2013 Group Practice Reporting Option (GPRO) Web Interface Support Call

Q&A Sessions

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Purpose

This document is intended for group practices who self-nominated/registered and are participating in the 2013 Physician Quality Reporting System (PQRS) through the group practice reporting option (GPRO) and for Medicare Accountable Care Organization (ACO), including the Medicare Shared Savings Program (Shared Savings Program or SSP) and the Pioneer ACO Model.

The Centers for Medicare and Medicaid Services (CMS) will invite group practices participating through the 2013 PQRS GPRO, SSP ACO and Pioneer ACO programs to attend a series of support calls via webinar to provide educational support on various GPRO Web Interface-related topics. During the 2013 GPRO Support Calls, CMS will provide groups the opportunity to submit questions during the Question & Answer (Q&A) session, allowing CMS to answer the questions during the meeting. This document provides cumulative questions and answers from all of the 2013 GPRO Support Call Q&A sessions with CMS in addition to frequently asked questions (FAQs) from the 2012 submission period that are relevant to the 2013 PQRS submission. This document should be used for reference by group practices participating in the 2013 PQRS GPRO, SSP ACO and Pioneer ACO programs.

This document contains questions and answers from the Q&A sessions of the following 2013 GPRO Support Calls:

> 11/7/2013 – Topic: GPRO Measures Specifications / Supporting Documents
> 12/5/2013 – Topic: Web Interface Support Call
> 12/12/2013 – Topic: XML Training
> 1/9/2014 – Topic: Web Interface Training
> 1/16/2014 – Topic: Questions and Answers Session
> 1/27/2014 – 1/31/2014 – Topic: Daily Submission Support Calls
> 2/6/2014 – Topic: Weekly Submission Support Call
> 2/20/2014 – Topic: Weekly Submission Support Call
> 2/27/2014 – Topic: Weekly Submission Support Call

Pre-recorded webinars about the following GPRO topics can be accessed any time on the CMS YouTube site, http://go.cms.gov/GPROPlaylist:

- 2013 PQRS GPRO 101 Part 1
- 2013 PQRS GPRO 101 Part 2
- 2013 PQRS GPRO Which Reporting Method? Part 1
- 2013 PQRS GPRO Which Reporting Method? Part 2
- 2013 PQRS GPRO Value-Based Payment Modifier
- 2013 PQRS Group Practice Measures Overview
- 2013 PQRS GPRO Public Reporting
- 2013 PQRS GPRO and ACO Web Interface Submission -- IACS
- 2013 PQRS GPRO and ACO Web Interface Measure Specifications/ Supporting Documents Part 1
- 2013 PQRS GPRO and ACO Web Interface Measure Specifications/ Supporting Documents Part 2
- 2013 PQRS GPRO and ACO Web Interface Measure Specifications/ Supporting Documents Part 3
- 2013 PQRS GPRO and ACO Web Interface Assignment and Sampling
- 2013 PQRS GPRO and ACO CAHPS Overview
- 2013 ACO/PQRS GPRO Web Interface Overview

User guides for the Web Interface are available on the **Physician and Other Health Care Professionals Quality Reporting Portal** (Portal), direct link http://www.qualitynet.org/pqrs:

- 2013 PQRS/ACO GPRO Web Interface User Manual
    - o This guide provides information on how to access the Web Interface, how to set accessibility preferences, and how to customize the Web Interface by selecting the default page and modules.
    - o The Introduction page for the 2013 PQRS/ACO GPRO Web Interface User Manual contains a link to a PDF version of the Quick Start User Guide
    - o The Introduction page for the 2013 PQRS/ACO GPRO Web Interface User Manual also contains and a link to the GPRO Web Interface Online Help

- The GPRO Web Interface Online Help provides information on using the Web Interface including how to enter measure data, generating reports, and submitting data to CMS.
    - o The Welcome page for the GPRO Web Interface Online Help contains a link for a PDF version of the GPRO Web Interface Online Help.
    - o The online help may also be accessed during the submission period from the Web Interface.

If you have questions that are not answered in the following document, please contact the QualityNet Help Desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org.**

2013 GPRO SUPPORT CALLS Q&A AND FAQS

IACS

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	What is the role/responsibility of the Security Official in IACS? Can the individual who has PQRS Security Official role also have a submitter role?	The Security Official's primary responsibility is to first set-up your organization in the IACS system and then act in an approval role to approve the PQRS Submitter role requests in IACS and the ACO or GPRO Submission 2013 role in the Portal. The Security Official cannot have the PQRS Submitter role. It is possible to transfer the Security Official role to another person in your organization.	X	X	X
2	FAQ	What is the difference between a PQRS Submitter and an ACO or GPRO Submission 2013 role? How do I request the ACO or GPRO Submission 2013 role?	The PQRS Submitter role and the ACO Submission 2013 role (or GPRO Submission 2013 role) must be held by the same person and both are necessary in order to login to the Web Interface. The PQRS Submitter role is requested in IACS. The ACO Submission 2013 role and the GPRO Submission 2013 role can only be requested though QRMS once the PQRS Submitter role is obtained. Once that role is obtained the QRMS role of ACO Submission 2013 may be requested. The ACO or GPRO Submission 2013 role is requested in the PQRS Portal Roles Management application (https://qualitynet.org/pqrs) in the PQRS Portal. Please see the YouTube video on IACS accounts for more information.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
3	FAQ	Is the PV-PQRS role the same as the GPRO submission 2013 role?	No, the PV-PQRS role used during registration or to pull your QRUR reports is not the same as the GPRO Submission role. You will need to request a new role for GPRO Submission. Also, if the Security Officer for your group only has a PV-PQRS role, they will need to go through additional step and verification to have the PQRS Security Official role. This is outlined in the IACS presentation on the CMS YouTube site: http://go.cms.gov/GPROPlaylist.	X	NA	NA
4	FAQ	If we had a PQRS submitter role last year and have maintained our IACS account by updating our password when requested, do we need to request it again this year?	No, no additional steps need to be taken.	X	X	X
5	FAQ	How many IACS users can one organization have?	Organizations are limited to 15 IACS users. CMS increased the number of submitter roles in response to requests from ACOs. We hope this will enable ACOs with multiple TINs and large GPROs with many EPs to submit data efficiently while also maintaining internal controls to ensure data accuracy. Medium GPROs with 25-99 EPs may opt for fewer users depending on the organization's structure and personnel, as well as whether the organization is doing manual abstraction or using XML.	X	X	X
6	FAQ	If someone is a submitter for 2 organizations, can they do so with one IACS? If so how will they access one ACO versus the other's sample?	The ACO reporting goes by the ACO Primary TIN. If the submitter needs a role for two different ACO Primary TINs they would use the same IACS account and request to add the additional role/TIN to the existing IACS account.	NA	X	X
7	FAQ	To manually enter data in the Web Interface do we need to have a submitter or end user role?	The user must have the PQRS Submitter role within IACS and the ACO or GPRO Submission 2013 role within the PQRS Portal Roles Management Application. The PQRS Submitter role and the appropriate QRMS role are needed for utilizing the Web Interface.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
8	FAQ	Can we create generic IACS accounts for our submitters?	No, each IACS account may only be requested and accessed by the person who will use the account.	X	X	X
9	FAQ	I am the IACS Security Official for the PQRS GPRO submission using my IACS account from last year. This year, I will also be the Security Official for a Shared Savings Program ACO submission. Do I modify my account to add the ACO?	Yes, since you already have existing account, you will need to modify your existing account if you want to add an additional TIN. IACS accounts for ACOs need to be associated to the Primary ACOs TIN. Contact the QualityNet help desk at 1-866-288-8912 or qnetsupport@sdps.org for further assistance.	X	X	X
10	FAQ	Do submitter roles require a CMS user ID?	To obtain the submitter role you need to obtain an IACS account. The IACS account is sometimes called CMS ID but you do need an IACS account that will give you access to a PQRS Submitter Role and the Web Interface. You will have an IACS User ID for the IACS account that will be needed for logging into the PQRS Portal to submit data.	X	X	X
11	FAQ	We submit for 2 GPROs. Do we need to request the GPRO Submission 2013 role in the portal for each TIN?	The user will need to have the IACS PQRS Submitter role for each TIN. After the IACS PQRS Submitter role is obtained for a specific TIN, the user should be able to have the Portal QRMS role of GPRO Submission 2013 added for the same TIN. The GPRO Submission 2013 role will need to be added for each of the PQRS Submitter TIN(s) the user has in order to be able to access the web interface for each of the TIN(s). If you are having trouble adding the role for another TIN, please contact the QualityNet Help Desk for assistance.	X	X	X
12	FAQ	If you have a security official in one ACO, what is the process for requesting security official for the second ACO?	If you are using the same Security Official, you just modify the account in IACS to request that the additional TIN be added. Note that for ACO reporting, your IACS account needs to be registered for the primary TIN and not a child TIN.	NA	X	X

