2014 GPRO Web Interface Quality Reporting

Questions & Answers

January 13, 2015

7500 Security Blvd., Baltimore, MD 21244-1850

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Quality Reporting for Calendar Year 2014: Overview

Activity	Estimated* Timeline
ACOs and PQRS group practices provide care to patients during the reporting period	January 1, 2014–December 31, 2014
CMS assigns beneficiaries to the ACO or PQRS group practice, samples them into the GPRO Web Interface for data collection, and prefills some beneficiary information.	November 2014–January 2015
GPRO Web Interface opens so that patient ranking files can be downloaded	January 5–January 9, 2015
GPRO Web Interface training environment available (with masked, dummy data)	January 12–January 23, 2015
GPRO Web Interface opens for data abstraction by ACOs and applicable PQRS group practices	January 26–March 20, 2015 (Data Collection Period)
ACOs and PQRS group practices attend technical assistance webinars	January 27– March 21, 2015 (Data Collection Period)
GPRO Web Interface closes to data abstraction by ACOs and applicable PQRS group practices; no more abstraction possible	March 20, 2015 *Closes at 8:00pm ET / 7:00pm CT / 6:00pm MT / 5:00pm PT*
Continued access to GPRO Web Interface to generate, view, and print reports (all other functionality disabled)	March 30–April 24, 2015
ACOs selected for audit notified	Mid May 2015
ACOs' audit materials due to CMS	Mid June 2015
Quality scores reported to ACOs	Late Summer/Early Fall 2015

*Dates subject to change.

GPRO Web Interface

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	Can you please clarify the terms "for analysis" means? Why is the "complete" patients higher than "for analysis" count?	The **For Analysis** count reflects patients that are consecutively confirmed and completed starting with the patient ranked #1 in the module. The **Complete** count is the number of completed patients in any order in the module. If some of your patients have not been consecutively confirmed and completed, you may see a higher count of **Complete** patients than the **For Analysis** count. The For Analysis line is on the Home page in the Group Status section. Home is the initial page seen when logging on or when the "Home" option is selected from the global navigation. The For Analysis line also appears on the Totals Report. The **For Analysis** count is the count used to determine if you have met the minimum reporting requirements.	X	X	X
2.	When should we click the "submit" button?	In order to be marked as complete for reporting, you do need to go to the Submit screen and press the "Send Data to CMS" button. This will indicate to CMS that your data collection is complete. If you need to enter additional data after you have pressed "Send Data to CMS," you may do so, but will need to press "Send Data to CMS" again once you have finished data collection. The Submit screen is accessed by clicking the "Submit" link at the top of the Web Interface.	X	X	X
3.	Where is the submission link in the Portal on the GPRO Web Interface?	The link is https://qualitynet.org/pqrs. After signing into the PQRS Portal, select the "GPRO Submission" link in the Site Navigation on the left side of the screen.	X	X	X
4.	Do you lose data when the system logs you out after a period of inactivity?	Yes, if the user is manually entering data and has not saved the information. The system will also lock the patient with the user account that last updated the information. If you are uploading an XML file and get timed out the data will not be lost.	X	X	X
5.	Can you edit information in the patient record after saving it?	Yes. The user can save the record multiple times and edit it at any time before the data collection period closes.	X	X	X
6.	Can we provide the data all modules for a given patient even if the patient is not ranked in all modules?	The XML file will pass format validation. Only the patients ranked in the module containing the measure data will be updated. The data will be discarded for patients not ranked in the module containing the measure.	X	X	X

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7.	One of our measure specific reports shows no data. Is this normal?	Yes, this report will be blank if you do not have any consecutively confirmed and completed patients. Percentages are calculated only on the consecutively confirmed and completed patients. The final percentage will not be reported until all required consecutive patients have been entered.	X	X	X
8.	How can we tell when we have completed data collection (i.e. satisfied the complete reporting requirements)?	The For Analysis line on the **Totals Report** reflects patients that have been consecutively confirmed and completed. If your report indicates "The minimum number of consecutively confirmed and completed patients for this module has been met" then you have successfully consecutively completed all necessary patients in the module. The For Analysis line on the Home page will indicate then number of patients meeting the reporting requirements. If you have met the minimum number of consecutively confirmed and completed patients, there will be a green checkmark next to the For Analysis count in each module. If all 15 modules have a green checkmark, then you have met the reporting requirements. The Submit screen and "Submit Status Report" will indicate "The minimum number of consecutively confirmed and completed patients for this module has been met." for each module that has been satisfactorily reported. If you see this message for each of the 15 modules, then you have met the satisfactory reporting requirements. The Submit Screen and the Submit Status Report will also have text indicating if you have or have not met the reporting requirements.	X	X	X
9.	How do we export all prepopulated patient information?	Downloading the Patient file and the Patient Discharge file will contain all information that was prepopulated into the GPRO Web Interface. To get all PREV-7 pre-filled data you must select the PREV-7 module when exporting the Patient XML file. The pre-filled discharge dates for CARE-1 are in the Patient Discharge XML file.	X	X	X
10.	Which reports do you recommend we print and keep?	Though this is not required, you may want to print the Measure Rates Report (shows performance on each of the measures and modules) and the Totals Report, which will give you a sense of how many patients were complete, skipped, etc. The Submit Status Report gives you a record of the modules complete at the time you pushed the "Send Data to CMS" button on the Submit screen.	X	X	X

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11.	Does reporting on the GPRO Web Interface measures require manual chart abstraction? Is there any alternate method of data submission?	GPRO Web Interface measures must be reported via the Web Interface. However, some data can be uploaded from your EHR using XML. The slides from the XML training will be posted on the GPRO Web Interface page of the CMS website.	X	X	X

System Requirements and Users

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1.	Do security officials have GPRO Web Interface access or only the submitters?	Security officials do not have access to the GPRO Web Interface and cannot submit data for your ACO or group practice in the GPRO Web Interface. Security Officials (SOs) approve the IACS PQRS submitter roles and the Quality Roles Management System (QRMS) ACO Submission 2014 or the QRMS GPRO submission 2014 roles. The SO should be from the ACO or group practice, this means the SO should not be a vendor.	X	X	X
2.	How long does it take to get access to the GPRO Web Interface after completing the security official registration forms?	Approval should occur within a couple days. Once all the roles are approved in the PQRS system; there should be immediate access.	X	X	X
3.	Our organization will be using more than 15 nurse reviewers for abstraction. Can we approve all of them as Submitters?	ACOs and PQRS group practices are limited to 15 Submitters per TIN (or ACO Primary TIN) due to capacity. What you might consider doing is exporting the patient and patient discharge XML file to upload in an Excel file. The Excel file can be used by the nurse reviewers to gather the data offline. The data they collect could then be exported from the Excel file into an XML file for upload into the GPRO Web Interface.	X	X	X
4.	Will users be required to do two-factor authentication each time they log into the GPRO Web Interface?	When a user logs in for the first time each day, the GPRO Web Interface will ask for the second factor passcode. There is a checkbox that can be selected so the user isn't prompted for the second factor passcode for twelve hours.	X	X	X

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5.	The passcodes that are sent for two-factor authentication purposes are often delayed. What can be done about this?	For some email addresses, there may be firewalls causing delays. We also have reports that emails sent to Yahoo addresses seem to arrive more slowly, although we do not know why. You can request changes to the mode of receipt for these codes: for example, you may opt to receive them by text message instead of email. The method of delivery is set in your IACS account.	X	X	X
6.	When I log into the PQRS portal, my profile indicates that I am a PQRS Representative and a PQRS Submitter, however I do not see the GPRO submission link. Why is this?	In order to gain access to the GPRO submission link, you will need to request the Submitter role via the QualityNet Roles Management System (QRMS) application. You must have the ACO Submission or GPRO Submission QRMS role. Please refer to the IACS Overview slides, which are available for download on the GPRO Web Interface web site.	X	X	X
7.	Can we use the GPRO Web Interface with Internet Explorer 7 or Google Chrome?	Internet Explorer 9 (IE9) is the browser officially supported by CMS and is the recommended version. Internet Explorer 8 (IE8) may also be used. Versions of Internet Explorer other than IE8 or IE9 ***cannot*** be used. Minimal testing of the GPRO Web Interface has been done with Google Chrome 38.0.2125.111m, Firefox 20.0.1, and Safari 5.1.7. These browsers can be used, but you will see minor changes on the screens.	X	X	X
8.	I have access to multiple organizations through my QualityNet account. What do I need to do to navigate from one organization to another in the system?	You need to log out and log back in, in order to see the Profile Manager screen which allows you to switch between Profiles / Organizations.	X	X	

XML Specifications

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1.	Where can we find documentation on use of XML to load data into the GPRO Web Interface?	The 2014 GPRO XML Specifications and Release Notes have been posted on the GPRO Web Interface web site.	X	X	X
2.	After entering some data into the GPRO Web Interface, will that data be available immediately for XML export?	Yes. When you request an XML file, it will contain all information that is currently saved in the GPRO Web Interface. After uploading an XML file the data will be available to export once the status of the upload indicated processing is complete.	X	X	X
3.	If we upload data via XML, will it erase any data that was entered manually by another user?	If you have a value in the XML tag that is associated with data entered by another user, then yes, your XML upload would overwrite that value. However, if, the XML file does not contain a tag or contains an empty tag for the data that was manually entered, the data will not be overwritten or erased. For example, one user is manually entering information in the diabetes module and you are uploading data for the CAD module. As long as you do not enter values in the diabetes tags when uploading the CAD XML file your upload of CAD data would not overwrite the previously-entered diabetes data.	X	X	X
4.	Can we upload all of our sampled patients in one XML file?	We would recommend you try the upload with a few patients to make sure that there are no errors, but you can also upload the entire sample at one time.	X	X	X
5.	If a data field is not applicable to a patient, do we leave the field blank or enter a -1?	If a data field is not applicable (for example patient does not have LVSD so do not need to enter the beta blocker data), the tag may be left blank in the XML or the tag may be left out of the XML file. The -1 was removed as an available option in 2014 to prevent accidental erasure of data.	X	X	X
6.	Does the XML upload automatically "save" the patient's information?	Yes. Uploading of the XML automatically updates and saves the patient's information.	X	X	X

