Hello, everyone. Thank you for joining today's Web Interface Support Webinar. This series of webinars is for Accountable Care Organizations (ACOs) and groups that are reporting data for the Quality performance category of the Quality Payment Program through the CMS Web Interface for the 2018 performance period. These webinars will highlight important information and updates about reporting quality data and provides 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 will 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 Fiona Larbi from the Center for Medicare at CMS. Please go ahead.

Thank you. Good afternoon, everyone, and welcome to the 2018 CMS Web Interface Quality Reporting Webinar for mixed groups and ACOs. My name is Fiona Larbi, and I worked on the Shared Savings Program. Also joining me today are other CMS Web Interface subject matter experts who will share helpful information and answer your questions during today's Q&A session. Next slide, please.

This is our standard disclaimer slide, which you can review at your leisure. Next slide, please.

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

As a reminder, the Web Interface submission period closes at 8:00 p.m. on Friday, March the 22nd. The Web Interface will save your progress with each step, and your submission will be automatically accepted after the Web Interface closes. If you have accessibility issues, please contact the Quality Payment Program Help Desk, and the contact details for the Help Desk are provided on the last slide, which is slide 20. Next slide, please.

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

This slide includes the steps that you should follow to request a CMS Approved Reason. Next slide. This slide includes information on upcoming Web Interface Supporting Webinars. As you can see, there are only two more webinars before the web Interface Supporting Period closes. The next webinar is on March 13th. And now I will turn it over to Ozlem Tasel.

Good afternoon, everyone. This is Ozlem Tasel. Next slide, please. The frequently asked question on the recording today is, "How do I earn end-to-end bonus points in CMS Web Interface? And the answer is, "Measure data electronically uploaded into the CMS Web Interface via API or Excel file upload are eligible for end-to-end electronic reporting bonus. You can earn one bonus point per each Web Interface measure. Please note that it is capped at 10% of your denominator. To earn end-to-end bonus points in CMS Web Interface, you need to update or complete at least one more beneficiaries in a measure via API or Excel file upload to earn one bonus point for that measure. Once you earn end-to-end bonus for a measure for

using the Excel upload, you can then update your beneficiaries in that measure manually and still keep the bonus point. You will not lose your bonus manually updating a beneficiary. Please note that end-to-end scoring, if earned, applies to everyone under the MIPs or the MIPS APM scoring standard." Next slide. I will now pass to Angie.

Thanks, Ozlem. Everyone, this is Angie Stevenson with the PIMMS Measures Team. We'd like to talk about some inquiries we've been receiving at the Quality Payment Program regarding denial of the CMS Approved Reason requests. Next slide, please.

Inquirers are asking, "Why wasn't my CMS Approved Reason request approved?" And the answer is, "the CMS Medical Officer reviews the 2018 CMS Approved Reason requests and makes the final determination. Generally, if the measure developer did not include an applicable exclusion or exception for measure and it does not appear the request presents a unique circumstance, the request will be denied. And in these cases, you will report this measure in the same fashion as it's reported using other submission mechanisms. All providers will be held to the same standard, and the data would likely be consistent and comparable across ACOs in this group." We wanted to note, "We are unable to accept requests for CMS Approved Reasons 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 that case number into the Web Interface and skip the patient." A lot of them also have been reopened, and this same advice would apply. Unless you had additional information from the medical record to provide that was not included in your first request, then the decision will not change because it's already been reviewed by the medical officer. Thank you. I will turn it over to Fiona.

Fiona, your line may be on "mute."

Yes, it is. I apologize. Sorry. The next two slides are going to go through some available resources for you. Next slide, please. This slide provides a list of Web Interface Resources available under Quality Payment Program Resource Library. And these are instructional videos for the Web Interface. Next slide, please. Next slide.

And this slide includes links to the prior webinars that are also in the QPP Webinar Library. Next slide, please. And this slide has additional information and resources for the Medicare Shared Savings Program and the N ext Generation ACO model. Next slide, please. This is the final slide, and this is where you can go if you need assistance from the CMS team. And now I'm actually going to hand it back to Haley for the Q&A session.