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13	FAQ	If an IACS account has not been kept active, how do we re-apply?	To create a new IACS account, go to https://applications.cms.hhs.gov/home.html and navigate to the new user registration link.	X	X	X
14	FAQ	I have the PQRS Submitter role from last year, but when I try to request roles, I don't have the option to request the ACO submission 2013 role.	If you had the PQRS Submitter role last year and you obtained the ACO Submitter role last year, you will be able to use what you already have to submit data this year. If you did not have the ACO Submitter role last year, please contact the QualityNet Help Desk and we can walk you through how to request that.	NA	X	X
15	FAQ	After IACS access is obtained, are additional steps required to make the Web Interface available?	Yes, you will need to access the submitter role. The PQRS Submitter needs to go to PQRS portal under manage roles and request the QRMS role of ACO submission 2013 or GPRO submission 2013 and the SO will need to approve that role. Alternatively, the SO can manually add the submission role and approve for the role for the PQRS Submitter.	X	X	X
16	FAQ	What is the web link to access QRMS?	To have the Portal QRMS role added to an IACS PQRS Submitter account, go to https://www.qualitynet.org/pqrs and login there. Once logged in, utilize the manage roles link.	X	X	X
17	FAQ	What if the previous IACS account is not linked to the ACO TIN? Do we have to create a new account?	If the IACS account is not linked to the ACO primary TIN, then either the IACS user needs to request an SO role and register the primary TIN on the existing account or a new user who wants to be the SO needs to register for the SO role under the ACO primary TIN as a new user.	X	X	X
18	FAQ	If submitters are not changing from the 2012 Quality Reporting Submission, does the Security Official need to re-approve anything?	As long as everyone still has their active accounts that they had last year, and you have all of the submitters you want with active accounts, then no, there is no need for the Security Official to re-approve anything. There could be certification approvals coming in as IACS accounts need to be recertified every year in order to keep them active.	X	X	X

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19	FAQ	Is the IACS account specific to the organization? Does each submitter require an IACS account? Does this include the IT staff who will be doing the XML uploads?	Yes to all three questions. Each submitter will need an IACS account to log into the Web Interface. Each role you have with an IACS is specific to that organization. For example, your PQRS Submitter Role must be linked to the correct organization you wish you submit for. If you are submitting for two organizations, you would need PQRS submitter role associated to each of those organizations.	X	X	X
20	FAQ	We are an organization with multiple TINs. Please provide more information regarding the "QRMS" role.	Once an organization has a Security Official with two-factor in place, the next step is to have each submitter gain access to the PQRS Submitter role. In order to submit data and access Web Interface there is an additional role - the QRMS role. For ACO that's the ACO Submission 2013 role for GPRO that's the GPRO Submission 2013 role.	NA	X	X
21	FAQ	Where do we find the Portal role in IACS?	That role is not in the IACS application. That role is in the PQRS portal itself. That's at https://www.qualitynet.org/pqrs. If you log in there with your IACS credentials, you will be able to request or add that role.	X	X	X
22	FAQ	If submitting for more than one TIN, do I need to request the PORTAL GPRO Submission 2013 role for each TIN?	If you are submitting for multiple TINs, you need an IACS PQRS Submitter role for each of the TINs. Each of those PQRS Submitter roles under those TINs need the QRMS role attached to them.	X	X	X
23	FAQ	What's the difference between the submitter role and the GPRO role?	The PQRS Submitter role is a role in IACS, which gives you access to the PQRS Portal. The ACO/GPRO Submission 2013 role is a role in the PQRS Portal and gives you access to the Web Interface.	X	X	X