Patient Ranking File

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	What information will be provided in the patient ranking file that will be available in the GPRO Web Interface in early January?	The file will include: • HICNO • Patient first name • Patient last name • Sex • Birth Date • Patient Rank for each of the modules into which the patient was sampled • The TIN or CCN that provided the patient with the most primary care service visits • NPIs, first names, and last names of the 3 providers within the ACO or PQRS group practice who provided the highest number of primary care services to the patient	X	X	X
2.	What are we supposed to do with the patient ranking data?	The purpose of the patient ranking data is to give the ACOs and PQRS group practices a list of the assigned beneficiaries who have been sampled for GPRO Web Interface data collection, the TIN or CCN at which the beneficiary received the most primary care services, and the names and NPIs of the three providers who provided the plurality of primary care services visits to the beneficiary—all based on Medicare claims data. The purpose of this list is to assist the ACOs and PQRS group practices in finding patient records. It is possible, however, that the patient's record is located with none of these providers. If that is the case, the ACO or PQRS group practice should make every effort to locate the patient's record in order to collect data on this patient.	X	X	X

Sampling and Prepopulation

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1.	Will all of our assigned/ aligned beneficiaries be populated into the GPRO Web Interface?	No. Patients will be sampled randomly (based on third quarter assignment/ alignment) into the GPRO Web Interface using the specifications in the 2014 Web Interface Sampling Document, posted on the GPRO Web Interface webpage.	X	X	X
2.	What is the significance of a patient's rank?	Each sampled patient in the module is randomly assigned a rank order number for that module. Patients will be ranked 1-616, or the maximum number of eligible beneficiaries if fewer than 616 are eligible for a given module. For PQRS group practices with 25–99 eligible professionals (EPs), the sample size will include ranks from 1- 327, or the maximum number of eligible beneficiaries should 327 not be available. The purpose is to facilitate completion of 411 cases (or 218 cases for PQRS group practices with 25-99 EPs) in consecutive order.	X	X	X
3.	Will each ACO (participant) TIN receive its own set of samples?	No. Quality data collection, measurement and reporting in the ACO program are conducted at the ACO-level. The 15 samples on which ACOs will need to submit clinical quality data will be drawn from all assigned/aligned beneficiaries across the entire ACO, that is, all participant TINs. In other words, there will be one set of 15 samples drawn for the entire ACO, not for each participant TIN in the ACO.	X	X	
4.	Many of the measures have age restrictions. As of when is a patient's age calculated?	Patients are sampled based on their age on the first day of the measurement period. For the 2014 measurement period this is the patient's age as of January 1, 2014.	X	X	X
5.	What if one or more of our modules contains fewer than 411 (for ACOs and PQRS group practices with 100 or more EPs) or 218 (for PQRS group practices with 25-99 EPs) ranked patients?	Not every module or measure will have a sample of 616 patients (or even 411 patients) for ACOs and PQRS group practices with 100 or more EPs or 327 (or even 218) for PQRS group practices with 25-99 EPs; this is particularly true in modules with diseases that have low disease prevalence rates. If CMS' contractor was unable to identify 616/327 patients who met the module sampling criteria, then all patients who meet the criteria will be sampled. If fewer than 411 or 218 patients are found eligible for a measure/module, then the ACO or PQRS group practice should report on all eligible patients. For example, we have historically seen low numbers of patients sampled into the Heart Failure module.	X	X	X

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6.	What will be populated into the GPRO Web Interface?	The following information will be pre-populated by CMS using Medicare claims, enrollment, and provider information available in the Integrated Data Repository (IDR) as of October 31 of the measurement year (2014). • Medicare HIC ID of the patient • First and last name of the patient • Gender • Patient date of birth • Patient rank in each module, if applicable • The 3 providers that provided the most primary care services to the patient • Clinic at which the patient received the most primary care services • Flu shot (PREV-7) • Discharge dates (CARE-1)	X	X	X
7.	What if prepopulated demographic information is not accurate?	While the end-user can modify the demographic information prefilled into the GPRO Web Interface, we expect little need for ACOs and PQRS group practices to modify this information. However, if the patient's demographic information in your records and in the GPRO Web Interface do not match, then the abstractor may need to correct the information in the GPRO Web Interface. For example, Medicare claims may not have the accurate date of birth for a patient. Your ACO or PQRS group practice should correct this information because it may affect that patient's denominator eligibility for certain measures. Note that any demographic information you change in the GPRO Web Interface does not get reported back to the CMS claims system. You should urge your patient to contact the Social Security Administration directly to have that information updated.	X	X	X

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8.	Is the ACO or PQRS group practice responsible for validating the data that is prepopulated into the GPRO Web Interface?	The ACO or PQRS group practice should validate each patient's demographic information, as changes to age and gender may affect a patient's denominator eligibility. Provider information populated in the GPRO Web Interface is for informational purposes only, so validation of this data are at the discretion of the ACO or PQRS group practice. PREV-7 (flu shot) and CARE-1 (medication reconciliation) are the only modules where measure specific data are prepopulated. Note that influenza immunization data are not prepopulated for all beneficiaries ranked in PREV-7, but only those for whom an immunization could be identified in the claims data. If influenza immunization data has been prepopulated for a patient, the ACO or PQRS group practice does not have to validate that data. If the ACO or PQRS group practice is selected for an audit, the ACO or PQRS group practice will not have to provide medical record documentation for prepopulated influenza immunization data. However, if influenza immunization data are not prepopulated, the ACO or PQRS group practice should refer to the patient's medical record to determine if an influenza immunization was administered in accordance with the measure specifications, and should document their findings in the GPRO Web Interface. Influenza immunization data obtained from the medical record (i.e., not prepopulated from claims data) is subject to provision of supporting documentation should your organization be selected for an audit. CARE-1 will have prepopulated inpatient facility (hospital, skilled nursing facility, or a rehabilitation facility) discharge dates where an office visit also occurred within 30 days of each discharge. The ACO or PQRS group practice is responsible for validating these dates (plus or minus 2 days) in the GPRO Web Interface. Should the ACO or PQRS group practice be audited, supporting documentation related to the inpatient facility discharge will be required.	X	X	X

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9.	Is CMS able to exclude from sampling patients who were enrolled in an HMO at some point during the measurement period, who entered hospice, or who died during the measurement period?	Yes. If Medicare claims pulled on October 31, 2014 indicate that the patient had HMO coverage as a primary payer, died, or entered hospice, then CMS would exclude them from the quality sample. However, the claims we pull in October may not have the most up-to-date information (same for 'deceased' or 'hospice'.) If the abstractor finds additional or more recent information indicating that the beneficiary was enrolled in an HMO (as primary payer), entered hospice, or died at some point during the measurement period, then it would be appropriate to select "Not Qualified for Sample" with the appropriate reason indicated.	X	X	X
10.	Can patients receiving comfort care be excluded from quality reporting?	In the Patient Confirmation tab in the Supporting Documents hospice is defined as "hospice care at any time in the measurement period and includes non-hospice patients receiving palliative goals or comfort care". Patients for whom "In Hospice" is selected will be removed from the sample(s).	X	X	X

Abstraction into the GPRO Web Interface

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	For modules and measures in the Web Interface, what makes the patient "complete"?	Complete means that you have confirmed the disease diagnosis (for CAD, DM, HF, HTN, IVD samples) and provided all the required information under that module/measure (e.g., for a DM patient, that includes but is not limited to HbA1c value, most recent BP, tobacco use, etc.); or, for those measures that do not require confirmation of a diagnosis (CARE and PREV), that you have found the medical record, confirmed the patient is qualified for the measure, and provided all the required information (e.g., indicate whether or not the patient received a mammography screening).	X	X	X
2.	Do we have to enter our data in rank order? Or can we abstract information on patients out of rank order?	The actual order of data entry does not matter, however, the ACO or PQRS group practice must consecutively report on at least the first 411/218 ranked beneficiaries (or all sampled beneficiaries if fewer than 411/218 are ranked) in order to satisfy the reporting requirement for each measure or module.	X	X	X

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3.	How many unique patients should we expect we will need to abstract?	There are 15 GPRO Web Interface modules, but many modules have similar criteria. For ACOs and PQRS group practices with 100 or more EPs, CMS will sample no more than 616 patients for each of the 15 modules. For PQRS group practices with 25-99 EPs, CMS will sample no more than 327 patients for each of the 15 modules. In 2012 and 2013, patients were sampled using a method that would increase the likelihood that they would be sampled into multiple modules (if they were eligible for multiple modules). Typically we saw sample sizes between 4,000 and 6,000 unique patients, but ACOs or PQRS group practices could potentially see over 9,000 (15 samples x 616 beneficiaries). We are using similar sampling methodology for 2014 so we expect similar sample sizes. We would expect a smaller number of unique beneficiaries for PQRS group practices with 25-99 EPs. The sampling methodology is described in the 2014 Web Interface Sampling Document available for download from the GPRO Web Interface website. ACOs and PQRS group practices with 100 or more EPs are required to completely report on the first 411 consecutively ranked patients in each module. PQRS Group practices with 25-99 EPs are required to completely report on the first 218 consecutively ranked patients in each module. The additional sampled patients allow for cases in which some lower ranked patients may not be eligible for quality reporting. In such cases, the patient may be “skipped” and an additional consecutively ranked patient must be reported for each “skipped” patient until the ACO or PQRS group practice has completely reported on 411 (or all, if there are fewer than 411) consecutively ranked patients.	X	X	X

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4.	What does "consecutively complete" mean?	*For ACOs and PQRS group practices with 100 or more EPs*: Patients are numbered 1-616 (or 1 to the maximum number available if less than 616), and 411 of these patients need to be completed in the GPRO Web Interface. *For PQRS group practices with 25-99 EPs*: Patients are numbered 1-327 (or 1 to the maximum number available if less than 327), and 218 of these patients need to be completed in the GPRO Web Interface. If you need to skip a patient (e.g., due to "medical record not found," or the diagnosis could not be confirmed), you must complete the next record that follows consecutively. For example, if an ACO had to skip one patient, their final completed patient should be ranked 412 instead of 411. For several examples, see Appendix A.	X	X	X
5.	What if one of our sampled patients was not seen at our facility during the measurement period?	*ACOs*: Though the patient may not have been seen at your facility, the patient has to have been seen at least twice at one of participant TINs affiliated with your ACO during the measurement period in order to be included in the samples. Specifically, beneficiaries were assigned to your ACO based on 3rd quarter 2014 assignment or alignment and must have had two or more primary care services at one of the ACO's Participant TINs to be sampled into the module. Since your organization is deemed accountable for such a case, you may not select 'not qualified for sample' under this circumstance. *PQRS Group Practices*: PQRS group practices are responsible for the beneficiaries assigned to them, and claims data indicated that beneficiaries assigned to a PQRS group practice have had at least two primary care services during the measurement year. Please refer to the 2014 GPRO Web Interface Assignment Methodology Specifications for more details. The PQRS group practice must use best efforts to obtain required quality data for such patients.	X	X	X

