was provided. So anything that you can use that shows that the flu vaccine provided was during the flu season or previous receipt, so August 1, 2015 through March 31, 2016, um, this would be appropriate. And in your example, it this would be appropriate, as you've said the encounter is 10/1, um, I'm sorry the encounter was November 2015 and the documentation is patient received immunization during the flu season and that is during the appropriate flu season.

[pause]

Michael Kerachsky [question]**:** If a Medicare ID number is incorrect, can this be corrected? The name and date of birth are correct.

Olivia Berzin [answer]**:** Sure, this is Olivia Berzin. And so the HIC number, unfortunately, cannot be corrected in the Web Interface; however, if you can confirm, um, the beneficiary based on their first name, last name, date of birth, and gender, so like other demographic information, then it would be appropriate to confirm this patient.

[pause]

Michael Kerachsky [question]**:** Thank you. For PREV-8, can we request an exclusion for a patient's refusal of a pneumonia vaccine?

Deb Kaldenberg [answer]**:** So this is one of those measures where the measure developer, and in this case it's NCQA, has not included a patient, a denominator exception patient reason or a denominator exception medical reason, so there's for a patient refusal, um, this would be a performance not met that the patient didn't receive the vaccine. If there are extenuating circumstances and you want CMS to review, certainly you can request a CMS approved reason to skip. CMS would have to look at those details and make a determination whether or not they would allow that, um, and as in, um, earlier explanation that requires the patient rank, the reason for the request, and the measure in question.

[pause]

Michael Kerachsky [question]**:** Okay, for CARE-2. If, sorry for CARE-2, if a provider or health professional performed a gait or balance assessment, would that meet the measure?

Carol Noyes [answer]**:** Only if that gait and balance, um, assessment included did the patient fall, was there a history of falls, so, um, then it would be OK, but if it does not address history of falls or fall status then it would not.

[long pause]

Michael Kerachsky [question]**:** Okay, next question. EM2 - do results from A1C finger sticks count?

Carol Noyes [answer]**:** If you have documentation of the value and the date it was performed, then yes, otherwise please refer to the coding that's supplied for the types of testing that are appropriate for this measure.

[long pause]

Michael Kerachsky [question]**:** Okay, for MH-1, if we did not start CHQ-9 until 2016 will this affect us negatively if it looks as if we haven't recorded this when an audit change is not confirmed?

Deb Kaldenberg [answer]**:** I'll answer, from, this is Deb, from the measure perspective, um, basically all you're saying when you are not confirming your entire patient sample for MH-1, is that you didn't have any denominator eligible patients, um, so in that regard there would not be a negative impact.

[pause]

Michael Kerachsky [question]**:** Okay, again for the MH-1 measure, is zero considered an acceptable score for the follow-up screening?

Deb Kaldenberg [answer]**:** Um, zero would be an acceptable score as long as that came from a PHQ-9, um, it is a score that is less than 5.

[pause]

Michael Kerachsky [question]: Okay. PREV-12 Medical reason exceptions. Does the provider have to explicitly document the reason for not conducting the depression screen? Or can it be implicit based on the patient's diagnosis and condition - dementia or advanced Alzheimer's?

Deb Kaldenberg [answer]**:** Um, in this case, you would need to have specific documentation, as Alzheimer's and dementia are not considered automatic exceptions for that particular measure.

[long pause]

Michael Kerachsky [question]**:** Next question. If the medical record has a section entitled tobacco use and the medical record notes that patient is a quote "never smoker or former smoker" but says nothing about smokeless tobacco; will this meet the tobacco screening measure?

Deb Kaldenberg [answer]**:** So PREV-10 is a tobacco use measure. You would need documentation, um, that the patient was queried at least once within that 24 months, so this calendar year or the year prior for whether or not they're a tobacco user. If the only thing being addressed is smoking, this would not meet the measure. If, however, if you have say a policy that states that your question about tobacco includes smokeless, or your question about smoking includes smokeless tobacco, then you could certainly use that policy to substantiate the fact that you are querying the patients for all tobacco use, and not just smoking.

Sherry Grund [answer]**:** This is Sherry from ah ACO PAC. Um, should you be chosen for audit, all that we would ask in addition to the, um, information to support that you've queried the patient, is a copy of that policy if it is not inherent in every medical record.

[pause]

Michael Kerachsky [question]: Next question. Last week it was stated that for PREV-12; if the tool was not named but it was easily identified as a PHQ-2, it could be used. What if the depression screening has the same questions as PHQ-2 but the answers are yes/no rather than a zero to three scale?

Debra Kaldenberg [answer]**:** This is Deb, this is kind of a new question. Ah, my preference would be that you would go ahead and open a QualityNet Help Desk ticket so that we can discuss this further, unless someone else wants to make that call without a help desk ticket being, opened...

[long pause]

Okay, it sounds like if you don't mind going ahead and opening up a help desk ticket so we have a little bit of time to do some research on your question, thank you.