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24	FAQ	What accounts do I need to be able to access the web interface (enter, import, export data)?	In order to access the Web Interface, a person needs the IACS PQRS Submitter role and you will also need the portal role for that PQRS Submitter. After you get your PQRS Submitter role, you will need to go to the PQRS Portal and request a specific QRMS role. If you're a PQRS GPRO it will be the GPRO Submission 2013 Role **OR** if you're an ACO it will be the ACO Submission 2013. You can either request this role and your SO can approve it, or your SO can request it and approve the role all in one shot.	X	X	X
25	FAQ	What was the logic for CMS increasing the submitter roles from 10 to 15? Did you find that 2012 submissions were using this many resources? How many ACOs used the XML methodology?	The reason of the increase is because of user requests. Most of the GPROs and ACOs used a mixture of both XML and manual entry. There were a handful that used strictly XML or strictly manual entry.	X	X	X
26	FAQ	Please verify if the submitters must register for IACS access by January 27th.	The Web Interface is open January 27, 2014 through March 21, 2014. You must have an IACS account in order to log into the Web Interface.	X	X	X
27	FAQ	Will all users be able to run reports in the Web Interface?	Any user logged into the Web Interface will be able to run reports in the Web Interface. Reports are only available during the submission period of January 27, 2014 through March 21, 2014.	X	X	X
28	FAQ	Will we get a new password daily or just one for login into the web interface?	The password does not change daily. When you log in you will receive a "User Authentication Challenge" screen which requires a one-time pass code. The pass code is received by the method selected in your IACS profile. If you check the box below Pass Code entry field, you may log in without receiving the User Authentication Challenge for 12 hours.	X	X	X
29	FAQ	Can more than 1 person access the Web Interface at the same time and do all who access need a separate IACS ID and login?	You may only have one person at a time working on a patient but more than 1 person can be in the web interface working on the same module. However, everyone entering data in Web Interface must have their own IACS account and log in with the appropriate role.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
30	1/31/2014	For purposes of entering data into the Web Interface, what is the difference in IACS between submitter and end user? Should all of our entry staff be submitters or end users?	For the GPRO reporting, you will need the PQRS Submitter role in IACS as well as the ACO/GPRO Submission 2013 role in the CMS Portal.	X	X	X

MEASURES

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
			General Clinical Quality Measure Information			
1	FAQ	Please clarify how a zero percent performance will work. Is a zero percent not allowed for any of the measures' performance calculations or is it for each individual patient/beneficiary?	The 0% performance threshold doesn't apply to reporting through the GPRO Web Interface. The criteria for satisfactorily reporting PQRS via the GPRO Web Interface is outlined in the following manner: Report on all PQRS GPRO measures included in the Web Interface; AND Populate data fields for the first 218 (groups of 25-99) or 411 (ACOs or GPRO groups of 100+) consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or patient care measures. If the pool of eligible assigned beneficiaries is less than 218 (groups of 25-99) or 411 (ACOs of GPRO groups of 100+), then report on 100 percent of assigned beneficiaries.	X	X	X
2	FAQ	In several of the quality measures, "patient declined/patient refuses" is an acceptable exclusion reason. Can we apply this exclusion generally to other measures? Is there a list of measures where this exclusion would apply?	No, the "patient declined/patient refuses" exclusion cannot be applied across all measures, as not all measures include a patient reason exclusion. Thoroughly review the Narrative Specifications for applicable exclusions. Also, use the Data Guidance tab within the Supporting Documents to help determine exclusions available for a measure in the Web Interface. The Data Guidance will let you know whether or not there is an exclusion for a measure, and if there's an exclusion, it will show if "patient declined/patient refuses" is an acceptable exclusion. If a measure has an exclusion, the pull-down menu on the Web Interface will list allowable exclusions. In addition, the XML Specification will list the corresponding values for the exclusion in the allowable values for the XML tag.	X	X	X
3	FAQ	Is the Supporting Documentation clear in where only codes listed in Resource Tables can be used as opposed to where the codes and medication lists are simply references to help those with EMRs (i.e. where the lists are not all inclusive)?	The coding provided is there to assist you and is based on measure owner recommendations. However, you will notice in the Narrative Specifications as well as the Supporting Documents, there are instances where specific direction is provided. For example, the heart failure measure only allows use of the three generic medications listed within the Narrative Specifications. Although not specifically listed, the brand name equivalents to the 3 generics also meet the numerator. Please use all of the documentation provided when entering data into the Web Interface.	X	X	X

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4	FAQ	Will there be "paper tools" available for the measures?	It is recommended that you utilize all documents CMS has provided, such as the flows, the data guidance, the different tabs in the supporting documents and the other specifications. Everything has been provided for the process that the ACOs/GPROs will be going through. You may find that there are certain tools that you can create that will help you specifically as each entity may be different. Printing off each patient's Case Summary is something you may want to explore for those ranked near to 411 and below for ACOs and GPROs and near to 218 for those GPROs required to report to that extent.	X	X	X
5	FAQ	Several measures note exclusions including "terminal illness" or "receiving palliative care." Can we apply this exclusion generally to other quality measures?	If you go to patient confirmation tab in supporting documents, there is a way to remove patients from the Web Interface if they are labeled as being in hospice. The definition of this says: select option if patient is not qualified for sample due to being in hospice care at any time during the measurement period. This includes non-hospice patients if receiving palliative or comfort care.	X	X	X
6	FAQ	Can you please define "hospice?" Does this include patients who are located in a nursing home?	Patients in a nursing home would be included if they are receiving palliative care or comfort care, but it would need to be specifically stated in the record that they are receiving either palliative or comfort care.	X	X	X
7	FAQ	There is a lot of dialogue concerning physical health measures of the identified patients (diabetes, etc). Are there quality measures specific for outpatient mental health clinics (like major depression etc)?	Review the 2013 PQRS GPRO Measures List posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. Please call the QualityNet Help Desk if you have specific questions.	X	X	X
8	FAQ	Will the CPT codes for a few of the quality measures like influenza, smoking status etc, sent through claims satisfy some of the quality measures for GPRO?	This is specified in the Data Guidance by measure.	X	X	X
9	FAQ	Are we able to take documentation from the entire calendar year including November - December or only for the first 10 months of the year?	You are able to use documentation available for the entire measurement year (January 1 - December 31, 2013).	X	X	X

