2015 GPRO Web Interface Quality Reporting

Questions & Answers

December 11, 2015

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Quality Reporting for Calendar Year 2015: Overview

Activity	Estimated* Timeline
ACOs and PQRS group practices provide care to patients during the reporting period	January 1, 2015–December 31, 2015
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 2015–January 2016
GPRO Web Interface opens so that patient ranking files can be downloaded	January 4–January 8, 2016
GPRO Web Interface training environment available (with masked, dummy data)	January 11–January 15, 2016
GPRO Web Interface opens for data abstraction by ACOs and applicable PQRS group practices	January 18–March 11, 2016 (Data Collection Period)
ACOs and PQRS group practices attend technical assistance webinars	January 20–March 10, 2016
GPRO Web Interface closes to data abstraction by ACOs and applicable PQRS group practices; no more abstraction possible	March 11, 2016 *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 28–April 22, 2016
ACOs selected for audit notified	May 2016
ACOs' audit materials due to CMS	June 2016
Quality scores reported to ACOs	Late Summer/Early Fall 2016

*Dates subject to change.

GPRO Web Interface

ID	Question	Answer
1.	Can you please clarify what the term “for analysis” means? Why is the “complete” patients higher than the “for analysis” count?	The **For Analysis** count reflects patients that are consecutively confirmed and completed starting with the patient ranked #1 in the disease module or patient care measure. The **Complete** count is the number of completed patients in any order in the disease module or patient care measure. 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.
2.	When should we click the “Submit Data to CMS” button?	After you have completed reporting, you will need to go to the Submit screen and press the “Submit 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 “Submit Data to CMS,” you may do so, but will need to press “Submit Data to CMS” again once you have finished data collection so that all data entered is transmitted to CMS. The Submit screen is accessed by clicking the “Submit” link at the top of the Web Interface.
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.
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 Extensible Markup Language (XML) file and get timed out the data will not be lost.
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. However, only updates made prior to pressing the “Submit Data to CMS” button will be transmitted to CMS.
6.	Can we provide the data for all disease modules or patient care measures for a given patient even if the patient is not ranked in all disease module or patient care measures?	The XML file will pass format validation. However, only the patients ranked in the disease modules or patient care measures containing the measure data will be updated. The data will be discarded for patients not ranked in the disease modules or patient care measures containing the data.
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 for that measure. 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.

ID	Question	Answer
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 data you have submitted has been received by CMS and MEETS the requirements for ACO GPRO Web Interface satisfactory reporting," or "The data you have submitted has been received by CMS and MEETS the requirements for PQRS GPRO Web Interface satisfactory reporting. Please note: Some group practices are required to complete CAHPS for PQRS. If your group is required to do so, successful completion of CAHPS for PQRS is required to avoid the negative PQRS Payment Adjustment," then you have successfully consecutively completed all necessary patients. The For Analysis line on the Home page will indicate the 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 disease module and patient care measure. If all disease modules or patient care measures (15 individual measures and the diabetes composite comprised of 2 individual component measures) have a green checkmark, then you have met the reporting requirements. The Submit screen and "Submit Status Report" will indicate that the disease module or patient care measure "is complete" for each disease module or patient care measure that has been satisfactorily reported. If you see this message for each of the disease modules and patient care measures, 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.
9.	How do we export all prepopulated patient information?	The Patient file contains all patient information populated in the GPRO Web Interface with the exception of the CARE-3 data. To export Patient files, you must select one or more disease module or patient care measure to be reported. The Patient Medications file contains the CARE-3 information needed for medication documentation and disease modules or patient care measures need to be selected when exporting this file.
10.	Which reports do you recommend we print and keep?	Though this is not required, you may want to print the Measure Rates Report, which shows performance on each of the disease modules and patient care measures, and the Totals Report, which will give you the number of patients that were complete, skipped, etc. for each disease module and patient care measure. The Submit Status Report gives you a record of the disease modules or patient care measures completed at the time you pushed the "Submit Data to CMS" button on the Submit screen.
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, this can be via electronic upload using XML or manual abstraction. More detailed resources regarding XML reporting are included in the XML section of this document, the XML specifications and a recorded demonstration regarding electronic upload of data using XML will be posted on the GPRO Web Interface page of the CMS website.

System Requirements and Users

ID	Question	Answer
1.	Where do I go to access the Web interface?	www.qualitynet.org/pqrs. After you sign in you will get the GPRO Web Interface Link during the submission period.
2.	Do security officials have GPRO Web Interface access or only the Web Interface submitters?	Security officials (SOs) do not have access to the GPRO Web Interface and cannot submit data for your ACO or group practice in the GPRO Web Interface. SOs approve the Web Interface submitter roles in Enterprise Identity Management (EIDM). The SO must be from the ACO or group practice and may not be a vendor.
3.	How long does it take to get access to the Web Interface after completing the security official registration forms?	The SO role approval should occur within a couple days. Once approved, the SO can immediately approve any Web Interface submitter roles for their organization. All submitter should be able to immediately access the Web Interface.
4.	Are organizations limited in the number of Web Interface submitters they can have?	No, organizations are not limited in the number of submitters they can have. We do recommend no more than 15 users per organization.
5.	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 Web Interface Submitter role. For more information, please see the recording of the EIDM demonstration, which is available on the GPRO Web Interface web site. A***pplicable to Shared Savings Program (SSP) ACOs only:*** The 2015 EIDM Guidance document is posted on the SSP Portal (located in the Program Announcement titled, *2015 Quality Measurement, Reporting and Scoring Quick Reference Guides).*
6.	Can we use the GPRO Web Interface with Internet Explorer 7 or Google Chrome?	Internet Explorer 11 (IE11) is the browser officially supported by CMS and is the recommended version. 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.
7.	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.

XML Specifications

ID	Question	Answer
1.	Where can we find documentation on use of XML to load data into the GPRO Web Interface?	The 2015 GPRO XML Specifications and Release Notes have been posted on the GPRO Web Interface web site.
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.
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 heart failure disease module and you are uploading data for the CAD disease 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.
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.
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.
6.	Does the XML upload automatically “save” the patient’s information?	Yes. Uploading of the XML automatically updates and saves the patient’s information.

Patient Ranking File

ID	Question	Answer
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: • Health Insurance Claim Number (HICNO) • Patient first name • Patient last name • Sex • Birth Date • Patient Rank for each of the disease modules and patient care measures into which the patient was sampled • The Taxpayer Identification Number (TIN) or CMS Certification Number (CCN) that provided the patient with the most primary care service visits • National Provider Identifiers (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
2.	What are we supposed to do with the patient ranking data?	The patient ranking gives 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.

