POM ACO
TRANSFORMING HEALTH CARE TOGETHER

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CMS Weekly Webinar Notes

February 14, 2018

CAVEAT

I'm not a medical professional and have not read all of the measure documentation. Please ask for clarification if you find the information below to be questionable.

Thanks.

James Malayang
2/20/2018

ANNOUNCEMENTS

Now available in the QPP Resource Library: Data dictionary and Excel to XML Mapping.

Q&A SESSION

1. For **PREV-5** is a patient eligible for exclusion from the measure if they have a history of one unilateral mastectomy? To be eligible for an exclusion, the patient will have to have had a left and a right unilateral mastectomy. They may have happened at two different times. The expectation is that a mammogram be done for the existing breast.
2. Does it matter how the spreadsheet that is uploaded is sorted (i.e. Is it okay to sort the spreadsheet by Medicare ID), and is the Cerner supplied version of the spreadsheet okay to upload? The sort order of the beneficiaries does not affect the upload. Please be aware that only the excel template provided through the application is accepted via upload. You may either download without data to get a spreadsheet without any data reported. Or, you may download with data to obtain a spreadsheet with all data reported for your organization.
3. For the screening measures (mammography & colon cancer screening), can the patient be considered as having the screening done if the physician has the result noted in their progress notes but does not have the actual report? For both measures, documentation in the medical record must include both of the following: A note indicating the date the screening was performed AND the result or findings Documentation of 'normal' or 'abnormal' is acceptable
4. Does the visit information you just described for **Prev 7** apply generally to all measures? Do we need to check visits or does Medicare have claims that support visits for all measures? That answer applies to all measures - CMS has ensured the visit criteria have been met based on what your organization billed Medicare.
5. At what point will the Measure score appear for the web interface? For groups, the measure score will be available once the minimum reporting requirements are met for that measure.

6. **CARE 2:** If documented that gait status must use the verbiage? Must be med rec doc stating that an assessment of gait or balance is performed.
7. **CARE 1:** Patient expired? Pg. 6 of the specs, indicate that deceased. Will remove from all measures.
8. **CARE 1:** If patient does fup with specialist and med is rec, use? Yes, any outpatient visit within 30 days.
9. Where find a guide to know the skips, measure rate reports? User guide
10. **PREV 12**, documentation g8433 OK? Only those diagnoses are allowable.
11. **PREV 7,** what is preventive visit? Refer back to the coding documents.
12. **PREV 9,** age group of exclusion and exception? 18 or older. Denom exceptions are not.
13. We have a patient on our list who has a DOB that is different than what we have in our system. Do we still report on the measures? If you are able to confirm it's the same patient based on identifiers like HICN/name/gender, then please correct the date of birth in the CMS Web Interface and continue reporting on them. If they become ineligible for a measure in which they are ranked, they will be removed from the measure's sample.
14. What are the numbers in the comment section of reported patients for? I see some have 5 digit numbers once they have been reported. Can you provide a screen shot and open a Service Center ticket? We are not sure what you are referring to. But, we would be happy to help explain if we can see a screen of what you are seeking information on.
15. **ACO 20:** Breast CA Screening: if pt turns 75 during measurement period (ex: Nov 2017), are they still included as eligible? The beneficiary sample should include beneficiaries between 51 and 74 years of age during the measurement period. So in this case, the beneficiary would not be eligible. If you are seeing beneficiaries outside of the appropriate age range, please submit a ticket to the QPP help desk.
16. **ACO 20: Breast CA Screening**: if pt turns 75 during measurement period (ex: Nov 2017), are they still included as eligible? The beneficiary sample should include beneficiaries between 51 and 74 years of age during the measurement period. So in this case, the beneficiary would not be eligible. If you are seeing beneficiaries outside of the appropriate age range, please submit a ticket to the QPP help desk.
17. **For CARE-1**, so we don't need to confirm the discharge date given to us by CMS. Only that a med rec was performed within 30 days +/- 2 days of the discharge date given to us by CMS? You do need to confirm that an inpatient discharge occurred within +/-2 days of the prepopulated discharge date, in addition to confirming that a visit took place within 30 days and indicating whether or not medication reconciliation was performed.
18. Why can you not link the supporting documents to the measures within the web interface? Also information from these sessions for each measure? It is difficult to get to and find the correct documentation on the QPP website. We can take that information into account for next year's system. The documentation available can be found on the resource library located here: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Resources.html
19. For IVD measure, how to handle a patient who has both anticoagulant and aspirin/antiplatelet medications at some points during the measurement period (2017)? In case of an overlapping period in 2017? What about in case of not overlapping period but within CY2017 (for example,

May-June anticoagulant, July-Dec aspirin)? Are we required to report an exclusion or would the patient be numerator compliant? Patients who had documentation of use of anticoagulant medication at any time during the measurement year are excluded--even if they were also on aspirin.

FREQUENT MEASURE QUESTIONS

These were shared via slides and rather than transcribe them, they are pictured below.

