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 reminders to assist during submission. This call will be recorded and made available on the PQRS Web Interface webpage and ACO Portal. Questions will be accepted through the Q&A feature on the right hand side of your screen and will be addressed at the end of the session as time permits.

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

Rabia Khan: Thanks Ashley.

[Coughing]

Slide 2

Rabia Khan: I'm Rabia Khan from our Division of Shared Savings Program, and I want to welcome all of you to our CMS Support Call for 2016 PQRS Group Practice and ACO GPRO Web Interface reporting. During the support call, our subject matter experts are going to go over some helpful information, including important reminders about key dates, ah, information on, ah, on the, ah, Web Interface system, as well as frequently asked measure questions.

Following our presentation, we will host a Q&A session where our experts on the call are going to 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.

As noted, today's slides are, will be available on the GPRO Web Interface webpage. Um, they are available on the Shared Savings program ACO portal, under the program announcement titled 2017 Web Interface Q&A Support Call Slides and Recordings, and it's also posted on the Next Generation and Pioneer connect sites, for those ACOs.

Next slide please: **Slide 3**

So during this support call, Pioneer, uh, Next Generation, and Shared Savings Program ACOs, as well as PQRS group practices, will all be 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 measure specifications and supporting documents as a resource when reporting your quality data. As a reminder, please use 2016 measure documents for 2016 reporting.

Next slide please: **Slide 4**

So as you know, the Web Interface is open for data entry and submission. Users access the Web Interface through the PQRS portal. Web Interface will be closing March 17, right at 8:00 PM Eastern Time. We strongly encourage your organization not wait until the last day to submit data, and do it well before 8:00 PM Eastern Time, 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 have these weekly Web Interface submission support calls. Please mark your calendars with each of these dates and times for all of these upcoming calls. In addition, we will be hosting a Web Interface lessons learned session shortly after the Web Interface closes. We'll go over your feedback on 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.

Next Slide Please: **Slide 6**

There are some scheduled, ah, outages and maintenance weekends for, for the PQRS portal, which means that the Web Interface will not be accessible during these dates and times. So again, mark your calendars with this information. The Web Interface is not accessible:

- Every Tuesday starting at 8:00PM Eastern Time through Wednesday at 6:00AM Eastern Time
- Every Thursday at 8:00PM Eastern Time through Friday at 6:00AM Eastern Time
- And the, next, ah, weekend outage is actually February 24th through the 27th.

I do understand that is not the third week of the month, it is 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 available in the sample.

Next Slide Please: **Slide 8**

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

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 data for reporting through the Web Interface.

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

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

Please note, EPs still need to individually attest separately to the EHR Incentive Program for all other program requirements. When they go to the attestation system and reach the screens for reporting CQMs, eligible professionals should select option 1 since they are reporting through an eReporting option. EPs can also choose to submit their CQM data instead of selecting that eReporting option.

And finally, Shared Savings Program 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 they've earned.

Next Slide Please: **Slide 9**

Alright, so now I'm going to turn it over to Sue Hanlon to go over information on the Web Interface.

Sue Hanlon: Thank you Rabia. Today we have two questions and in case they look familiar to you, they are a repeat of last week's questions.

Um, next slide please: **Slide 10**

Our first question: Can the submission of a new XML file overwrite existing data values in the Web Interface? And the answer is, it depends. The answer can be yes because an XML element, which contains a value (anything other than a NULL) will replace the value for that same element in the Web Interface. It also can be a yes answer because an XML element which contains a value (anything other than a NULL) will replace the NULL value for that same element in the Web Interface. And, most importantly, and the thing we always like to emphasize is the answer will be no, because an XML element which contains a NULL value will NOT replace the value for that same element in the Web Interface.

Our second question is, 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. Manual data entry and using the save patient button will save your data in the Web Interface, but the data submission screen in submitting your data, makes your data available to CMS for 'official' scoring and reporting.

And that covers our two questions and I think we turn this over to, um, Deb Kaldenberg at this point.

Slide 11

Deb Kaldenberg: Good afternoon, this is Deb.

