Hello, everyone. Thank you for joining today's Web Interface Support Webinar. This series of webinars is for the Accountable Care Organizations (ACOs) and groups that are reporting data for the Quality Performance Category and the Quality Payment Program to the CMS Web Interface for the 2018 performance period. These webinars will highlight important information and updates about reporting quality data and provide ACOs and groups with the opportunity to ask CMS subject matter experts their questions. During today's webinar, we will also share links to various resources and other information that will appear as announcements on your screen. Please note that these calls only focus on reporting data for the Quality Performance Category. We will not cover reporting data for the other performance categories during these calls. Now I will turn it over to Aruna Jhasti from the Center for Medicare and Medicaid Innovation at CMS. Please go ahead.

Thank you. Good afternoon, everyone, and welcome to the 2018 CMS Web Interface Quality Reporting webinar for MIPS Groups and ACOs. My name is Aruna Jhasti and I work on the next-generation ACO model. Also, joining me today are other CMS Web Interface experts who will share helpful information and answer your questions during our Q&A session after today's brief presentation. Next slide, please.

This is our disclaimer slide. Please contact the Quality Payment Program if you have any questions. Next slide, please.

Please note links to recordings and materials for the previous CMS Web Interface webinars are available on the Quality Payment Program library. Next slide, please.

As a reminder, the Web Interface submission period closes at 8:00 p.m. on Friday, March 22nd. Your submissions will be automatically accepted after the Web Interface closes. Next slide, please.

Another important reminder -- please submit requests for the 2018 CMS Approved Reason as soon as possible. Requests sent after March 15th are unlikely to be processed prior to the close of submission. Please note this option can be selected for the patient only after the request has been approved by CMS. Next slide.

And this slide includes the steps you should follow to request a CMS Approved Reason. Next slide, please. And this slide includes information on all the upcoming CMS Web Interface weekly support calls. Please note the next webinar is on February 13th. And now I will turn it over to Ozlem Tasel.

Thank you, Aruna. Hi, this is Ozlem Tasel. Today I'll review frequent reporting questions. Next slide, please. This question is on PREV-10 measure. This year, the PREV-10 measure will break down into three performance rates. What number of beneficiaries must be confirmed and completed to meet the minimum requirement? If there are three rates, does the ACO or group need to report on more than 248 beneficiaries? The answer is no. The ACO or group needs only to confirm and completely report on 248 unique beneficiaries from this measure's sample. From the data reported, each beneficiary will fall into one, two, or three performance calculations depending on how the questions are answered. Therefore, the denominators for each rate will not necessarily be 248 and will not add up to 248. Next slide. Okay, I'll hand it over to Kristin Williams to review frequent scoring questions.

Thanks, Ozlem. I'm reviewing a frequent scoring question on PREV-10. Next slide, please. This year, PREV-10 will be scored on the performance rate for Population 2. In previous years, the PREV-10 performance rate was equivalent to Population 3. How was PREV-10 benchmarked this year if the same rate did not exist previously? To answer that, although the rate for Population 2 was not previously calculated in the Web Interface, the data elements used to calculate it were captured. These data elements were used to simulate rates for Population 2, and those rates were used to create a benchmark for 2018. Thank you, and now I'll pass it over to Angie to answer some frequent measures questions.

Hi, this is Angie from the CMS Measures team. Today we're gonna review some frequently asked questions that we received for the PREV-10 measure, the Tobacco Use Screening and Cessation Intervention measure. The first question is, "Does tobacco use status of 'smoker' satisfy the measure if we screened for both smoking and smokeless tobacco?" The answer is if there's medical record documentation that the patient was asked if they were a user of either smoking or smokeless tobacco and the answer was yes, they are a smoker, it would meet the intent of the measure.

Question two -- a patient was -- this is an example a patient asked about. A patient was noted to be active smoker on December 7, 2018, but the last cessation counseling was done on June 15, 2018. Do we have to mark "no" for cessation of counseling because it should be done after the most recent tobacco status is noted? That is correct. You would select "no" if additional tobacco cessation intervention -- and a reminder that that does include brief counseling of three minutes or less and/or pharmacotherapy. If that was not given at the later visit in the example, then you would select "no." If cessation counseling was done at a visit, but the patient is screened again at a later visit and is still using tobacco, the intent is for additional tobacco cessation intervention to be given. That's because tobacco cessation intervention may not be successful at one visit, but may be successful when given at a subsequent visit where the patient still identified as a tobacco user.

