CMS Web Interface Support Call #4: 2024 Data

February 19, 2025

>>Ketchum: Hello, everyone. Thanks for joining today's Web Interface Support Call. This presentation will be followed by a Q&A session where attendees will have an opportunity to ask questions and CMS subject matter experts will address as many questions as time allows. To note, a recording and the slide deck from today's call will be posted to the QPP Webinar Library in the coming weeks. Now, I'll turn it over to Lisa Marie Gomez at CMS to begin.

>>Lisa Marie Gomez, CMS: Thanks, Hallie. Welcome everyone. And thank you for joining us today as APM Entities and Shared Savings Program ACOs prepare for quality reporting. Again, my name's Lisa Marie Gomez from CMS. Joining me today on the call are other CMS experts who will share helpful information on the CMS Web Interface quality reporting and answer your questions following today's presentation.

Today's support call will only focus on 2024 CMS Web Interface quality reporting. You can contact the Quality Payment Program Service Center with any of your questions regarding cost, Promoting Interoperability, improvement activities, MIPS, or quality reporting in general. Today's slide deck, recording, and transcripts will be available in the near future, and it will be posted on the QPP Webinar Library.

Next slide, please.

This is a disclaimer slide. And with this slide, it includes information that is current at the time of this presentation. But we encourage you to ensure that you're using the resource documents that pertain to the CMS Web Interface measures.

Next slide, please.

And I'm going to discuss announcements and reminders.

Next slide, please.

The CMS Web Interface will close at 8 p.m. Eastern Time on March 31, 2025. Your submission will automatically be accepted as submission closes. As a reminder, the CMS Web Interface is accessible using the “Sign In” link on the Quality Payment Program website.

Next slide, please.

And I'm going to discuss the CMS Web Interface Application Programming Interface. So the CMS Web Interface API is available all year for testing in the Developer Preview Environment. Please review the links listed here for more information.

Next slide, please.

And I'm going to discuss skip requests, also known as “Other CMS Approved Reason” requests.

Next slide, please.

So, when you're submitting your “Other CMS Approved Reasons” during the last day of the submission period could cause your request to not be processed. Please ensure to submit your “Other CMS Approved Reasons” as soon as possible. And note that any submitted after Monday, March 24, 2025, may not be processed prior to the close of submission. For more information on how to submit an “Other CMS Approved Reason” request, please review page 45 of the 2024 CMS Web Interface User Guide. Please note that when you are submitting such a request, please include as much information as possible pertaining to the case at hand. Please do not include PII, but sufficient information that will allow us to comprehensively review your request. We want to process the “Other CMS Approved Reasons” sufficiently, but there have been instances where we've needed additional information, and in these cases, we've emailed the requester but do not receive a response, so please note that we may contact you requesting additional information pertaining to your submission for “Other CMS Approved Reasons.” I

just want to note that if we do not receive the additional information that we need, we will make a decision based on the information, the limited information we have. Now I will turn the presentation over to Aroush to go over some frequently asked questions.

Next slide, please. Yeah, thank you.

>>Aroush Anis, PIMMS: Thanks, Lisa Marie. If we can go on to the next slide, please.

So the two CMS Web Interface measures that we'll be reviewing today are PREV-5, Breast Cancer Screening, and PREV-6, Colorectal Cancer Screening.

Next slide, please. Thank you.

The intent for PREV-5 is for women between the ages of 41 and 74 to have a mammogram screening for breast cancer. Please note that documentation of screening for breast cancer may be completed during a telehealth encounter.

Next slide, please. Thank you.

So now we'll go over some frequently asked questions for PREV-5. So question for the PREV-5 measure: Does a unilateral mammogram count for the numerator?

Answer: A unilateral mammography counts only if there's medical record documentation of a mastectomy of the breast-- of the other breast. If only one breast is present, unilateral screening on one side must be performed on the remaining breast.

The second question: The PREV-5 measure includes-- the PREV-5 Coding Document only includes Logical Observation Identifiers Names and Codes to represent mammograms on the 'Numerator Codes' tab. Concurrent Procedural Terminology, or CPT codes, such as 77065, 77066, and 77067 that are billed on claims with supporting documentation available, can they be used?

The answer: If you're mapping to an EHR, you must use the coding within the 2024 CMS Web Interface PREV-5 Coding Document. The coding provided within the CMS Web Interface coding documents are considered all-inclusive when mapping to an EHR. If you aren't mapping to an EHR, the coding documents may be used as a guide to assist in reporting. Other coding representatives of the numerator quality action, denominator inclusion criteria, or referenced exclusions or exceptions may be used to assist in locating the required medical record documentation.

The third question: The description in the PREV-5 Measure Specification states, “women between the ages of 40 and 74 years of age,” while the initial population states “women between the ages of 41 and 74 years of age.” Which one's correct?