Um, next slide please: **Slide 12**

We have two questions to go over today and these may seem somewhat repetitive as well. We have IVD-2: If the patient is prescribed an anticoagulant medication, and there is a list of medications, instead of one of the antithrombotic therapy medications identified as numerator compliant in the measure, how do I report? And this is one of those scenarios where if you're finding, um, and and some of you already have that a patient is on Warfarin, Coumadin, some of the other medications, that you would not be prescribing aspirin or one of the antithrombotic medications identified, we would recommend that you open up a CMS approved reason to skip question through the QualityNet Help Desk. Um, those requests will be sent to CMS for review and they will provide you a resolution, um, approval or denial within the resolution of that inquiry. Um, as with any other inquiry you request for CMS approved reason to skip, please do not send any PHI information. However, for every request you send, we do need the patient rank, the measuring question, and the reason for the request. You can submit more than one patient on one help desk ticket. Um, so for, um, instance, if you had five patients that were on Warfarin and you wanted CMS to review that for a skip, you could include all fi- five patients on the one inquiry.

The other question is the one that we did go over last week, but I wanted to make sure you had it in print; and this is MH-1 Depression Remission at 12 months. 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? Um, and from the measure developer, this patient should be considered eligible for the denominator, assuming that there is also a PHQ-9 greater than 9 during the index period. And those are two questions for today so we'll hand it over to, I believe, Michael.

Slide 13

Michael Kerachsky: Thank you, Deb, and good afternoon to all the attendees on the line. My name is Michael Kerachsky from the PQPMI team. I will present on the available educational and help desk resources and then move on to the question and answer portion of today's presentation.

Next slide please: **Slide 14**

Okay, this slide includes, um, website and portal links specific to PQRS group practices and each of the ACO models. The Web Interface page includes links to Web Interface support call transcripts and presentations, assignment methodology, and sampling documentation, XML and measure specifications, as well as supporting documentation and data guidance. Finally, there is also a Question and Answer document. In addition, there are three educational demonstrations, including the Web Interface Overview, Web Interface Measures, and EIDM for Web Interface; all posted on the Web Interface webpage. We strongly encourage organizations to review these step-by-step instructions, uh, included our instructions on how to access the Web Interface, as well as how to utilize the documentation, which is listed on this slide.

Next slide please: **Slide 15**

Slide 15 includes a list of available help desk contacts for the PQRS group practice and ACO models. Please note that for any PQRS EIDM Web Interface questions, please contact the QualityNet Help Desk.

Next Slide please: **Slide 16**

Slide 16 includes a list of acronyms which you may find useful during the reporting period. Again the slide 15, help desk resources, and slide 16 acronyms, uh, will be included in each of the presentations.

Next slide please: **Slide 17**

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

And a couple requests for our attendees today: Please submit your questions in writing via the Q&A box located at the top of the webinar screen. You may need to click the Q&A tab at the top of your screen to access this feature. When submitting questions we ask that you please identify if you are a PQRS group practice, or one of the ACO models: Shared Savings Program, Pioneer, or Next Generation.

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

On today's call, we will not be responding to MIPS related questions.

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

[Pause]

Question and Answers:

Question Moderator: Michael Kerachsky

Michael Kerachsky [question]**:** Okay first question regarding PREV-11: Blood pressure screen. Are all urgent care visits considered exclusions or only if the patient isn't, is in an urgent/emergent situation. If the patient is seen, blood pressure taken and it is normal or pre-hypertensive, do we leave the patient in the measure?

Deb Kaldenberg [answer]**:** And this is Deb from the PQMM team. For PREV 11, the screen measure, urgent care visits are considered appropriate encounters. Um, you would use the denominator exception medical reason only if the patient is documented as being in an urgent or emergent situation where time is of the essence. So in your scenario if the patient is seen in an urgent care visit, the blood pressure is taken and whatever that blood pressure is, if it's considered the most recent, you would continue reporting on that patient. Again, unless there is documentation that the patient is an urgent or emergent situation where time is of the essence. Thank you.

[Pause]

Michael Kerachsky [question]**:** K, next question regarding PREV 10, if there is an American Cancer Society smoking cessation document dated in the measurement period with the question, refer to quit line, and the answer no, is this sufficient to meet the intent of the measure?

Deb Kaldenberg [answer]**:** So this is Deb. I'm assuming what you're saying is that there is documentation that this was offered and it was declined by the patient during the measurement period. In which case, this would be sufficient to meet the measure. If I'm not understanding your question and it's not a case where the patient has refused to call the Quitline, um, in that case you would want to open up a QualityNet help desk ticket, um, and and ask your question through that avenue and we'll provide you a written response.