Frequent Assignment, Sampling, and Prepopulation Questions

No.	Measure	Question	Answer
1	PREV-7	I have a patient that was only seen once during the flu season of October 1, 2016-March 31, 2017. Would this would make them not qualified for the sample for PREV-7?	According to Medicare claims, all beneficiaries sampled into the CMS Web Interface have had at least two visits with a provider in your organization during 2017. Additionally, CMS ensures (using Medicare claims billed by your organization) that the beneficiary had at least 1 visit with the encounter codes listed in the Supporting Documents for PREV-7 at the organization during the flu season (October 1, 2016 through March 31, 2017). Please note, users are not responsible for confirming that the qualifying encounters occurred. You would only need to determine if the patient received or reported previous receipt of the influenza immunization (if not pre-filled) between August 1, 2016 and March 31, 2017.

Frequent Assignment, Sampling, and Prepopulation Questions

No.	Measure	Question	Answer
2	All	We are finding a small number of patients in our beneficiary sample have not been seen by any of our organization's providers in the past three years. When we find a patient whom our providers haven't seen, should we mark "Medical Record Not Found" since a medical record is unavailable for the reporting period? Or should we mark something else?	By the assignment algorithm, the patient was assigned to your organization because they were deemed to have the plurality of their Medicare services with your organization [per claims submitted by your organization's participants to Medicare]. Further, patients sampled into the CMS Web Interface had at least 2 Evaluation & Management (E&M) visits with your organization between January 1 and October 27, 2017 [again, per claims submitted by your organization participants to Medicare] therefore your organization is considered accountable for this patient's care, and you should do your best to obtain the needed quality of care information to complete the CMS Web Interface.

Frequent Assignment, Sampling, and Prepopulation Questions

No.	Measure	Question	Answer
3	All	Some of the Medicare IDs (Health Insurance Claim Numbers) that were provided in the CMS Web Interface are different than what we have on file for the patient. What should we do?	A patient's Medicare ID or HICN may change over time as eligibility reasons change (for example, the last two digits of a patient's HICN may change if the patient's eligibility status changes from spouse to widow or the entire HICN may change if a patient changes eligibility from self to dependent status). Please also note that HICNs with brackets are not necessarily incorrect - they are used for beneficiaries who are eligible for Medicare through the Railroad Retiree board. Whenever possible you should confirm the patient based on other criteria (e.g., name, gender, date of birth). The HICN cannot be edited in the CMS Web Interface although you can make note of this in the Comments field for your reference.

PREV-9 Measure Review

PREV-9 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan Measure

Denominator Confirmation:

The denominator includes the initial patient population minus any denominator exclusions.

Denominator Exclusions apply to patients with either of the following:

- Patients who are pregnant any time during the measurement period
- Patients who refuse measurement of height and/or weight or refuse follow-up at any encounter during the measurement period
- Note: Wheelchair bound patients or amputees are not excluded from the measure. If a BMI was not performed, the patient would not meet the intent of the measure.

PREV-9 Measure Review

Denominator Exceptions apply only to the Follow-up Plan not medical record documentation of the calculated BMI.

The Medical Reason denominator exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider:

- Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions
- Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Note: Just having a medical condition does not qualify the patient for a denominator exception. Weight loss/weight gain must complicate such underlying medical condition to be considered an exception.

PREV-9 Measure Review

Numerator Reporting:

- Start with the most recent visit in the measurement period. If a calculated BMI is documented in the medical record at that visit, and if the BMI is abnormal a recommended follow-up plan is also documented at the visit, the intent of the measure has been met.
- If at the most recent encounter in the measurement period there is no medical record documentation of a calculated BMI, you may look back 6 months from the encounter for a calculated BMI, and if abnormal a recommended follow-up must be tied to the abnormal BMI.
- If there is no BMI documented in the medical record for the patient at the most recent visit during the measurement period or in the 6 months prior to the visit, you must answer "No" for the Numerator.

Frequent Measure Questions

No.	Measure	Question	Answer
1	All	Why wasn't my CMS Approved Reason request approved?	The CMS Medical Officer reviews the 2017 CMS Approved Reason Requests and makes the final determination. Generally, if the measure developer did not include an applicable exclusion or exception for this measure and it does not appear the request presents a unique circumstance, the request will be denied. In these cases, you will report this measure in the same fashion as it is reported using other submission mechanisms. All providers will be held to the same standard and data would likely be consistent and comparable across ACOs and groups. We are unable to accept requests for CMS Approved Reason on the weekly web interface webinars. You must have a CMS Approved Reason "approved" response from the QPP Service Center in order to appropriately place the case number into the web interface and skip the patient.

Frequent Measure Questions

No.	Measure	Question	Answer
2	PREV-6	Is the new FDA Approved Epi ProColon blood test acceptable?	No. The Epi ProColon test (SEPT9 serology test) is not acceptable for the Colorectal Cancer Screening measure. While, the FDA has approved the Epi ProColon test for use, this is separate from a clinical practice guideline. The Colorectal Cancer Screening measure is based on the USPSTF Guidelines and expert consensus. The USPSTF stated there is limited evidence evaluating the use of the SEPT9 serology test.
3	MH-1	Is there a way to exclude Alzheimer's or dementia patients from this measure?	A denominator exclusion only applies if the patient has died, received hospice or palliative care services, was a permanent nursing home residents, or has a diagnosis of bipolar disorder or personality disorder. Assuming the patient has an active diagnosis of depression (including remission) or dysthymia during the denominator identification measurement period, you should look to see if the patient has one or more PHQ-9s administered (or a PHQ-9 >9 is not present) during the denominator identification measurement period. If no, then the patient will be skipped and replaced.