Great. Thank you, Fiona. We are now going to start the Q&A portion of the webinar. You can ask questions via chat or phone. To ask a question via phone, dial 1-866-452-7887. If prompted, provide conference ID number 3765498, then press star-1 to be added to the queue. These numbers are also listed on the screen here. If you have follow-up questions or clarifications that you want to share in the chat, please check "follow-up question" at the beginning of your chat.

All right, our first question is "For PREV-10, if the most recent encounter only had a screen for smoking but the previous encounter in the measurement period had screens for "smoking" and "smokeless," can we use the screens from the previous encounter?"

Hi, this is Angie from PIMMS. You should use the date of the most recent tobacco screening and if the patient was identified as a tobacco user at that visit. Cessation intervention must occur during that visit or after to meet the intent of the measure. Thank you.

Our next question -- "For the PREV-9 measure, if the beneficiary's most recent encounter is November 1, 2018, with an abnormal BMI and no follow-up plan, but upon further review of the chart, we have an encounter June 1, 2018, with an abnormal BMI and a follow-up plan. Which DOS would be appropriate to capture for the BMI?"

This is Deb from the PIMMS team. You're certainly looking at the right flow of information. Your November 1st date is the date you're going to start with. But since you have an abnormal BMI on November 1, 2018, without a recommended follow-up, you are able to look back 12 months to see if you can locate another abnormal BMI with a recommended follow-up, which you have stated that you've found June 1, 2018, as within that 12-month period of time. There's an abnormal BMI on that date, and there is a recommended follow-up on that date. So, you would abstract based on the information you found on June 1st. Thank you.

Our next question -- "When we upload to the CMS portal, will a lowercase 'yes' be accepted, or does the 'Y' need to be uppercase for all yeses in the columns?"

Hi, this is Ozlem. As long as you enter "yes" lowercase or uppercase, it will work. Just entering "Y" alone is not going to work, but the "yes" needs to be entered in full. Any time you are unsure, we recommend that you look at the pull-down values in the Excel template to see what the acceptable values are for each question. Thank you.

Okay. Our next question -- "For PREV-9, what are the qualification definitions for the referral component of the follow-up plan? For example, does a referral to physical therapy for tendonitis count as an abnormal BMI follow-up plan if it was placed on the same day as an abnormal BMI, even though there is no mention of weight loss?"

This is Deb again from the PIMMS team. The one thing you have to have documentation of for a recommended follow-up for an abnormal BMI is a recommended follow-up that is something that would address that abnormal BMI. So, typically, we would expect to see that there is language in there that, "Due to the abnormal BMI recommendations for diet and exercise." However, we've also provided guidance in the past that we've recognized the fact that there may be more than one condition that is being addressed at a particular encounter. You may have an abnormal BMI documented, and you also have documentation that the patient is a diabetic patient. And so, there may be documentation of recommendation of diet and weight loss, exercise, and you recognize that that recommended follow-up would be relevant to both the abnormal BMI and to the diagnosis of diabetes. And so, in that case, we'll take it, even though it does not specifically say it's due to the abnormal BMI. It is relevant to those conditions, so what you would want to look for in your documentation is to ensure that that recommended follow-up can be something that would be specific guidance, follow-up recommendations that would be addressing the BMI condition. Thank you.

Thank you. Do we have any phone-line questions?

We have a question from Jason Shropshire.

Hi, can you hear me?

Yes, we can hear you.

I need some clarification regarding what counts as counseling for PREV-10, the smoking if the patient is a tobacco user. I'll give you an example. I'll give you two examples. You tell me if this counts toward counseling or not. And this is all from a provider's progress notes: "The patient has significantly reduced his cigarette usage, but he is not interested in quitting." And then the other is, "He has reduced his smoking to 1/2 pack per day or less." Does that count as counseling, or can you be more descriptive in what you are requiring in terms of cessation counseling?

Hi, Jason. This is Angie from the PIMMS team. You may want to -- I think it would be best if you submitted a ticket or a case to the Quality Payment Program.