Sampling and Prepopulation

ID	Question	Answer
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 2015 Web Interface Sampling Document, posted on the GPRO Web Interface webpage.
2.	What is the significance of a patient's rank?	Each sampled patient in a disease module or patient care measure is randomly assigned a rank order number for that disease module or patient care measure. Patients will be ranked 1-616, or the maximum number of eligible beneficiaries if fewer than 616 are eligible for a given disease module or patient care measure. ACOs and PQRS Group Practices must report on at least 248 consecutively ranked beneficiaries or the maximum number of eligible beneficiaries should 248 not be available to completely report a disease module or patient care measure. Additional patients (the oversample) are included in the sample in the event some need to be skipped (e.g., medical record not found, not qualified for sample, etc.). In this case, the skipped beneficiary will be replaced with the next ranked beneficiary in the sample to facilitate completion of reporting on 248 cases in consecutive order. For more information on consecutive completion, please see Appendix A.
3.	Will each ACO (participant) TIN receive its own set of samples?	**Applicable to SSP ACOs and Pioneer ACOs only**: No. Quality data collection, measurement and reporting in the ACO program are conducted at the ACO-level. The 16 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 16 samples drawn for the entire ACO, not for each participant TIN in the ACO.
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 2015 measurement period this is the patient's age as of January 1, 2015.
5.	What if one or more of our disease module/patient care measures contain fewer than 248 ranked patients?	Not every disease module or patient care measure will have a sample of 248 patients; this is particularly true in disease modules with diseases that have low prevalence rates. If CMS' contractor was unable to identify 248 patients who met the sampling criteria, then all patients who meet the criteria will be sampled. If fewer than 248 patients are found eligible for a disease module or patient care measure, 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 disease module.
6.	Can patients receiving comfort care be excluded from quality reporting?	Yes. 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 in the web interface will be removed from the sample(s).

ID	Question	Answer
7.	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 (2015). • Medicare HIC ID of the patient • First and last name of the patient • Gender • Patient date of birth • Patient rank in each disease module or patient care measure, if applicable • The 3 providers that provided the most primary care services to the patient • TIN at which the patient received the most primary care services • If the influenza vaccine was received (PREV-7) • Visits Dates that must be reported on for CARE-3
8.	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.
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 extracted for analysis on October 31, 2015 indicate that the patient had HMO coverage as a primary payer, died, or entered hospice at any time during the measurement period, 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" in the web interface with the appropriate reason indicated.

ID	Question	Answer
10.	Is the ACO or PQRS group practice responsible for validating the data that is prepopulated into the GPRO Web Interface?	Yes. 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) is the only instance where numerator-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-3 will have up to 12 visits pre-populated. The ACO or PQRS group practice will be responsible for validating that these visits occurred within the group practice or ACO.

Abstraction into the GPRO Web Interface

ID	Question	Answer
1.	For disease modules and patient care measures in the GPRO Web Interface, what makes the patient "complete"?	Complete means that for disease modules, you have confirmed the disease diagnosis and provided all the required information under that disease module (e.g., for a DM patient, that includes HbA1c value and an eye exam); or, for patient care measures, which do not require confirmation of a diagnosis (CARE and PREV), indicate whether or not 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).
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, by the end of the submission period the ACO or PQRS group practice must have consecutively reported on at least the first 248 ranked beneficiaries (or all sampled beneficiaries if fewer than 248 are ranked) and submitted the data to CSM in order to satisfy the reporting requirement for each measure.
3.	How many unique patients should we expect we will need to abstract?	There are 16 patient samples provided to each organization (1 for each of the two patient safety measures, one for each of the 6 disease modules, and one for each of the 8 preventive care measures). Each of these samples will have no more than 616 beneficiaries. In 2012, 2013, and 2014 patients were sampled using a method that would increase the likelihood that they would be sampled into multiple disease modules or patient care measures (if they were eligible for multiple disease modules or patient care measures). Typically we saw sample sizes between 4,000 and 6,000 unique patients, but ACOs or PQRS group practices could potentially see over 9,800 (16 samples x 616 beneficiaries). We are using similar sampling methodology for 2015 so we expect similar sample sizes. The sampling methodology is described in the 2015 Web Interface Sampling Document available for download from the GPRO Web Interface website. ACOs and PQRS group practices are required to completely report on the first 248 consecutively ranked patients in each disease module and patient care measure. 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 248 (or all, if there are fewer than 248) consecutively ranked patients.
4.	What does "consecutively complete" mean?	Patients are numbered 1-616 (or 1 to the maximum number available if less than 616), and 248 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 you had to skip one patient, the final completed patient should be ranked 249 instead of 248. For several examples, see Appendix A.

ID	Question	Answer
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, due to how patients are chosen for inclusion in a disease module or patient care measure sample, the patient was seen at least twice at one of the participant TINs affiliated with your ACO during the measurement period. Specifically, beneficiaries were assigned to your ACO based on 3rd quarter 2015 assignment or alignment and must have had two or more was primary care services at one of the ACO's Participant TINs to be sampled into the disease module or patient care measure. 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 2015 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.
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 Evaluation & Management (E&M) visits with your ACO or group practice between January 1 and October 31, 2015therefore your ACO or PQRS group practice is considered accountable for this patient's care, and you should do your best to obtain the needed quality of care information to complete the GPRO Web Interface.
7.	Some of our beneficiaries have declined to share their data. Will they be eligible for sampling into the GPRO Web Interface?	**Applicable to SSP ACOs and Pioneer ACOs only**: Quality data collection is not related to the data sharing processes that have been established for the Claims and Claims Line Feed (CCLF) data. A beneficiary who declines to share their data is not exempt from quality reporting.
8.	Can we exclude a sampled patient if they were only seen by a specialist at our facility?	No, this patient was assigned to your organization and has received the plurality of his or her primary care services at your organization so your organization is considered accountable for his/her care. Please refer to your program's assignment/alignment specifications for more information on how beneficiaries are assigned/aligned: • SSP ACOs: Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications • Group Practices: 2015 GPRO Web Interface Assignment Methodology Specifications • Pioneer ACOs: Pioneer ACO Benchmark Methodology for Performance Years 4-5

ID	Question	Answer
9.	Is there any benefit or harm to abstracting additional ranks in the disease module or patient care measure than what is required?	Some organizations may choose to report data for more than the minimum number of beneficiaries for their own quality tracking or quality improvement efforts. If you enter the beneficiaries consecutively, the first 248 consecutively confirmed and completed patients will be used in the completeness determination, but all consecutively confirmed and completed beneficiaries reported on will be used in the measure rate calculations (i.e., if you complete 310 consecutively confirmed beneficiaries, then all 310 will be used in the measure rate calculations.)
10.	What do we have to do in order to be eligible for shared savings under pay for reporting?	**ACOs only**: If you completely and accurately reported on the minimum 248 beneficiaries for each of the disease modules and patient care measures, or all sampled beneficiaries if <248 were included in the sample you would have satisfactorily reported under pay for reporting.
11.	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
12.	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 2015 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
13.	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.
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., the diagnosis of hypertension is defined differently for HTN-2 to determine the initial population and PREV-11 where it is used as a denominator exclusion. 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 for that measure when using codes to extract the data from your EHR or another data source.
15.	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.