Answer: The patient isn't considered eligible for the denominator until age 41, but mammograms received beginning at age 40 can be used to satisfy the numerator. The lookback period allows for a mammogram during a measurement year-- during the measurement year, the year prior to the measurement year, and a three-month grace period for a total of 27 months.

Question four: Is it acceptable for the patient to report previous receipt of a mammogram and can it be done during a telehealth visit?

Answer: Yes. It is acceptable for a patient to report previous receipt of a mammogram if the documentation includes the date, type of test, and result or finding. Documentation of ‘normal’ or ‘abnormal’ is acceptable. Documentation of screening for breast cancer may be completed during a telehealth encounter.

Next slide, please.

The intent for PREV-6 is to screen for patients between the ages of 45 and 75 years of age for colorectal cancer. Please note that documentation of colorectal cancer screening may be completed during a telehealth encounter.

Next slide, please. Thank you.

So, some frequently asked questions and answers for PREV-6. So, the first one: Does a Cologuard test count for the PREV-6 measure?

Yes. A stool DNA with fecal immunochemical tests conducted during the measurement period or two years prior to the measurement period is acceptable for the measure.

Does a fecal immunochemical test, or FIT DNA count for the 2024 CMS Web Interface PREV-6 measure?

Answer: Yes. A fecal immunochemical test during the measurement period would be acceptable based on the coding in the PREV-6 Coding Document numerator codes, according to the description of the fecal occult blood test or FOBT CODE variable.

Third question: If the fecal occult blood test, or FOBT, is done in the office, at the point of care, and sent to a lab, is it acceptable for this measure? If not, where must it be done to be valid?

So the answer is no, fecal occult blood tests performed at home and brought to the office to be sent to a lab meet the intent and performance for this measure. The measure steward, National Committee for Quality Assurance, or NCQA, intends to exclude all fecal occult blood tests performed in an office setting, including digital rectal exams-acquired fecal occult blood tests performed in an office setting or fecal occult blood tests performed on a sample collected via the digital rectal exam in an office setting. Sorry. Thank you.

Question four: Can we report the fecal occult blood test results that are interpreted by our in-house labs? We understand fecal occult blood tests obtained in the office via direct rectal exam aren't accepted.

If the fecal occult blood test itself wasn't performed in an office or performed on a sample collected via a direct rectal exam, the test results are acceptable for the purpose of reporting the 2024 CMS Web Interface PREV-6 measure. The PREV-6 Measure Specification isn't prescriptive on the type or location of a lab that can interpret a fecal occult blood test. The type of colorectal cancer screening with the date it was performed and the result or findings must be documented in the medical record to meet the intent of the measure.

Question five: Has the Guardant Health's Shield colorectal screening test been added to the PREV-6 measure?

The answer is no. The Food and Drug Administration or FDA-approved Guardant Health's Shield colorectal cancer screening test wasn't added to the PREV-6 measure. Therefore, it wouldn't meet the numerator compliance for the 2024 performance period.

Next slide, please. Thank you.

Question six: The initial population in the PREV-6 measure states “patients between the ages of 45 and 75 years of age with a visit during the measurement period.” We know the data can be documented during the telehealth visit. Is an in-office visit required if a telehealth visit has been done during the measurement period?

The answer: The quality action isn't tied to a particular encounter by the clinician may have with a patient, including telehealth. If there's medical record documentation to support that a colorectal cancer screening was completed within the appropriate timeframe specified by the type of screen and results documented, then the performance of the measure is met.

Question seven: Will Epi proColon, ColoVantage (Methylated Septin 9), Guardant Health's Shield, or other blood-based screenings be added to the list of acceptable colorectal screenings for the 2024 CMS Web Interface PREV-6 measure?

The answer is no. The numerator for the 2024 CMS Web Interface PREV-6 measure doesn't include blood-based colorectal screenings that look for biomarkers of colorectal cancer in the blood. The PREV-6 Measure Specification defines appropriate screenings as follows: fecal occult blood tests during the measurement period; flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period; colonoscopy during the measurement period or nine years prior to the measurement period; computed tomography, or CT, Colonography during the measurement period or the four years prior to the measurement period; and stool DNA with a FIT during the measurement period or two years prior to the measurement period.

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And for this last FAQ slide, we're just going to go over some general questions. So the first one: For the CMS Web Interface measures, if we don't have clear documentation in the EHR indicating the numerator quality action was performed during the performance year, but during abstraction between January 1 of 2025, and March 31 of 2025, we find documentation that supports the quality action was completed but hadn't been updated in the EHR, can it be used for reporting?

The QPP measure or the answer to the QPP measures should be completed based on information that's available in the medical record prior to the end of the measurement period. There could be instances where the procedure or encounter occurred toward the end of the measurement year and the medical record was updated early in 2025, but these instances shouldn't be the norm.

And then the last question: Can CMS respond to questions regarding verification of the documentation within the medical record?