The problem is I have dozens of cases like this. I mean, I can't submit a ticket for every patient.

Right. I'm trying to get to --

Angie.

Go ahead, Deb.

Yeah, and while you're looking for that, because you may want to pull it out of the spec, I would say, we typically think of cessation intervention as a provider -- it's identified as three minutes or less of counseling for cessation intervention. What you're stating does not seem like the provider is necessarily providing cessation intervention. They're just documenting tobacco usage. However, again, knowing you're an ACO and that's who you're representing and so what you're looking for is "would an audit team take that documentation as cessation intervention?" I wonder if, Mary, you would like to weigh in on that or if that's something that you would also feel would be important to have through QNet.

The first example that you gave, the one where the patient has significantly reduced tobacco usage and refuses to quit or whatever, from that, I can tell that the physician at least was counseling him to quit and they were talking about him quitting. The second one, I agree with Deb. They're just documenting tobacco use. Even if the patient refuses to quit smoking or using smokeless tobacco, we at least need to be able to see that it was discussed with them.

So, you would accept the first case, where it says they have reduced the usage, but they're not interested in quitting?

Correct, because the physician at least tried and discussed it with the patient, and that's what we're looking for there.

Okay, thanks.

Stephanie, do we have any more phone-line questions?

Your next question is from Darren Barnes.

Good afternoon. This is in regards to PREV-10 scoring. On session five, it was stated that PREV-10 performance rate score was going to be based on the performance rate for population two. In previous years, PREV-10 performance rate was equivalent to population three. So, it was questioned at that time how PREV-10 benchmarked this year if the same rate did not exist previously, and the answer was although the rate for population two was not previously calculated in the Web Interface, the data elements used to calculate it were captured. I would argue that that is not valid, since the measure specifications for definition of screened tobacco use and cessation changed from 2017 to 2018. In 2017, page 9 of the specs manual, it stated, "Screening for tobacco use and cessation do not have to occur on the same encounter but must occur during the 24-month look-back period." 2008, it changed to add, on page 11, add to that same statement, "and the cessation intervention must occur after the most recent tobacco use or status is documented." That change in definition dramatically changes how things were abstracted previous to '18 as they are being abstracted in '18, which would invalidate the benchmark. Anybody have any comments?

This is Fiona from the shared savings program. We thank you for your input, and we'll definitely take this back to look and have discussions amongst ourselves.

Should I submit a ticket with this, as well, just to make sure?

You can submit a ticket to the shared savings program mailbox, or you can do it to the QPP Help Desk. If you're an ACO, it would be easier if you sent it to the shared savings program mailbox.

I'm not.

Then submit it to the QPP Help Desk, and then we can address it that way.

Okay.

Great. Our next question -- "Will you please explain how scoring will occur under the following conditions for group practice, not in ACO submitting mixed quality via WI?" And the conditions in question are "data completeness" and "case meant no benchmark for measure."

This is Lisa Marie. If you're a group, and you're wanting to know how scoring will occur for completing all of the measures -- if you know there's like 15 measures, and so not every measure has a benchmark. However, in order to have data completeness, you have to actually report on every single measure. In this case, even instances where a measure does not have a benchmark. In the instance that, let's say, you complete all reporting for every measure, the measures that do not have a benchmark, you will not be scored, meaning those numbers will not be included in the denominator. If you do not complete reporting for measures that have a benchmark, then those will actually be calculated into your score and included in the denominator. So, in order to meet -- for example, there's also cases where there will be some measures where you have 248 beneficiaries. You have to report on all of those beneficiaries. In the instance you have less than 248 beneficiaries for a measure, then you would report all of the beneficiaries that you have for that particular measure in order to meet all the requirements for reporting. So, it's important to remember that when you are thinking about

benchmarks or no benchmarks, you just have to report on all measures within the Web Interface.

Our next question -- "For PREV-9 BMI, if the patient only refused the height to be taken but did not allow height to be taken at another time during the year, should this patient be marked as a denominator exclusion even though the BMI can still be calculated because weight was allowed to be taken and height was carried forward from a previous visit within the measurement period?"