Michael Kerachsky [question]**:** Ok, another, um, PREV 10 question similar… If the patient is documented as a quote-unquote former smoker but identified as a smoker within the 24 month look-back period, the patient would still be identified as a tobacco user, right?

Deb Kaldenberg [answer]**:** So based on guidance provided in the supporting document data guidance tab, if there is more than one patient query regarding tobacco use, please use the most recent and respond to the remaining questions based on that most recent screen. So in the most recent screen, if the patient is considered a tobacco user, then you would need to look for cessation intervention. If it's the most recent screen that patient is considered to be a non-tobacco user, then you would be, um, finished reporting the measure as that patient would be considered compliant.

Michael Kerachsky [question]**:** For PREV 7, what are the exact dates that are acceptable for this measure? Are they given in the office? 10-1-2015 to 3-31-2016 and previously reported 8-1-2015 through 3-31-2016?

Deb Kaldenberg [answer]**:** So for PREV 7 there's two different sets of dates are two um, both identifying the flu season, which is your October, through October 2015 through March of 2016. However, um, the measure developer, ANA, understands that the flu vaccines are provided prior to encounters during the flu season. So you are allowed to look back to August 1st of 2015. Um, in the event that the patient has a prior receipt of the flu vaccine during a time that maybe they didn't have the encounters during the flu season. So-so basically that all of the dates are sufficient for receipt of the flu vaccine. The August 1, 2015 through March 31 2016.

Michael Kerachsky [question]**:** Ok, next question: PREV 9. If dyslipidemia or lipid disorder and an abnormal DMI are documented on the same encounter note, along with the provider's recommendation for a low-fat diet weight reduction and exercise, will this meet the intent of the measure?

Deb Kaldenberg [answer]**:** This would meet the intent of the measure, and the reason it would meet the intent of the measure, is that that recommended follow-up is pertinent to both of those conditions. Um, so that would be a sufficient link. It's that BMI is calculated on that encounter with the other conditions; the recommended follow-up is relevant to both; and so it would meet the intent of the measure.

Michael Kerachsky [question]**:** Ok for heart failure, if patient is on a non-approved beta-blocker, are they a failure or might an exception still be used?

Olivia Berzin [answer]**: Hi,** only one of the three, um, beta blockers identified within the supporting documents and, um, their specifications are to be used for this measure. Um, so if they are not on one of those medications, then you would need to select no. Um, if there is documentation, um, supporting why a patient is not on one those medications or unable- are unable to tolerate beta- blockers, than that would, um, be acceptable for a medical use exception. So it would depend on circumstances, but no, um, only those three medications are identified as medications that meet the intent of this measure.

[Pause]

Michael Kerachsky [question]**:** Ok, we have a question to clarify some information from last week's call or a few weeks' call. During a call a few weeks ago, there was a question about asking for information in 2017 that was supposed to be asked in 2016. Is this Ok to do? It had to do with any measure, I believe.

Deb Kaldenberg [answer]: In general this would not be okay and basically what it sounds like people are asking is, if they are identifying during abstraction that there were certain things that weren't documented during the measurement period, can they go back and potentially make calls to try and fill in those gaps. And and that wouldn't be, um, that would not be appropriate. If however, you're finding maybe you have documentation that wasn't, um, screened into the medical records until 2017, that that documentation is from 2016, and maybe it wasn't received until later on in the year, um, that could potentially be used. But what we don't, um, want to come across as being acceptable, is that basically you're realizing that you don't have documentation anywhere in the medical records. That there was a mammogram or colorectal cancer screen. So you call the patient in 2017, to try and find out hey, did you get this, and then try and fill in those gaps in 2017 for quality action that should have occurred in 2016. If you need more specific information on a scenario, we would recommend you open up a QualityNet help desk ticket and, and ask the question through that avenue.

Michael Kerachsky [question]**:** Ok, next question: For measure CARE 2, fall screening, if our problem list has at high risk for falls coded in 2016 note, but no other documentation, does this qualify as met in the numerator?

Carol Noyes [answer]: Hi, um, this is Carol, and no that would not qualify. Um, so within the data guidance, there is within the inclusion synonym tab, um, falls are defined and what type of screening necessities are also there. And the documentation of an actual fall or a history of falls or even asking the question of have you fallen, would be a requirement for this measure.

Michael Kerachsky [question]**:** Ok for PREV 6, colorectal cancer screening measure, if the primary care physician has documented in the patient's medical record, that the patient had a colonoscopy on, uh, April 2010 with no polyps, would this satisfy the measure?