So, I would like to summarize that. If the patient is found to be a tobacco user at the most recent screening documented, the cessation intervention must occur during or after that encounter to meet the intent of the measure. Next slide, please.

Question three. For the PREV-10 tobacco screening and smoking cessation measure, if a patient was screened and identified to be a smoker and then refuses cessation counseling, can they be considered as an exception, or would they be non-performance? Patient refusal is not a denominator exclusion or exception for this measure. If there's medical record documentation that the eligible clinician screened the patient, identified them as a tobacco user, and then advised them to stop using tobacco, offering cessation intervention, the intent of the measure is met. There needs to be documentation that brief counseling was attempted and/or pharmacotherapy was offered to the patient at the visit. Question four is, "When submitting PREV-10, are the patients that are screened for tobacco and identified as non-user counted in the sample, or are they excluded from the sample?" The answer is all the beneficiaries the meet the initial population criteria are included in your sample. You must report on all the patients attributed to your sample unless they are determined to be not qualified for the measure during the patient confirmation. Patients that were screened for tobacco use and identified as non-tobacco users, and tobacco users who received tobacco

cessation will be included in the numerator for Population 3. And with that, I'll turn it over to Aruna. Thank you.

Next slide, please. The next few slides will provide information on the resources available to you. This slide provides a list of Web Interface resources available on the QPP resource library. Next slide, please. This slide includes the link to the CMS Web Interface instructional video playlist that are now available on the QPP resource library. Next slide, please. And this slide includes links to the QPP help and support page and the webinar library. Next slide, please. This slide has additional resources for the Medicare Shared Savings Program and the next-generation ACO model. Next slide, please. And if you need any assistance from the CMS team, please refer to the information listed on the slide. And now I'll turn this back to Michaela for the Q&A session.

Great, thanks, Aruna. We are now going to start the Q&A portion of the webinar. You can ask questions either via chat or via phone. To ask a question via phone, please dial 1-866-452-7887. If prompted, please provide the conference ID number, which is 1097841 and then press star-1 to be added to the question queue. And, if you do have any follow-up questions or clarification that you'd like to share with us in the chat, please type "follow-up question" at the beginning of your chat question so that you can flag that for us. So, let me pull up our first question here." Can you please clarify for PREV-6 if a physician type in their note for colonoscopy completed in 2010, which was normal, would that meet the measure?"

Hi, this is Jessica Schumacher from the PIMMS measures team. From a measure perspective, there is no specification as to what provider type. In order to meet the measure, there needs to be medical record documentation of one of the approved procedures within the specific timeframe and documentation of the date and of the results from that procedure. Thank you.

This next question comes from a group, and they say, "For MH-1, if a patient has a nursing home in their patient address, would this be enough to exclude for nursing home being the permanent residence?

This is Jessica again from the PIMMS team. If that is how you indicate long-term residency, that would qualify. They must be a permanent nursing home resident defined as a beneficiary who lives long-term residential facility during the denominator ID period or before the end of that measurement assessment period. It does not apply to those who are receiving short-term rehab services, so unfortunately, I'm not familiar with that patient or the process used at that group, so I can't let you know whether or not that's how you communicate with each other about their residence. If you have any additional details, feel free to send us a question through the Quality Payment Program service center. Thank you.

Thank you. This next question is on PREV-12 screening for depression. What number is considered a positive screening? Greater than five or greater than nine?

Sure. So, for PREV-12, the beginning of the measure specification indicates that any validated, normalized depression screening qualifies, and if your organization decides to use PHQ-2, PHQ-9, it would be up to the provider who's administering and reviewing and interpreting the results of that screening whether or not the patient is or is not positive for depression. For PREV-12, it doesn't matter what the score is for the assessment as

different assessments are used for this measure, so you're gonna have to look for that medical record documentation of the provider's interpretation in order to meet the intent of this measure. If your group is using PHQ-2 and PHQ-9, if there's medical record documentation of a score of zero, in the event of an audit, that would be acceptable to indicate that the result was negative for depression. Thank you.

Thank you. So, this next question asks, "If the patient was alive during 2018 but deceased in 2019, for the patient qualification portion, should the patient be marked as deceased or should we report as they were alive during the measurement period and they would be included?"