ID	Question	Answer
16.	Is there a list of CMS Approved Reasons to remove patients from any of disease modules or patient care measures 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 disease module or patient care measure for a CMS approved reason you must open a QualityNet Help Desk inquiry that includes the patient rank, the disease module or patient care measure, and reason for the request. CMS will provide their decision in the resolution of the inquiry. You are not to select this option without prior approval from CMS.
17.	What is the definition of active diagnosis?	Active diagnosis is defined as a diagnosis that is on the patient's problem list, a diagnosis code listed on the encounter, or documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the denominator identification measurement period.

Care Coordination/Patient Safety

ID	Question	Answer
1.	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 includes whether the patient had been assessed for a history of falls or any fall with injury. Documentation of no falls is sufficient in those instances where that is the case.
2.	For CARE-2, who can perform the falls screening?	Any healthcare professional may perform the fall risk screening.
3.	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.
4.	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.
5.	For CARE-2, is the "Timed Up and Go" (TUG) 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. The TUG tests that have been shared with us do not.
6.	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.

ID	Question	Answer
7.	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.
8.	For CARE-2, can we use the Morse Fall Screen?	The Morse Fall Screen is an acceptable screening because it addresses the question of past history of falls.
9.	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).
10.	For CARE-3, can we add visits to the pre-populated visits in the Web Interface?	No. You may only report on the visit dates that are pre-populated in the Web Interface.
11.	What if our records indicate the patient's visit date happened a few days before or after the pre-populated date in the Web Interface?	You can confirm the visit date in the Web Interface if the date in the patient record is within 2 calendar days (before or after) of the pre-populated date. If your records indicate the patient's visit happened more than 2 calendar days before or after the pre-populated visit, it would be appropriate to indicate that you cannot confirm the visit.
12.	For CARE-3, can you define "current medications"?	Current medications are defined as medications the patient is presently taking including ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements with each medications' name, dosage, frequency and route of administration.
13.	What documentation is required to confirm that there is adequate documentation of the patient's current medications?	Your documentation needs to include the following for each pre-populated visit: • A list of all of the patient's current medications, including each medication's name, dosage, frequency, and route of administration; or • Indication that the patient is not currently taking any medications; or • Documentation of the reason why the Quality Action is not performed due to an exception (see Data Guidance for specific medical reason exceptions).

At Risk Populations: Coronary Artery Disease

ID	Question	Answer
1.	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 dysfunction.
2.	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 be present in 2015 or anytime in the history?	The patient should have an active diagnosis of diabetes during the measurement period (2015).
3.	For CAD-7, does Amlodipine alone (not mixed with another drug) count as an ACE/ARB?	No, Amlodipine alone does not count as an ACE/ARB. Review the CAD Drug Codes tab of the 2015 GPRO Web Interface CAD Supporting Document for Amlodipine combinations acceptable for CAD-7.
4.	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?"	A medical reason used to exclude a patient from CAD-7, e.g., chronic kidney disease (CKD), needs to be documented in the patient's medical record and occur anytime in the patient's history up through the last day of the measurement period. If the medical exception is due to pregnancy complications, the beneficiary must be pregnant for at least 1 day of the measurement period (2015).
5.	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)
6.	For CAD-7, what are other medical reasons that would count for not prescribing ACE inhibitor or ARB therapy aside from allergy, intolerance?	As noted in the Denominator Exceptions in the CAD Data Guidance tab, Other medical reasons include any medical reasons documented by the provider for not prescribing ACE/ARB therapy.
7.	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.
8.	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" because the patient was prescribed an ACE inhibitor or ARB therapy at some time during the measurement period.

At Risk Populations: Diabetes

ID	Question	Answer
1.	Are there any exclusions for the diabetes measures?	No, the measure steward has removed all denominator exclusions for the DM measures for 2015.
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."
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. When confirming the diagnosis, organizations should also look at the measurement year and one year prior.
4.	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?	DM-2 is considered an inverse measure which means a lower rate indicates better clinical care or control. Patient is numerator compliant if their most recent HbA1c level is > 9%, the HbA1c result is missing, or if there are no HbA1c tests performed with a documented result during the measurement year.
5.	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.
6.	For DM-7, if the eye exam is performed at the PCP office and is sent for interpretation to the optometrist/ophthalmologist, would this meet the intent of the measure? Does the eye exam specifically have to be performed by the optometrist/ophthalmologist?	The intent of the measure is for the patient to have a retinal or dilated eye exam performed by an eye care professional (optometrist or ophthalmologist). The measure does permit the use of retinal imaging provided it includes the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. For example, if an endocrinologist or PCP performs the appropriate imaging in their office and the results are reviewed by an eye care professional (optometrist or ophthalmologist) during the measurement period or the year prior to the measurement period (if negative for retinopathy) then it is eligible for use in reporting.
7.	If the practitioner documents that he instructs the patient to have an eye exam performed but the patient does not follow through; this will be entered as a 'no' response. Is this appropriate since the practitioner did refer the patient?	There must be clear documentation that the dilated eye exam was performed in order to enter a 'yes' response. Documentation noting a referral for a dilated eye exam was made is not sufficient to pass the measure.

ID	Question	Answer
8.	Are patient reported dates and results that are documented in the EMR acceptable for the DM-7, Eye Exam, or do we have to have the actual report from the eye care professional?	Regarding DM-7, patient reported data is acceptable as long as date (year) and result/finding are known. This information is necessary to ensure the exam was performed in the measurement period of the current reporting program year or performed in the year prior to the measurement period with no evidence of retinopathy. Additionally, the information would need to meet the measure requirements and be collected by the end of the measurement period by the provider while taking the patient's history. The information must be maintained in the patient's legal medical record.

At Risk Populations: Heart Failure

ID	Question	Answer
1.	Are pulmonary hypertension and chronic heart disease considered heart failure?	Neither of these conditions are 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.
2.	Does the diagnosis of heart failure have to include 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.
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 because the measure specifies that the patient has had, at any time in their history, an ejection fraction < 40%.
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.
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, and 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.
6.	For HF-6, the exclusions include pleural effusions. Can we only exclude a patient if this is an active problem during 2015?	Yes. 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.