Deb Kaldenberg [answer]: Yes this would satisfy the measure, and the reason it would, is because the colonoscopy needs to be done during the measurement period or nine years prior to the measurement period. So the 2010 date meets that requirement. You also have, um, the type of test, the colonoscopy, and you have the results of no polyps.

Sherry Grund: Um, Deb, this is Sherry from ACO-PAC. Um, the question that you answered, um, just prior to the last one that Carol, um, fielded, um, I just wanted to add something to believe we discussed that if results of a test, um, that occurred perhaps late in the year, so late in 2016, maybe in December, um, and the results did not get back on the record until early

2017, that that would be acceptable. So in your example, in this question of the, um, colonoscopy that maybe occurred in December instead of April, um, if that had occurred, um, and then not getting that result um, back into the record until 2017 may be appropriate, and we would accept that.

Michael Kerachsky [question]**:** how is the diabetes composite being evaluated this year; reporting or performance; the benchmark chart shows performance, but there's an asterisk starting at the eye exam portion, won't be performance until 2017. How does that work for the composite measure?

Olivia Berzin [answer]**:** And actually, this is the Olivia Berzin. I'm actually going to request they submit that to the shared savings program mailbox, since this webinar is really specific to Web Interface reporting.

Michael Kerachsky [question]**:** Ok next question- Please help me understand the impact on overall results for reporting on all ranked beneficiaries, not just the 248 consecutive. Is it advantageous to stop once you reach the 248? What is done with the data entered for those above that 248?

Catherine Hersey [answer]: Hi, this is Catherine from ACO-PAC. So the full number of beneficiaries that you consecutively confirm and complete, will be using your performance calculations. So you only have to consecutively confirm and complete 248, but if for whatever, um, your organization decides that you want to consecutively confirm and complete 300 of your beneficiaries, then all three hundred of those beneficiaries will be counted towards your performance calculations. So the answer is yes. If you choose to report above and beyond that 248, the total number of consecutively confirmed and completed beneficiaries will be included in your performance calculations. As to whether that's advantageous, it really depends on how your reporting goes, what kinds of things you've done for your patients. That’s- it really depend on the experience of your particular group practice or ACO.

Olivia Berzin [answer]**:** And this Olivia Berzin. I would also recommend you take a look at question 9 on page 12 the Q&A document, which kind of walks through a math example. It will help you figure that out.

Michael Kerachsky [question]**: Ok,** for PREV 12 - If a patient has a positive PHQ-2 score, does the administration and score of the PHQ-9 meet the standards for follow-up?

Deb Kaldenberg [answer]: So this particular question was answered on the 1/26 support call, and so this can be found in writing in the slide, um, and I don't see what slide number it is, but the answer is yes, if the initial screening is considered positive and the recommendation is to follow-up with additional screening, the additional screening must occur on the same encounter and the measure is considered met. If the recommendation is to follow-up with additional screening and the additional screening does not occur on the same encounter, the intent of the measure has not been met. If additional screening occurs during the measurement period, not on the same day as the initial positive screening, this new screening would be considered most recent, and results should be used to report the measure. If positive, a recommended follow-up is negative, measure is met. So I'm assuming in your scenario, you have a PHQ-2 that's identified as positive, you immediately do a PHQ-9. If that is the scenario you're referring to, this would be considered numerator compliant for PREV 12 within the 2016 program year. And again, that- that answer if you want it in writing, can be found on the January 26th support call slide deck.

Michael Kerachsky [question]**:** Thank you. For measure CARE 3, if there are multiple medications on the medication list, but only one of those medications have the full SIG, frequence route of administration dose and the provider states that the medications were reconciled, does this count?

Presenter [answer]**:** As long as you have documentation supporting, um, I guess what you are reporting, then this would count. So as long as you have what the doctor, I guess, is feeling is, um, I guess acceptable for the measure, meaning they feel like they reconcile what they can for that, at that visit and you have documentation of the medication reconciliation, then yes.

[Pause]

Michael Kerachsky [question]**:** Ok, for PREV 7, flu screening, if medical record states, quote previously immunized this flu season, does this count as met, but there is no date?

Deb Kaldenberg: I'm sorry Michael, can you repeat that question?

Michael Kerachsky [question]**:** Sure. So for PREV 7, flu screening. If medical records states quote previously immunized this flu season, does this count as met if there, even if, I guess, even if there is no date?