Answer: We are limited to clarifying the intent of the measure you're attempting to report. Due to the comprehensive and individual nature of patient medical records only available to the

CMS Web Interface reporters, CMS can't provide specific feedback regarding patient medical record documentation. Documentation should support the data that was reported.

Next slide. And I'll pass it back to you, Lisa Marie. Thank you.

>>Lisa Marie Gomez, CMS: Great. Thank you so much. Next. Well, now I'm going to discuss resources and where to go for help.

So next slide, please. Okay.

On this slide, as you can see, there are a lot of resources available for this CMS Web Interface, and these are the resources that we encourage you all to utilize as you continue to navigate through reporting for 2024.

Next slide, please.

This slide outlines places to receive further information or assistance. So here you can contact the Quality Payment Program or, you know, contact your ACO-- or contact your ACO contact with your points of contact that you have.

Next slide, please. Now I'm going to turn the presentation over to Hallie.

>>Ketchum: Thanks, Lisa Marie. So we're going to start the Q&A portion of the webinar. As a reminder, you can ask questions via the Q&A box. To submit a question anonymously via the Q&A box, please click "Send Anonymously." Otherwise, all attendees will be able to view your question.

To get us started today, we have a question for Deb. The question is asking, "For PREV-12 if your electronic health record does not calculate the ASCVD risk score, can you manually calculate the patient's risk score? Does this score need to be documented in your chart?"

>>Deb Kaldenberg, PIMMS: Thank you very much for this question. This is Deb. And I do want to point to a couple of things. First of all, within the measure specification, to ensure that you are using a standardized depression screening tool, there is information on page five of that specification that further defines that. And in addition, at a minimum, the medical record must contain documentation of the tool's name and results of the screening with a score or the clinical interpretation of positive or negative for depression. The intent of the language is to allow flexibility in how organizations are documenting the outcomes of depression screening. The measure specification does state that a clinician should review the results of the depression screening but how the results are documented is up to the organization, as the measure specification allows for some flexibility. Medical record documentation should support whatever it is that you do report. Thank you.

>>Ketchum: Thank you, Deb. As a reminder, we will be taking questions through the Q&A box today, so go ahead and type any questions you may have in there and we will answer as many as time allows.

Deb, we do have another question for you. This question asks, “I have a patient for PREV-12 depression screening and follow-up. The patient had a positive screening score of seven with his PCP. The PCP and patient discussed his depression and reviewed medications and need for exercise and decreased alcohol consumption. Would that be sufficient for follow-up as it was completed during the PCP visit?”

>>Deb Kaldenberg, PIMMS: So one thing I do want to reiterate that was answered earlier is we really can't speak to your medical record documentation. I can, however, restate that the follow-up plan must be related to the positive depression screen. For example, you could have something like a patient referred to psychiatric evaluation due to positive depression screening. Within your example, you could have, based on positive depression screening, alcohol consumption, and medication was discussed. So you need to determine whether or not the documentation you find within the medical record is a follow-up to a positive depression screening. Thank you.

>>Ketchum: Thanks, Deb. We do have another question asking to go back to slide 10. So we have gone back to slide 10 and hopefully that helps answer your question there.

And we just wanted to thank you for your patience as we're reviewing the questions in the queue and determining which ones have the right people on board to answer today and compiling those answers for you. So while we are waiting, if you want to take some time to type more questions in and help us build out our queue, that would be much appreciated. Thanks.

We do have another question for Deb asking, "For MH1 F32.A, unspecified depression, is not listed in the codes for the denominator. It begins with F32.0. Is this an acceptable code for diagnosis for depression for this pressure?"

>>Deb Kaldenberg, PIMMS: Thank you for that question. The one thing you do want to be aware of is that the coding within the coding documents for the CMS Web Interface are considered all-inclusive when you are mapping to that code set. So it would not be-- it wouldn't be that you would not want to use a code that is outside of what has been provided. Thank you.

>>Ketchum: Thanks, Deb. Our next question is for Michael. It's asking, "Is it required to resolve the data irregularities? If we do not resolve them, will that impact the score in any way?"

>>Michael Conn, PIMMS: Hi, thanks. So for this question, the data irregularities do not need to be resolved. They have no impact on the score. They are for informational use only, indicating that some data that you submitted will not be used for scoring. It usually has to do with the flow of the question. So, yeah, they do not need to be resolved.

>>Ketchum: Thank you, Michael. We have another question for Jamie. The question's asking, "If a fecal occult test is sent directly to the patient from the lab and returned directly to the lab, assume this is compliant as long as practice gets the result from the lab?"

>>Jamie Welch, PIMMS: Right. Yep. Thanks so much for this question. As long as the FOBT itself wasn't performed in the office or performed on a sample collected via DRE, the test results are acceptable for the purpose of reporting the 2024 CMS Web Interface for PREV-6. The measure specification isn't prescriptive on the type or location of the lab that can interpret the FOBT. The type of colorectal cancer screening with the date it was performed and the result or finding must be documented in the medical record to meet the intent of the measure. Thank you.