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6.	What if one of our sampled patients is no longer being seen at one of the ACO's participant TINs, or at the PQRS group practice (e.g., patient moved or the provider is no longer with the ACO participant TIN or PQRS group practice)?	By the assignment/alignment algorithm, the patient was assigned/aligned to your ACO or PQRS group practice because they were deemed to have the plurality of their Medicare services with your ACO or PQRS group practice. Further, patients sampled into the GPRO Web Interface had at least 2 E&M visits with your ACO or group practice between January 1 and October 31, 2014. As an ACO or PQRS group practice, you will need to be accountable for this patient's care, and should do your best to obtain the needed quality of care information to complete the GPRO Web Interface.	X	X	X
7.	What are reasons to select "Not Qualified for Sample"?	An ACO or group practice may select "Not Qualified for Sample" in the GPRO Web Interface if: • The patient was in hospice during the measurement period • The patient moved out of the country during the measurement period • The patient was deceased during the measurement period (if patient died after the measurement period, you should still abstract information on them) • The patient was enrolled in a Medicare Advantage plan	X	X	X
8.	Some of our beneficiaries have declined to share their data. Will they be eligible for sampling into the GPRO Web Interface?	Quality data collection is not related to the data sharing processes that have been established for the Claims and Claims Line Feed data. A beneficiary who declines to share their data is not exempt from quality reporting.	X	X	
9.	Can we exclude a sampled patient if they were only seen by a specialist at our facility?	No, this patient was assigned to your ACO, so you will need to be accountable for his/her care. Please refer to the Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications for more information on how beneficiaries are assigned to an SSP ACO. Similarly, group practices are responsible for the patient's assigned to them, and the group practice has provided the plurality of that patient's primary care. Please refer to the 2014 GPRO Web Interface Assignment Methodology Specifications.	X	X	X
10.	Is there any benefit or harm to abstracting additional ranks in the module than what is required?	Some organizations may choose to upload more records for their own quality tracking or quality improvement efforts. If you enter the beneficiaries consecutively, only the first 411 patients (or 218 for groups with 25-99 EPs) will be used in the completeness determination, but all 616 beneficiaries (or 327 for groups with 25-99 EPs) will used in the measure rate calculations.	X	X	X

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11.	Are there repercussions for skipping a lot of patients in our sample (i.e., if we are not able to locate their medical records)?	Patients for which the ACO or PQRS group practice has selected no medical record found, diagnosis not confirmed, or not qualified for the sample (for CMS approved reasons, deceased, entered hospice, enrolled in an HMO, moved out of the country) are considered "skips". The GPRO Web Interface will produce a warning when 10% of a given sample has been skipped. However, this warning is only a system warning. ACOs and group practices will not be penalized for skipping 10% of a module's sampled patients. As long as you have met the minimum requirement of 411 consecutively completed patients (or 100% of the sample if fewer than 411 are available), then you will have completely reported on the module. *ACOs only: If there seems to be a consistent unexplainable pattern that CMS observes in your skips, then it may raise a flag, and that may be one of the selection criteria for a targeted audit or for targeted education with your ACO.* The medical record not found option should only be used for extenuating circumstances such as a provider leaving a practice and taking all the records or a natural disaster. If claims are being billed through ACO participant TIN(s) or a PQRS group practice TIN, we would assume that the ACO or PQRS group practice is documenting the care provided in a medical record.	X	X	X
12.	What do we have to do in order to be eligible for shared savings under pay for reporting?	If you have completely and accurately reported on the minimum 411 beneficiaries per each of the 15 modules or if you didn't have 411 to report on but have exhausted the samples provided to you, you would have satisfactorily reported for under pay for reporting.	X	X	
13.	Where can we find a list of diagnosis, procedure, and exclusion codes (e.g., reasons for excluding for "medical reason" or "patient reason") that can be used for reporting?	This information can be found in the 2014 GPRO Web Interface Supporting Documents and Release Notes, which is available for download from the GPRO Web Interface Website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X

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14.	Different measures define the same condition differently. Why is that? Do we use just one of them?	We acknowledge there are differences in the coding for similar elements provided when that element is used in multiple measures, e.g., ischemic vascular disease in DM-16 and in the IVD Module. CMS encourages alignment of measures especially in regards to the coding used to represent various measure elements; however, these two measures were developed and are maintained by different measure stewards. You are to follow the individual code list for each measure as they are listed when using codes to extract the data from your EHR or another data source.	X	X	X
15.	Can we use NQF's specifications for a measure when they are available?	Please follow the GPRO Web Interface specifications as these specifications have been developed specifically for the GPRO Web Interface reporting mechanism. Additionally, the GPRO Web Interface Narrative specifications are approved by the measure developer for use in the GPRO Web Interface and reflect the intention of the NQF measure.	X	X	X
16.	Is it possible to use data from multiple sources for abstraction?	Yes, any documentation the physician has available to them at the point of care is eligible for use in data collection.	X	X	X
17.	Is there a list of CMS Approved Reasons to remove patients from any of the measures/modules and how do you get approval?	No, requesting and approving removal of patients for a CMS approved reason is on a case by case basis. To remove a patient from a module/measure for a CMS approved reason, open a QualityNet Help Desk inquiry. Include the patient rank, measure/module, and reason for the request. CMS will provide their decision in the resolution of the inquiry. Please do not select this option without approval from CMS.	X	X	X

Care Coordination/Patient Safety

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	Can we add discharges to the pre-populated discharges in CARE-1?	No, only report on the inpatient discharges that are pre-populated in the GPRO Web Interface.	X	X	X
2.	What if our records indicate the patient's inpatient discharge happened a few days after the date pre-populated into the GPRO Web Interface?	You can confirm the discharge in the GPRO Web Interface if the discharge date in your records is within 2 days (before or after) of the pre-populated discharge date noted in the GPRO Web Interface.	X	X	X
3.	What if the patient did not have an office visit within 30 days of discharge?	Patients are sampled into this measure only if Medicare claims indicate an office visit within 30 days of the inpatient discharge occurred. However, if you are unable to confirm an office visit, you would select "No" under "Office Visit" in the GPRO Web Interface. If "No" is selected the discharge would not be included in the denominator of the measure.	X	X	X
4.	Are patients only counted as numerator compliant for medication reconciliation if, after each discharge, their medications were reconciled?	Each of the patient's inpatient discharges is counted as a single observation. For each discharge/office visit combination in the GPRO Web Interface, you will need to confirm the discharge, confirm an office visit within 30 days, and confirm that medication reconciliation was done. For example, if a patient has two discharges (each with an office visit within 30 days), but medication reconciliation was only done at one office visit after the first discharge, then the patient will contribute two observations to the denominator, but only one to the numerator.	X	X	X
5.	What documentation is required to confirm that medication reconciliation was performed?	Your documentation needs to cover the following: • a note indicating the physician, PA, NP, registered nurse, or clinical pharmacist is aware of the patient's discharge medications • a note that the discharge medications were reconciled with the current medication list (including dosage) in the outpatient record • a note further outlining whether the medications are staying status quo or changing (discontinuation, adding new, changing dosage)	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
6.	If we do not have access to our patient's discharge information (e.g., no information at all or only the date of admission), how do we validate the discharge date that is prefilled in the GPRO Web Interface?	It is the ACO's or PQRS group practice's responsibility to obtain this information to the best of its ability to account for the patient's care. If the documentation in the patient's medical record, registry, or other information (e.g., a list received from the hospital) does not reflect an inpatient hospital discharge on this date, or within 2 days prior or after this date, then you would select "No." This will disable the medication reconciliation question. If the medical record documentation reflects a different discharge date, again select "No."	X	X	X
7.	If a patient is discharged once and has three office visits within 30 days, will the patient appear in the denominator three times?	No. The patient would appear in the denominator once (for one discharge). In order to meet the numerator criteria, medication reconciliation would need to have been performed at one or more of the office visits.	X	X	X
8.	For CARE-1, are we to use the first office visit after discharge to answer the medication reconciliation question, or, can we use any office visit within the 30 days?	You can use any office visit within 30 days of the discharge date during which medication reconciliation was accomplished.	X	X	X
9.	If the patient is in the hospital for rehabilitation, is that considered an inpatient status?	Yes, as noted in the Data Guidance tab of the CARE Supporting Document, rehabilitation, psychiatric, skilled nursing, or acute care stay discharges are considered inpatient facility discharges for the purposes of this measure.	X	X	X
10.	For CARE-1, we have implemented a process by pharmacists to ensure that a patient's medication list is reconciled on the day of discharge. Is this acceptable?	In addition to having the reconciliation at discharge, you would also need to follow-up with a discharge or office visit reconciliation within 30 days of the inpatient facility discharge. When CMS looks for patients who are eligible for this measure, we look in the claims data for the office visit to have occurred at least one day after and within 30 days of the discharge.	X	X	X
11.	Please define the term, "providing ongoing care."	The term, "providing ongoing care" is interpreted as anyone the patient sees post-hospitalization for follow-up care.	X	X	X
12.	Can the inpatient facility discharge occur outside the group practice?	Yes, the inpatient facility discharge may have occurred under a non-group practice provider.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
13.	For CARE-2, if a patient had a fall with resulting fracture within the measurement period, had physical therapy (PT) at home, and was evaluated for safety by PT, would this count as a fall screening?	Yes, this would count as long as the documentation is inclusive of the documentation of any of the following regarding the patient's fall history: • No falls; or • One fall without major injury; or • Two or more falls; or • Any fall with major injury	X	X	X
14.	For CARE-2, who can perform the falls screening?	Any healthcare professional may perform the fall risk screening.	X	X	X
15.	For screening for Future Fall risk, should we look for a screening during the 12-month measurement period, or 12 months from the last visit?	The screening must be done during the measurement period in order to be included in the numerator.	X	X	X
16.	For CARE-2, we have many skilled nursing facility patients. The skilled nursing facility uses a quarterly MDS that are signed by nurses. Do these satisfy the fall risk measure?	This would be appropriate as long as it addresses the patient's fall history.	X	X	X
17.	For CARE-2, is the "Timed Up and Go" test (used to assess patient mobility) acceptable as a fall risk screening?	It would count as a future fall risk screening if it includes documentation of the patient's fall history.	X	X	X
18.	Does the CARE-2 fall screen apply to all patients, or only patients having had a previous fall?	This screen applies to all patients in your sample.	X	X	X
19.	For CARE-2, can we count screenings for future fall risk regardless of the setting where they were performed, outpatient or inpatient?	Yes. The Falls assessment screening in CARE-2 does not have to be completed in the office.	X	X	X
20.	For CARE-2, can we use the Morse Fall Screen?	New for 2014—Morse Fall Screen is an acceptable screening because it addresses the question of past history of falls.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
21.	For CARE-2, please define non-ambulatory.	Non-ambulatory is defined as non-ambulatory at the most recent encounter (when screening is done) during the measurement period (i.e., patient is not ambulatory, bedridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair).	X	X	X