Deb Kaldenberg [answer]: And-and I would say that really depends, um, because it depends on when you're documenting that the flu season, that the flu vaccine was provided- what at, at what encounter, um, to ensure that the receipt of that flu vaccine is specific to the flu season being reported. Um, I would- I would suggest, if you would like, um, a more specific answer to your scenario, to go ahead and open up a QualityNet Help Desk ticket, with um, a little more detail, as far as you know, um, again if- if it's a, if it's an encounter that's during the flu season, then that would meet the requirement; if it's an encounter that's not during that flu season, it may not.

Michael Kerachsky [question]**:** Ok for heart failure; if patient is not on a beta-blocker in 2016 but has a pacemaker, is that an exception or does the provider have to state explicitly, no beta blocker due to pacemaker?

Olivia Berzin [answer]: Um, the measure owner does not consider a pacemaker and exclusion or an exception for this measure, so you would look for the use of beta blocker within your patient population, unless your patient would have an AV block without a pacemaker present. Then that would be an acceptable medical exception.

Carol Noyes [answer]: For audit purposes, if you uh, would go ahead and document that that was why, um, the patient was not on a beta-blocker, um, that definitely would be acceptable.

Michael Kerachsky [question]**:** Ok, if an ACO completes abstraction or a hundred percent of the beneficiaries for a measure, but it does not meet the 248, will it cause the ACO to fail that measure?

Catherine Hersey [answer]: This is Catherine. No, I mean, as long as you report on all the beneficiaries that are available to you, ah, then you've completely and accurately reported. We understand that there are some cases where your just sample isn't big enough to have 248;

they just won't be available to you. So in the event they're not available to you, report on one hundred percent of what is available to you and- and you'll be fine.

[Long pause]

Michael Kerachsky [question]**:** Ok, um, next question. If a patient has never had a lipid panel complete, how do you recommend responding to this question, if the patient has never had a lipid panel completed and therefore we have no record of any LDL-C value?

Deb Kaldenberg [answer]: So I'm assuming that you're referring to PREV 13, and so I'll provide a response based on the PREV 13 measure. Um, basically, if you have said no to the ASCVD diagnosis and you're moving on to risk category 2 for that measure, to determine if the patient has ever had a fasting or direct LDL-C less than or equal to 190 no, yes. Greater than or equal to 190; my apologies; and you can't find that LDL-C, um, documented anywhere in the patient's history, then you would select no and move on to risk category 3. Risk category 3, if you answer yes to diagnosis of type 1 or type 2 diabetes, and you're moving into the LDL-C 70 to 189 during the measurement period or two years prior to the beginning of the measurement period, and again you cannot find an LDL-C that meets those timing component, you would answer no and stop abstraction for that particular patient. That patient would be skipped and replaced, um, as they're not considered denominator eligible. If I'm not providing an answer to the right measure for you, please open up a QualityNet help desk ticket and we will provide you and we will provide you an answer for whichever measure you're referring to.

Michael Kerachsky [question]**:** Ok next question concerns breast cancer screening- PREV 5. Please confirm, does the 27 month look-back period require a mammogram anytime between October 1st, 2014 in December 31st, 2016?

Deb Kaldenberg [answer]: That would be to 27 months look back, yes, for PREV 5. And just to confirm for the other question I answered, um, I think we were getting caught up in the old DM composite, thinking of another LDL-C measure. So that answer would be relevant for the PREV 13 measure on the LDL-C. Um, and just so I don't confuse things, yes, for PREV-5, the breast cancer screening, the look back period is the measurement year, the year prior, and the three-month grace period.

Michael Kerachsky [question]**:** Ok, for the mental health measure, we have audited all our patient samples and are currently recording a 0 percent, as none of our physicians use PHQ-9. Will that be a problem, or is it acceptable to report 0 percent at this time?

Deb Kaldenberg [answer]: So, from the measure perspective, if you're not using a PHQ-9, um, this would mean that none of the patients were considered denominator eligible. So it's not a surprise in that case that there's a 0 percent.

[Pause]

Michael Kerachsky [question]**:** For measures, ah, MH, CAD, heart failure; if an ACO exists, exhausts their sample and cannot confirm diagnoses is there any penalty from the perspective of reporting?