Michael Kerachsky [question]**:** Okay, um. Next question regarding PREV-7. If we can't confirm the visits seen for at least two visits or at least one preventive visit during the measure period, but we do but we do have the patients' medical records, can we confirm the patient?

Debra Kaldenberg [answer]**:** Yes, you can confirm the patient. We don't ask you in the PREV-7 to confirm the encounters. Within the PREV-7 measure, when you're asked to confirm that the, um, patient is qualified for the measure, you're really just looking at, does the patient meet the age criteria, and of course this measure is six months and older, so ,um, we would anticipate they would meet age criteria. You do not have to confirm the visit. Um, the visits that were used, there's at least one visit during the flu season, um, so you would just move on to whether or not the patient received the influenza immunization.

[pause]

Michael Kerachsky [question]**:** Okay, next question. We are an FQHC ACO, our FQHCs usually attest to Medicaid meaningful use, due to the incentives. Will we/they receive credits for the meaningful use measure under the Shared Savings Program measure requirement and are those deadlines different for meaningful use attestation?

Rabia Kahn [answer]**:** Hi, this is Rabia Kahn from CMS. So, our alignment with the, is with the Medicare EHR Incentive program for EPs, so EPs, um, who would be attesting to Medicare, um, would meet their CQM requirements through their ACO and not Medicaid. Um, your FQHC or EPs, who do attest to Medicaid for meaningful use, um, you'll need to follow your state guidelines, your state Medicaid guidelines and timelines for attestation. Um, and when it comes to EHR measure, um, for the Shared Savings Programs, the way that we calculate it, um, we do use a two-year look back period. We do understand that the states do have different, um, timelines in terms of attestation and there could there could be potentially a data lag that comes in from the states to Medicare. So, we do, um, when we calculate the measure, we do have a two-year look back period in terms of if you've met the meaningful use requirement for Medicaid So we do we do include you in our numerator. So, if you do have further questions about that, um, you can send it to the Quality Net Help Desk and we can help answer anything additional.

Michael Kerachsky [question]**:** Okay. For heart failure, when the patient qualifies for the measure does not receive a qualifying beta blocker, does the provider need to explicitly document the reason, or, if an exception code diagnosis is found, can this be used? If yes, what timeframe should be reviewed?

[pause]

Deb Kaldenberg [answer]**:** *[Inaudible]* Um, I, I believe I know what your question is. So you're looking for the denominator exception medical reason for HF-6, and you have a specific code that you can show as a denominator exception, and you want to know if you can just use that code. And, it is my understanding that if you can, in the event of an audit, have a screenshot of that code that would be acceptable. Just, um, be careful within the heart failure measure that some of the denominator exceptions require very specific, um, medical record documentation. So this would be in response to a particular diagnosis, um, that in and of itself is considered a denominator exception for that measure, and if you're mapping to your EHR, your screenshot of that code would show, um, a proper denominator exception as long as that code is part of the code set.

Sherry Grund [answer]**:** We. This is Sherry from ACO PAC. We really like to see documentation of that medical reason. Um, the description that often accompanies the, um, code is, um, helpful. It allows us to know that those, um, caregivers that are watching and looking and using that medical record as a document to care for the patient, uh, are aware of that that code really means. And allows, um, everybody to know that that represents, um, what needs to go into a care plan for that plan patient. Um, so we really prefer to have, um, the actual, um, say for this particular measure, you may have someone that, um, is not receiving a particular beta blocker, um, because they have an allergy or because they have asthma or something that, um, makes it hard for them to tolerate. So, those kinds of things, um, having those written in the medical record in note or listed, um, in an MAR are very, um, are very informative to all those that are caring for the patient. Um, so we prefer to see something like that.

Michael Kerachsky [question]**:** Okay, we have a follow up to a previously asked CAD-7 drug question. Would a combination drug with an ACER also be acceptable or does it depend on what drug the ACER is combined with?

Carol Noyes [answer]**:** Well, yes it would depend on the drug, I mean, um. Hi, this is Carol again…If you have documentation that the patient is taking an ACE or an ARB then that would be acceptable. So, also, within the measures documentation; the supporting documents, in the inclusion synonyms column, there is guidance that says that the CAD drug list is not, um, considered all inclusive. So there are additional medications that you may run into that have either an ACE or an ARB in combination and into and you can select yes for those drugs.

Carol Noyes [answer]**:** Michael?

Michael Kerachsky: Yes

Carol Noyes [answer]**:** Hey can I hop in? It looks like Amanda had a follow up question regarding CARE-3 and I may have misinterpreted it, I guess that PCM question. And, assuming that visit occurred outside of, um, perhaps the provider's scope there. Um, so, no we,

confirming, those visits did come from claims and, um, you're supposed to validate them within two, um, one to two days of the actual visit. So, if you don't have, um, I guess medication reconciliation within that time frame, then you'd have to select no. Now if you find they are outside of your practice or that visit is outside of your, um, hold on a second, office then that is the only time you'd select that, that particular option. And, if that doesn't clarify it for you Amanda, please open another ticket. Sorry about that.