At Risk Populations: Coronary Artery Disease

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	For CAD-2, does LDL Controlled require an LDL-C result or is documentation of the patient being on a statin enough to satisfy the measure?	You need to know the value of the LDL-C test to complete the measure. If the LDL-C is less than 100 they pass the measure OR if the LDL-C result is greater than or equal to 100 and the patient is prescribed a statin, they will also pass the measure.	X	X	X
2.	For CAD-2, if an LDL is not calculated or recorded due to high triglycerides, but the patient is on a statin, do we select "No?"	Select "No" if the laboratory was unable to calculate the LDL-C value due to high triglycerides.	X	X	X
3.	For CAD-2, if the patient has been prescribed a statin, but does not have a plan of care, does that still satisfy the measure?	According to the measure owner (AMA-PCPI), it would satisfy the measure. The definition of a documented plan of care, noted in the Narrative Specification for CAD-2, states a plan of care includes at a minimum the prescription of a statin. A statin is the minimum requirement for a plan of care.	X	X	X
4.	For CAD-2, would allergy or adverse effect to statins documented anytime in the patient's history be acceptable to answer "No—Medical Reasons?"	If the allergy to the statin is documented in the medical record, it would be acceptable to use as a medical exclusion.	X	X	X
5.	For CAD-2, can Welchol and Colestipol (lipid lowering drugs) be used? They are not listed as statins, but in previous years were allowed.	A prescription of a statin is required. Welchol and Colestipol are not statins.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
6.	For CAD-2, we have RxNorm codes for statins not in the list provided in the measure specifications for CAD. Must we limit our results to only the statin RxNorm codes in the specs?	Please see the Data Guidance for CAD-2. Within the Inclusions/Synonyms column you will see the following: "See CAD Drug Code tab for a list of statin medications (list may not be all inclusive)." You may use RxNorm codes representing statins included on your list that are not on the list included in the downloadable resource.	X	X	X
7.	For CAD-2, you need documentation of LDL-C and result, and if >100, a plan of care must include at a minimum, the prescription of a statin. Can this be found in any setting, such as inpatient or other? Does it not need to be found in the physician office medical record?	Documentation within the patient medical record would need to substantiate that the patient was prescribed a statin (at minimum) as a plan of care. You can obtain the information from any setting. Any documentation the provider has at the point of care may be used for CAD-2.	X	X	X
8.	For CAD-7, does the ejection fraction have to be recorded during the measurement period?	No. The ejection fraction that is used to confirm the patient has left ventricular systolic dysfunction (LVSD) may have been performed at any time in the patient's history up through the last day of the measurement period. The result of the LVEF may be expressed quantitatively as < 40% or qualitatively as moderate or severe.	X	X	X
9.	For CAD-7, to confirm whether a CAD patient also has DM, what is the timeframe of the DM diagnosis? Does the DM diagnosis need to present in 2013 or 2014 or anytime in the history?	The patient should have an active diagnosis of diabetes during the measurement period.	X	X	X
10.	For CAD-7, does Amlodipine alone (not mixed with another drug) count as an ACE/ARB (calcium channel blocker)?	No, Amlodipine alone does not count as an ACE/ARB. Review the CAD Drug Codes tab of the 2014 GPRO Web Interface CAD Supporting Document for Amlodipine combinations acceptable for CAD-7.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
11.	For CAD-7, can the acceptable diagnoses for "No-Medical Reasons" be documented anytime in the patient's history? Would this meet criteria to answer "No-Medical Reasons?"	The medical reason used to exclude a patient from CAD-7 needs to be documented in the patient's medical record and occur anytime in the patient's history.	X	X	X
12.	For CAD-7, if a patient has LVSD but they have chronic kidney disease and are not on an ACE/ARB do we select "No-Medical Reasons?"	• Select "Yes" to LVSD • Select "No—Denominator Exception—Medical Reasons" (if the medical record has documentation of CKD as a medical reason for not prescribing ACE/ARB)	X	X	X
13.	For CAD-7, what are other medical reasons that would count for not prescribing ACE inhibitor or ARB therapy aside from allergy, intolerance?	Refer to the Denominator Exceptions in the CAD Data Guidance: Other medical reasons include any medical reasons documented by the provider for not prescribing ACE/ARB therapy.	X	X	X
14.	For CAD-7, it appears that some ACE-Inhibitors and ARBs that should qualify for the measure aren't covered by the RxNorm codes provided in the Supporting Documents. Are we limited to just those codes?	No, you are not limited to the medications listed in the specifications. For CAD-7, the Data Guidance says that the medication list may not be all inclusive.	X	X	X
15.	For CAD-7, medications were stopped due to symptoms, but a plan of care to start on a lower dose was noted. Do we answer "No—Denominator Exception—Medical Reasons" or "Yes?"	If the medication was started anytime during the measurement period, then you would select "Yes."	X	X	X

At Risk Populations: Diabetes

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	Are the denominator exclusions different for DM-2 and the DM Composite?	The denominator exclusions are different for DM-2 and the DM Composite, based on measure steward directions.	X	X	X
2.	Is a diagnosis of impaired fasting glucose, pre-diabetes, or hyperglycemia considered a diagnosis of diabetes?	These diagnoses are not synonymous with diabetes mellitus. In instances where you cannot confirm diabetes, please select—"Not Confirmed: Select this option if you are unable to confirm the diagnosis of DM for this patient."	X	X	X
3.	For the diabetes measures, will patients only be pulled into the denominator if they have a diagnosis of diabetes during the measurement year, or will they be included if they have a prior diagnosis, but no diagnosis in the measurement year?	CMS does look back to the prior year for a diagnosis of diabetes in the administrative claims in addition to the measurement year when populating the patient sample	X	X	X
4.	For the DM composite module, most of our patients do not have an IVD diagnosis. Will this mean the patient is excluded from the entire DM composite measure?	No. If the patient is excluded from DM-16: Daily Aspirin or Antiplatelet Medication use for Patients with Diabetes and Ischemic Vascular Disease because they are not diagnosed with IVD, that patient passes the DM-16 component of the composite.	X	X	X
5.	For DM-2, (Diabetes Poor Control), the flow charts indicate that patients with a value > 9.0 or missing (0 value) will count in the numerator. Why is this?	For DM-2, a lower rate indicates better clinical care or control. DM-2 is considered an inverse measure. The numerator includes a missing value, an HbA1c is greater than 9, or if an HbA1c test was not performed during the measurement period.	X	X	X
6.	For an HbA1c or blood sugar result, does the entry into the interface need to be a "draw" from a lab or may a Point of Care result be used for reporting?	The requirements for this element do not include a specific location for the drawn sample. The HbA1c result should be included in the medical record or be available to the practitioner at the point of care.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
7.	Is steroid induced or polycystic ovaries considered a denominator exclusion for DM-2?	Please refer to the Instructions column of the Data Guidance tab of the DM Supporting Document. The only acceptable denominator exclusion for DM-2 is gestational diabetes.	X	X	X
8.	For DM-2, regarding HbA1c, the data guidance says there must be a note in the record. Does the actual lab report showing the date and value count as the note, or is a specific progress note entry required?	The date and the value are the two components needed. They can either be in a dated note or be present as part of the dated laboratory report.	X	X	X
9.	For DM-13, high blood pressure control, if the patient has multiple systolic and diastolic blood pressure values for their most recent date, are we permitted to take the lowest diastolic and lowest systolic as outlined in HEDIS specifications?	The DM Data Guidance states, "Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP." Please use GPRO Web Interface measure specifications that are located on the CMS Website.	X	X	X
10.	For the most recent blood pressure documentation, does the data need to be pulled from a Primary Care visit or would a Specialty office visit be okay to use for the data?	As long as the blood pressure is documented in the medical record, it can be either a primary care visit or a specialty office visit.	X	X	X
11.	For DM-14, regarding LDL-C, the data guidance says there must be a note in the record. Does the actual lab report showing the date and value count as the note, or is a specific progress note entry required?	The date and the value are the two components needed. They can either be in a dated note or be present as part of the dated laboratory report.	X	X	X
12.	We have a few patients with triglycerides so high that LDL cannot be calculated. What should we enter as an LDL value?	As noted in the Data Guidance, you should enter a zero in these instances.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
13.	For DM-14, what is the time frame for an acceptable LDL level? Does it have to be in the measurement period or can it be prior?	The Data Guidance tab of the DM Supporting Document provides the following information in the Instructions column: Determine if the patient had one or more LDL-C tests during the measurement period.	X	X	X
14.	Regarding the DM-14 component of the Diabetes Composite measure for LDL control, if the chart documentation reveals that the LDL has been controlled <100 mg/dL throughout the last 12-24 months, but the "most recent" LDL is > 100, has the measure been met?	You must answer using the most recent test in the measurement period and provide the date and value for that test.	X	X	X
15.	Follow up question regarding Diabetes Composite measure and the "most recent" LDL >100. If the documentation shows that the patient is non-compliant with the plan of care, is there an exception or exclusion available?	For DM-14, Low Density Lipoprotein (LDL-C) Control there is no requirement for a plan of care based on an elevated LDL-C and there are no denominator exceptions allowed by the measure steward.	X	X	X
16.	How does a result of 0 (zero) for "unable to calculate LDL-C due to high triglyceride" affect the performance calculation?	For this measure you would fail performance if you enter "0" (zero). For questions such as this we recommend you take a look at the GPRO Web Interface measure flows that are available on the CMS website. These measure flows can help you determine performance rates for all the measures.	X	X	X
17.	Regarding the measures requiring the use of aspirin (e.g., DM-16), does aspirin need to be on the medication list or does the aspirin actually have to be prescribed in 2014?	As long as there is evidence in the medical record that the patient has an active prescription of daily aspirin/reported as taking daily aspirin, then that is sufficient.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
18.	For DM-16, is TIA or Transient cerebral ischemia part of the definition of IVD?	TIA or Transient cerebral ischemia (ICD-9 codes 435.x) are not a part of the denominator definition of ischemic vascular disease. The Intent of the use of aspirin or anti-platelets for diabetic patients is when they also have ischemic vascular disease, specifically atherosclerosis of any artery. The ICD-9 code "443.9 Peripheral vascular disease, unspecified" is not included in the definition of ischemic vascular disease because it excludes atherosclerosis. If PAD (peripheral artery disease) is documented, include the patient in the diabetes aspirin component. If PVD (peripheral vascular disease), is documented, then look for other diagnoses codes in the IVD code range, specifically codes/diagnoses with atherosclerosis. If no other codes are found and "443.9 Peripheral vascular disease, unspecified" is the only code, then do not include the patient as having ischemic vascular disease.	X	X	X
19.	Is there a reason that the diagnosis list for IVD confirmation is different for the DM module than the IVD module?	There is a difference because the measures are developed and maintained by different measure owners. The measure owner for IVD is National Committee for Quality Assurance (NCQA) and the measure owner for DM is Minnesota Community Measurement (MNCM).	X	X	X
20.	What is the look back period for denominator IVD diagnosis?	Determine if the patient has a documented history of ischemic vascular disease (IVD).History is defined as any time in the patient's history up through the last day of the measurement period.	X	X	X
21.	For DM-16, is the expectation that if they are on Coumadin, then they should also be on aspirin?	For DM-16, Warfarin is listed as a denominator exception (medical reason). Please refer to the Exclusions/Exceptions column within the Data Guidance tab in the DM Supporting Documents for details relating to drug exclusions.	X	X	X
22.	In the GPRO Web Interface DM tab, for the Tobacco Non-Use measure, if the patient is a non-user of tobacco, would we select "Yes?"	Correct. If you select "Yes" to this question, you are indicating that the patient has been screened and identified as a tobacco non user. If you select "No," then you are identifying the patient as a tobacco user.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
23.	If the medical record says that the patient is a “non-smoker” but does not address other tobacco use possibilities (e.g., chew), can we indicate that the patient is a “non-smoker”?	Yes. It would be appropriate to indicate that the patient is a non-smoker since the medical record indicates this.	X	X	X
24.	Are e Cigarettes considered tobacco use?	The measure steward does not consider e Cigarettes as tobacco use.	X	X	X
25.	Please clarify the definition for Former Smoker that is addressed in PREV-10 and DM-17.	If you can show documentation that they are not a current smoker, you can mark them as “nonsmoker” regardless of former smoker status.	X	X	X
26.	One of our patients is in the tobacco screening measures for both DM and PREV. This patient was last screened in 2013. It seems that this patient would be considered “screened” for the Preventive Care measure, but not for the Diabetes measure. Is this correct?	Yes, you are correct. The PREV-10 measure has a 24 month look back period of time from the measurement period end date and the DM-17 measure is looking for screening any time during the 12 month measurement period. Therefore, it is possible for these measures to be answered differently for the same patient.	X	X	X
27.	For Tobacco use, if you look at an EHR and notice that the patient is listed as “non-user,” but there is no date listed, is that acceptable? Or, do we need to find office notes to make sure that the patient was questioned within the appropriate time period?	Both PREV-10 and DM-17 require that the patient was screened for tobacco use within a specific time period; therefore, a screening date would be required.	X	X	X