Catherine Hersey [answer]: I mean this is Catherine again. I mean, I just want to stress that the patients in your sample, particularly these disease modules, do have claims evidence of these diagnoses, um, say, I it would be unusual for you to go through your entire sample and not be

able to confirm any of these diagnoses. If that is in fact what you're experiencing, particularly if it's for multiple measures, please do submit to help ticket, but as I mentioned before you know the the expectation is that you will completely report on the required number of beneficiaries. So if you exhaust your sample and you have completely reported, and still find yourself unable to complete to confirm that threshold of 248, um, you know there is really nothing else you can do, so that is acceptable. Um, if- if you consecutively complete all of the beneficiaries available to you and there's no one left, um, you know that's the expectation that you; that you either complete that 248 or you report on your entire sample. So hopefully that- that makes sense. But again, if you're finding that for multiple disease modules you're coming up with no beneficiaries for whom you can confirm a diagnosis, you should submit a help desk ticket for that.

Michael Kerachsky [question]**:** Ok regarding PREV 7 on the XML upload process, if a patient does not have a visit in the October through March time periods, do we use a 17 to remove them from the denominator?

Sue Hanlon [answer]: This is Sue Hanlon from DECC. Ah, 17 is a denominator exclusion and that is not a valid answer for that, for the PREV 7 question.

Catherine Hersey [answer]: And to confirm that from a sampling perspective, again this is a case, for PREV 7, there is claims evidence that a visit did occur in that timeframe, within your organization, so you should be finding a visit. Uh, if you have concerns about that, again, please do submit a help desk ticket.

Deb Kaldenberg: Hey Michael, this is Deb. I'd like to jump in real quick if that's Ok.

Michael Kerachsky: Sure.

Deb Kaldenberg: Okay we, we have a question. They just want to conf, I, I apparently caused some confusion with my lipid panel LDL-C question, um, and and the answer is specific to PREV 13. As in 2016, that is the only measure that we are looking for the LDL-C and the basic answer is to go ahead and use this, the data guidance tab of the supporting document and what you'll find is that as you go through each of the risk categories, when you get to the LDL-C and risk category 2, if you cannot find in the documentation, in the medical record, that the patient has ever had an LDL-C greater than or equal to 190, you would select no and move into the risk category 3. And the same would be said for risk category 3. If you can confirm diagnosis of diabetes, but you cannot confirm an LDL-C value, then you would select no, the patient would be skipped and replaced. Basically, even if you are showing that the LDL-C cannot be calculated, due to high triglycerides, you don't have documentation that shows the, um, the value that would be required to, um, and document that the patient had the LDL-C value required for denominator exclusion in risk category 2 or risk category 3. So you wouldn't be able to report that that patient is denominator eligible. If that doesn't help clarify, please open up a help desk ticket and we can provide that response in writing.

[Pause]

Michael Kerachsky [question]**:** Kay, we have another Web Interface question related to heart failure EMR mapping. So the EMR mapping has a YC next to some beta blockers or exceptions, Metrop- Metoprolol Tartrate alone does not count, but is flagged as YC drug exception. If the patient is on Metoprolol Tartrate alone, do we have to answer no or no exception? What does the YC mean next to medication?

Carol Noyes [answer]: So, within the data guidance there is a note that speaks to this YC, um, and it says for mapping from the EHR, when an accepted drug allergy or medication is found, look for drugs with a YC, the yes conditional, and the drug exception column of the drug tab. These drugs may be used as a denominator exception if present in the patient's record, accompanied by the appropriate conditional reason why the patient isn't taking the drug, such as an allergy or an intolerance or specific medication. However, Metoprol-Metoprolol Tartrate is a medication that is not extended release. So because it is not extended release, it is not acceptable for this particular measure. Now, if it is something that is extended release or sustained release and it is Metoprol-Metopro-eh-Metoprolol let me get that straight guys- then it would be, um, acceptable. But as a short-acting drug, it is not acceptable for this measure.

Michael Kerachsky [question]**:** Ok. If the patient is documented as having only diastolic failure, with normal ejection fraction and normal left ventricular systolic function, should they be listed as heart failure confirmed but LVSD 40 or more, or diagnosis not confirmed?

Carol Noyes [answer]: So, I would need to look at the evaluations tab in order to I guess respond correctly to this, um, and I would encourage you to actually take a look to see if that diagnosis is within the evaluations tab. Um, if you can confirm that they have a diagnosis of heart failure, then you would continue to respond to the questions, um, that were follow along within the data guidance for the questions that you would need to answer, related to that. Um, and you can look for an, um, a PS at for any time within the patient's history. So that would be another place to check if you do confirm the diagnosis. And this is Carol; I keep forgetting to tell you all that.