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10	FAQ	I thought there were 22 ACO measures to report via GPRO but you mention 15 modules. How do these match up?	There are 22 GPRO quality measures that span 3 of the domains of care and 15 modules. Modules are defined by the shared denominator criteria for the measure or measure groups (e.g., all patients with diabetes in the DM module; all patients with discharge + office visit within 30 days in CARE-1, etc.) Following are the GPRO measures: CARE – 2 measures that are their own module PREV – 8 measures that are their own module At Risk Population - 1 module for each disease category DM – 1 individual measure, DM-2 and 1 composite made up of 5 component measures scored as one composite measure, DM-13 – DM-17 HTN – 1 measure IVD – 2 measures HF – 1 measure CAD – 2 component measures scored as one composite measure	X	X	X
11	FAQ	When you say at the beginning of the measurement period, say the parameter is 18 or older, should we exclude someone that turned 18 during measurement period?	The age of a patient is determined on Jan 1, 2013 for 2013 GPRO Web Interface reporting. A patient who is not the correct age for a measure or module should not be pulled into the sample to begin with if they are not the age required for denominator inclusion.	X	X	X
12	FAQ	According to the Data Guidance sheets, there is an "HMO Enrollment" option for indicating a patient is not qualified for the sample. Does this mean that any patient who has an HMO supplement is required to be excluded from our sample?	Beneficiaries enrolled in a group health plan as their primary payer—including beneficiaries enrolled in Medicare Advantage (MA) plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly (PACE) programs under section 1894—are not eligible for assignment. If an ACO/GPRO has more recent confirmation that a beneficiary was enrolled in an MA plan during the reporting year, they may exclude the beneficiary in the WI. **Note that Medicare Secondary Payer (MSP) status doesn't exclude a beneficiary from assignment to an ACO/GPRO.**	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
13	FAQ	Our entity performs all manual chart review (no EHR). How can we confirm a patient diagnosis to include or exclude from a measure if we do not have codes in the medical record? Does verbiage of DM, CAD, etc suffice or is there something else to confirm?	If you are performing manual abstraction it would be acceptable to confirm the patient's diagnosis by locating the verbiage of diabetes mellitus, coronary artery disease, etc. within the medical records. Please utilize all of the documentation provided to assist group practices reporting via the 2013 GPRO Web Interface. These documents include the 2013 GPRO Narrative Specifications, 2013 GPRO Web Interface Flows, 2013 GPRO Measures List, and the 2013 Supporting Documents.	X	X	X
14	FAQ	Will the reported quality measure (QM) through claims be included in the numerator?	Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. If you are an ACO and are selected for audit, you will also be required to provide this supporting medical record documentation following the data collection period. This is not the case if the Web Interface has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: • A note indicating the date the breast cancer screening was performed AND • The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the ACO be selected for audit.	X	X	X

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15	FAQ	Will GPRO have any pre-filled values for measures such as Influenza Immunization?	For the module that includes pre-filled fields the following will be pre-filled: Diabetes Module, Ischemic Vascular Disease Module, and Preventive Care Module (mammogram, colorectal screening, flu shot and pneumonia shot) in addition to the discharges for the GPRO CARE-1 medication reconciliation measure. As previously mentioned, the medication reconciliation measure is at **every** discharge so for sample patients we will provide the discharge date for each discharge that we can associate with an office visit up to 30 days following the discharge. For some measures, such as colorectal screening, flu and pneumonia shot, we will look in the claims but we may not find for some measures where the time period acceptable for screening is longer than claims we are analyzing.	X	X	X
16	FAQ	There is a 2013 GPRO CAD Data Guidance document and a 2013 ACO GPRO CAD Data Guidance document. Which should we be looking at? We are a Pioneer ACO.	All ACO GPRO Data Guidance documents are now aligned with PQRS GPRO documents, and can be found here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html or simply follow the "GPRO Web Interface Page" link on the ACO Quality Measures and Performance Standards page. The document you need to reference is the first document located in the download section at the bottom of this page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
17	FAQ	Please clarify which narrative measure specs we are to use for Pioneer ACO 2013 reporting. There are significant differences in the logic of several measures in the QMAT NARRATIVE Specifications versus the GPRO Narrative CQM Specifications. Do we use the GPRO Narrative Specifications now?	Pioneer ACOs are reporting 2013 clinical quality measures via the GPRO Web Interface. Please refer to the "2013 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes" zip file available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	NA	NA	X
18	FAQ	Are the Release Notes in the GPRO Web Interface supporting documents new this year?	No, the concept is not new; however, new Release Notes are provided each year to outline what documents have been changed since the prior year.	X	X	X
19	FAQ	Is the prefilled data elements list posted on the website?	The prefilled data elements list is not currently available but will be shared before the submission period begins.	X	X	X

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20	FAQ	In the measurement specifications, unless otherwise specified, is the "within measurement period" referring to the 12-month reporting period or an 18-month reporting period?	"Within measurement period" refers to the 12-month measurement period unless otherwise specified. For GPRO Web Interface submission in 2014 for program year 2013, within the measurement period would specifically be in reference to Jan 1, 2013 to Dec 31, 2013.	X	X	X
21	FAQ	What are the measure values for CARE-1 and CARE-2?	Please refer to the CARE supporting documents posted on the GPRO Web Interface page of the CMS website for the criteria to confirm a patient. The allowable values for these measures are included in the XML specifications.	X	X	X
22	FAQ	Will you be changing any of the measure specifications prior to the Web Interface opening?	No, the measures specifications will not change prior to the opening of the Web Interface.	X	X	X
23	FAQ	If we answer "No" to medical record found, but we don't know the exact date that a patient moved out of the country, for example, what date do we enter?	Please use 12/31/13. You can refer to the "Patient Confirmation" tab GPRO supporting documents for this information.	X	X	X
24	FAQ	Are there duplicate fields in the different modules? Like BPs - if you enter in one module - does it populate the others?	There are measures that have similar fields in multiple modules. Because the measures can have different owners, coding, or exclusions, the Web Interface does not populate values entered in one module into another module.	X	X	X
25	FAQ	Can you provide a clarification about "Medical Record Not Found"? When we went live with our EHR we created a patient record for patients who had ever been seen by our organization going back many years. There is no clinical/encounter data for some of these.	If the medical record cannot be found, then you would answer "No: Select this option if you are unable to find the patient's medical record" in the Patient Confirmation section of the Web Interface.	X	X	X
26	FAQ	Could you provide us an example of where in the supporting documentation that will indicate if a measure that is prefilled needs to be verified in the medical chart?	Pre-filled value information is not located within the supporting documents, but is in the Online Help, which will be available to all groups upon logging in to the Web Interface.	X	X	X

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27	FAQ	Do we have to update the patient measures in GPRO by March 21st?	The Web Interface is open between January 27, 2014 and March 21, 2014. All patient data must be updated in the Web Interface between these dates. Once the submission period closes, you will not be able to access the Web Interface to update data, view data, upload or generate XML, run or view reports. These activities are only available while the Web Interface is open during the submission period.	X	X	X
28	FAQ	If the patient is given a drug (for e.g. - anti-platelet) but is not listed on the drug choices listed in the supporting document, would we choose the answer as a Yes or No?	Because of the complexity of the GPRO program, it is difficult to answer generalized questions. If you have a question regarding a specific medication for a certain measure, please contact the QualityNet Help Desk.	X	X	X
29	FAQ	Is it correct that the HTN confirmation diagnosis was expanded from the 2012 list than the 2013 spec list?	Please use only 2013 documents when abstracting for program year 2013. Refer to the Release Notes for areas in the specification documents that were changed.	X	X	X
30	FAQ	On the exclusions tab it only specifies for the CPTs and not the diagnosis? Please advise.	CPT is not the only type of code you will find within the Exclusion Tab for each module; you will find different code nomenclatures (e.g., ICD-9, ICD-10, SNOMED, etc.). If you have a more specific question, please contact the QualityNet Help Desk.	X	X	X
31	FAQ	Panelist just stated dates had to be from the current program year. How does that apply to measures such as influenza vaccine (2012 influenza season) and pneumococcal vaccine?	The dates referenced were in regards to measures requiring dates be added within the Web Interface. For the influenza and pneumococcal measures, you are not required to add a date, you need to confirm that the vaccines were received within the specified time period if they were not pre-populated for you from claims data. The dates entered in the Web Interface where a date value is required must be for the program year.	X	X	X
32	FAQ	Can we confirm diagnosis based on our own claims analysis or must the information be documented in the chart? Can we confirm a diagnosis from one physician and obtain the supplemental data questions from another physician? Does it matter from whom we collect the patient information?	The information must be documented within the medical record. It does not matter which provider has documented the information; only that the information is available to all at the point of care.	X	X	X