At Risk Populations: Heart Failure

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	Are pulmonary hypertension and chronic heart disease considered heart failure? If not, what are they classified as?	Neither of these conditions is listed as a synonym for heart failure in the HF Data Guidance. You may also use the code descriptions in the Evaluation tab of each of the Supporting Documents as a resource.	X	X	X
2.	Does the diagnosis of heart failure have to include a documentation in the medical record of current or prior LVEF < 40%?	The measure steward requires that in order to be eligible for the denominator, the patient must have a diagnosis of heart failure confirmed in the medical record AND also have a current or prior LVEF < 40% or one referred to as moderate or severe. Note that the date/value of the LVEF does not need to be recorded in the Web Interface.	X	X	X
3.	If a patient had an EF < 40% in 2005 but then in 2014 has an EF of 45%, would he or she be included in the denominator of the HF-6 measure?	In the scenario you describe, you would select "Yes" for the LVSD element as the patient has had, at any time in their history, an ejection fraction < 40%.	X	X	X
4.	In HF-6, does the reason for not prescribing beta-blocker therapy need to be documented during the measurement period to count, or does it count if it was documented anytime in the patient's history?	You may find documentation of a medical reason for not prescribing beta-blocker therapy at any time in the patient's history.	X	X	X
5.	For HF-6, if the patient is allergic to one of the beta-blockers, are they excluded for medical reasons, or, do we have to show allergies to all three medications (carvedilol, Bisoprolol fumarate, metoprolol succinate extended release?	It would be acceptable to select "No—Denominator Exception—Medical Reasons" when documentation in the medical record reflects the patient has an allergy to any beta-blocker.	X	X	X
6.	For HF-6, the exclusions include pleural effusions. Can we only exclude a patient if this is an active problem during 2014?	Transient conditions that are listed as exclusions that may be due to causes other than heart failure should be restricted to documentation within the measurement period.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
7.	For HF-6, if there is an echo report showing moderate LV dysfunction and an ejection fraction of 40-45%, does the patient not meet the measure?	You would use the most severe result in the patient's history (moderate LV dysfunction) and select "Yes" under LVSD.	X	X	X
8.	Where can we find the most current list of beta blockers acceptable for use in HF-6?	The 2014 GPRO Supporting Documents contain the list of-beta blockers for the HF-6 measure. Bisoprolol, carvedilol, or sustained release metoprolol succinate are the ONLY beta-blockers allowed for this measure. Within the RxNorm terminology, "metoprolol succinate extended release" is identified as "metoprolol tartrate extended release." You will note that metoprolol tartrate alone, meaning not the extended release form, is not included in the medication list. The measure steward, the AMA Physician Consortium for Performance Improvement, has been assured by their pharmacy experts who helped them develop the value set of allowable medications that the "metoprolol tartrate extended release" as specified in RxNorm maps to the "metoprolol succinate extended release." Brand names that map to these three generic medicines are appropriate to use to satisfy the numerator.	X	X	X
9.	Pacemaker (V4501) is an exception for HF-Beta Blocker. If patient has a Biventricular ACID which is a Defibrillator (V4502), is this considered an exception for beta-blockers?	If documentation in the medical record indicates the patient is not prescribed a beta-blocker due to a Biventricular ACID, this would be considered acceptable as a medical exception.	X	X	X
10.	For HF-6, if a patient is on a beta blocker, but it is not one of the beta blockers in the list provided by CMS, how would we answer the question?	You would select "No" if the beta blocker is not one of the three generic beta-blockers listed for this measure or one of the brand name beta-blockers equivalent to one of the three generics.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
11.	For HF-6, Beta Blocker, "Fibrillation" was listed as an exclusion for beta blockers. Is it referring to atrial fibrillation, ventricular fibrillation, or both?	Coding provided in the HF Exclusions codes tab of the HF Supporting Document includes both atrial fibrillation and ventricular fibrillation codes.	X	X	X

At Risk Populations: Hypertension

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	If a sampled patient for HTN-2 did not have a blood pressure reading, will the patient be excluded from the denominator and not included in the performance calculation?	If a blood pressure reading was not taken, the patient will not be excluded from the denominator or performance calculation unless there is a valid medical reason for the blood pressure measurement not being done (see the HTN Supporting Documents).	X	X	X
2.	For the hypertension domain, if we confirmed the diagnosis but do not have a blood pressure recorded within the measurement period, should we answer "No"?	That is correct. If you have no blood pressure measurement within the measurement period you should select "No."	X	X	X
3.	On HTN-2, if I have a series of readings on different days, do I take the most recent one? For example, does the most recent value take precedence over the lowest one?	If a series of blood pressure readings are not on the same day, you would use the most recent reading.	X	X	X
4.	For HTN-2, is the patient's position during the blood pressure reading taken into account? Would we use the lowest systolic and lowest diastolic reading regardless of sitting, standing, or lying down?	You would use the lowest values regardless of position if there are multiple blood pressures on the same date of service.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
5.	For the most recent blood pressure documentation, does the data need to be pulled from a primary care visit or would a specialty office be okay to use?	As long as the blood pressure is documented in the medical record, it can be either a primary care visit or a specialty office visit.	X	X	X
6.	For the hypertension and blood pressure screening measures, if the provider only documents "HBP" (high blood pressure), can we accept this abbreviation as confirming the diagnosis of hypertension, or, does the note have to say "Hypertension?"	This is an accepted abbreviation for high blood pressure; however, further documentation to support hypertension must be present to confirm the hypertension diagnosis.	X	X	X
7.	Regarding the medical reason for not including blood pressure, is this a pregnancy anytime in 2014, or only if the patient is still pregnant at the last office visit?	This is referencing anytime within 2014.	X	X	X
8.	When there are multiple blood pressures on the same date of service, can we mix/match the systolic and diastolic values to create our own "lowest" value?	2014 GPRO Web Interface measure HTN-2 allows the mix/match of the systolic and diastolic values if there are multiple blood pressures taken on the same date of service.	X	X	X
9.	As part of a patient evaluation in 2014, a GPRO HTN-2 patient was monitored at home for blood pressure with Welch Allyn CardioPerfect. Can we take the most recent blood pressure from the 24 hour blood pressure monitoring that was done?	Blood pressures taken at home are not acceptable. The most recent blood pressure must have been obtained during a visit to the practitioner's office or other non-emergency outpatient facility, such as a clinic or urgent care center.	X	X	X