So, in this scenario, you should go ahead and mark that patient as if they are alive and you would report on them as the measures require. You would only mark that patient as deceased once we get 2019's submission in 2020. So, if the patient was alive in 2019 and they were not deceased prior to 12/31 of 2018, you should submit data for them.

Great, thank you, Jess. And Stephanie, do we have any questions on the phone at this time?

I have one question regarding CARE-1 measure. If a patient has two discharges, one from a hospital on January 16th, and then a rehab facility on January 23rd after the hospital discharge, if the patient had a primary care visit on 1/26 that had med rec, then would the PCP visit meet for both discharges?

Hi, this is Jessica from the PIMMS team. So, if that one visit is within the 30-day window for both discharges, and there's indication of medication reconciliation from both discharges with the outpatient, then it would. And this is outlined in the Q&A document. I'm working to pull that up right now. If I misspoke, please jump in.

Great. So, we will move on to the next question. This is another question from a group, and they're asking for IVD-2, does it matter if we disqualify due to no diagnosis versus anti-coagulant medications? And they listed as an example, "What if I find heparin right away but need to search further for the diagnosis? Can I just exclude right away for heparin without finding the prescription or the diagnosis?"

Hi, this is Angie from PIMMS. You are going to want to confirm that the patient is qualified for this sample in the first place and then answer the questions for denominator, but you should step through the steps for denominator confirmation that are in the measure specifications, and page seven, the first step is to verify the diagnosis of IVD or an acute myocardial infarction or a CABG or PCI in the 12 months prior to the measure treatment period. So, that is the first step, but I think that they result in the same. I'm sorry, I need to look at this a little bit further. I misunderstood the question when I first looked at it. Can we come back to this?

Yeah, we can jump back to this one. So, our next question, this person's asking if we could please define the following terms with respect to the reporting and documentation requirements. So, the terms they listed here are tobacco use, the included types for that, and then tobacco screening and tobacco intervention.

Can you repeat that, please?

Yeah. So, this person asks, "Can you please define the following terms with respect to the reporting and documentation requirements," and I think they're just looking for some additional details that aren't included in the measures specs. And so, the terms they want to hear more about are tobacco use, tobacco screening, and tobacco intervention.

Okay, all that is, really, included in the measure specifications, so I encourage you to look there. Tobacco use is defined. That is on page six of the measure specifications, and it includes any type of tobacco, smoking or smokeless. Tobacco cessation intervention is also defined on that page, which includes brief counseling three minutes or less and/or pharmacotherapy. In the -- I believe it's in the numerator guidance. You're going to find what constitutes a screening. And really, it's just asking if a patient uses tobacco, both smoking or smokeless, and I'm sorry, what was the third thing?

Yeah, we have tobacco use, screening, and then tobacco intervention. Okay. So, the intervention information I just quoted is counseling or pharmacotherapy, and the screening simply must ask about all forms of tobacco use and be documented. Thank you.

Thank you. And our next question is on PREV-9 BMI. Can the follow-up plan show in any section of the note? For example, a plan for hypertension included weight loss and exercise plan. Is this acceptable for the follow-up?

Hi, this is Angie. Yes, that would be. If the most recent BMI is abnormal and there's documentation of recommendation of diet and exercise, and it is noted for another diagnosis -- hypertension, for example -- if it impacts, it would also impact the abnormal BMI is documented the same, it is acceptable. Thanks.

Thank you, and for this next question, if we could go back to slide 11, I think this person just wanted to go back to that slide, and if you could, you know, just touch on some of those details again.

Hi, this is Ozlem. Although PREV-10 has three populations, you will still receive just one sample. Your PREV-10 sample will have up to 616 beneficiaries for the measure, and in order to meet minimum recording requirements for PREV-10, you need to complete the first 248 beneficiaries, similar to the other measures. If you skip a beneficiary in the 248th rank, your minimum requirement rank will move to 249. So, instead of repeating the questions in PREV-10 for each population in the Web Interface, the questions are asked only once for each beneficiary, and depending on how the questions are answered, your performance rate for each population will be calculated and updated. If you look at the data entry screen in the CMS users interface, next to each question, there's an indicator that saves your answer for that question. Or actually, if you look at the user interface, next to each question, there's an indicator for which population your answers will be used to determine your performance rate. Thank you.

This next question says, "The specs say if 'not qualified for sample' is selected and the date is unknown, to enter the last date of the measurement period. If this is correct and the patient is selected for an audit, what documentation would need to be provided?"