ID	Question	Answer
7.	For HF-6, if there is an echo report showing moderate LV dysfunction and an ejection fraction of 40-45%, does the patient meet the measure?	Yes. You would use the most severe result in the patient's history (moderate LV dysfunction) and select "Yes" under LVSD.
8.	Where can we find the most current list of beta blockers acceptable for use in HF-6?	The 2015 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 developer, 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.
9.	Pacemaker (V4501) is an exception for HF-6: Beta Blocker for LVSD. If the patient has a Biventricular ACID which is a Defibrillator (V4502), is this considered an exception for beta-blockers?	Yes. 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.
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.
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.

At Risk Populations: Hypertension

ID	Question	Answer
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).
2.	For the hypertension measure, 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."
3.	On HTN-2, if I have a series of readings on different days for a patient, do I take the most recent one? For example, does the most recent value take precedence over the lowest one?	If you have more than one blood pressure reading in the measurement period you would use the most recent reading. If you have multiple readings during the last encounter during the measurement year the lowest systolic and lowest diastolic reading is used for GPRO Web Interface reporting.
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 systolic and lowest diastolic values regardless of position if there are multiple blood pressures on the same date of service.
5.	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?	Yes. 2015 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.
6.	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.
7.	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?"	"HBP" is an accepted abbreviation for high blood pressure; however, further documentation to support hypertension must be present to confirm the hypertension diagnosis. As noted in the HTN Supporting Document: Determine if the patient has a documented diagnosis of essential HTN within the first six months of the measurement period or any time prior to the measurement period but does not end before the start of the measurement period

ID	Question	Answer
8.	To use pregnancy as a medical reason for not including blood pressure, is this a pregnancy anytime in 2015, or only if the patient is still pregnant at the last office visit?	This is referencing a pregnancy at any time within 2015.
9.	As part of a patient evaluation in 2015, 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.

At Risk Populations: Ischemic Vascular Disease

ID	Question	Answer
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.
2.	IVD-2, what antithrombotics are considered for the IVD measure?	There is a list provided within the Inclusions/Synonyms column of the Data Guidance for IVD-2. For 2015 GPRO Web Interface IVD-2, oral antithrombotic therapy includes: Aspirin, clopidogrel or combination of aspirin and extended release dipyridamole, Prasugrel, Ticagrelor, and Ticlopidine. Xarelto, Pradaxa and Coumadin are not included. The Medication list is considered to be all inclusive per the measure steward.
3.	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" (i.e., the quality action was not performed).

At-Risk Populations: Mental Health

ID	Question	Answer
1.	What if my patient has a personality disorder and we are unable to screen with a PHQ-9? Do I have to answer "No" to screening?	You are able to exclude this patient from the denominator of this measure. Select "Denominator Exclusion".
2.	Do we have to use the PHQ-9 as the depression screening tool?	The MH-1 measure is based on using the PHQ-9 results to establish a quantitative definition for depression and for remission. Please follow instructions in the Data Guidance regarding how to complete the data in the web interface if you do not use the PHQ-9 as the depression screening tool.
3.	Does it matter when the PHQ-9 score <5 occurs as long as it's after the date of the PHQ-9 that is >9?	Yes, it does. The measure steward defines a narrow window when you can use the PHQ-9 score as indicating remission if the score is <5. You establish an "Index Date" which is the date between 12/1/2013 and 11/30/2014 where your patient had a PHQ-9 score >9 (use the first if more than one within the index window). Then you determine if your patient achieved remission with a follow-up score at 12 months out from the "Index Date" (+/- 30 days). If there is more than one PHQ-9 score obtained during the 11 through 13 month remission window, use the most recent. Please see the Data Guidance tab within the 2015 PREV Supporting Documents for additional information.

Preventive Health

ID	Question	Answer
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 10/1/2013 and 12/31/2015) and result of the mammography in the medical record. This includes the 3 month grace period.
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" (the quality action was not performed) in the GPRO Web Interface and it would be a performance failure as there is no patient exception option for this measure
3.	For PREV-5, does thermal gram count?	No, this does not count toward numerator compliance.
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. You must submit a QualityNet Help Desk ticket to request approval and more details may be required.

ID	Question	Answer
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 report is acceptable as long as the patient reports the date and type of test and result/findings.
6.	In PREV-6, Colorectal Cancer Screening, will ColoGuard qualify for the Colorectal screening quality measure?	From the measure steward: No, ColoGuard 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.
7.	For GPRO PREV-6, is FIT (Fecal Immunochemical Test) considered to be an FOBT?	The Fecal Immunochemical Test (FIT) would be considered an FOBT. The FIT is included in the 2015 PREV-6 Data Guidance, Inclusions/Synonyms tab.
8.	For PREV-6, 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.
9.	For PREV-6, 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 therefore you would fail the measure if the patient refused the screening.
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?”	You may select “Yes” if there is documentation in the medical record indicating the colorectal screening is up-to-date or current. This is explained within the Data Guidance, under the Inclusions and Synonyms column. If you have a copy of the screening, you don’t necessarily need “up-to-date” or “current” in the medical record.
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 indicates 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.
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 (FIT) 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 the Colorectal Cancer Screening measure.

ID	Question	Answer
13.	For PREV-7, will immunizations found in claims be included in the numerator?	Claims data is used when available to pre-populate the field used in the numerator for PREV-7 (influenza immunization).
14.	Do we only include vaccinations administered between January and March 2015? Or can we look back into 2014 for documentation of an influenza immunization?	The influenza immunization measure is one of the measures that allow you to look back to before January 1, 2015. If your medical record contains documentation that the patient was administered the influenza immunization between August 1, 2014 and March 31, 2015, 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 GPRO Web Interface.
15.	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.
16.	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.
17.	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.
18.	For PREV-7, is there an allowable patient reason for instances where the patient has refused the flu immunization?	Yes. Please refer to the 2015 PREV Supporting Documents, Data Guidance tab, for all applicable exceptions.
19.	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.
20.	For the influenza vaccine exception, what qualifies as a "system reason"?	An example of a system reason is if there were a vaccine shortage like we had a few years ago.
21.	Based on new ACIP recommendations for pneumonia vaccine for patients 65 years and older, will PCV13 count for the PREV-8 measure for the 2015 reporting year?	This measure is met if either PCV 13 or PPSV23 (or both) was received.

ID	Question	Answer
22.	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.
23.	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 PREV-8: Pneumonia Vaccination Status for Older Adults measure would be acceptable. Patient reported requirements for this measure are date (year) and type of vaccine.
24.	For PREV-9, 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 2015 (the measurement period) and find the last visit for that patient during this year. 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 and answer "No". The only exception to this would be if there is a documented patient or medical reason for not performing the BMI calculation. In these cases you would select either "No—Denominator Exception—Patient Reasons" or "No—Denominator Exception—Medical Reasons" respectively. Please refer to the Data Guidance for exceptions and exclusions for this measure.
25.	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 provide the BMI value in the GPRO Web Interface.
26.	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.
27.	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 GPRO Web Interface is where you are able to indicate "No—Denominator Exception—Medical Reasons."
28.	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 2015 measure.