At Risk Populations: Ischemic Vascular Disease

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	Will a diagnosis of CAD be considered sufficient to confirm a diagnosis of IVD?	You would need to look at the codes in the Supporting Documentation to determine which CAD codes are used to represent IVD.	X	X	X
2.	What are the lab components required for the lipid profile?	The component tests are: Total Cholesterol, HDL, LDL, and Triglycerides. All components of the lipid panel need to be drawn and the results documented in the medical record. Specific codes related to this measure can be found in the evaluation code tab of the IVD supporting documentation.	X	X	X
3.	Is an LDL alone sufficient to answer "Yes" for the Lipid Panel performed question for both IVD-1 and DM?	No, an LDL is not sufficient for IVD-1 as all components of the lipid panel need to be obtained; however, LDL direct or calculated value can be used for both IVD-1 and DM-14.	X	X	X
4.	For IVD-1, if high triglycerides prevent an LDL from being calculated, what do we put into the field for LDL?	For LDL-C, if you can't get a value, enter "0" (zero).	X	X	X
5.	What antithrombotics are considered for the IVD modules?	There is a list provided within the Inclusions/Synonyms column of the Data Guidance for IVD-2. For 2014 GPRO Web Interface IVD-2, oral antithrombotic therapy includes: Aspirin, clopidogrel or combination of aspirin and extended release dipyridamole, Prasugrel, Ticagrelor, and Ticlopidine. Plavix is included. Xarelto, Pradaxa and Coumadin are not included.	X	X	X
6.	For IVD-1, can we use an LDL direct result if an LDL-C is unavailable?	Yes, you can use an LDL direct as one component of the lipid panel that is required.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
7.	For IVD-1, regarding LDL-C, if we can use an LDL direct, does that need to be done on the same day as the other components of the lipid profile? If an LDL direct is done a different day during the measurement period, which day do we use for the result date?	Use the most recent date that blood was drawn for the lipid profile. Also note that you are to use the most recent LDL-C as the recorded value. The LDL-C can be drawn on a different day than the lipid profile test if the LDL-C is a more recent test.	X	X	X
8.	For IVD-2, how do we handle the situation where the provider indicates the patient is allergic to aspirin? Are there any medical reasons we can use to explain why a patient is not on medications? Does patient refusal count?	There are no exceptions for this measure, so you would have to select "No."	X	X	X
9.	Is there a reason that the diagnosis list for IVD confirmation is different for the DM module than the IVD module?	There is a difference, because the measures are developed by different measure owners. The measure owner for IVD is the National Committee for Quality Assurance (NCQA) and the measure owner for DM is Minnesota community Measurement (MNCM).	X	X	X