Would you repeat that again, please? I'm not sure I got all of it.

Yes. So, if the specs say 'not qualified for sample' is selected and the date is unknown, then you have to enter the last date of the measurement period. If this is correct and patient is selected for an audit, what documentation would need to be provided?

Just whatever documentation was used to make that determination. So, it doesn't have to be dated 12/31 of the measurement period, but whatever documentation was used to come to the conclusion, you know, whether it be patient death or the patient was in hospice or that kind of thing.

Great, thank you. And Stephanie, do we have any phone questions at this time?

Again, if you would like to ask a phone question, please press star then the number 1 on your telephone keypad. One moment for the question. Caller, please state your question. The caller withdrew their question. Our next question is from Haley Butts.

Haley, go ahead with your question. I will access the participant and see if they still have a question. You may proceed.

All right, thank you, Stephanie. So, our next question is on PREV-10. If the provider documents the patient is not ready to quit, will this meet cessation follow-up as some of the providers document this after talking with the patient about quitting tobacco use?

Hi, this is Angie. The documentation really needs to include that tobacco cessation was given to the patient. This might be his answer to "I'm not ready to quit," but there still needs to be documentation of what intervention was provided and the results of whether he was a smoker or not, or he or she. And then the follow-up would have to -- it would have to reflect if counseling pharmacotherapy was done besides those things.

Thank you. Our next question is on PREV-12. If a patient had an active diagnosis of depression at any time during the period, should it be a denominator exclusion, or does the diagnosis have to be active at the time of the screening?

Hi, this is Jessica from the PIMMS measures team, and in order to claim that exclusion for PREV-12, there must be an active diagnosis prior to the numerator event, so that diagnosis needs to be documented before the -- and I'm just scrolling to see -- I believe it's the most recent screening. Thank you.

Thank you. Our next question asks, "Is there any way to tell that my submission is complete and ready to submit prior to this deadline?"

Hi, this is Ozlem. You can navigate on the left navigation menu. There is a link to view reports, and on the view reports page, there's a link to the data confirmation report. You can click on the data confirmation report to view your completeness on all the measures at any time during submission. Once you have viewed your data confirmation and you have completed your submission requirements, you do not need to press any buttons to submit data. Any data that you enter in the Web Interface at the time of closing will be considered submitted to CMS. Thank you.

Thank you. This next question says, "When using 'no record found' in a specific TIN within our ACO, are we allowed to go outside of the ACO participants to find that data?" And then they're saying that the large gastro group in their area is not a part of their ACO, but they can potentially look up colonoscopy results. Is that allowed, or can they only search other TINs that are participating in their ACO?

This is Amy Mills with ACO PAC. ACOs are encouraged to collaborate with physicians inside and outside the ACO.

Thank you, and Stephanie, do we have any callers with questions?

Again, to ask a question, star then the number 1. We do have a question from Jennifer.

Yes, I had a question regarding PREV-9. If the patient had an abnormal BMI at the last encounter but no follow-up plan was noted, but the patient did have a previous encounter with an abnormal BMI and had a follow-up plan on that encounter, can we use that encounter to meet the measure?

Hi, this is Angie. Yes, you're gonna start with the most recent visit, and if there is no BMI or if there's an abnormal BMI with no follow-up plan, you can look back 12 months from that encounter to find another abnormal BMI with a follow-up plan, both documented at the same visit. As long as it's within the 12 months, that would meet the intent of the measure.

Okay, great. Thank you.

Great. Our next question is on CARE-2. If a fall screening is found in the ER records, is that acceptable to meet the measure?

This is Deb. As long as that fall screening is documented in the medical records and it's documented during the measurement period, then that screening can be used.

Great, thank you. Our next question asks, "Is PHQ-9 acceptable for a depression screening on PREV-12?"

This is Deb, and yes, the PHQ-9 would be an acceptable depression screen for the PREV-12 measure. That measure does not dictate any specific screening tool. You just have to look to see if it is considered a normalized and validated screening tool, and then ensure that you have the name of the tool documented in the medical records, and whether or not the result of it is positive or negative. And then of course, if it's positive, ensure that you have a recommended follow-up.

Great, thank you. This next question says, "In past years, it seemed that all statin patients needed to be interred in order to get to the 248 minimum. Is it expected that this will be the same this year?