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33	FAQ	Can we give guidance to all of our Practices to use the most recent available dates in the Medical record for where the specific values are asked?	We would prefer that you look at this on a measure by measure basis. If the measure you are reporting for requires the most recent quality action then you are correct. However, for GPRO measures it's hard for us to answer generic questions such as this one. Again, please look at the documentation for each measure.	X	X	X
34	FAQ	Can you confirm that "last 12 months" refers to the 2013 calendar year for purposes of current reporting?	The statement "within the last 12 months" in the Data Guidance typically refers to the current 12 month measurement period. However, some measures allow look back periods. Use the 2013 GPRO Web Interface documents provided by CMS to determine the specific requirements for each measure/module.	X	X	X
35	FAQ	Claims data from the CCLF (ACOs only) files should not be used for ANY measures. Only data documented in the medical records should be used, correct?	Correct. CMS will use claims data when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your ACO is selected for audit following the data collection period. This is not the case if the Web Interface has been pre-filled with claims information.	X	X	X
36	FAQ	If the patient is listed under specialty but most data is available in the primary care physician records do records have to be transferred to the specialist to include in their record or is the primary care physician record acceptable?	GPROs and ACOs should follow their specific documentation policies. For PQRS reporting, as long as records are available to the specialist the records do not need to be transferred from the primary care provider to the specialist.	X	X	X
37	FAQ	In the Part D table, the NDC Code is 11 digits long, whereas the standard NDC Code is 10 digits. Is there a cross reference table to tie the 11 digit NDC Codes back to the standard NDC codes?	CMS does not have a recommendation for a cross-reference or website to map the codes. Utilize appropriate staff or a Google search to map the codes.	X	X	X

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38	FAQ	Please confirm that documentation for data pre-populated by claims is not required.	With pre-populated data, some of the measures will require additional information. For example, for PREV-5: Breast Cancer Screening, a "Yes" will be pre-filled if there is a claim for a mammogram during the measurement period or year prior to the measurement period. In order to maintain this "Yes" answer in the Web Interface you need to ensure the patient's medical record contains the date and results of the screening. **See the 2013 GPRO Web Interface Pre-filled Elements dated 2/11/2014 distributed to ACOs and PQRS GPROs the week of 2/17/2014 for additional information on pre-filled elements.**	X	X	X
39	FAQ	We have patients sampled for which we know their primary care provider is out of network. If we can gain access to those charts, can we report that data? We have no record of the patient in 2013. The patient is likely in the local skilled nursing facility. Are we responsible for reporting on this patient?	If you can access those charts at the time of care, then yes you can report that data.	X	X	X
40	FAQ	Do I need to confirm the diagnosis for each patient or just use the provided patient list as the denominator?	You must use information documented within the medical record to confirm a diagnosis. It does not matter which provider has documented the information; only that the information is available to all at the point of care.	X	X	X
41	FAQ	Can we use NQF's specifications for a measure when they are available?	On rare occasions, the NQF specifications will differ from the GPRO measure specifications (generally for logistic reasons). Please follow the GPRO specifications, which will reflect the intention of the NQF measure.	X	X	X

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42	FAQ	Can we use the claims data we received from CMS to confirm a diagnosis?	No, you may not use the CMS data to confirm a diagnosis. The confirmation is meant to be a confirmation by the ACO or GPRO based on information **in the patient's medical record**. We would like to know that you have a record of what you are trying to confirm. The confirmation can be from documentation anytime in the patient's history up through the last day of the measurement period (the exception being the diabetes module, where documentation must be from the measurement period or the year prior to the measurement period).	X	X	X
43	FAQ	Are abstractors responsible for reporting actual values (e.g., HbA1c) or will CPT II codes that correspond to the measures suffice?	If the measure specifications indicate that a value must be entered (e.g., HbA1c), then the ACO or GPRO is expected to enter the value (e.g., 8.0). A CPT II code would not suffice.	X	X	X
44	FAQ	Are there implications for a "0" numerator for one or more modules?	When participating via the 2013 GPRO Web Interface, a 0% performance rate will not affect incentive eligibility. The implications of 0% performance may affect Physician Compare percentages for a group practice. Also, if quality tiering was elected, a 0% performance may affect the group.	X	X	X
45	1/27/2014	Does the problem list to confirm patient need to be signed by the physician?	While the physician should be cognizant of the contents of the medical record, there is no specific requirement for physician signature related to the problem list.	X	X	X
46	1/27/2014	Can we take lab values from a progress note if the lab date isn't specified?	No, the requirement associated with labs reported through the 2013 GPRO Web Interface includes the lab date as well as the lab value.	X	X	X
47	1/27/2014	Can you confirm exactly which components of which measures must have occurred in an ambulatory setting? (i.e. the blood pressure measurement earlier addressed)	The GPRO Web Interface Supporting Documents provide the ACOs and PQRS GPROs with ambulatory setting requirements. Confirmation of the proper setting for HTN-2 is to match DM-13 for reporting purposes of the 2013 GPRO Web Interface.	X	X	X
48	1/27/2014	Could you confirm whether a medication appearing in the active medication list from a previous year would qualify as meeting the measure?	All documentation used for 2013 reporting must be created for 2013 except for measures that allow for a history of diagnosis.	X	X	X