Preventive Health

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	If our ACO can prove via claims data that breast cancer screening was performed, but the results are not in the medical record, will this count as a numerator hit?	For PREV-5, Breast Cancer Screening, you need to have the date of the mammography (between 10/1/2012 and 12/31/2014) and result of the mammography in the medical record. This includes the 3 month grace period.	X	X	X
2.	For PREV-5, Breast Cancer Screening, how should we answer if the patient refused the screening?	In this instance, you will have to select "No" in the Web Interface and it would be a performance failure for the measure.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
3.	For PREV-5, breast cancer screening, does thermal gram count?	No, this does not count.	X	X	X
4.	For PREV-5, what if a patient had a unilateral mastectomy and has metastatic disease and, therefore, receives PET scans and CTs rather than a mammogram?	If the patient had a unilateral mastectomy and has metastatic disease and now a screening mammography is no longer performed, it would be appropriate to request "Other CMS Approved Reason" to exclude the patient. However, approval should not be considered automatic. More details may be required in order to receive approval from CMS.	X	X	X
5.	For PREV-5, if a patient reports both a date of mammogram and results to the provider which is then documented in the medical record as patient reported, is the measure met?	For PREV-5, documentation in the medical records needs to include both of the following: A note indicating the date the breast cancer screening was performed AND the results of the findings. Patient reported findings are not appropriate.	X	X	X
6.	In PREV-6, will ColoGuard qualify for the Colorectal screening quality measure?	From the measure steward: No, the test does not meet numerator criteria for the Colorectal Cancer Screening measure. This measure was developed based on the US Preventive Services Task Force (USPSTF) guidelines for Colorectal Cancer Screening which does not recognize DNA testing as a recommended method of screening for colorectal cancer.	X	X	X
7.	For GPRO PREV-6, Colorectal Cancer Screening, is FIT (Fecal Immunochemical Test) considered to be an FOBT?	The Fecal Immunochemical Test (FIT) would be considered an FOBT. The FIT was included in the 2014 PREV-6 Data Guidance, Inclusions/Synonyms tab.	X	X	X
8.	For PREV-6, Colorectal Cancer Screening is one FOBT okay for reporting, or, do you need three FOBT results?	Yes, one FOBT would be acceptable for the purposes of this measure. If you look within the Data Guidance, it provides you with other tests and associated timing that would be considered "current" screening.	X	X	X
9.	For PREV-6, Colorectal Cancer Screening, is it true that if a patient refused a colorectal screen, that this is now considered a "No" response?	There is no patient reason exception for this measure. The patient record would fail the measure if the patient refused the screening.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
10.	For PREV-6, if we have documentation in the medical record indicating colorectal screening is “up-to-date” or “current” alone, is this enough to select “Yes?” Do we need to have evidence that the screening was FOBT, Flex Sigmoidoscopy or Colonoscopy for “Yes?”	Within the Data Guidance, under the Inclusions and Synonyms column, there is a section that states colorectal cancer screening is current may include documentation in the medical record indicating the colorectal screening is up-to-date or current. If you have a copy of the screening, you don’t necessarily need “up-to-date” or “current” in the medical record.	X	X	X
11.	If a provider states that a patient had a colonoscopy in 2011, but does not give the specific date, what would the default date be?	This measure does not require a date. Because the reference in the record ensures the reader that a colonoscopy was performed during the measurement period or the nine years prior to the measurement period, a “Yes” answer is appropriate to signify the patient is current.	X	X	X
12.	A patient didn’t receive a colonoscopy because he could not comply with the prep instructions and his primary care provider decided to use fecal immunochemical tests as an alternative, can we select “Yes” for screening? Would ColoVantage have been appropriate to meet the measure?	You can select “Yes” for the FIT test. However, ColoVantage is not considered acceptable for Colorectal Cancer Screening.	X	X	X
13.	For PREV-7, will the reported QM through claims be included in the numerator?	Claims data is used when available to pre-populate fields in PREV-7 (influenza immunization).	X	X	X
14.	Is every provider responsible for the preventive measures if they have only seen the patient once a year?	Yes, the ACO or PQRS group practice is responsible for reporting on any patient attributed to their sample regardless of measure/module.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
15.	Do we only include vaccinations administered between January and March 2014? Or can we look back into 2013 for documentation of an influenza immunization?	The influenza immunization measure is one of the measures that allow you to look back to before 1/1/2014. If your medical record contains documentation that the patient was administered the influenza immunization between August 1, 2013 and March 31, 2014, then you can select "Yes" to indicate that an influenza immunization was received. You do not have to verify that the patient received the influenza vaccine if this information is pre-populated into the Web Interface.	X	X	X
16.	For immunization measures, if our documentation only includes the month and year of the vaccination, should we fill in a default day of the month?	Neither of the immunization measures (Influenza and Pneumonia) require that a date be included as part of the abstraction. You need only indicate whether or not the vaccination was given during the timeframe specified in the measure specifications.	X	X	X
17.	If the medical record does not indicate that the patient has been vaccinated for influenza and the patient is unable to recall, how would you recommend answering PREV-7?	In this situation, you would select "No," unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.	X	X	X
18.	For the influenza vaccinations, we are seeing patients with vaccinations, but the CVX code associated is 88, which is the non-specific vaccination code. This is not listed as an acceptable code in the Data Guidance. Is this acceptable?	A generic code would not be acceptable. Documentation in the medical record should confirm that influenza vaccination was received.	X	X	X
19.	For PREV-7, is there an allowable patient reason in instances where the patient has refused the flu immunization?	Yes. Please refer to the 2014 PREV Supporting Documents, Data Guidance tab, for all applicable exceptions.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
20.	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the immunization measures?	If that information is available at the point of care, then that information can be used.	X	X	X
21.	For the influenza vaccine exception, what qualifies as a "system reason"?	For example, if there was a vaccine shortage like we had a few years ago, that -would be a system reason.	X	X	X
22.	Based on new ACIP recommendations for pneumonia vaccine for patients 65 years and older, will PCV13 count for the PREV-8 measure for the 2014 reporting year?	As currently specified, the PCV13 vaccine alone does not meet numerator criteria for the Pneumonia Vaccination Status for Older Adults (GPRO PREV-8) measure. This response has been provided by the measure steward National Commission for Quality Assurance (NCQA).	X	X	X
23.	If the medical record does not indicate that the patient has been vaccinated for pneumonia and the patient is unable to recall, how would you recommend answering PREV-8?	In this situation, you would select "No," unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.	X	X	X
24.	For immunization measures, if our documentation only includes the month and year of the vaccination, should we fill in a default day of the month?	Neither of the immunization measures (Influenza and Pneumonia) require that a date be included as part of the abstraction. You need only indicate whether or not the vaccination was given during the timeframe specified in the measure specifications.	X	X	X
25.	For pneumococcal vaccination, the specs do not mention patient reported data. Since it is unlikely the patient received the vaccination during the measurement year, we assume we should be counting patient reported data. Is this acceptable?	Yes, a patient report for the PQRS PREV-8: Pneumonia Vaccination Status for Older Adults measure would be acceptable. The patient would need to provide the date of the vaccination (i.e., month, day and year) and confirm the type of vaccine as PPSV23. The information would need to be collected by the end of the measurement year by the provider while taking the patient's history and it must be maintained in the patient's legal medical record.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
26.	For the BMI Screening measure, the description reads "Percentage of patients aged 18 and older with a calculated BMI in the past six months or during the current visit…" What does this mean in context of the measurement year?	For this measure, you are asked to look at calendar year 2014 (the measurement period) and find the last visit for that patient. You should then determine if a BMI was calculated at this visit. If a BMI was not calculated at this visit, then you should look back 6 months (from the most recent visit) to determine if a BMI was calculated. If you are unable to find a visit and recorded BMI within the 6 months preceding the most recent visit, you would indicate that a BMI was not calculated.	X	X	X
27.	Does the calculated BMI need to be recorded in the GPRO Web Interface?	No. There is not a field in the GPRO Web Interface to record the actual BMI, so ACOs and PQRS group practices do not need to record it.	X	X	X
28.	Is there any exclusion for patients whose BMI cannot be calculated (e.g., paraplegia)?	Paraplegia would be considered a medical reason for not calculating a BMI.	X	X	X
29.	One of our terminally ill patients has a BMI outside of normal parameters, but there was no follow-up plan. How do we record this scenario?	Terminal patients are excluded from this measure. The BMI measurement screen of the Web Interface is where you are able to indicate "No—Denominator Exception—Medical Reasons."	X	X	X
30.	For the BMI follow-up plan; is the documentation of a future visit enough to satisfy the measure? Does it have to be a specific type of visit?	It doesn't have to be a specific type of visit—it just has to be linked to the out of range BMI. Documentation of a future visit does satisfy the 2014 measure.	X	X	X
31.	For BMI, if the only office visit was March 2014 and there was no BMI recorded, can we look back 6 months into 2013 to a visit where the BMI is recorded? Or, is this a failed measure?	Yes, if the most recent office visit was March 2014, PREV-9 allows a 6 month look back from the most recent visit to determine if a BMI was calculated, or, in this case, October 2013.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
32.	Please clarify again what types of visits count for assessing whether the BMI was recorded at the most recent visit (i.e., all outpatient visits including specialists, ED, urgent care, hospital stay).	PREV-9 does not specify what type of visit, only that an eligible professional or their staff needs to have measured the patient's height and weight that is used for the calculation of the BMI.	X	X	X
33.	For a patient with a BMI out of range, does a previous visit's follow-up plan count within 6 months? Or, do we need to document a follow-up plan at each visit with an abnormal BMI?	The numerator is met when the BMI is calculated at the most recent visit or within the past 6 months of this visit. A follow-up plan must be documented within the last 6 months or during the current visit if the BMI is outside normal parameters (see Narrative Specifications).	X	X	X
34.	For PREV-9, can we exclude a patient from PREV-9's denominator for medical reasons if the patient is in a wheelchair?	Yes, you may exclude a patient who is confined to a wheelchair.	X	X	X
35.	If a physician puts a patient on a diet for high BMI, and they also have high BP, does the physician have to say that the plan for diet is to reduce BP specifically, or, is it acceptable to just have diet documented?	We would expect if you're putting a patient on a specific diet, that this part of the follow-up plan should reference the elevated BMI or high blood pressure or both.	X	X	X
36.	Will a BMI of 31 be considered passing?	The normal parameters for the BMI are in PREV Data Guidance Inclusions/Synonyms column for age 65 and older BMI $\geq$ 23 and < 30 are considered normal. For ages 18-64 years, BMI $\geq$ 18.5 and < 25 are considered normal.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
37.	For PREV-9, if a patient has a BMI value below the accepted parameters, but is described as "well-nourished" within the visit note, would this be an acceptable explanation as to why the patient is "Not Eligible/Not Appropriate for BMI Follow-Up"?	No. It would be anticipated the medical records would indicate a follow-up is not necessary and the reasoning for that determination.	X	X	X
38.	For BMI, if a patient is over 65 years old and has a BMI lower than normal parameters, what should be selected for follow-up, since follow-up is for BMI higher than the normal parameter?	A follow-up would be required as the BMI is outside of normal parameters whether it is below or above these parameters. The follow-up plan for a BMI lower than the parameters listed may include education, such as referral to a nutritionist; documentation of a future follow-up appointment related to BMI, referral to a registered dietician, or referral to online resources, among others that the physician may determine appropriate for that individual.	X	X	X
39.	For PREV-10, if the medical record only indicates "smoking", will that patient be numerator compliant?	We can deduce from this entry in the medical record that the patient was asked if they were a smoker and they answered positively. However, in order to be numerator compliant, there also needs to be indication that the patient received tobacco cessation counseling. In this case, there is no indication of tobacco cessation counseling, so the patient would not be numerator compliant.	X	X	X
40.	Please clarify the definition for Former Smoker that is addressed in PREV-10.	If you can show documentation that they are not a current smoker, you can mark them as "nonsmoker" regardless of former smoker status.	X	X	X
41.	For PREV-10, the Narrative Specification states that the screening would be valid if done within 24 months. When does the 24 month date look back to? Is it the first day of the measurement year?	24 months refers to the current measurement period and the year prior.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
42.	For PREV-10, the patient was screened for tobacco use during a telephonic outreach and is identified as a tobacco user. If they accept instructions and educational materials on smoking cessation, will this count as meeting the measure?	Yes, this would meet the measure assuming that all required documentation is in the medical record.	X	X	X
43.	For PREV-10, does Chantix (Varenicline Tartrate) count as a medication for Tobacco use intervention for patients identified as smokers? This medication was not listed on the med list.	Yes, Chantix (Varenicline Tartrate) is acceptable.	X	X	X
44.	For PREV-10, does tobacco screening at a hospital count?	If that information is available at the point of care, it may be used in determining your answer. The setting is not specified for this measure.	X	X	X
45.	For PREV-10, if the notes state "Status Unknown" and the member has Alzheimer's, would this be a medical reason for exception?	Yes—as long as there is documentation from the provider linking this diagnosis to the reason the patient was not screened.	X	X	X
46.	If a patient quit smoking in the last 3 months, will the patient be considered to be a non-tobacco user?	Yes, they would be identified as a non-user of tobacco if they quit smoking in the last 3 months of the measurement period.	X	X	X
47.	For PREV-11, for documenting the follow-up visit for the Screening for High Blood Pressure measure, is a future appointment sufficient to satisfy the documentation follow-up?	In order for a future appointment to satisfy the follow-up requirement, there would need to be documentation that links the appointment to the fact that the patient has an elevated blood pressure and requires monitoring of this elevation. In addition, recommended lifestyle modifications, referrals to alternative/primary care provider, anti-hypertensive pharmacological therapy, laboratory tests, or an electrocardiogram are considered recommended follow-up depending on the BP reading. Specific direction is provided in the 2014 GPRO Preventive Care Data Guidance document.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
48.	For Screening for High Blood Pressure measure, if a patient is screened by a specialist, does the specialist need to document a follow up or does this measure only apply to PCPs?	This measure applies to anyone who provides care to the patient. If the specialist notes an elevated blood pressure, then there should be a follow-up plan documented in the record in order to satisfy the numerator requirement.	X	X	X
49.	For PREV-11, if the patient's blood pressure has fluctuated during the year, but the last blood pressure is within normal levels, can we select "Yes" that screening was performed?	Yes, this is acceptable because you are using the most recent BP. We do not expect to see a follow-up plan if the most recent blood pressure is normal.	X	X	X
50.	When a patient has a reason for exclusion that is listed in the GPRO supporting documents, such as having a diagnosis of hypertension, should that be marked as "No—Other CMS Approved Reason"?	No, the patient would be excluded. Select "Denominator Exclusion."	X	X	X
51.	For PREV-11, in the Data Guidance, it states "use the most recent BP." What does this mean if the measure only needs to be done "at least once per measurement period?"	The measure only has to be reported once, but the most recent BP should be used if there is more than one reading documented during the measurement period.	X	X	X
52.	For PREV-11, if we are looking at the most recent blood pressure, what is meant by the second hypertensive reading?	The Hypertensive BP Readings included in the Inclusions/Synonyms column of the Data Guidance tab are to assist in determining the most appropriate follow-up. The most recent BP is used, but the medical records might indicate the most recent reading is a second hypertensive reading, and, therefore, the follow-up documented should be based on a second hypertensive reading.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
53.	For PREV-11, can you please clarify the exclusion for "Active Hypertension?"	If a patient has an active diagnosis of hypertension on the date you are using for their most recent blood pressure reading, they can be excluded from PREV-11. This would indicate the patient is being medically managed for hypertension. During the sampling process, patients with a submitted claim with the hypertension diagnosis are not included in the sample.	X	X	X
54.	For PREV-11, can you please clarify the "and/or" instructions for pre, first and second hypertension reading?	The recommended follow-up information in the Inclusions/Synonyms column of the PREV-11 Data Guidance is clinical recommendations for follow-up due to BP classification. The Narrative Specifications contain a table that outlines the expected follow-up for each category and may be the most comprehensive source.	X	X	X
55.	For PREV-11, a patient has a blood pressure > 120/80 with recommendation stated to return in 6 months, not 12 months. Does the return to office need to be 12 months out?	If a patient was screened and has a systolic BP $\geq$ 120 and $\leq$ 139 or diastolic BP $\geq$ 80 and $\leq$ 89, the following Follow-Up is recommended: Rescreen BP within a minimum of one year AND Recommend Lifestyle Modifications OR Referral to Alternative/Primary Care Provider. We aren't looking to see if the follow-up visit actually occurred. We want to determine if the patient was screened for high blood pressure and if a follow-up was recommended as appropriate.	X	X	X
56.	For PREV-11, the provider documented blood pressure of 122/60 as well as an abnormal BMI. In the section for follow-up plan, he documented that he counseled the patient to reduce salt and to diet to lose weight. Does this meet the follow-up for both measures?	If the provider documented an abnormal blood pressure as well as an abnormal BMI on the same patient encounter, and these are considered most recent for both PREV-9; Body Mass Index Screening and Follow-Up and PREV-11, Screening for High Blood Pressure and Follow-Up Documented, recommending lower sodium intake and weight loss would address follow-up for both BP and BMI. PREV-11 would also require a recommended follow-up visit be documented.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
57.	For PREV-11, if a physician directed the patient to increase exercise for a reason other than BP management and plan for a return visit in a year, but there was no correlation to the elevated BP, would the patient fail as a follow-up plan was not directly linked?	Correct, the follow-up recommended should be appropriately linked to blood pressure management when reporting PREV-11.	X	X	X
58.	Can we use ambulatory blood pressure monitor readings for the screening blood pressure?	Ambulatory blood pressure monitor readings from the patient are not acceptable. Eligible professionals who report this measure must perform the blood pressure screening at the time of the qualifying visit and may not obtain measurements from external sources.	X	X	X
59.	What documentation is needed for depression screening?	The screening component of the measure is looking at whether or not an age-appropriate standardized screening tool was used. Although the specification provides examples of tools that can be used, use of a specific standardized tool is not required. If the tool used indicates a potential diagnosis of depression, the second part of the measure will require documentation of a follow-up plan. Please note that documentation from the provider that the patient does not have depression is not sufficient evidence of a screening. The medical record does not need to include a copy of the standardized tool that was used.	X	X	X
60.	If there is a notation in the patient record (in 2014) that the patient is under care of a mental health professional sufficient to exclude the patient from the depression measure?	Patients with a diagnosis of depression or bipolar disorder prior to the first day of the measurement period are to be excluded from the measure. If documentation reflects that treatment by a mental health professional for depression or bipolar disorder began or a diagnosis was made prior to the measurement period, then the exclusion requirement has been fulfilled.	X	X	X
61.	If the documentation states that a depression screening was performed, and then states the patient is not depressed, does that qualify for the measure?	This would qualify as a depression screen as long as an age appropriate standardized screening tool was used.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
62.	If a patient was administered a PHQ-9 during the measurement year, but also had a documented diagnosis of depression prior to the measurement year, do we indicate "Yes" for clinical depression screening, or, do we indicate "No-Medical Reasons?"	If the patient has an active diagnosis of depression, diagnosed before the first day of the measurement period, you would select "Denominator Exclusion."	X	X	X
63.	If the patient has a negative screen for depression, what is the appropriate answer since "No" is not a listed option?	Select "Yes" indicating that the patient was documented as being screened. Then select "No," patient's screen was not positive for clinical depression using an age appropriate standardized tool. If you selected "No," then you do not answer the follow-up plan questions.	X	X	X
64.	Please confirm whether we have to confirm the use of PHQ2-9 for depression screening. If PHQ2-9 is not required to be in the medical record, how would we confirm that it is being used?	PREV-12 requires a standardized age appropriate screening tool be used during the measurement period for depression screening. You need to have documentation that the age appropriate standardized depression screening tool was used, but the actual screening tool does not need to be present in its entirety, just the result of whether it revealed the patient to have depression.	X	X	X
65.	Is traumatic brain injury an exclusion for PREV-12, depression screening?	If the physician decides this is a situation in which the patient's functional capacity or motivation to improve may impact the accuracy of the results of the standardized depression assessment tool, then yes. It depends on the functionality of the patient and the extent of the patient's injury and that would be up to the physician's discretion. The patient's medical record should contain this information.	X	X	X
66.	For the Depression Screen, does there have to be evidence in the EMR of a valid depression screening tool used, and not just a diagnosis of depression?	If no depression screening tools are documented, then you would have to select "No" to whether or not the patient was screened for depression. To exclude the patient from this measure, the diagnosis of depression would have to be made prior to 2014. If the diagnosis of depression occurred on or after January 1, 2014, there needs to be evidence of a depression screen in the measurement period, January 1, 2014 to December 31, 2014.	X	X	X