ID	Question	Answer
29.	For BMI, if the only office visit was March 2015 and there was no BMI recorded, can we look back 6 months into 2014 to a visit where the BMI is recorded? Or, is this a failed measure?	Yes, if the most recent office visit was March 2015, 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 2014. In your scenario this would be numerator compliant as long as the BMI was within normal parameters or outside normal parameters with a documented follow-up plan addressing the variance.
30.	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.
31.	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).
32.	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.
33.	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.
34.	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 years and older BMI $\geq$ 23 and < 30 are considered normal. For ages 18-64 years, BMI $\geq$ 18.5 and < 25 are considered normal.
35.	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. If the BMI value is below acceptable parameters the provider must indicate in the medical records why the patient was not eligible or not appropriate for a BMI follow-up. Stating that the patient is "well-nourished" alone is not sufficient reasoning for that determination.

ID	Question	Answer
36.	The provider documented an elevated blood pressure 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.
37.	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?	A follow-up is required when 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.
38.	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.
39.	Please clarify the definition of Former Smoker that is addressed in PREV-10.	If you can show documentation that the beneficiary is not a current smoker, you can mark them as “nonsmoker” regardless of former smoker status.
40.	For PREV-10, the Narrative Specification states that the screening would be valid if done within 24 months. When does the 24 month look back start? Is it the first day of the measurement year?	24 months refers to the current measurement period and the year prior. For this year, that means calendar years 2014 and 2015.
41.	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.
42.	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.
43.	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.

ID	Question	Answer
44.	For PREV-10, if the notes state "Status Unknown" and the beneficiary 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.
45.	If a patient quit smoking in the last 3 months, will the patient be considered to be a non-tobacco user?	Yes. If a patient indicates that they are a non-smoker during the most recent inquiry regarding their smoking status then they are considered a non-tobacco user for the purposes of this measure.
46.	For PREV-11, when 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 plans for a future appointment to satisfy the follow-up requirement, there would need to be documentation (at the appointment where the elevated BP occurred) that links the future 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 PREV Data Guidance tab of the 2015 PREV Supporting Documents.
47.	For the Screening for High Blood Pressure measure (PREV-11), 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.
48.	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. Normal blood pressure parameters for this measure are systolic blood pressure <120 AND diastolic blood pressure <80.
49.	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 based on meeting a specified denominator exclusion for this measure. You would select "Denominator Exclusion" and stop abstraction on that patient for this measure. Note: No—Other CMS Approved Reason cannot be used without CMS prior approval and is not appropriate in this example.
50.	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. For more information, please refer to the PREV Supporting Document.

ID	Question	Answer
51.	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 because it is the most recent.
52.	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 already being medically managed for hypertension. During the sampling process, patients with a submitted claim with the hypertension diagnosis prior to the measurement period are not included in the sample.
53.	For PREV-11, can you please clarify the 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: pre, first, and second hypertensive reading. However, we recently received some clarification on the intent of the follow-up plan as it applies to patients with blood pressures in the pre-hypertensive range. If the blood pressure is pre-hypertensive (SBP ≥120 and <139 OR DBP ≥80 and <89) at a PCP encounter, no additional follow-up would be needed. This meets the intent of the measure and you can select "Yes" to the follow-up plan element in the GPRO Web Interface.
54.	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 within the medical record documentation when reporting PREV-11.
55.	Can we use ambulatory blood pressure monitor readings from the patient 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.
56.	(PREV-11) Our physicians have expressed concern over this measure not aligning fully with the current guidelines on blood pressure management.	There is discussion in the medical community regarding the definition of pre-hypertension and hypertension. There is currently a lack of consensus regarding whether the guidelines on which the measure are currently based should be updated. If that consensus is achieved and if it involves a modification of the guidelines, efforts will be taken to update the measure as well.

ID	Question	Answer
57.	What documentation is needed for depression screening?	The use of a standardized screening tool must be documented and, if the tool used indicates a potential diagnosis of depression, the second part of the measure will require documentation of a follow-up plan. 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. 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.
58.	If there is a notation in the patient record (in 2015) that the patient is under care of a mental health professional, is that 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.
59.	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 documentation indicates an age appropriate standardized screening tool was used.
60.	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?"	In this situation you would not select "Yes" for clinical depression screening nor would you indicate "No Medical Reason" as a denominator exception. Instead, if the patient has an active diagnosis of depression, diagnosed before the first day of the measurement period, you would select "Denominator Exclusion." Please refer to the PREV supporting documents, data guidance tab for PREV 12.
61.	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" (the patient's screen is not positive), then you do not answer the follow-up plan questions.
62.	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 (not limited to PHQ-2 or PHQ-9). 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 (positive or negative for depression).

ID	Question	Answer
63.	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 it could be considered a Denominator Exception, medical reason for not screening for depression. 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.
64.	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 age appropriate standardized 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 2015. If the diagnosis of depression occurred on or after January 1, 2015, there needs to be evidence of a depression screen using an age appropriate standardized tool during the measurement period, January 1, 2015 to December 31, 2015.
65.	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 record 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 also be documented.
66.	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 active diagnosis of depression or bipolar disorder occurred before the first day of the measurement period you may select the Denominator Exclusion option. For 2015 an active diagnosis of depression or bipolar disorder needs to occur before January 1, 2015 for the Denominator Exclusion to apply.
67.	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).
68.	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.

Skipping Beneficiaries

ID	Question	Answer
1.	When is it appropriate to skip reporting on a beneficiary?	Each disease module or patient care measure in the GPRO Web Interface has a sample of beneficiaries to be reported on that is chosen from the pool of beneficiaries assigned to the organization.[1] CMS claims data are used to determine if a beneficiary meets the criteria to be included in a given disease module/patient care measure's sample.[2] However, due to the timing of quality sampling, a full 12 months of claims are not available for analysis when the quality samples are created. The result is that a beneficiary may lose eligibility for the quality sample in general, or a particular measure denominator, between the time the sample is generated and the end of the performance year. It is also possible that data derived from the claims cannot be substantiated by information in the medical record. For these reasons, as well as the possibility that a medical record cannot be located, the GPRO Web Interface allows an organization to remove ("skip") a beneficiary from the sample if he/she does not meet one or more of the quality sampling and/or disease module or patient care measure-specific criteria. Organizations can skip beneficiaries in the GPRO Web Interface using one of several options. If an appropriate skip reason is entered for a sampled beneficiary, that beneficiary is considered completed, but not confirmed. This means the beneficiary will not be counted towards the reporting requirement of 248 consecutively confirmed and completed beneficiaries, and will be replaced with the next consecutively ranked beneficiary who in turn must be reported on, or, if they do not meet criteria for quality reporting, skipped. Some skip reasons remove a beneficiary from all disease modules and patient care measures, and other skip reasons only remove the beneficiary from that specific disease module or patient care measure. Specific skip reasons are discusses in this document. They include: Medical Record Not Found, Not Qualified for Sample, Diagnosis Not Confirmed, measure-specific exclusion criteria, and Other CMS Approved Reason.