Hi, this is Ozlem. I am not sure if I understand the question correctly. I believe they are referring to PREV-13. The minimum reporting requirement is 248. The first 248 beneficiaries must be completed in order to meet the minimum requirement of this measure. Thank you.

Great, thank you. This next question is on CARE-1. If a patient's residence is a nursing home and this is where the follow-up within 30 days occurred, would this qualify as an office visit?

Hi, this is Katie from the PIMMS team. So, with CARE-1, the discharge -- excuse me, the follow-up within 30 days must be a follow-up with an outpatient visit. If the patient was not considered inpatient during the visit and seen within the 30 days of the pre-filled discharge date, then they may be included in the denominator. So, this also applies to skilled nursing facilities, nursing homes, home health rehab, et cetera. That particular visit must be considered outpatient in order to include it in the measure. Thank you.

Thank you, and Stephanie, do we have any phone questions at this time?

There are no questions at this time. If you would like to ask a question, please press star then the number 1.

Great. All right, our next question is on CARE-2. If there is documentation in the medical record of a patient following on two separate occasions, does this count as meeting the measure for fall screening?

Yes, as long as you have documentation during the measurement period of falls, this can be considered a fall screen because you are screening for a future fall risk, so therefore, if you have documentation that the patient has fallen, then that assessment has been completed by virtue of the fall.

All right, and Stephanie, just want to check in to see if we have anymore phone questions.

No additional questions at this time.

All right, and just one minute. We are looking through all of these questions and we'll pull one shortly. All right, so this next question is on PREV-6. Regarding the colonoscopy screening question, we answered earlier, if the outcome of the screening is not mentioned, does it meet the measure?

Hi, this is Katie from the PIMMS team. Here, the measure does require a note indicating the date the colorectal cancer screening was performed and the results are finding. So, if those results are not documented, it will not meet the measure.

Thank you, and this next question is on the depression remission measure and MH-1, and it says, "The population is determined if the patient showed a PHQ screening of a score greater than nine within the December 2016, November 2017 period. What if the patient did have a PHQ, but it was not a score greater than nine and the patient was not showing to be depressed within that year, and the remission screening also did not show the patient as depressed?"

This is Deb from the PIMMS team. My recommendation would be to look at the measure calculation flow for MH-1. Part of the denominator criteria is determining whether during that index period a PHQ-9 greater than nine result occurred. If you are unable to find a PHQ-9 greater than nine during the index period, that patient would not be considered denominator-eligible, and you would make that selection within the Web Interface. This is one of the reasons why, for this measure, you may find that you have a lot of skips,

because even though you may be able to confirm the diagnosis of major depression or dysthymia, you cannot find a PHQ-9 greater than nine result during that time. So, again, it's just part of that denominator criteria, and if you are unable to confirm, then you would make the appropriate selection, and that patient would be skipped and replaced.

Great, thank you. And Stephanie, do we have any phone questions?

We have a question from Andra Santangelo.

Hi, good afternoon. I had a question on PREV-12, and I wanted to know do you need to have the actual tool in the record, the age-appropriate tool, or just the reference to the name of the tool with the results.

This is Deb. You would just need the name of the tool and the results, whether positive or negative, so even in the case of, say you're using a PHQ-9 or a PHQ-2, we don't ask for the results of that, whether it's five, two, whatever it is. Just that the name of the tool, whether or not it's positive or negative. If it is positive, then what the recommended follow-up is.

Thank you so much. Have a good day.

Great, all right. Our next question is -- it says, "Would brochures or handouts from the EHR cover the follow-up for tobacco cessation?"

This is Deb from the PIMMS team, and I just wanted to kind of point you to page six of the measure specifications of this particular measure, as it does have some additional information from previous years, where they basically say things like written self-help materials, brochures, some pamphlets, complementary alternative therapies are not included and do not qualify for the numerator. So your scenario would not qualify as numerator compliance where it would be considered sufficient intervention.

Thank you. This next question is on IVD-2. If there is a procedure report that states one liter of heparinized saline solution instilled, is this an exclusion? They said they don't see the specific dose on the list. Does it need to match one?

Hi, this is Angie. I'm sorry, I have an answer for that right here and I'm looking for it. Okay. First of all, if there's documentation that the patient received an anti-coagulant during the measurement year in the patient's medical record, then you would exclude the patient regardless of dosage or anything like that. And the brief use of heparin or other anti-coagulants during a hospital stay, if the heparin was prescribed for the patient, then it would meet the denominator exclusion. But if the brief use is just the heparin as an I.V. line added to the I.V. catheter to keep it flowing and open, this would not meet the definition of the denominator exclusion. Thank you.