Michael Kerachsky [question]: For tobacco screening; if the patient is marked as never smoker or former smoker, do we have to include the smokeless screening as well to meet this measure?

Deb Kaldenberg [answer]: Yes, you would have to include the smokeless screen as well. The intent of this measure is tobacco use. It is not specific to smoking only. So you would need to, um, query both smoke smoke smoking and smokeless tobacco.

[Long pause]

Michael Kerachsky [question]: If we know that another clinic has results for a mammography via claims, but we don't have those results documented in our EMR as of 12/31/2016, can we reach out to the other clinic to obtain the results and add them to the EMR, for purposes of reporting to program year 2016?

Deb Kaldenberg [answer]: So this would be similar to what we answered earlier; um, both Sherry and I; and that if if you know that if, if you're trying to fill in the gaps because the patient has been attributed and you realize that you don't have the information needed, it would not be an appropriate time to try and update your documentation. If, however, the screening was done later on in the year and you just haven't had an opportunity yet to get those documents, it would be acceptable, basically if you're trying to to ensure that you have all documentation for patients, especially if screening took place later on in the year.

Michael Kerachsky [question]: Ok next question. Where can the patient attribution to a TIN be found? Is attribution based on plurality of primary care charges or all charges?

Olivia Berzin [question]: So the answer to this question differs a little bit depending on whether you're in an ACO or a group practice. Uh, if you're a group practice, you can look on the PQRS GPRO Web Interface web page. There is a document called the PQRS GPRO Assignment Methodology, uh, that will give you all the details around what goes into a beneficiary assignment for the PQRS program, um, and- and yes, at a high level, it is based on plurality of primary care services, as determined by allowed charges. If you're an accountable care organization, um, the Shared Savings Program or the Pioneer ACO model, or the Next Generation ACO model will, on their respective websites, have a detailed information on those, ah, models, or program specific assignment methodologies. So I would refer you back to those sources.

Michael Kerachsky [question]: Ok, because transition of care visits are billed 30 days after hospital discharge and not on the date of the face-to-face visit or medication reconciliation would have occurred, should we answer no visit outside practice for these visits?

Deb Kaldenberg [answer]: So in this case, I mean basically you're looking for the actual encounter to have occurred. So the date that's been pre-populated; if you cannot find an encounter within two days of the pre-populated date, then you would go ahead and select visit outside of practice. And we do understand that those transition care, on the way those are built apparently, you know there is a possibility or the likelihood that your actual encounter incurred way outside of that two day, um, leeway. And, so yes, you would select visit outside of your practice.

[Pause]

Michael Kerachsky [question]: For PREV 12, if our EHR as a template checklist for depression screening, yes/no, is this considered standardized?

Deb Kaldenberg [answer]: So PREV 12, in the data guidance tab of supporting document, does give some guidance on, um, screenings that are considered appropriate and if I can get to that I can read the language to you. Um, so standardized clinical depression screening tool would be considered a normalized and validated depression screening tool developed for the patient population where it is being utilized. Um, and then of course, there's some examples included. So it does not appear as if your example meets the requirement for a PREV 12 normalized standardized screening tool.

[Pause]

Michael Kerachsky [question]: Ok have a Web Interface question – an ACO for the shared savings program. I understand the ACO can upload information to the website. Can an ACO submit data multiple times and only the last submit is the one accepted for final reporting?

Sue Hanlon [answer]: The answer is yes.

[Pause]

Michael Kerachsky [question]: Ok. Regarding the missing documentation question; I thought they had said in the past, we are expected to fill in missing information in the EMR, if the patient was assigned to us. And we were expected to reach out to other providers to complete the measure.

Deb Kaldenberg [answer]: And this is Deb…and I, I understand what you're saying and yes the-the-the continuity of care is what is being requested. What we're saying is that if you are identifying after the measurement period, that you didn't have that continuity of care that is not necessarily the time to be trying to fill in those gaps. Um, eh, as the basically you're reporting based on what was supposed to have occurred in 2016; not trying to find out what you missed in 2017 and fill it in at that point in time.

Michael Kerachsky [question]: What score on a PHQ-9 is considered positive score? The narrative spec-specification does not state this.