>>Ketchum: Thank you, Jamie. Again, we want to remind everyone that you are welcome to submit questions via the Q&A box. If you want to submit your question anonymously, you can check the "Send Anonymously" box and it will send that anonymously. Otherwise, all attendees will be able to see your question.

We have another question for Jamie in the queue. They're asking about PREV-13. “If your EHR does not calculate the ASCVD risk score, can you manually calculate the patient's risk score and does the score need to be documented in your chart?”

>>Jamie Welch, PIMMS: Yeah, thank you so much for this question. I had to go on a little bit of a hunt within that measure specification. The guidance within the measure specification itself, it's indicating that the ASCVD's risk score is calculated using the pooled cohort equations. And it references the 2013 ACC AHA ASCVD risk estimator or the ACC Risk Estimator Plus. And it goes on to indicate that if the EHR doesn't have either one of these risk calculators, there's a recommendation that you use the online versions. I know your physicians are very capable or clinicians are very capable of like doing this kind of math in their head, but the measure itself is sort of indicating the use of online versions or EHR based on the references I provided to be populated within your medical record. I can say that the outcome has to be documented within your medical record in order to meet the intent of the measure. If this response is not clear, my other suggestion is to go ahead and submit a Service Now and we'll take a deeper look into this question. Thank you so much.

>>Ketchum: Thanks, Jaime. The next question we have is for Deb. It's asking, “Is a diagnosis of moderate cognitive impairment enough to meet the denominator exception for the PREV-12 measure? Or does there need to be a documented note to link the moderate cognitive impairment that prevented the provider to conduct a depression screening?”

>>Deb Kaldenberg, PIMMS: This is Deb. Thank you for that question. And I actually read it wrong the first time, so I am rethinking about this a little bit. I understand you are asking about the medical reason, and you actually need-- should have medical record documentation that provides information that that depression screening was not done due to the cognitive, functional, or motivational limitations that may have impacted the accuracy of the results. So just finding documentation of a code that indicates that is not sufficient, you would need to have documentation that the screening wasn't completed due to that reason. Thank you.

>>Ketchum: Thank you, Deb. We are still accepting questions through the Q&A box. So if you would like to have your question answered today, you are more than welcome to go ahead and type your question into the Q&A box. And we will have our subject matter experts answer it over the line. If you wish to submit your question anonymously, all you need to do is check that “Send Anonymously” button and we will make sure that it is sent anonymously.

We do have another question for Jamie. The question is asking, “For PREV-5 breast cancer, we have located a few mammographies where the report sent back to the PCP provider indicated that full screening was performed, but the findings were zero, inconclusive. Are inconclusive findings permitted to be used to meet our findings in the medical record?”

>>Jamie Welch, PIMMS: Yeah, and thank you for this question. I really do appreciate it. The intent of the measure is that the screening is being provided to the patient and that the results are being communicated back to them. In the instance that you have a finding here that is inconclusive, the intent of the measure itself is not to-- I mean, the results for the patient are important. Please understand clinically from that perspective, I understand where you're at. But for the purposes of reporting the measure, it is the completion of the mammography screening, and not necessarily the follow-up that would come from that type of finding in the report, just

that those findings were communicated to that patient, and that's documented within the medical record. Again, that's a great question, and if you have any questions, please go ahead and submit a Service Now inquiry, and we can chat about that a little bit more. Thanks.

>>Ketchum: Thanks, Jamie. We do have another question in the queue for Deb. Deb, this person's just asking for some clarifications around PREV-13, if you would like to answer that.

>>Deb Kaldenberg, PIMMS: Yeah, and I actually just wanted to say I do believe that question was answered by Jamie earlier. So if the answer was not provided to this particular attendee, if you could go ahead and restate your question so that we can either answer a new question that we haven't seen on PREV-13 or if it is a restatement of the manual calculation of the ASCVD score. Thank you.

>>Ketchum: Thanks, Deb. Deb, we have another question for you. It's asking, "Is age alone an exclusion for the statin measure? The patient is 101, and the doctor wrote that due to her age, she is excluded from taking a statin."

>>Deb Kaldenberg, PIMMS: So I would recommend that you go and look at the measure specification for each of the different populations. There are age requirements for three of the populations, but the first population is all patients who were previously diagnosed with or currently have a diagnosis of ASCVD, including an ASCVD procedure. So if that is the denominator population that the patient is considered eligible for, then the age would not preclude them from reporting the numerator. If, however, the patient is falling into Populations Two, Three, or Four, the age requirements there are patients age 20 to 75 for Population Two, and then also-- 20 to 75 for Population Two and 40 to 75 for Populations Three and Four. So, it really all depends on at what point you are finding that that patient is denominator eligible. Thank you.