This is Deb from the PIMMS team. Just ensure if that height and weight are both taken during the measurement period. You are absolutely able to use both that height and weight and calculate a BMI. You just want to make sure that that height and weight are done within the measurement year. And I'll give you an example. The dates are not going to be accurate, so please keep that in mind. But it's basically an example that kind of addresses your question. If you have weight measured on July 1st of 2018 and the height is measured and documented on November of 2018, you can go ahead and use that height and that weight that's documented at two different times for your most recent BMI. If you want some additional background around that, it may be, especially to get it in writing, I would certainly suggest opening up a QualityNet Help Desk ticket. We can get that to you in writing, maybe with a specific scenario with dates that you have, but just know that you don't have to use the height and the weight that's taken from a single visit. And the rationale behind this is there are a lot of physicians that their processes are that the weight is taken at every single encounter during the year, but height may only be taken during the first encounter of the year, or it may be taken during a very specific type of encounter during the year. So, the measure steward recognizes that and will allow you to use the height and the weight from two different encounters. I hope that's addressed your question. Thank you.

Okay, our next question -- "For the PREV-7 measure, if we find a physician note during the measurement period in which the physician states that the patient is up to date on all vaccines, will that meet the measure?"

This is Deb again. That would really depend on when that documentation occurred. Vaccines all being up to date, if that happened during the flu season, then that would certainly indicate that the flu vaccine is also up to date. However, let's say that documentation you're finding in June of 2018, that would not mean that the flu vaccine has been met because that's outside of the flu season that's being measured, and so there's no way to tell if the flu vaccine was provided for the right measurement of the flu vaccine for the Web Interface. Thank you.

Our next question -- "If the population used for scoring the tobacco-use measure has changed for 2018, doesn't this conflict with the published 2018/2019 quality measure benchmark percentiles for tobacco use?"

This is Kristen. The benchmark was recalculated to reflect that population, too.

Okay, thank you. Our next question -- "For the CARE measure, if CMS provides two discharge dates when we are only able to find the second discharge date in the medical record review, does this skip the patient or give partial credit?"

Hi, this is Kayte from the PIMMS team. If you're not able to verify the discharge date, you should not confirm the patient for the measure. The patient will apply to your scoring as recorded appropriately for each specific discharge. Thank you.

Okay. Stephanie, do we have any phone line questions?

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

Okay. Our next question -- "For PREV-13, if the patient is taking a statin medication but could also qualify as an exception, should we say yes to taking the statin or make them an exception?"

This is Angie from the PIMMS team. You would say yes. If the patient is taking or prescribed statin therapy during the measurement period, then the intent of the measure is met, and you would not need to take the denominator exception. Thank you.

Our next question -- "We are finding a lot of claims with Medicare-other liability listed as primary ends in the EHR. Which billing set is the third-party liability that replaces MC for certain billed visits? How do we interpret this as pertaining to not FFS?"

Hi, this is Sarah from ACO PAC. I'm not 100% certain I understand the question, but a beneficiary would be excluded if their primary payer is not Medicare fee for service. And I'm not sure if that fully answers the question or if others have anything to add to that.

All right, I think we can go ahead on to the next question, but if that individual who submitted that question has any clarifying notes, just type it into the chat box. Our next question -- "IVD-2 for a denominator exclusion, patient has documentation of use of anticoagulant medication overlapping the measurement year. Does this mean if a patient is on an anticoagulant medication in 2018, they are excluded?"

Hi, this is Olga from the PIMMS team. The term overlapping for the denominator exclusion refers to when the initial prescription for anticoagulant does not have to occur during the measurement year, but the patient records should reflect that the patient is currently on an anticoagulant during a measurement year.

Okay. Our next question -- "Is diagnosis coded as major depression, however documentation and patient chart only says 'depression,' would the ICD-10 code of F32.9 indicating major depression -- Will this count as diagnosis of major depression, or do you have to mark 'no' for 'diagnosis not confirmed?'"