[1] For the Shared Savings Program, refer to the Shared Savings and Losses Assignment Methodology Specifications. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html

For the Pioneer ACO model, refer to the Alignment and Financial Reconciliation Methods. Available at: http://innovation.cms.gov/Files/x/PioneerACOBmarkMeghodology4to5.pdf

For PQRS, refer to the GPRO Web Interface Assignment Methodology Specifications. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

[2] Refer to the 2015 GPRO Web Interface Sampling Methodology, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_WebInterfaceSamplingDoc.pdf

ID	Question	Answer
2.	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 is only a system warning and the system will continue to allow you to skip patients. ACOs and group practices will not be penalized for skipping 10% of a given disease module or patient care measure's sampled patients. As long as you have met the minimum requirement of 248 consecutively completed patients (or 100% of the sample if fewer than 248 are available), then you will have completely reported on the disease module/patient care measure. ***ACOs only**: If you skip reporting on a large percentage of beneficiaries you may be selected for a targeted audit and/or for targeted education with your ACO.*
3.	When can I use "Medical Record Not Found?"	The Medical Record Not Found option should be used only if there is truly an inability to locate and access the beneficiary's medical record after concerted effort is put forth. CMS expects that beneficiary medical care is being coordinated, that the organization make every effort to locate and obtain access to the medical record, and that providers share the necessary records for the purposes of coordinating care and reporting quality data. CMS encourages organizations to put systems and processes in place so that patient care is more coordinated for the dual purposes of patient safety and quality improvement. It is likely that data for sampled patients are available from medical records maintained by the organization's providers because sampled patients are those with: 1) the largest share of their primary care services provided by the organization (i.e., they have been assigned to the organization), and 2) at least 2 primary care office or other outpatient visits billed by the organization[3] during the reporting period. CMS expects organizations to make a **concerted effort** to obtain medical records for their assigned and sampled beneficiaries. This includes collaborating with physicians and/or other clinic staff both inside and outside the organization (including but not limited to the three NPIs provided in the GPRO Web Interface), as well as facilities both inside and outside the organization, with such collaboration attempts being repeated throughout the course of the data collection period, if needed. Medical Record Not Found is not an appropriate response when you are able to locate and access a medical record, but are unable to locate certain data within it. Refer to Appendix B, Table B-1 for examples.

[3] For ACOs, the ACO's participants would have billed for these services.

ID	Question	Answer
4.	When can I use "Not Qualified for Sample?"	CMS makes efforts to exclude beneficiaries that are not qualified for the sample, but because there are limitations in the claims data used to identify the sample, the GPRO Web Interface allows a beneficiary to be skipped because they are not qualified for the sample. The beneficiary must meet one of the following criteria to be considered not qualified for the sample and will be removed from all disease module and patient care measure samples: • In hospice[4] • Moved out of the U.S. • Deceased • HMO enrolled[5] If any of the above are true for a sampled beneficiary, at any time during the measurement period, that beneficiary is not qualified for the sample. If Not Qualified for Sample is selected, you must also select the specific reason from the drop down menu provided (which matches the above stated list). The GPRO Web Interface will also ask for a date that corresponds with the reason a beneficiary is not qualified for the sample. If the exact date is unknown (e.g., beneficiary date of death), you may enter the last day of the measurement period (i.e., December 31, 2015). Refer to Appendix B, Table B-2 for examples.
5.	When can I use "Diagnosis Not Confirmed?"	For disease modules and patient care measures that evaluate quality of care as it pertains to a specific medical condition, relevant diagnoses will be identified using claims data as part of the sampling process. However, organizations will be asked to confirm that the sampled beneficiary has documentation of that medical condition in the medical record. For example, before entering data for the diabetes disease module, organizations will be asked to confirm if the beneficiary has an active diagnosis of diabetes. If the diagnosis cannot be confirmed with the information the organization has access to in the beneficiary's medical record, then the organization should skip that beneficiary and "diagnosis not confirmed" should be the reason chosen as the skip reason. Refer to Appendix B, Table B-3 for examples.

[4] Hospice includes non-hospice beneficiaries receiving palliative goals or comfort care.

[5] A beneficiary who is enrolled in an HMO as their primary payer for at least one month during the performance year is may be excluded from data collection. However, the exclusion does not apply if the beneficiary has a secondary HMO insurance or if the beneficiary is enrolled in a Medicare supplement plan.

ID	Question	Answer
6.	How do I know if a beneficiary meets measure-specific exclusion criteria?	Measure owners may specify a certain category of patient that should be excluded from a particular measure. The most common reason for this type of exclusion is that the quality intervention would not be appropriate for that patient population. For example, it would not be appropriate to provide follow-up for an out of range BMI for a pregnant patient therefore, the measure owner has specified pregnancy as an exclusion for the BMI Assessment and Follow-up measure (ACO-19/PREV-9). Exclusions for a given measure are determined by the measure owner and not all measures have exclusions. For measures where the measure owner has identified an appropriate exclusion category, this will be specified in the Narrative Specifications and the Supporting Documents and an option will be made available in the GPRO Web Interface that allows organizations to indicate that a given beneficiary meets the exclusion criteria for a measure. Refer to Appendix B, Table B-4 for examples.
7.	When can I select "Other CMS Approved Reason?"	Other CMS approved reason is reserved for cases that are unique, unusual, and not covered by any of the above stated skip reasons. Though this option is available as a drop down, it may not be used without prior approval from CMS. To gain CMS approval, a QualityNet Help Desk ticket should be submitted with the disease module or patient care measure, and beneficiary rank number (never any protected health information, "PHI"), along with an explanation of why you think it is appropriate to skip the beneficiary. CMS will either approve or deny the request and will identify appropriate next steps (if any) that need to be taken. This information will be provided in the resolution of the QualityNet Help Desk ticket. You should retain this documentation and enter the QualityNet Help Desk resolution number in the Web Interface. Refer to Table B-5 for examples.

Quality Measures Validation Audit

ID	Question	Answer
1.	When would an ACO know whether it has been selected for auditing?	**Applicable to SSP ACOs and Pioneer ACOs only**: ACOs participating in Performance year 2015 quality reporting will be notified in the late spring of 2016, after the close of the reporting period, if they have been selected for audit.
2.	What kind of documentation do we have to send in if we are chosen for audit?	You need to have medical record documentation for every option you choose in the GPRO Web Interface that results in numerator compliance or a denominator exclusion. In addition, rationale for your use of confirmation options that remove the patient from all measures (i.e., medical record not found, other CMS approved reason, etc.) should be documented.