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49	1/27/2014	If the labs were done, but not by our organization, and we have the values in the chart can we take credit for this? Or does the lab have to be done by our providers/practice?	Yes, you can use the lab results from outside the organization. The lab results do not have to be from your practice. Documentation for lab results typically requires the date and the result of the labs.	X	X	X
50	1/27/2014	What is the difference between LDL Direct & LDLC?	LDL-C, the amount of cholesterol contained in LDL. The LDL direct test, unlike what is reported in the chemistry profile, is not a calculation but rather a direct test for the best accurate evaluation and monitoring of this risk factor. It is also used for monitoring lipid (fat) - lowering lifestyle changes and therapy.	X	X	X
51	1/27/2014	We have a lab data that lists the LDL-Cholesterol with the normal being <130. Is this the same LDL-C that CMS wants to be <100?	CAD-2 is looking for a most recent value or most current test. In order to answer "Yes" in the 2013 GPRO Web Interface, the LDL-C results need to be <100 mg/dL or >= 100 mg/dL and a documented plan of care including, at a minimum, the prescription of a statin. DM-14 is not looking for a specific value. IVD-1 is also not looking for a specific value. Please reference the Clinical Recommendation Statements in each measure's Narrative Specification for the AHA/ACC Guideline, etc.	X	X	X
52	1/27/2014	If we see that there has been a claim for a medication, can we use this as active (prescribed) or do we also need to find the documentation in the record?	Documentation in the medical record needs to verify the active (prescribed) medication.	X	X	X
53	1/27/2014	If there is a pre-filled date for a Blood Pressure, HbA1c or LDL-C, must we find evidence in the medical record of a test that is at least as recent as that date, or would entry of a prior date be acceptable?	We would expect that the information you put into the Web Interface should correlate with the date provided. If can't find information for that date, then you can use the most recent date for which you have a value. You would change the date then put in the value or result that you do have. Blood pressure is not pre-filled in the Web Interface.	X	X	X
54	1/28/2014	Is the data guidance the same as the narrative specifications?	No, these are different documents. You can find the data guidance on the GPRO Web Interface page of the CMS Website. Under the downloadable section, there is a zip file for 2013 GPRO supporting documents. In the zip file, there is an excel file for each module and in each excel file, you can find the data guidance on the third tab: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X

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55	1/28/2014	We do not have RXNORM med codes and rather have NDC codes, is it OK to just use the closest match using the RXNORM med name?	RX Norm is the recommended standard for EHR measures. Because GPRO is working towards alignment with EHR, CMS instructed GPRO to follow the same standards. We cannot direct how you choose to map coding to ensure the correct medication is selected. CMS does not endorse any mapping websites or software. It is up to your company to utilize available resources to ensure the correct coding medication is selected.	X	X	X
56	1/28/2014	Should we report BP or lab results from a specialist that occurred outside of our ACO or revert back to the latest results that were derived from the last office visit within our ACO?	Report the most recent values documented regardless of where the results were derived.	X	X	X
57	1/28/2014	For all measures related to blood pressure, can you provide further clarification on the definition of "office or other non-emergent outpatient facility"? Does an urgent care visit count as a non-emergent outpatient facility?	Yes, an urgent care visit does count as a non-emergent outpatient facility.	X	X	X
58	1/29/2014	The supporting documents instruct us to use the default date of 12/31/2013 if the date the patient became ineligible for the sample during the measurement period is unknown (HMO, deceased, in hospice, moved out of country). Can you please clarify?	If you know the date, you can fill in the date. If you have unknown, then use 12/31/2013. If you know that the patient has been using HMO for entire year, use 1/1/2013.	X	X	X
59	1/29/2014	We are finding some examples where we could either report inclusion (e.g. colorectal screening is current, patient is taking aspirin) or an exclusion (e.g. colectomy or patient taking warfarin) for the same patient. Which should take precedence?	The exclusion would take precedence.	X	X	X

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60	1/29/2014	In the data guidance, for measures that say in the instructions: "Determine if the patient is qualified for the measure", does this refer to what would qualify a person to be counted in the denominator for a measure? (i.e. All female patients aged 40-69)	In CARE and PREV measures only the following options are available when determining if the patient is qualified for the measure: · Yes · No-Other CMS Approved Reason For the remainder of the measures the following options are available when determining if the patient is qualified for the measure: · Yes · Not Confirmed · No-Other CMS Approved Reason	X	X	X
61	1/30/2014	If a patient has passed away between January 1, 2014 and the present, do we still need to report on this patient's measures for 2013?	Yes, as long as patient alive for measurement period (through 12/31/13) they are eligible for reporting.	X	X	X
62	1/30/2014	If the record says patient deceased, but does not have a date, what shall we input in for a date?	This direction is provided on the Patient Confirmation tab within the Data Guidance: Instruction: Enter the date in MM/DD/YYYY format the patient became ineligible for the sample during the measurement period (if date unknown enter 12/31/2013)	X	X	X
63	1/31/2014	If there is a Pennsylvania Orders for Life Sustaining Treatment form on the patient's chart for comfort measures only and it is dated and signed in the medical record, should we select in hospice?	Yes, you may select in hospice. In the patient confirmation guidance tab, the definition of in hospice is if the patient in hospice care at any time during the measurement period. This includes non-hospice patients receiving palliative goals or comfort care.	X	X	X
64	1/31/2014	We are seeing that many of our heart failure measures have comfort measures and would be excluded for the measure under the hospice reason. What happens if we exceed the 10% skip threshold?	If the 10% skip threshold is exceeded, CMS will potentially review and audit it.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
65	2/6/2014	If a diagnosis is inactive or in past medical history, (not current in 2013), do we answer "not confirmed"?	CAD – documented diagnosis of CAD (active or history of) at any time in the patient's history up through the last day of the measurement period. DM – documented history of DM during the measurement period or year prior to the measurement period HF – documented diagnosis of HF (active or history of) at any time in the patient's history up through the last day of the measurement period. HTN – documented history of HTN at any time in the patient's history up through the last day of the measurement period. IVD – documented history of IVD or was discharged alive for AMI, CABG, or PCI at any time in the patient's history up through the last day of the measurement period.	X	X	X
66	2/6/2014	What is the difference between choosing "not qualified", "medical", "patient", "system reason" or choosing "No - Other CMS Approved Reason"?	You can't select "No - Other CMS Approved Reason" unless you submit a request to the QualityNet Help Desk and CMS approves your request. If you are not approved for a CMS approved reason, other reasons that you have listed may be appropriate. Each measure's Data Guidance contained within the Supporting Documents provides the listing of possible options for each measure and their corresponding definitions.	X	X	X
67	2/6/2014	If a patient is noted as palliative, DNR/DNI in a note, but there is no mention of hospice/comfort care only, should the patient be excluded from the sample or would we need additional documentation to exclude from the sample?	If there is documentation in the medical record that the patient is receiving palliative care, you can select "Not Qualified for Sample" "In Hospice: Patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)."	X	X	X
68	2/6/2014	If a patient is using snuff but not smoking, can you document "yes" for non-tobacco use?	Snuff is considered "smokeless tobacco". For DM-17 you would answer "No: patient was screened and identified as a tobacco user". For PREV-11 you would answer, "Yes, patient was screened for tobacco use and identified as a tobacco user."	X	X	X
69	2/6/2014	If an LDL or HbA1C is pre-populated and we cannot confirm the diagnosis, do we leave the date in after answering "cannot confirm diagnosis?"	If you are unable to confirm any diagnosis for the disease modules, you would stop abstraction for that specific patient and therefore would not answer the remaining questions. In this case, it would be specific to LDL or HbA1c in the applicable modules for the patient you were unable to confirm the diagnosis.	X	X	X