Hi, this is Jessica from the PIMMS Measures team. And, yes, for MH-1, if there's an eligible ICD-10 code, such as F32.9 in the problem list and it's associated with an applicable description, then that would be appropriate for inclusion in the denominator. So, for example, if you have F32.9 with depression, then that would be acceptable, and that's only because that code is there to help back it up. We discussed this with CMS and with the measure owner, Minnesota Community Measurements, and it's understood that it's not a perfect world where all EMRs have the same description with code. So, they understand there might be influx in what groups are saying across providers.

If you have any additional questions about this, please feel free to contact the Help Desk. Thank you.

Okay. Stephanie, are there any phone-line questions?

We do have two questions. The first question is from Trudy Pearcy.

Yes, we have a patient who's ranked in quite a few measures, and the only claims that we have for this patient are claims that are code 99309, which is a nursing-home-facility encounter for subsequent significant complications, but they're ranked in things -- and that 99309 code is only in the CMS supporting documents for measures CARE-2 and PREV-7. But yet, CMS ranked this patient in other measures that are not clinically appropriate for those two visits. And yet, they're asking us to report on that patient for those other measures, which would basically -- we would be failing the patient because it's not clinically appropriate. So, it's like CMS is intentionally putting patients in our ranking, knowing that it's going to drop our measure rates. Now, I've heard this talked about on this call before, but it doesn't sound like CMS is adapting to those concerns by the ACOs. So, I'm kind of wondering if this is why each year we're seeing fewer and fewer Web Interface measures. Is it because CMS has found this to be kind of a problem area, and they're going to eCQMs, which would avoid this? Can you speak to this conundrum?

Hi, this is Sarah Grallert from ACO PAC. I can speak to the first part of your question around why beneficiaries would be ranked with that code, where you only see claims with that specific code 99309, or 039. For the denominator-specific sampling, the way that we sample into each measure doesn't necessarily require that the claim come from the ACO. So, those visits or those encounters could actually occur outside of the ACO. However, that being said, we did, indeed, before we sample for the measure-specific level criteria, we first look to be sure that the beneficiary has been seen by our ACO twice during the performance year, and that's looking for what we call quality eligibility. And during that process, we do indeed use that code to determine quality eligibility is considered an appropriate code. As far as the rest of your question about clinical appropriateness and the drop-in measures, I would need to defer to others. But I hope that answered your beneficiary rankings question.

Only remotely, because in CMS' own documentation of their supporting docs and their narrative specs, they say that the codes that are in the supporting docs are considered to be all-inclusive. But then, they turn around and defy that in how they rank the patients, based on those codes.

Perhaps I'm not understanding, but the way that those specific codes are used, you are correct. Just in, I believe, two of the measures for performance year 2018 for the denominator sampling, but the visits to be considered for reporting don't necessarily need to occur within the ACO. So, the beneficiary may have seen the provider outside of the ACO with a different encounter code that was appropriate for that measure, and the expectation is that as part of care coordination, providers are following up both inside and outside of the ACO.

So, our care coordinator would have to contact this patient and say, "Where else were you seen, so we can go call them?" Is that what you mean?

I would expect that the medical record would reflect information about visits, or that it would be thought out if it weren't in the medical record.

That's why I'm trying to figure out what the process is to seek that out when it's not in the medical record. That's the only thing I can think of is CMS wants us to call the patient and ask them, "Where else were you seen, so that we can contact whoever else that might be?" Because if it's not in our EHR, how would we know that?

I don't know if others have anything to add to how to complete reporting, quality reporting when looking for records outside of the ACO. I don't know, but that is an expectation and has been.

Yeah, I've heard it on the call many, many times, but I've often sat here wondering, "Well, it's an illogical path and expectation. It's not a viable expectation. Even though it still is one, it's not a reasonable one." And so, this has just now come up in our world, and that's why I ask the question again because it's CMS intentionally asking us to take a nosedive on this patient on all these measures, knowing that we didn't have an encounter with them to meet the measure.