>>Ketchum: Thanks, Deb. Our next question is for Jamie. It's asking, "What is the turnaround time on 'CMS Approved Reason' requests? We submitted a request in early January and have not seen our response yet."

>>Jamie Welch, PIMMS: Yeah, thank you so much for this question. We are working through the skip requests as they come through. In some instances, we're reaching out to get more information. As we process these requests, please just hold tight. We'll be getting back to you as soon as possible. I appreciate that question. Thank you.

>>Ketchum: Thanks, Jamie. We're just going to hang on a couple more moments to see if folks have more questions that they would like to get answered today. We have another question for Deb. Deb, this question is asking, "For the MH measure, can the provider list a screening date from the original diagnosis date, even if it was outside of the measurement period? Or should initial screening be within the performance year, and then re-measured within the specified timeframe post-initial screening?"

>>Deb Kaldenberg, PIMMS: Thank you for this question, and hopefully I'm going to answer it. If this is overly simplistic, and there is more to your question, please provide some additional details, and I will try and get into that piece of the response as well. And no, I know that MH1 sometimes is a bit of a difficult measure to break down. So if I don't answer and we end up out of time, please open a Service Now case and we'll make sure to spend some additional time helping you out. However, to answer hopefully your question, the diagnosis of depression or dysthymia needs to be present in order to consider the PHQ-9 or PHQ-9M score greater than nine as an index event date. So as long as that diagnosis is considered active and you have that PHQ-9 or PHQ-9M score greater than nine during the measurement period, that would be your index event date. If you don't have those two things, please keep in mind for the MH-1 measure, that means that the patient is not considered denominator eligible and you would be able to skip them and replace them. Thank you.

>>Ketchum: Thanks, Deb. Again, you're more than welcome to submit any questions you may have today through the Q&A box. You're welcome to use the "Send Anonymous" feature to send your question anonymously.

In the meantime, we do have a couple of more questions in the queue for Deb. This first question is asking, “If a patient tells their PCP the results of an A1C ordered and performed by their endocrinologist, date, and value, would this be sufficient for the primary care provider to put the date and results in their patient notes in order to meet the diabetes measure?”

>>Deb Kaldenberg, PIMMS: And once again, I was answering in my head a question that is not exactly what's being asked. If you would give me just a second, I think I can verify that response as well. Go ahead and skip to the next one, and I'll come back to that A1C. Thank you.

>>Ketchum: All right, Deb. It looks like the next questions for you as well. It's asking, “In the same vein as the MH measure, if a patient is a nonsmoker and identified for the tobacco screening and cessation measure, can they be skipped?”

>>Deb Kaldenberg, PIMMS: And that answer is no. So you basically want to look at each of the individual measure specifications and determine. Your denominator criteria for MH1 is very unique to where you are determining within the denominator two components, both a diagnosis and a PHQ-9 or PHQ-9M score of greater than nine. Those two pieces are what is determining if that patient is denominator eligible. For your PREV-10 tobacco screening measure that particular measure is that the denominator doesn't have those specific requirements. So, you'll work through that particular measure specification as it's defined. Thank you.

>>Ketchum: Thanks, Deb. We have another question for Aroush. Aroush, this question is asking, “On PREV-6, if a Cologuard test is sent in, and the results are unable to process, would that count as meeting the intent of the measure?”

>>Aroush Anis, PIMMS: Sorry, I'm having trouble getting off mute. So, no, we would want to see -- when you get the results, you would want documentation if the results are normal or abnormal. So, for that reason, if you can't process the results, I don't think it would meet that intent, no. Thank you.

>>Deb Kaldenberg, PIMMS: And, Hallie, I'm going to go back real quick to at least a component of that diabetes question about the A1C. I can verify that documentation of the most recent hemoglobin A1C result may be completed during a telehealth encounter. I am going to try and look through some past information. I do believe that patient-reported of hemoglobin A1C is no longer acceptable. So in that case, your documentation, the most recent hemoglobin A1C would not be able to be patient-reported. However, I do want to note that I am not sure if that is the case and so what I would say is I will either try and get back to it during this call or I would encourage that individual to go ahead and open up a Service Now help desk case and we will be able to dig into that further. I just don't want to give you information that is from previous years. And so, at this point in time, the only thing I can say for sure is that it can be completed during a telehealth encounter. Thank you.

>>Ketchum: Thank you, Deb. We just wanted to provide another reminder. If you have any questions that you want answered today, please go ahead and type them in and we have subject matter experts who will either answer those questions over the phone or type their answer into the Q&A box in response to you.

We have another question for Deb. This question is asking, “If there is documentation in the chart that the patient was called in March of 2024 about the status of their influenza vaccine, and the patient reported they had completed it at the pharmacy in 2023. Would this be enough, or do we need the actual pharmacy date in 2023?”