Avoiding the PQRS Payment Adjustment

ID	Question	Answer
1.	How do ACOs use the Web Interface to meet PQRS reporting requirements?	**Applicable to SSP ACOs only**: PQRS-eligible professionals (regardless of specialty) that bill through an ACO participant TIN will avoid the PQRS payment adjustment when their ACO completely reports quality measures via the GPRO Web Interface and fields the CAHPS survey. Shared Savings Program Participant TINs will not be able to report to the PQRS program as a group separately from what the ACO reports. **Applicable to Pioneers only:** The 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 quality measures via the GPRO Web Interface and by fielding the CAHPS survey as a participant of their Pioneer Model ACO. Note that both the TIN and the NPI must be documented as part of the ACO to receive PQRS credit as a result of the successful ACO reporting. Pioneer Model ACO participant TINs may separately register for the PQRS Group Practice Reporting Option (GPRO).
2.	My TIN joined an ACO as an ACO participant in the middle of 2015. Will the eligible professionals that bill through this TIN avoid the PQRS payment adjustment through ACO reporting under the Shared Savings Program for this reporting period?	**Applicable to SSP ACOs only**: No. In order for your TIN to 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 (i.e., at the beginning of 2015). TINs that are not on the ACO's certified participant list at that time must satisfy PQRS reporting requirements separately. For more information, please refer to the following guide: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PQRS-FAQs.pdf

Performance Scoring and Benchmarks

ID	Question	Answer
1.	For ACOs that joined the Shared Savings Program or Pioneer model before 2015, a number of measures are Pay for Performance in 2015. Where can we find the benchmarks for the quality measures that are in Pay for Performance?	**Applicable to SSP ACOs and Pioneer ACOs only**: The quality measure benchmarks for the 2015 reporting year are available on the Shared Savings Program website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html) and on the Pioneer Collaboration site.
2.	Where can I find more information on how the benchmarks are used to determine our overall quality score?	**Applicable to SSP ACOs and Pioneer ACOs only**: *SSP ACOs*: This information is presented in the benchmarking document https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2015.pdf. Additional information is also available in a Quick Reference Guide on the Shared Savings Program Portlet. *Pioneer ACOs:* This information is presented in the 2015 benchmarking document available on the Pioneer Collaboration site.
3.	Regarding calculation of measures that are 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 the individual measures (component measures) that comprise the composite. The GPRO 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 but the ACO or PQRS group practice will be scored on the overall composite measure.

General

ID	Question	Answer
1.	You often reference 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 2015 Quality Performance Standards Narrative Specifications document for ACOs and the 2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes file for group practices and ACOs reporting via the GPRO Web Interface.

Appendix A: Consecutively Completed Requirement

The minimum number of patients that must be completed for satisfactory reporting via the GPRO Web Interface is 248 for each disease module and patient care measure (or the maximum number available to you if less than 248). This means that ACOs and PQRS group practices must consecutively confirm and complete data for 248 patients, starting with the beneficiary ranked #1 in each measure's sample. If you skip a beneficiary because (a) the medical record was not found, (b) the patient is no longer qualified for the sample, (c) the beneficiary meets measure-specific exclusion criteria, (d) the diagnosis could not be confirmed, (e) the patient age or date of birth has changed such the patient is not eligible for the measure, or (f) an "Other CMS Approved Reason" then an additional patient must be completed for each beneficiary that was skipped.

Confirmed means that you have obtained the patient's medical record, confirmed the patient is eligible for quality sampling, confirmed the disease diagnosis if applicable (for CAD, DM, HF, HTN, IVD), confirmed the beneficiary's age and sex, and confirmed that the beneficiary does not meet exclusion criteria for a given measure.

Complete means that you have provided all the information required for a given patient for the measure for which they were sampled.

Consecutive means that you have completed the patient that was ranked immediately after the previously completed patient.

In Example 1 (see **Table A-1**), three patient ranks need to be skipped and replaced. After patient rank #251, the disease module or patient care measure is considered complete and no additional abstraction required since 248 ranked patients were consecutively completed.

Table A-1. Example 1

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
2	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
3	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
4	Y	**N**	Y	No—Medical Record Not Found	Yes—"Medical Record Not Found" has been selected for this beneficiary	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
5	Y	**N**	Y	No—Patient is not qualified for the sample because they meet measure specific exclusion criteria.	Yes—"Denominator Exclusion" has been selected for this beneficiary	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
6	Y	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
7–248	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
249–251	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—these additional beneficiaries replace skipped beneficiary #4, skipped beneficiary #5 and skipped beneficiary #6

No additional beneficiaries need to be abstracted.

In Example 2 (see **Table A-2**), two patient ranks need to be skipped, but there are fewer than 248 patients available for abstraction. After patient rank #231, the disease module or patient care measure is considered complete since all available ranked patients have been consecutively confirmed and completed.

Table A-2. Example 2

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
2	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
3	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
4	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—"Not Confirmed—Diagnosis" has been selected	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
5	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
6	Y	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
7–230	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
231	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—this additional beneficiary replaces skipped beneficiary #64

No additional beneficiaries are available for abstraction.

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

Table A-3. Example 3

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
2	Y	Y	**N**	Yes—all relevant beneficiary data have been confirmed	No—Lab test data required for the numerator was not provided. If this patient is not completed you will have only 1 patient counting towards your reporting requirement.	No—this patient is incomplete
3	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed
4	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed
5	**N**	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample. This beneficiary is also not considered consecutive until rank #2 is completed.
6–248	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed
249	**N**	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	No—this beneficiary is not consecutive until rank #2 is completed. Note this beneficiary must be completed to replace skipped rank #5

No additional beneficiaries need to be abstracted.

In Example 4 (see **Table A-4**), three patient ranks need to be skipped. While there are more than 248 beneficiaries in the original sample, there are not enough beneficiaries sampled to replace those that were skipped. After patient rank #250, the disease module or patient care measure is considered complete since all available ranked patients have been consecutively completed.

Table A-4. Example 4

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1-3	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
4	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—"Not Confirmed—Diagnosis" has been selected	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
5	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
6	Y	**N**	Y	No—the patient is not qualified for the sample because they are deceased during the performance year.	Yes—"Not Qualified for Sample" has been selected for this beneficiary, and the date of death has been entered.	No—This patient is not confirmed and must be replaced with another beneficiary from the sample.
7–178	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
179	Y	**N**	Y	No—the diagnosis required for this measure has cannot been confirmed	Yes—"Not Confirmed—Diagnosis" has been selected	No—This patient is not confirmed and must be replaced with another beneficiary from the sample
180–248	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
249	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—this additional beneficiary replaces skipped beneficiary #4
250	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—this additional beneficiary replaces skipped beneficiary #6

No additional beneficiaries are available for abstraction.