Hi, this is Sandra from the Shared Savings Program. The assignment and sampling guidance can be found online, and this will provide some information as to how the beneficiaries are assigned to your ACO and how they're sampled for the measures. There would have been claims from your ACO for the beneficiary in order for them to be in your sample. And if you have additional questions or you want to share rank number that you would like evaluated, you can send that to the Quality Payment Program Help Desk.

We did that, and all they did was close it and said, "Report on them." They basically said the same thing you guys said -- "Go figure it out." I mean, we can see which claims. We know based on the methodology. We know it's code 99309. But 99309 in CMS's own documentation of supporting docs is only for CARE-2 and PREV-7.

Hello. Could you please send your ticket number to the Shared Savings Program mailbox? And we'll look into this for you. Thank you.

Sounds good. Thank you.

Okay, our next question -- "Can we count depression screenings done during ED visits for PREV-12?"

This is Jessica from the PIMMS Measures team. Yes, you can, as long as the results are reviewed and verified. CMS does not provide direction on the workflow within the organization. So, if an ED assessment is given and that provider documents the results and interpretations of the assessment, then that would count. Thank you.

Our next question is in regards to the CARE-1 measure. "A patient had two hospital discharges within a few days of each other. They did see a PCP in office within the 30 days with medication reconciliation done, and they have in their notes that this one office visit will meet the numerator for discharges as the office visit/medical recommendation fell within both 30-day time frames. Is this correct?"

Hi, this is Kayte from the PIMMS team. The intent of this measure is to provide reconciliation of medications for each discharge during the measurement period. In this scenario, where an office visit overlaps with two separate discharges, that visit can be used to meet the intent of the measure for both discharges if you have the appropriate documentation as outlined on page five of the measure specification. If the office visit is compliant with the medication reconciliation and you can correlate the medications prescribed at each discharge with the discharge date, you may use that office visit. Thank you.

Our next question is a follow-up about BMI, and they're asking, "Does the BMI not need to be calculated? Is that correct? Previous guidances said it did."

Yeah, and this is Deb. I'm sorry if I somehow articulated that the BMI doesn't have to be calculated. The BMI absolutely has to be calculated. I think what I was trying to get at was you do not have to use a height and a weight from the same encounter. You can use a height from a previous encounter, along with a weight from the current encounter to calculate that BMI. Of course, if you're using height and weight from two different encounters, you have to ensure that they are within the measurement period. My apologies if it came across as if a BMI doesn't have to be calculated because that would have been incorrect. A BMI does have to be calculated. Thank you.

Thanks. "For the DM eye exam, if there is a note that states, "Eye exam in September 2017. No diabetic retinopathy,' is that enough to meet the measure, or do I have to see the actual exam notes?"

I'm sorry. Can you read that again, for the DM-7 measure?

Sure. "For DM eye exam, if there is a note that states, 'Eye exam in September 2017. No diabetic retinopathy,' is that enough to meet the measure, or do I have to see the actual eye exam notes?"

You don't have to see the actual -- Okay, go ahead, Angie.

Thanks, Deb. I had it ready. I just did not hear it was the DM question. The actual report from the eye-care professional is not required. If medical records indicate the patient had a retinal exam by an eye-care professional in 2017 with no diabetic retinopathy noted, then it would meet the intent. Thank you.

Okay. Our next question is a follow-up to the BMI question. They're asking, "Does that mean that you would want us to document only the information from the date we find the plans? Should we not document the BMI from the most recent encounters that we are looking back two months to find the counseling within? For example, a BMI of 29 in November with no plan and a BMI of 29.5 in June with education. Should we record the 29 from November for the most recent BMI date, or should all of our submitted data be from the date the plan was found in June, when we submitted the 29.5?"

And this is Deb. Thank you so much for the opportunity to clarify that. The November 1st BMI as your most recent is the BMI you should enter into the Web Interface as the abnormal BMI. The fact that you're looking back 12 months for a recommended follow-up because you did not find a recommended follow-up at the November 1st date is appropriate. But you certainly would

want to go ahead and use that most recent documented BMI for purposes for entering into the Web Interface. Thank you.