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70	2/6/2014	If triglycerides are greater than 400 mg/dl and the LDL cannot be measured although the lipid panel was completed, how should I proceed with that measure? What should be entered for an LDL value when it states "Unable to calculate due to non-linear result"?	CAD-2: If laboratory results reveal that they were unable to calculate the LDL-C value due to high triglycerides or other clinical reasons, select "No" DM-14: If the laboratory was unable to calculate the LDL-C value due to high triglycerides or other clinical reasons, record 0 (zero) IVD-1: If the LDL-C could not be calculated due to high triglycerides or other clinical reasons, answer "Yes" to complete lipid profile and record 0 (zero). For the non-linear result, please consult with the laboratory.	X	X	X
71	2/6/2014	Is Coumadin an acceptable medical reason for not being on Aspirin for the DM measure, but not a medical reason for the IVD measure?	Yes, Coumadin (warfarin) is an accepted contraindication for DM-16. There is not a medical exclusion available for IVD-2.	X	X	X
72	2/6/2014	Should we be reporting on patients that live full time in a nursing home or long-term care facility?	Yes, you will report on these patients.	X	X	X
73	2/6/2014	We have a prefilled date for a lab test that was completed outside our TIN. If we can't find that value, but have a value from earlier in the measurement period, can we record that date and value?	**See the 2013 GPRO Web Interface Pre-filled Elements dated 2/11/2014 distributed to ACOs and PQRS GPROs the week of 2/17/2014 for additional information on pre-filled elements.** If a value for the pre-filled date or more recent test cannot be found in the patient record, the pre-filled date may be replaced with the most recent date of the test found in the medical record within the measurement period. If the GPRO cannot find any test within this allotted period, leave the "Yes" and use a "0" (zero) for the value within the Web Interface.	X	X	X
74	2/6/2014	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 has to say "Hypertension"?	Yes, HBP is an accepted abbreviation for hypertension.	X	X	X
75	2/6/2014	Can you clarify the definition of a passive smoker or passive smoke exposure?	Passive smoke exposure would be those who don't smoke but are in the presence of those that do.	X	X	X

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76	2/20/2014	If we cannot confirm the pre-populated laboratory value and don't have any laboratory values on the chart for the measurement period, will that affect our performance?	Pre-populated elements would only be the "Yes" answer that indicates a test was performed and the date of the test. Laboratory values are not pre-populated. Any time the medical record does not support the laboratory value falls within the measure's parameters, that patient will not be included in the numerator of the measure. **See the 2013 GPRO Web Interface Pre-filled Elements dated 2/11/2014 distributed to ACOs and PQRS GPROs the week of 2/17/2014 for additional information on pre-filled elements.**	X	X	X
77	2/20/2014	If I have a patient that was referred to hospice on 12/30/13, can I abstract that as that patient being a hospice patient in 2013?	You would indicate that they entered hospice during the measurement period and record the date they entered hospice. Also, if patient dies during 2013, you would indicate they not qualified for sample and report date of death if available. Please note, if a patient dies after the end of the measurement period you would be expected to report on the patient.	X	X	X
78	2/20/2014	If a laboratory measure is pre-populated with a laboratory value that we do not see in the medical record, are we allowed to remove the date and enter one we found? Does this count against us in a negative manner?	Yes. From the 2013 GPRO Web Interface Pre-filled Elements document: If a value for the pre-filled date or more recent test cannot be found in the patient record, the pre-filled date may be replaced with the most recent date of the test found in the medical record within the measurement period. This action does not count against your quality performance on the measure in question unless the value falls outside the parameters of the measure. If the GPRO cannot find any test within this allotted period, leave the "Yes" and use a zero for the value within the Web Interface. This action will count against your quality performance on the measure.	X	X	X
79	2/20/2014	Can you verify the approved combinations of antithrombotics for IVD and DM?	Please utilize the 2013 Supporting Documents Drug Code tab for a comprehensive list of medications for each measure. Additionally, the Inclusions/Synonyms and Exclusions columns provide further details or examples of medications for each measure.	X	X	X

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80	2/27/2014	If we are only submitting data on one CARE measure, do we have to complete all the fields for the other CARE measure assigned to that patient?	No, you don't need to submit data for patients who are not ranked in the other CARE measure. Note that each CARE measure and each PREV measures has a confirmation for the patient. You would enter data for the patients that you confirm as eligible for the measure. When you save the data, you will receive a pop-up message that there missing data for the measure but it is okay.	X	X	X
81	2/27/2014	We have a patient-reported survey that was filled out in the provider's office indicating they are a tobacco smoker. Can we accept if not signed off by the doctor?	Yes, this is acceptable as long as it is part of the medical record and the patient-reported survey is completed within the time frame specified in the tobacco measures.	X	X	X
82	2/27/2014	If a patient does not fit the age criteria for a specific measure, but the medical record is found, does this qualify as a "No - Other CMS Approved Reason"?	If you are finding that the age in the Web Interface is incorrect, then you can change it by going to the patient's demographics tab. The patient's age during the measurement period should be considered. If the patient is out of the age range for a specific measure, you would need to contact the QualityNet help desk and include the patient rank and module in order for CMS to review your case and provide for an "Other CMS Approved Reason".	X	X	X
83	2/27/2014	Is CAD an acceptable diagnosis for the DM IVD measure and the IVD module?	For both DM IVD and the IVD module, cardiovascular disease unspecified is acceptable per the Evaluations Codes tab of the Data Guidance. A diagnosis of CAD is acceptable.	X	X	X
84	2/27/2014	If a patient is seen in the office and all modules related to that patients known diagnosis are documented (i.e. BMI, most recent A1C), do those have to be updated if the patient is seen in the office later in the year for an non-scheduled visit?	You should use the most recent laboratory test if you have access to that date and value.	X	X	X