Appendix B: Skipping Beneficiaries (Examples)

Table B-1: Medical Record Not Found Examples

ID	Example	Should I select Medical Record Not Found?
1.	Dr. Ruiz has Mrs. Liu's medical record, but there isn't a lot of information in it.	No. If you have a medical record you may not select medical record not found. You must complete reporting with the data available to you. If data are required that you cannot find either in the medical record you have, or through information obtained from other providers, you must answer the questions in the negative; e.g., that a diagnosis cannot be confirmed, or that a quality action was not performed.
2.	Ms. Jenkins sees one of our physicians, but her physician visits are at the nursing home she resides in, which also maintains her medical record onsite.	Maybe. This beneficiary has been assigned to your organization based on the professional services rendered by providers participating in your organization. You are expected to work with your participating providers and any facilities to obtain any medical record data you need. If after a concerted effort your organization cannot get the nursing home to share data, you may select Medical Record Not Found.
3.	Dr. Menlo left our practice in March, and took all his patients and their medical records with him. We have tried our best but he still refuses to provide us with data on his patients	Maybe. Your organization should have policies in place that address data sharing for quality reporting purposes, including for those providers that leave the organization mid-year. You are expected to work with all providers to obtain any medical record data you need. If after a concerted effort your organization is unable to obtain the record or its contents from Dr. Menlo, you may select Medical Record Not Found.
4.	Mr. Hyde sees Dr. Jones for routine care at our practice, but gets all of his diabetic care with Dr. Jekyll. Dr. Jekyll doesn't reliably share his data with us.	No. Mr. Hyde has been assigned your organization because your organization has provided the plurality of primary care services. You are expected to work with Dr. Jekyll to obtain any data you need. In the event you cannot get data from Dr. Jekyll, you must enter data based on what you can obtain from the medical record at your organization.
5.	Dr. Moriarty is currently under federal investigation, and all of his patient's records have been removed from our practice.	Yes, this would be appropriate use of medical record not found. Your organization is unable to access the medical records for affected sampled beneficiaries.
6.	Dr. Banks can find the patient's medical record, but can't find any of the information he needs in it.	No. A medical record is available. Dr. Banks is expected to use the data available to him, and coordinate with other providers for additional data where needed. If a specific piece of data needed to confirm a quality action was performed cannot be found, he must indicate that the quality action was not performed.
7.	There was a flood in our building just before the data collection period that destroyed many of our medical records.	Yes, this would be appropriate use of medical record not found. In this case your organization is unable to access the affected medical records.

Table B-2: Not Qualified for Sample Examples

ID	Example	Should I select Not Qualified for Sample?
1.	Ms. Alvarez had ABC Inc., a private insurer, as her primary payer through February of 2015.	Yes, this sampled beneficiary is not qualified for the sample because she was enrolled in an HMO during the measurement period.
2.	Mr. Bannister entered hospice care in December of 2015	Yes, this sample beneficiary is not qualified for the sample because he entered hospice care during the measurement period
3.	Mrs. Grey retired and moved to Argentina is November of 2015	Yes, this sampled beneficiary now permanently outside of the United States.
4.	Ms. Smith died in April 2015	Yes, this sampled beneficiary is deceased for part of the measurement period.
5.	Mr. Skywalker lives in New Jersey, but takes an extended vacation in Costa Rica every winter.	No, this sampled beneficiary has not changed his residence to outside the United States.
6.	Mr. Hughes died in 2013.	Yes, presumably Mr. Hughes remained deceased in 2015, and thus would not be qualified for the sample.

Table B-3: Diagnosis Not Confirmed Examples

ID	Example	Should I select Diagnosis Not Confirmed?
1.	Ms. Stackhouse has coronary artery disease (CAD) listed in her medical record, but she gets all her CAD treatment from her cardiologist.	No. The diagnosis is documented in the medical record. You are expected to coordinate care as needed to answer all coronary artery disease related questions
2.	Dr. Reeves is puzzled as to why Mr. Kent was sampled for the ischemic vascular disease measure, as Mr. Kent has no medical record documentation of any chronic medical condition.	Yes. CMS does identify diagnoses with claims data, but ultimately the diagnosis must be confirmed with medical record documentation. It is possible that claims-derived diagnosis data is inaccurate.

Table B-4: Meets Exclusion Criteria Examples

ID	Example	Should I select Meets Exclusion Criteria?
1.	Dr. Berzin does not believe any of his patients in a nursing home should receive BMI screenings, and does not screen or provide BMI follow-up to those patients.	No. Nursing home residence is not a specified exclusion for the BMI Screening and Follow-up measure. Exclusion criteria are determined by the measure owner and not all measures contain exclusion criteria. It is not appropriate to use this option for any reason other than those specified for the applicable measure by the measure owner.
2.	Dr. Beebe does not obtain a BMI for her pregnant patients.	Yes, pregnancy is a specific exclusion for the BMI screening measure.
3.	Mrs. Wagstaff is allergic to eggs and an influenza vaccination is contraindicated.	No. This allergy is specified as a measure exception—not a measure exclusion. You will be able to enter this data into the GPRO Web Interface further into the abstraction process. Exception criteria is also clearly defined in the Supporting Documents.

Table B-5: Other CMS Approved Reason Examples[6]

ID	Example	Should I select Other CMS Approved Reason?
1.	Dr. Lorusso can find the medical record, but he can't find documentation of Mr. Miyagi's colorectal cancer screening.	No. Dr. Lorusso cannot select Other CMS Approved Reason. He must indicate that Mr. Miyagi did not have a colorectal cancer screen.
2.	Ms. Lemon has located some beneficiaries that are outside of the age criteria for the measure they were sampled in.	No. You are able to correct a beneficiary's date of birth directly in the GPRO Web Interface. If doing so causes the patient to be outside of the age criteria for specific measures, the GPRO Web Interface will automatically skip those beneficiaries.
3.	Mr. McGrath has diabetes and history of traumatic eye injuries that have made him excessively fearful of eye exams. He has repeatedly refused to complete one due to his adverse physiological reaction.	No, you should submit a ticket to the QualityNet Help Desk (by emailing QNetSupport@hcqis.org or calling 1-866-288-8912; TTY: 1-877-715-6222). CMS will review the details of this specific situation and provide a written response with additional instructions.

[6] Other CMS approved reason is reserved for cases that are unique, unusual, and not covered by any other skip reasons. **It may not be used without prior approval from CMS which can be requested by submitting a QualityNet Help Desk ticket.** Please see the "Skipping Beneficiaries" section of this document for more information on obtaining CMS approval for using "Other CMS Approved Reason."