Our next question -- "This question is regarding IVD-2 -- ischemic vascular disease. If the patient has an active IVD diagnosis during the measurement period and is taking Aspirin and approved anti-platelet medication and a medication such as pradaxa, which is a denominator exclusion med, will the patient meet the measure due to taking Aspirin, or will they have to be a denominator exclusion?

Hi, this is Olga from the PIMMS team. Once you confirm the diagnosis, then you would choose the denominator exclusion for the patient. But if the patient is on Aspirin and an anticoagulant, then you would exclude that patient from the measure.

Our next question -- "For the IVD measure, is an allergy to aspirin considered a denominator exclusion?"

Hi, it's Olga again from the PIMMS team. No, an aspirin allergy would not be a denominator exclusion. Aspirin is not the only anti-platelet that can be prescribed. The measure guidance does include other oral anti-platelets, and for the IVD measure, the only denominator exclusion would be patients who had documentation of use of anticoagulant medications overlapping the measurement years.

Do we have any phone-line questions?

We have a question from Mackenzie Green.

Yes, I was wondering if a beneficiary in our first-quarter attribution report, but they were not in quarters two, three, and four. Could they still be included in our Web Interface patient sample?

Hi, this is Sarah from ACO PAC. We use quarter three for our sampling. It might be helpful if you submitted a Help Desk ticket to us, so that we could take a look at the cases you're referring to.

Okay, so, basically, if a patient was in quarter one, and let's say, they were not in quarter two or quarter three, but they're in quarter four, they would not be eligible? We have several beneficiaries that are coming in and out of assignment, and I'm just trying to figure out if they should be included or not.

Right, so our sampling process will use the quarter three as updated, but I think it might be helpful if we looked into some of the cases because there can be a variety of reasons that they might not show up. And it's hard to tell without looking at the instances. That would be helpful. That would be great. Thank you.

Thank you.

Are there any other phone-line questions?

No other phone-line questions at this time.

Our next question from the chat is a follow-up to a previous PREV-9 question. The question was specifically in regard to the denominator

exclusion and the refusal of a height. "In the section that says you have to evaluate refusals first, so my question is specifically with regard to an exclusion of only a height. Should that count as a denominator exclusion when there really was a qualifying BMI available during the measurement period?

This is Deb from the PIMMS team, and I wanted to make sure to answer this. Our recommendation and request would be to go ahead and provide us this question through the QualityNet with some specific detail because you're absolutely right. Typically, the guidance is pretty clean in that if you find the denominator exclusion, you should exclude that patient regardless if you find the qualifying event later on. So, I am going to anticipate that even the refusal of a height, even if they had other height measurements and weight measurements through the year, you're probably going to need to select that denominator exclusion. But because this is not a question and a scenario we've necessarily been asked about before, we want to make sure we're not missing any detail that would give you the opportunity to report on that patient and have that a completed patient, but keeping in mind, certainly, for other folks that are listening, if you are finding that you have a patient who's received the height and you are not able to find a documented BMI deed to this refusal, that is a denominator exclusion, and that is what you should select. My recommendation, again -- if you could go ahead and open up a QualityNet Help Desk ticket so we can assure we have all the details behind your question, we'd be certainly happy to approach it through that avenue. Thank you.

This is Jessica Schumacher from the PIMMS Measures Team. Just to add onto that. If you could open that inquiry with the Quality Payment Program, rather than QNet, then that will get to us. Thank you.

We will stand by for our next question. Our next question is in regard to PREV-6. "If the patient was not referred for a mammogram screening because they have breast implants, can they be exempt or excluded?"

Hi, this is Olga from the PIMMS team. No, the only denominator exclusions included in this specification will be women who had a bilateral mastectomy or who have a history of bilateral mastectomy or if there's evidence of a right and a left unilateral mastectomy. There's also a denominator exclusion for patients aged 65 and older in institutional special needs or that are residing in long-term care with uncertain codes. Those are the only denominator exclusions for the measure. And just to clarify, I believe that question was for PREV-5.

Thank you. Our next question is about IVD. "If a patient was removed from blood thinners due to severe GI bleed, could they qualify for exclusion?"