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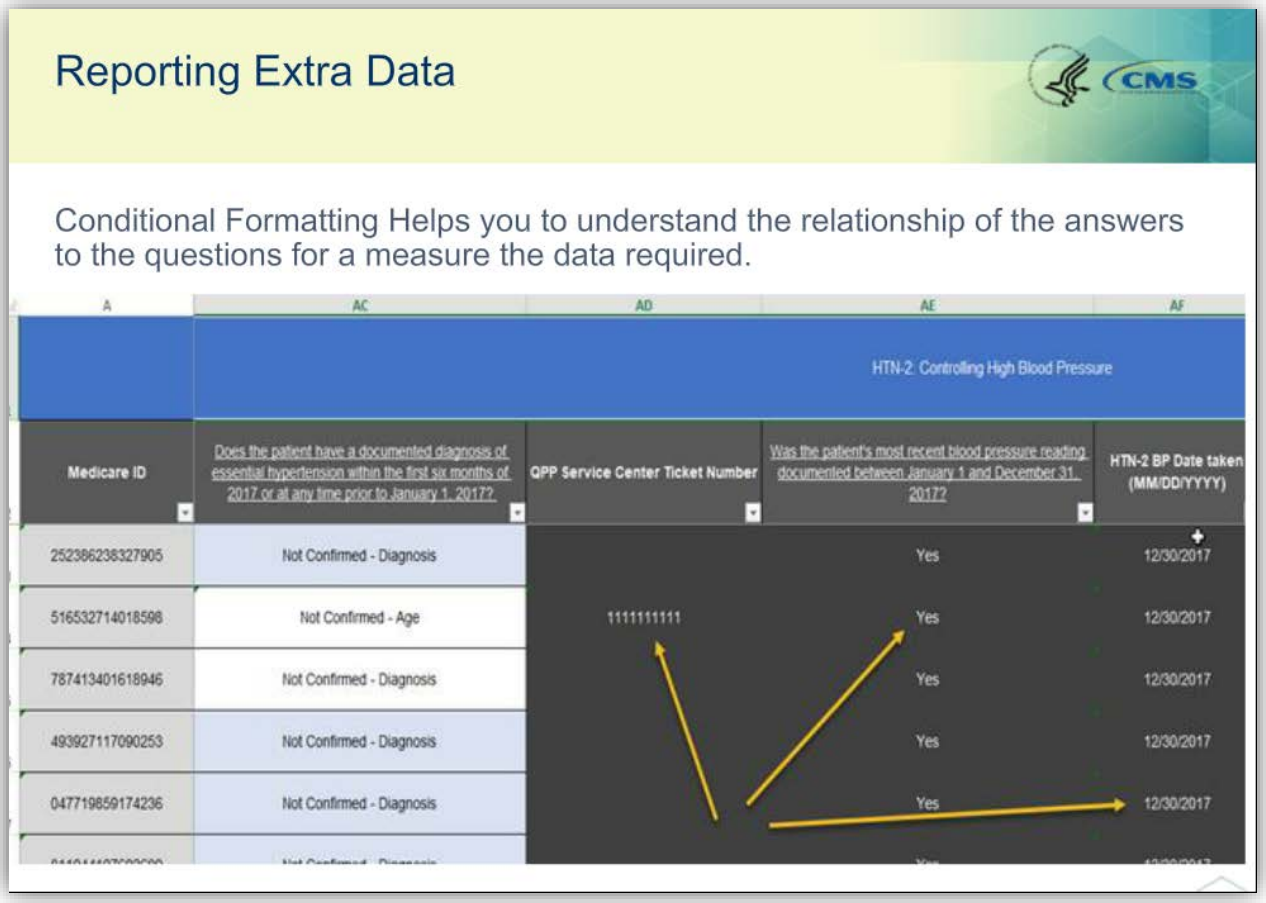
Reporting Extra Data
CMS
Conditional Formatting Helps you to understand the relationship of the answers to the questions for a measure the data required.
A
AC
AD
AE
AF
HTN-2: Controlling High Blood Pressure
Medicare ID
Does the patient have a documented diagnosis of essential hypertension within the first six months of 2017 or at any time prior to January 1, 2017?
QPP Service Center Ticket Number
Was the patient's most recent blood pressure reading documented between January 1 and December 31, 2017?
HTN-2 BP Date taken (MM/DD/YYYY)
252386238327905
Not Confirmed - Diagnosis
Yes
12/30/2017
516532714018598
Not Confirmed - Age
1111111111
Yes
12/30/2017
787413401618946
Not Confirmed - Diagnosis
Yes
12/30/2017
493927117090253
Not Confirmed - Diagnosis
Yes
12/30/2017
047719859174236
Not Confirmed - Diagnosis
Yes
12/30/2017