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
67.	For Depression screening, we have the capability to push out the questionnaires through our email portal. If the patient answers positive, we will have them come in for follow-up. Would this count?	From the measure owner: We agree this is an innovative approach. In order to meet the current measure, the results of the depression screening and follow-up plan (if positive depression screen) must be documented at the time of the encounter (i.e., the appointment with the provider). Although the patient may have access to the depression screening tool in advance of the appointment, the depression screening results need to be documented on the date of the encounter (date of the appointment). If it is evident the eligible provider documented/ verified the results of the depression screen in the medical records on the date of the encounter, this would meet the screening portion of this measure. But please note; if the depression screening was positive, a follow-up plan must be documented.	X	X	X
68.	Does a prior active diagnosis of depression or bipolar disorder without documentation of Depression screening, allow for marking the patient as medically excluded?	Yes, as long as the diagnosis of depression occurred before the first day of the measurement period select the Denominator Exclusion option. For 2014 a diagnosis of depression needs to occur before January 1, 2014.	X	X	X
69.	For PREV-12, if they have a positive screen, does the follow-up plan need to be documented on the same day that the positive test was documented?	Yes, if there is a positive screen documented during the measurement period, a follow-up plan must also be documented on the date of the positive screen (See Narrative Specifications).	X	X	X
70.	For PREV-12, does the denominator include all patients, or, only those who were screened for depression? Is the goal to be screening all patients 12 and older for depression?	The denominator for PREV-12 includes all patients 12 years and older. This measure complies with the latest guidance from the US Preventive Services Task Force which recommends depression screening for those 12 years old and older.	X	X	X

Qualifying for the PQRS Incentive

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	How do ACOs use the GPRO Web Interface to meet PQRS reporting requirements?	ACO TINs with PQRS-eligible professionals (regardless of specialty) will be eligible for the PQRS incentive, while it is available, and avoid the PQRS payment adjustment by reporting ACO quality measures via the GPRO Web Interface. For SSP ACOs, each ACO participant TIN will receive their own PQRS incentive payment if the ACO meets the quality reporting requirements. ACO Participant TINs will not be able to participate separately in the PQRS GPRO program.	X	X	
2.	My TIN joined an ACO as an ACO participant in the middle of a reporting period. Will the eligible professionals that bill through this TIN qualify for a PQRS incentive payment and/or avoid the PQRS payment adjustment through ACO reporting under the Shared Savings Program for this reporting period?	No. In order for eligible professionals to qualify for a PQRS incentive payment and/or avoid the PQRS payment adjustment through ACO reporting under the Shared Savings Program, their ACO participant TIN must appear on the certified list of ACO participants that the ACO submits to CMS at the beginning of each performance year which, beginning on January 1, 2013, corresponds to the PQRS reporting period under the Shared Savings Program. For more information, please refer to the following guide: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PQRS-FAQs.pdf	X		

Performance Scoring and Benchmarks

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	For ACOs that began in 2012 or 2013, 2014 is considered their second performance year. Where can we find the benchmarks for the quality measures that are in Pay for Performance?	The quality measure benchmarks for the 2014 and 2015 reporting years are available in the following document: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks.pdf	X	X	
2.	Where can I find more information on how the benchmarks are used to determine our overall quality score?	This information is presented in the benchmarking document http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks.pdf. Additional information is also available in a Quick Reference Guide on the Shared Savings Program Portlet.	X	X	
3.	Regarding calculation of measures when part of a composite, will we submit the measures separately and will CMS calculate the performance for the composite OR will we provide the Pass/Fail result directly to CMS?	The ACO or PQRS group practice will enter data that is relevant to individual measures (component measures) that comprise the composite. The Web Interface will calculate the composite rate as well as the rates for each component measure. The component measure results are generally valuable for targeting areas for quality improvement.	X	X	X

Audit

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	When would an ACO know whether it has been selected for auditing?	ACOs participating in CY2014 reporting will be notified in the late spring after the close of the reporting period if they have been selected for audit.	X	X	

General

ID	Question	Answer	SSP ACOs	Pioneer ACOs	PQRS Group Practices
1.	You often reference to the "Measures Steward" and "Measures Owner." Can you explain who they are and what their roles are in quality measures reporting?	These terms refer to the organizations that create, test, and maintain quality measures. When more than one organization is involved, they must designate a *measure steward* during the NQF endorsement process. The measure stewards for each measure are listed alongside the measure name in *Table 1* of the 2014 Quality Performance Standards Narrative Specifications document for ACOs and the 2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes file for Group Practices.	X	X	X

Appendix A: Consecutively Completed Requirement

The minimum number of patients that must be completed for satisfactory reporting is 411 consecutively confirmed and completed patients for ACOs and PQRS group practices with 100+ EPs and is 218 for PQRS group practices with 25-99 EPs[1], starting with the patient ranked #1 in the disease module or patient care/coordination measure. If you skip a patient because (a) the medical record was not found, (b) the patient is no longer qualified for the sample, (c) the patient has moved out of the country, or (d) the diagnosis could not be confirmed, then an additional patient, *on a one to one basis*, must be completed according to the criteria noted above.

Complete means that you have confirmed the disease diagnosis (for CAD, DM, HF, HTN, IVD) and provided all the required information; or, for those measures that do not require confirmation of a diagnosis (CARE and PREV), that you have found the medical record and provided all the required information.

In Example 1 (see **Table 1**), two patient ranks need to be skipped. An additional patient is eligible for a clinical exclusion per the measure specifications. After patient rank #413, the module is considered complete and no additional abstraction required since 411 ranked patients were consecutively completed.

Table 1. Example 1

Patient Rank	Disease Confirmation (not applicable to all measures) or eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes—confirmed	Yes—complete	Yes	–
2	Yes—confirmed	Yes—complete	Yes	–
3	Yes—confirmed	Yes—complete	Yes	–
4	N/A	N/A	No	Medical Record not found
5	Yes—confirmed	Yes—complete	Yes	Patient was eligible for one of the clinical exclusions in the specifications.
6	N/A	Yes (input date of death under “Not Qualified for Sample”)	No	Deceased during performance year
7 through 411	Yes—confirmed	Yes—complete	Yes	–

[1] Note that throughout these examples PQRS group practices with 25-99 EPs should replace references to 411 with references to 218.

Patient Rank	Disease Confirmation (not applicable to all measures) or eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
412	Yes—confirmed	Yes—complete	Yes	Must complete additional patient to make up for skipping Rank #4
413	Yes—confirmed	Yes—complete	Yes	Must complete additional patient to make up for skipping Rank #6

In Example 2 (see **Table 2**), two patient ranks need to be skipped, but there are fewer than 411 patients available for abstraction. After patient rank #387, the module is considered complete since all available ranked patients have been consecutively completed.

Table 2. Example 2

Patient Rank	Disease Confirmation (not applicable to all measures) or eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes—confirmed	Yes—complete	Yes	–
2	Yes—confirmed	Yes—complete	Yes	–
3	Yes—confirmed	Yes—complete	Yes	–
4	No—not confirmed	Yes—complete	No	Unable to confirm disease diagnosis
5	Yes—confirmed	Yes—complete	Yes	–
6	N/A	Yes (input date of death under “Not Qualified for Sample”)	No	Deceased during performance year
7 through 386	Yes—confirmed	Yes—complete	Yes	–
387	Yes—confirmed	Yes—complete	Yes	No additional patients available for abstraction.

In Example 3 (see **Table 3**), laboratory result data for patient rank #2 was not provided and causes the count of consecutively completed ranks to stop at rank #1. Module considered incomplete until Rank #2 is completed.

Table 3. Example 3

Patient Rank	Disease Confirmation (not applicable to all measures) or eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes—confirmed	Yes—complete	Yes	–
2	Yes—confirmed	No—didn't abstract information on lab test	No	If this patient is not completed, you will have consecutively completed only 1 patient (Rank #1). Once Rank #2 is completed, it will be considered consecutively completed.
3	Yes—confirmed	Yes—complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
4	Yes—confirmed	Yes—complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
5	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during performance year
6 through 411	Yes—confirmed	Yes—complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
412	Yes—confirmed	Yes—complete	No	Must complete additional patient to make up for skipping Rank #5. Once Rank #2 is completed, this will be considered consecutively completed.

In Example 4 (see **Table 2**), three patient ranks need to be skipped. While there are 411 beneficiaries in the sample, there are only 412 beneficiaries (meaning that the ACO cannot completely replace the three beneficiaries that were skipped). After patient rank #412, the module is considered complete since all available ranked patients have been consecutively completed.

Table 4. Example 4

Patient Rank	Disease Confirmation (not applicable to all measures) or eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes—confirmed	Yes—complete	Yes	–
2	Yes—confirmed	Yes—complete	Yes	–
3	Yes—confirmed	Yes—complete	Yes	–
4	No—not confirmed	Yes—complete	No	Unable to confirm disease diagnosis
5	Yes—confirmed	Yes—complete	Yes	–
6	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during performance year
7–386	Yes—confirmed	Yes—complete	Yes	–
387	No—not confirmed	Yes—complete	No	Unable to confirm disease diagnosis
388–411	Yes—confirmed	Yes—complete	Yes	–
412	Yes—confirmed	Yes—complete	Yes	No additional patients available for abstraction