Michael Kerachsky [question]**:** Thank you. Next question. If a provider left our ACO and is now employed elsewhere, and we cannot access their records, how should we proceed? Can we just mark his medical record not found and include a comment?

Olivia Berzin [answer]**:** This is Olivia. And, so, if you have made a concerted effort to find and access the medical record, um, but cannot do so, then, it would be appropriate to select medical record not found. Um, I would encourage you to look at our Q&A document, which is posted on the Web Interface webpage, which has a pretty lengthy explanation about when that option is appropriate to use.

Michael Kerachsky [question]**:** Ok. We have an XML upload question, based on one of the FAQs asked earlier. How do we replace a value with a null, when we mistakenly have a value that needs to be empty?

Sue Hanlon [answer]**:** Um, the only way you can do that is through the user interface. You cannot do that using XML.

[pause]

Michael Kerachsky [question]**:** Okay, for IVD-2 measure, we know it's looking for an antithrombotic, but can Coumadin, an anticoagulant be used? We reviewed the IVD supporting document drug code, and noticed Coumadin is not listed, but we wanted to ensure that this wasn't an error or typo.

Carol Noyes [answer]**:** I know, it is not an error or a typo. Um, if you refer to the measures documentation, the supporting document, there is a list of medications that are acceptable and Coumadin is not one of them. This measure does match the current eCQM, um, and there is not an exclusion or exception available. Now, if you do have a situation where you feel like, um, you would like CMS to review, for a CMS approved reason, then you can actually submit that through the help desk and we'll get that process started for you.

[pause]

Michael Kerachsky [question]**:** Okay, thanks. One practice was bought by a competitor in May. They can't turn over to us data from May 1st forward. Is the medical record not found exclusion appropriate for the entire list of patients attributed to this practice for the entire year?

Olivia Berzin [answer]**:** This is Olivia. I guess I would clarify one thing. If this was an ACO, um, beneficiaries aren't assigned to a particular practice, they're assigned to an ACO as a whole. Um, but I think also my answer to a previous question applies here. If you have made a concerted effort to access, um, to find and access the patient's medical record but you cannot do so, um, then it is appropriate to select medical record not found. And again, I refer you to the

skipping beneficiaries section of the, ah, Web Interface Q&A document that's posted on the Web Interface web page.

Michael Kerachsky [question]**:** For CARE-2, if EMR just states fall risk no or fall risk medium, is that enough information to meet the measure?

Carol Noyes [answer]**:** Um, that would not be enough information to meet, um, the measure. There would need to be a specific question, I guess, to address, um, had falls occurred in the past, um, or anything to that effect. So, if the risk is only addressed in that manner, then no.

Michael Kerachsky [question]**:** Okay, next question concerns CARE-3. If a patient has a TCM visit within two days of an in office visit, should we mark both visits as confirmed, since the TCM visit was within two days of the office visit, or should we only confirm the second?

Deb Kaldenberg [answer]**:** So, maybe what you're asking if you have a TCM visit that you're finding because of the coding and that particular date is pre-populated and then you're also finding another pre-populated date that is two days later that you're connecting your TCM to that and there's two specific dates. Um, the dates that are pulled in are pulled in based on the coding within that particular measure. So you're going to confirm a visit within one to two days, independently of each other. Um, if this does not answer the question, it may be best to open up a QualityNet Help Desk ticket. But, but basically the…

Carol Noyes [answer]**:** It's based on claims that were provided

Deb Kaldenberg [answer]: Yeah, it's based on claims and documentation of current medications is intended to be an each visit measure. Um, the number of visits has been limited to 12, um, per patient in the event that maybe this patient had 100 visits at your particular ACO or group practice and we didn't want to pull in all 100 visits. So understand that based on claims, the visits have been pre-populated, limited to no more than 12, but you're looking for 12 separate encounters that would have occurred, um, if you have total 12 visits that have been pre-populated.

Michael Kerachsky [question]**:** Okay, thank you. All right, at this point, we'll take one more question before closing out. For CARE-3, if a certified pharmacist technician or a pharmacist reviewed all of the medications on the date of the visit, does that count as an eligible professional attesting for numerator compliance?

Carol Noyes [answer]**:** So there's a list of eligible professionals on the CMS website that may be of some assistance to you. Um, and, that is…, well it's very lengthy, but it's on the CMS website related to who can perform the visit, um, when it comes to RNs and so on, you know CMS isn't dictating your practice, um, as long as the provider is overseeing, um, and/or attesting to those medications being correct.

Michael Kerachsky: Okay, that ends the question and answers portion of today's call. Back over to you Ashley.

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