>>Deb Kaldenberg, PIMMS: Thank you for this question. You don't need the actual date, but what you do need is for your medical record documentation to support that the influenza vaccine was provided during the appropriate flu season. So, again, we can't speak to your medical record documents as far as exactly what would be acceptable because you have access to a lot more information than we do. So, it's not that you need a very specific date, but your date does need to be able to show that the vaccine was received during the flu season that you are reporting. Thank you.

>>Ketchum: Thanks, Deb. We have a question in the queue for Jamie. And it's asking, “For PREV-13, if the patient does not qualify for Populations One through Three and there's no ASCVD risk score in the EMR, can I use the risk calculator to see if they can be in Population Four or does that score need to be in the EMR?”

>>Jamie Welch, PIMMS: So, Olivia, thank you so much for this question. I'm sorry I've been going back and forth between your question and the specification. I appreciate your patience as we research this. So I believe based on the scenario that as long as that ASCVD's risk score is documented in your EMR, and this patient needs the age parameter that's within Population Four, you would be able to report in this patient for that particular-- for that particular population. But by all means, Ellen, if we need to communicate a little bit more about that, please submit a Service Now help desk ticket. Thank you.

>>Ketchum: Thank you, Jamie. Deb, we have another question for you. “In addition to the other question for the A1C and endocrinologist, if the provider office then calls the endocrine office and verifies the result over the phone, can that meet the intent of the measure if the provider documents that in the medical record?”

>>Deb Kaldenberg, PIMMS: Thank you for this question and also for the opportunity to kind of clarify a question that was asked and answered before. I have been able to verify that you cannot include hemoglobin A1C results that are reported by the patient. So hopefully that fully answers the question that was previously asked. And as far as this particular question, I would recommend truly looking at page 10 of the posted specification. As we've said before, we can't specifically speak to your medical record documentation, but we can share that per the spec, the record-- your medical record must include the most recent date the blood was drawn and it needs to be in a month month/day day/year year year year format. In addition, the documentation in the medical record must include a note indicating the date on which the hemoglobin A1C test was performed as well as the result and documentation of the most recent hemoglobin A1C result may be completed during a telehealth encounter. So if your medical record documentation provides those, that information, then it would be acceptable for reporting. Thank you.

>>Ketchum: Thanks, Deb. Our next question is for Aroush. Aroush, this question is asking, "For PREV-6, there's evidence in our EHR of lab results of the colonoscopy, but not the colonoscopy report. We do have contact as part of our ACO with the practice to whom the patient was attributed to at the time of the colonoscopy who confirmed the date of the procedure."

>>Aroush Anis, PIMMS: Thank you. Yeah, so I'll refer back to the measure specification on page nine under the numerator guidance. So, it explains that documentation, the medical record must include two things, so a note indicating the date of the colorectal cancer screening, the date when it was performed, and the results of the finding, and then the results, documentation of normal or abnormal is acceptable. So, if you have both of those criteria or meet both of those criteria, then, you know, you've met the numerator intent. Thank you.

>>Ketchum: Thanks, Aroush. Our next question is for Jamie. It's asking, "How would I pull a list of just one measure of patients that have not had one done? We have another department that assists with locating these outside of our EHR systems." And I believe this is in regards to flu.

>>Jamie Welch, PIMMS: Yes, it is. This is in regards to PREV-10. And I'm going to-- I'm just coming online here to communicate. I'm really trying to follow this question, and I appreciate the question. However, I'm still not sure, and I know you've submitted it multiple times exactly what you're asking. And so my recommendation here is just so we can have that conversation and I can understand this question more clearly. Can you please submit a help desk ticket? I think that this particular question is going to help us drill down to what we need to provide to you as an answer. So, please reach out to us and we can have a phone conversation. We'll get you, an answer for you, but I appreciate the question. We do see it. Thanks so much.

>>Ketchum: Thanks, Jamie. We're going to stand by for a couple of moments while we give folks some time to ask some more questions. In the meantime, we do have a question for Aroush. It's asking, "If the intent of the colonoscopy measure is if the patient-- why is it

necessary to have abnormal or normal result if the quality timelines for when the next screening is?"

>>Aroush Anis, PIMMS: Thank you. Yeah. And I think this question was repeated. So, you know, the same answer for both. So I don't want to get into the why necessarily. I don't want to get like too deep into that. But for the part where it's asked, you know, like, why is it necessary to have normal or abnormal? I wouldn't say it's necessary. It's acceptable to have normal or abnormal as the results are finding. So again, kind of going back to my previous answer on page nine of the measure spec under the numerator guidance, you need two things. The date of the colorectal cancer screening when it was performed and the results are finding and that that results are finding a normal or abnormal result is acceptable. It's not, I wouldn't say necessary. Maybe we're just using different terminology. But yeah, thank you.