Deb Kaldenberg [answer]: No, the narrative specification doesn't state this because there is no one specific score for the PREV, the PHQ-9 that would be considered positive. Um, this would be something that would be determined by the eligible professional screening the patient, as it could be very specific to the patient being screened, as to what or might indicate a positive screen or not a positive screen for the PHQ-9.

[Long pause]

Michael Kerachsky [question]: How do we stop the calculation in a specific measure, without impacting the other measures?

[Long pause]

Rabia Khan [answer]: This is Rabia. I think we might need some additional information on that question. So if you asked that, if you could follow up and add some more context, that would be helpful or just given sort of that we only have a few more minutes on the call, it might be appropriate for you to send that one to the QualityNet Help Desk and we can respond there.

Sherry Grund: I think; this is Sherri from ACO-PAC; think what they might be referencing, is the fact that, where a single patient might be represented in more than one measure and if someone has a low rank, um, in one measure and has a higher rank in another, um, they're wondering about, um, how to handle that. Um, but as Rabia indicated, I think we can better, better serve you and answer your question if you give us specific example.

[Pause]

Michael Kerachsky [question]: Ok, next question. Would transitional care be outside your practice or no visit found?

Carol Noyes [answer]: If it's not found within one to two days of your of your visit; if you are not finding medication reconciliation within one to two days of your visit, then you can select no outside practice.

[Pause]

Rabia Khan [answer]: Um. This is Rabia. Yeah, I just want to sort of interject. I know there were some questions earlier about this but, um, when, um, I just want to stress that we we do encourage, if you're an ACO, to work with your providers inside and outside of your ACO, to be able to collect data for reporting. Now, um, I do believe we have a Q&A on this, and the uh, Q&A document. But if you are having issues with that, please, I urge you to send a Quality Net help desk ticket and we can help respond.

Michael Kerachsky [question]: Ok. There was a previous question regarding, um, PHQ-2 and this is a follow-up to that question. Question about the positive score for PHQ-2; this is a standardized tool. Are you saying there is no score to indicate it would be positive?

Deb Kaldenberg [answer]: For the PHQ-2 and the PHQ-9, if you were to, and I'm going to use the term, google, but if you were to look at the screening tools, there is not a specific score that indicates positive or negative. This is something that that that tool has been, um, created in such a way that that that, that determination is left up to the provider, based on the patient that is being screened. Now certainly if there is a score of a zero you can assume that that is a negative screen because they scored zero, but, but those screening tools leave leeway for the provider to make their determination based on the specific patient that they are seeing. This is a little difference in the MH-1 depression remission at 12 months measure, is that particular measure has identified a PHQ-9 greater than nine, to be an indication of depression, based on also having a diagnosis of dysthymia or major depression, and they're looking for an outcome of remission at 12 months, plus or minus 30 days. But for the purposes of PREV 12, the depression screening measure, this is really something that is based on, again, the eligible professional and the patient being screened, as and whether or not a specific score would be considered positive or negative.

Michael Kerachsky [question]: Ok. Is PREV 7, influenza, the only measure that can be met without chart documentation, if reported as pre populated to CMS?

Deb Kaldenberg [answer]: Yes. That would be the only measure, um, that you would not need additional information, if it was pre-populated by CMS.

Michael Kerachsky Okay, at this time, we'll take one more question.

Michael Kerachsky [question]: Um, regarding PREV 7. I'm sorry. Regarding PREV 11, please clarify; if the systolic blood pressure is greater than 120 and or diastolic is greater than 80, a care plan is required if that out of range blood pressure is collected in a visit with a primary care provider. Does that count as a care plan?

Deb Kaldenberg [answer]: So within the data guidance tab of the supporting document, we did try and identify this. So if your visit is with a primary care provider and the blood pressure is considered pre-hypertensive, no additional follow-up is needed. This would meet the intent of the measure and you would select yes to the follow-up plan. If not pre-hypertensive blood pressure reading is the most recent blood pressure reading and it is not taken by a provider considered the PCP, then you would have to have documentation of a recommended follow-up in order to meet the measure.

Michael Kerachsky: Ok. This concludes uh, today's question and answer portion. Um, back to you Ashley.

Ashley Burrell: Thank you Mike and thank you to all of our panelists for that informative session. If you have additional questions or feel that your question was not addressed on today's call, please contact the QualityNet help desk with your inquiry. At this time, I would 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.