Okay, thank you. This next question is on PREV-12. Do depression screenings done inpatient count for the 2018 performance year?

This is Deb. This is very similar to the CARE-2 question that was asked earlier. As long as the medical record documentation shows that that depression screen occurred during the measurement period, it is not necessary to not accept a depression screen that occurred at an inpatient stay. For as long as you have the screening occurring in the way that the measure

specified, so you have the name of the screening tool that was used, you have the documentation of the results, whether positive or negative, and then if positive, a recommended follow-up, then it would meet the intent of the measure.

Great, thank you, and Stephanie, do we have any phone questions at this time?

We have a question from Nina.

My measure -- can you take a BMI assess during an inpatient stay?

Hi, this is Angie. Yes, as long as the BMI's documented during the measurement year -- or I'm sorry. If the most recent BMI is documented, yeah, during the measurement year in the 12 months prior, it can be used.

Okay, great. Thank you.

All right, our next question says, "What do we do with patients that are showing as unknown within our ACO audit roster?"

This is Amy with ACO PAC. I'm not quite sure I'm understanding the question, but if there's a field that says unknown for the top NPI, than that's just normal, and you should still report quality data on that patient.

Thank you. This next question asks, "For offices that do not ever carry flu vaccines, can all the patients be considered denominator exclusion for not getting the flu vaccine?" They're asking for the flu vaccine if they have a group that never has the flu vaccine, can they just go ahead and submit all of those patients as denominator exceptions, and the answer to that is no. The expectation would be that it's not just a matter that you don't provide the flu vaccine, but it's that the patient is receiving the flu vaccine, which is also why you are able to accept previous receipt of flu vaccine or receipt from places like Walgreens, wherever the patient happens to get the flu vaccine. If you happen to run out and you are an organization that provides the flu vaccine, it's really intended to be used in those instances, and I believe this is information that PCPI has provided us in the past.

Okay, thank you, and this next question is on the BMI measure. Can we use the BMI assessed during an inpatient stay?

Hi, this is Angie. I think that was similar to the last question. There is no setting or place of service specified in the measure. You know, as long as it is documented at the most recent visit or in the 12 months prior, then it would count.

Thank you. All right, this next question, the person says they have "a patient for which I did the screening for tobacco use back in October of 2018, and the patient was a smoker and he was given cessation counseling. He came back in December of 2018 two months later and was documented as a smoker again. Should I have done another cessation intervention again in December in order to be able to comply with this measure, or can I use the one from October since the patient has not changed his tobacco use status?"

Hi, this is Angie. Yes, tobacco cessation intervention should have been given again. It has to be given at the most recent positive screen either during the visit or after, but not before. Thank you.

Thank you, and this next question, the person asks, "For IVD, does aspirin with caffeine satisfy the measure?"

Hi, this is Angie. Yes, it does. You can also refer to the coding documents for the numerator codes that are acceptable. I believe it is included there. Thank you.

Thank you. This next question says, "If the smoking status in the chart states non-smoker or former smoker, is this acceptable?"

Hi, this is Angie.

Go ahead, Angie.

I was gonna say there has to be documentation that the patient was asked if they were a smoking -- if they were a smoker or a smokeless tobacco user, and if that is documented and the response is that they are a smoker, then I believe that's acceptable. Deb, do you agree with that?

Yes, I do. I had tagged this one earlier, and I think the main point of trying to ensure that it's understood by the groups that the tobacco screening measure is for all tobacco use, and so if the only thing you're asking about is smoking and that's all you have documented, then that doesn't meet the intent of the measure, but if you have identified someone as a smoker and you're providing sufficient intervention, that's acceptable. Where I think some people get into a bit of a challenge is if you have identified someone as a former smoker and you are not asking if they are a tobacco user, then you really only asked about half of what this measure is intended to cover, which is all tobacco use. So yeah, you're absolutely right, Angie.

Thank you.

Great, thank you both. And Stephanie, we can take a phone question at this time. Stephanie, do we have anyone on the phone with a question?

To ask a phone question, press star then the number 1.

All right, so we'll go ahead and read another chat question here. We have one on PREV-10. If a patient is a tobacco non-smoker, however, they have a history and present use of marijuana, should they be indicated as a smoker?