>>Ketchum: Thanks, Aroush. The next question is for Jamie. It's asking, "Can you use the blood pressure from an infusion-only visit?"

>>Jamie Welch, PIMMS: Yeah, thanks so much for this question. I went back to the specification and there are three main settings or procedures, clinical situations in which you would not want to use those BP readings. The first one is an acute inpatient stay or ED visit. I'm assuming, and this is what's always tough about these calls is making those assumptions, is that this is an infusion clinic and not necessarily within one of those settings. However, if that's inaccurate, yeah, avoid those BP readings that are coming from the acute inpatient stay or ED visit, taking us the same day as a diagnostic test or a diagnostic or therapeutic procedure.

In this instance, if that is the situation that you're referencing here, as an infusion clinic, I'm not sure exactly of the type of infusion or the whole clinical picture there, so I think you'd have to take a look at the entirety of that visit and see if it sort of falls into any one of these types of examples that are provided within the specification, vaccinations, injections, an IUD insertion, eye exam with dilating agents, a wart or mole removal is included as some of the examples. And then if it's taken by a patient using a non-digital device such as a manual blood pressure

cuff. But by all means, please reach out if you need additional clarity in regards to whether or not a BP from an infusion clinic would be applicable to the measure. Thank you.

>>Ketchum: Thanks, Jamie. We're just giving folks a few more moments to ask any questions they may have. We have another question for Michael. It's asking, "I placed a ticket regarding the pre-populated responses in the PREV-12 metric, causing an error and limiting the ability to respond appropriately to the first question without creating an Excel error. It got fixed and the responses were removed, but now they're back again. Is this going to be resolved?"

>>Michael Conn, PIMMS: So what we need is for this person to open another Help Desk ticket, ask that it be forwarded to the Product team and we'll take another look at it because there's our belief that that issue was resolved. So we need to look into the specific scenario, but we'll get back with you if you open a ticket through the Help Desk.

>>Aroush Anis, PIMMS: Michael, is there any information that this individual should include that would make it easier for us? Maybe screenshots.

>>Michael Conn, PIMMS: Yeah, if they could provide some screenshots as to what they're seeing in the UI with the Excel errors and then the Excel upload that they're using, the sheet that they're using to upload, that would help us. But we can also pair if necessary, get on a call together and see exactly what steps are going on.

>>Ketchum: All right, thank you for your response there. Aroush, we do have another question for you, it's asking, "If you could please clarify in DM-2, you cannot use patient-reported HbA1C, but telehealth it is acceptable. What can you accept from telehealth around this measure?"

>>Aroush Anis, PIMMS: Yeah, so I'll refer back to the previous support call. We had two FAQs, I think, directly relate to this question. So the first FAQ was, is an HbA1c result reported during a telehealth visit acceptable? Yes. Documentation of the most recent HbA1c result may be completed during a telehealth encounter. And then the second question, some patients have

at-home HbA1c testing kits, meaning the patient is checking their lab values at home. Is this allowed for this measure? And the answer for that is no, do not include HbA1c levels reported by the patient. The 2024 CMS Web Interface DM-2 measure doesn't allow patient-reported HbA1c values as a qualification to meet the numerator. So, if it's a patient taking their own HbA1c, not during a telehealth visit, and they give you that result, that won't work. It has to be, you know, they're taking it during a telehealth visit. Thank you.

>>Ketchum: Thank you. Jamie, we do have a question for you asking for BP infusion. "Infusion is proline infusion at the infusion clinic. So is the BP okay to use?"

>>Jamie Welch, PIMMS: Yeah, again, as long as it's not meeting one of those three and it is in alignment with the specification's intent. I really shouldn't answer anything specifically outside because I can't see what's really in your medical record. So it's hard to make that determination, but it seems acceptable to use as long as it's not one of those situations as referenced in the specification under the guidance. So thanks for the follow-up.

>>Ketchum: Thanks, Jamie. We're going to do another call and see if anyone has additional questions they'd like to type into the Q&A box for us to answer today. We have another question for Deb. It's asking, "Is the suggestion that we submit a skip-- a request to skip a patient in the Web Interface tool ASAP even if we are still working on reviewing other patients in the same measure."

>>Deb Kaldenberg, PIMMS: Thank you for this question. And this is Deb, and Jamie may jump in as well. I would just say that if you know that you're going to request a skip for a particular patient to go ahead and submit that as soon as you can, depending on what your workflow is. As Lisa Marie stated earlier, the longer you wait, if you wait closer towards the end of the submission period, there is always the possibility that won't be reviewed and approved or denied. They won't have the time to review it. So, we would recommend submitting that as soon as you know that is something that you're going to request. Jamie, I don't know if there's anything else we can provide for this caller.

>>Jamie Welch, PIMMS: No, I appreciate that, Deb, that's exactly correct. Thank you.