Hi, this is Olga again. I would say that if you feel the patient should be disqualified from the denominator, you would need to request a CMS Approved Reason to skip the patient. To do this, you'd need to submit an inquiry to the QPP Service Center, including patient rank, measure, and the reason for the request. And a CMS decision will be provided in the resolution of the inquiry. We just ask that you please never include any PII or PHI.

Thanks. Are there any other phone-line questions?

We have a question from Nicole Moore.

Hi, good afternoon. I have a question about the PREV-10 measure, the tobacco cessation. We have a few patients that get coded for nicotine dependency on the last day of their esapho-assessments, and it usually states, "Nicotine dependency. Needs to quit smoking or gave educational pamphlet." Are either of these acceptable?

Hi, this is Angie from the PIMMS team. Can you say the last part again? I just want to be sure.

Sure. It's usually coded as nicotine dependency, and it either states, "Needs to quit smoking," or, "Gave educational pamphlet."

Okay, so, as long as the tobacco-use status is documented and there's documentation that cessation occurred, which I think your first example may need, but the second one is just giving a pamphlet alone, according to the measure specification, does not meet tobacco cessation definition. If there was a discussion regarding quitting smoking and then a pamphlet was given, then that's acceptable. Does that answer the question?

Yes, it does. Thank you very much.

You're welcome.

Stephanie, are there any other phone-line questions?

No additional questions at this time.

Okay. Our next question is about PREV-10. "If a tobacco-cessation counseling is performed by a nurse, MA, or care coordinator, does it count for this measure?"

Hi, this is Angie from PIMMS. Yes, as long as it occurred during or after the most recent documented tobacco-use screenings, CMS does not dictate internal-office protocol. So that would count. Thank you.

And our next question for PREV-8 -- "Would the documentation of all vaccines up to date work with the pneumonia vaccine? It was stated this documentation would work for PREV-7. So, I wanted to verify it would be the same for PREV-8."

This is Deb. And I want to clarify that I did not state that that would work for PREV-7. For PREV-7, it would be required that that documentation occurred during a period of time that was during the flu season to ensure that the flu-season vaccine that was being stated to be up to date without specifically pointing to the flu vaccine -- let me rephrases that. Basically, if the documentation is that vaccines are up to date, that counts if that documentation is during the flu season being measured. And that is to ensure that we've covered the flu vaccine during that period of time. When we're talking about the PREV-8 pneumococcal vaccination, I would say as long as it's not patient-reported, that the measure does expect that it's going to be PREV-13 or 23, that really meets the intent of the measure. However, Mary, I would ask you, from the perspective of an audit, if it said, "All vaccines up to date," would you take that to mean that includes the pneumococcal vaccine?

We do need to see what type of vaccine it was. So, we would have to have documentation of that.

Okay, but also, then, to clarify, just so folks don't -- we give them clear direction, if we are talking about the flu season and they say, "Vaccinations up to date," would you take that as the flu vaccine was included, or do they have to specifically say, "Flu vaccine up to date?"

I really have not seen that in documentation before. But I agree. If it says, "Vaccinations up to date," and it hits that right time frame, we can take that.

Okay. I hope that clarifies the caller's question, and I know we're running out of time. So, if you ended up with some additional questions or some follow-up questions, please feel free to open up a Help Desk ticket through Service Now and not QNet, and we should be able to get to those. Thank you.

All right, I believe that's all that we have time for today. If we weren't able to answer your question, please feel free to e-mail those addresses that are listed on the screen for help with the Quality Payment Program, the Medicare Shared Savings Program, and Next Generation. We did send those e-mails out as an announcement that you should have seen pop up on your screen, as well. And like I mentioned, they are listed here again. We also encourage you to join our next webinar on March 13th. Other than that, I will turn it over to CMS to close out the call.

Fiona, is your line on mute?

Oh, sorry. Thank you, everybody, for attending the webinar today, and please remember that the Web Interface reporting closes at 8:00 p.m. on March the 22nd. And hopefully we will have two more webinars before that date. And the next one will be on the 13th of March. Thank you for joining us today.

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