This is Deb, and marijuana is not covered by this particular measure. So whether or not a patient is a marijuana user is not taken into account for the tobacco screen PREV-10 measure. However, again, as Angie and I stated earlier, if the patient is only being asked about their smoking status and not tobacco status, then this would not be considered an accurate tobacco screen.

Great, thank you. And this next question is on MH-1, and I guess it's going off of a previous question that they said they didn't understand the whole answer. So they're saying the patient has the active diagnosis and was given in PHQ-2 in the period of December 1, 2016 through November 30, 2017, and it was negative. "Do I still put no because it was not a PHQ-9?"

This is Deb again, and yes, MH-1, which is a little bit different than your PREV-12 depression screening measure, MH-1, the only tool that can be used for this particular measure, whether you are establishing denominator

criteria with a PHQ-9 greater than nine or if you have established that the patient is denominator-eligible and you are now determining if they have achieved remission within that 12 months plus or minus 30 days, the only tool that can be used to show numerator compliance is also a PHQ-9. And then, of course, that result would be less than five. Another challenge we've seen in the past is some people have processes set up where they will start out with a PHQ-2, move into a PHQ-9, potentially have a PHQ-9 greater than nine and a patient who's denominator-eligible for MH-1, and when they do their follow-up PHQ screen, they use a PHQ-2, and if they receive a zero, then they don't do anything else. Well, the problem with that is the only thing that can be used to show remission is a PHQ-9, and all the questions have to be answered with a result of less than five. So, just make sure when you're looking at that MH-1 measure, the only tool that's acceptable is the PHQ-9 and the rate that requires the PHQ-9 greater than nine for denominator eligibility during the index period, and you'll need a PHQ-9 less than five to show remission for a denominator-eligible patient. The PREV-12 screening tool is a little bit different because you're just screening for depression. Any standardized tool, validated tool is acceptable for the screening measure itself. Hope that helps.

Great, thank you, and I think now we're gonna go back to that question that we skipped over earlier. So here's the question again from a group. For IVD-2, does it matter if we disqualify due to no diagnosis versus anti-coagulant medications? For example, "What if I find heparin right away, but need to search further for the diagnosis? Can I just exclude right away for heparin without finding the diagnosis?"

Hi, this is Angie again. According to the measure specifications, you should verify the diagnosis first before taking the denominator exclusion. So, confirming the diagnosis, because if you can't confirm the diagnosis, then you would select "not confirmed diagnosis" rather than denominator exclusions, so we want to make sure that the data is consistent with -- consistent in it doesn't throw it off based on answers that are given. Thank you.

Thank you. This next question is on PREV-6. If a physician documents a colonoscopy completed in 2010, is that sufficient, or does it have to have the complete date?

Hi, this is Jessica Schumacher from the PIMMS team, and the measure specification indicates that if that documentation is based on a patient reporting the procedure during the encounter, then CMS would accept just the year, the type of the test, and the results and findings. If it's a medical record entry that's based on a procedure that was done, then that date should be available on, like, the lab output or on the results page from any type of internal lab that was conducted locally or within your organization. Thank you.

Thank you, and this next question says, "Did you just state that the tobacco cessation materials provided to the patient out of the EHR would not count?"

This is Deb. What I am referring to, again, is page six of the PREV-10 measure specification where tobacco cessation intervention is defined. PCPI has defined concepts such as written self-help materials, for example, brochures, pamphlets, and complimentary alternative therapies are not included in the 2018 CMS Web Interface PREV coding document and do not qualify for the numerator. I hope that clears it up.

Thank you, and just one last question. Is it possible to delete an uploaded file?

Hi, this is Ozlem. You cannot delete an uploaded file. However, you can change your answers and do another upload. The answers you put in your latest upload will override the previous answer that you have uploaded into the system. If you would like to remove any of the answers that have already been uploaded into the system, then in the Excel file, you can select "N/A" for those questions, and that will remove any answers you have previously uploaded into the system. Thank you.

Thank you, and that is all the time that we have for today, so if we weren't able to answer your question, please feel free to e-mail those addresses for help with the Quality Payment Program, the Medicare Shared Savings Program, and Next Generation. We sent those out as an announcement earlier in the webinar, and if we can go to the next screen, those are located there again, and we also encourage you to join us for our next webinar next Wednesday on February 13th. Thank you.

Thank you. This concludes today's conference. You may now disconnect. Speakers, please hold the line.