>>Deb Kaldenberg PIMMS: Thank you.

>>Ketchum: Great. Thank you both. We have another question for Aroush asking, “Following up on the previous PREV-6 question. Is this acceptable evidence to support this measure?”

>>Aroush Anis, PIMMS: Thanks. I'm not sure if you, like, included a screenshot in your response. We don't see that come through the Q&A, so I'm not sure what like this is in quotes, but on the measure spec, we do say that documentation of a normal or abnormal result or finding is acceptable. If that doesn't answer your question, definitely feel free to contact the QPP Service Center and ask for your case to go to the Web Interface team and we can better help you. Thank you.

>>Ketchum: Thanks, Aroush. We have another question for Deb and it's asking, “If we have claims data indicating by the CPT code that a mammogram was done at an outside source, but we do not have an actual report, can we count that as being done for breast cancer screening?”

>>Deb Kaldenberg, PIMMS: Thank you for this question. No, you can't count that. Claims data alone is not sufficient. You need the medical record documentation that supports the mammogram was completed as well as the other requirements that have been communicated during this call and can also be found in the posted measure specification. Thank you.

>>Ketchum: Thanks, Deb. All right. We want to do one final call for questions. We'll give a couple more moments to see if anyone has any questions that they would like answered. We do have another question for Aroush. It is asking, “For telehealth-only remote patient monitoring, is HbA1c accepted?”

>>Aroush Anis, PIMMS: Thank you. So, I'll refer back to the last support call, the FAQs that we had. So documentation of the most recent HbA1c may be completed during a telehealth encounter. And then the other FAQ explains that you do not want to include HbA1c levels

reported by the patient and that this measure doesn't allow for patient-reported HbA1c values to qualify for the numerator. If this isn't answering, you know, your question specifically, we definitely advise that you contact the QPP Service Center and ask that your case go to the Web Interface team and we can better help you. Thank you.

>>Ketchum: Thank you, Aroush. We have another question asking, "Are we able to submit a request to skip a patient before we are ready to submit an entire measure."

>>Lisa Marie Gomez, CMS: Deb or Jamie, would you be able to address that question?

>>Deb Kaldenberg, PIMMS: Go ahead, Jamie.

>>Jamie Welch, PIMMS: I'm thinking, I guess I need a little help from others on this call, but if they're going to go ahead and submit for the whole measure that probably closes out their submission on that measure. So would they-- my belief would be that we would want to have them have that skip information before they close the measure out. But, by all means, if I am misspeaking, please, please indicate as so.

>>Michael Conn, PIMMS: They are free to submit the skip request at any point in the process prior to, you know, I think we said like a week out is probably not a good idea from the close. Yeah, go ahead.

>>Lisa Marie Gomez, CMS: Michael, I think the question is that like if they're about to complete reporting of the measure, that means that they met all the requirements. So, you know, the measures require 248 consecutive patients, ranked patients to be, to be reported. And if they're about to complete reporting of the measure, I think that's what Jamie's question is, that if they're meeting the requirements for the measure, would it be necessary for them to submit-- to skip a patient if they're actually already meeting the requirements for the measure? Jamie, am I understanding your question correctly? I think that's what it is.

>>Jamie Welch, PIMMS: Yeah, I think that's the question. But if we need to take this question back as a team and research it and provide that response, we can do that as well.

>>Lisa Marie Gomez, CMS: And for the person who submitted that question, you can always submit that question to our help center, our QPP Service Center, Quality Payment Program Service Center. We're going to take it and we can get back to you. But again, I think we want to just make sure we're understanding the full dynamic of the question because if you have met the requirements of the measure, then it doesn't seem like you need to skip a patient. But again, I think we just want to make sure we're providing the comprehensive response just given the limited information that we have in the chat in terms of what the question-- how it was posed.

>>Ketchum: All right. Thank you, everyone. We're going to do one final call and see if there's anyone else who has a question they would like answered today. If you'd like to get your question in, go ahead and use the Q&A box at the bottom of your screen to type your question in. You can click "Send Anonymously" if you so choose and that will send your question anonymously. And seeing no further questions, that will conclude the Q&A portion of today's webinar, so we'll turn it back to Lisa Marie to conclude the call.

>>Lisa Marie Gomez, CMS: Thanks, Hallie, so much for the Q&A session. I just want to thank everyone for joining us today. As you know, this is our last CMS Web Interface call for its entire duration. I know some of you have been with us since 2017 when the Quality Payment Program was enacted and implemented. And so-- and I know even some of you have been with us even before under the PQRS state. We want to just thank you for being with us, this entire journey, and we want to thank you for all your hard work and all that you've done to meet the requirements of the Web Interface and working with us throughout the years. So we want to thank you and we want to wish you the best as you continue to prepare reporting for 2024. But again, we want to thank you so much and we all hope you have a great day. Thank you. Bye-bye.