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85	2/27/2014	We understand claims data can be used to support the pneumococcal, influenza and colorectal measures. What type of supporting documentation will be requested during the quality validation period?	For these measures (PREV-6, PREV-7 and PREV-8 only), if the Web Interface is prefilled with a "Yes" from claims data, the ACO or PQRS GPRO is not responsible for having additional information. You would not be asked to provide the supporting documentation for audit purposes because this information could come from outside your ACO/GPRO. However, if you are either taking a blank element (not pre-filled) and are selecting Yes, then you will need to be able to provide documentation in the case that you are audited.	X	X	X
		% of PCPs Who Successfully Qualify for EHR Program Incentive Payment				
86	FAQ	Are we going to get the list of NPIs that you count towards the EHR incentive payment measure, given there were perceived discrepancies in the calculated percentage?	We are looking into providing that information in future years.	NA	X	X
87	FAQ	For ACO-11 measure regarding EHR use, how can we obtain a list of the physicians who were included in the numerator determination? Also, if there is a discrepancy that a physician should be included, how can we update the list and/or corrected?	This list is not available for this year. Based on feedback, we will consider it for next year. For ACOs that have questions outside of their GPRO measures, please contact the QualityNet Help Desk.	X	X	X
88	FAQ	We have a number of independent providers. How does our group know if the Meaningful Use measure is satisfied by them in the required timeframe?	This is related to the ACO measure based on administrative claims that is the percentage of primary care providers that are incentive eligible under the EHR incentive program. The measure requires that screening be completed in the office of the provider filing the code. For the 2013 reporting year, the measure is run by April 2014. We suggest that you provide education and outreach to providers letting them know that they should attest as close to the end of the measurement period (December 31, 2013) as possible.	NA	X	X
		CAD-2: Lipid Control				
89	FAQ	For CAD-2 if the patient has been prescribed a statin but does not have a plan of care, does that still satisfy the measure?	According to the measure owner (AMA-PCPI) it would satisfy the measure. The definition of a documented plan of care, noted in the Narrative Specification for CAD-2, states a plan of care includes at a minimum the prescription of a statin. In other words, a statin is the minimum requirement for a plan of care.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
90	FAQ	For CAD-2, the supporting documents do not state the LDL-C test had to come from 2013, does this mean if the LDL-C test was performed in 2012 and was less than 100, we answer "Yes"?	No, the LDL-C test must be performed during the measurement year (12-mo period per specification) for the GPRO Web Interface reporting year. This is outlined in the Narrative Specifications and the Data Guidance. Within the instructions, we realize that "during the measurement period" is not stated directly after the < 100, but it is when it is referring to > 100 and we will review this language for 2014 reporting period to clarify.	X	X	X
91	FAQ	We have RxNorm codes for statins not in the list provided in the measure specifications for CAD. Must we limit our results to only the statin RxNorm codes in the specs?	Please see the Data Guidance for CAD-2. Within the Inclusions/Synonyms column you will see the following: "See CAD Drug Code tab for a list of lipid-lowering medications (list may not be all inclusive)" In other words, you may use RxNorm codes representing statins included on your list that are not on the list included in the downloadable resource. In addition, please read the note included in this section regarding prescribed statins.	X	X	X
92	FAQ	Can an LDL done in an acute care hospital count?	Yes it can. Any documentation the provider has at the point of care may be used for CAD-2.	X	X	X
93	1/28/2014	CAD: The national LDL level treatment guidelines were changed in 2013. Can we use the new national guidelines? If yes, do we need to reference the updated national guidelines for supporting documentation?	For the purposes of reporting 2013 GPRO Web Interface measures, please follow the 2013 Narrative Specifications and the 2013 GPRO Supporting Documents.	X	X	X
94	1/28/2014	In CAD-2, the Data Guidance has LOINC codes; but our EHR only has CPT codes. Could you direct us how we could map these to obtain accurate data?	CMS does not have a program or website that they endorse for mapping LOINC codes to CPT codes. You should utilize the information in the record rather than the coding.	X	X	X
95	2/6/2014	CAD: If a LDL is not calculated or recorded due to high triglycerides but the patient is on a statin, do we select "No"?	Select "No" if the laboratory was unable to calculate the LDL-C value due to high triglycerides.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
96	2/6/2014	CAD-2: Can Welchol and Colestipol (lipid lowering drugs) be used? They are not listed as statins, but in previous years were allowed.	Requires a prescription of a statin and Welchol is not a statin.	X	X	X
97	2/20/2014	For CAD-2, would allergy to statins documented anytime in the patient's history be acceptable to answer "No - Medical Reasons"?	If the allergy to the statin is documented in the current medical record, it would be acceptable to use as a medical exclusion.	X	X	X
98	2/20/2014	For CAD-2, if a physician has documented lipid control values within a note with a comment that the testing was done in 2013, will that documentation satisfy the measure or is the actual laboratory result with a specific date required?	A date and laboratory value are required.	X	X	X
99	2/20/2014	For CAD-2, does the LDL-C result have to be performed during the reporting period? If a cancer patient undergoing cancer treatment has an LDL-C > 100 and is not on statin therapy, would this be considered a medical reason?	Yes the LDL-C result would need to be within the measurement period. Cancer treatment may be a valid medical reason if the medical record documentation notes the patient is not receiving statin therapy due to their cancer diagnosis and treatment plan.	X	X	X
100	2/20/2014	For CAD-2, if a patient with impaired renal function is not on statin therapy, would this be considered a medical reason?	Impaired renal function may be a valid medical reason if the medical record documentation notes the patient is not receiving statin therapy due to their impaired renal function.	X	X	X
101	2/27/2014	For CAD LDL management, if we don't have the actual result but we do have a prefilled date from another module) and the patient is on a statin and lifestyle modifications, can we answer "Yes" to LDL management?	For CAD-2, if you do not have the LDL test performed, you would have to select "No". You would also select "No" if the lab couldn't calculate the LDL value. If you think that the patient doesn't meet the intent of the measure, you can contact the QualityNet help desk for an Other CMS Approved Reason.	X	X	X
102	2/27/2014	For the CAD module, if the patient was on a statin, would we answer "Yes" even if LDL was unable to be calculated?	No, for the purposes of reporting CAD-2, if the patient did not have an LDL calculated during the measurement period (Jan 1, 2013 – Dec 31, 2013) you would select "No"	X	X	X

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CAD-7: ACE/ARB Therapy						
103	FAQ	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 specifications. Are we limited to just the RxNorm codes in the specifications?	No, you are not limited to the medications listed in the specifications. For this measure, the data guidance says that the medication list may not be all inclusive.	X	X	X
104	1/28/2014	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 - Medical Reasons" or "Yes"?	If the medication was started anytime during the measurement period than you would answer yes.	X	X	X
105	1/29/2014	For CAD-7, how should we respond if we cannot find LVEF results are on our chart (i.e. if our provider accepted a nursing home resident mid-year?	If there is no information in the medical record regarding LVEF, you would have to answer "No".	X	X	X
106	1/29/2014	For CAD-7, what are other medical reasons that would count for not prescribing ACE inhibitor or ARB therapy aside from allergy, intolerance?	Please refer to the exclusions in the CAD data guidance: Other medical reasons include any medical reasons documented by the provider of care for not prescribing ACE/ARB therapy (CAD-7).	X	X	X
107	2/6/2014	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. If the medical record has documentation of CKD as a medical reason for not prescribing ACE/ARB, it would be acceptable to exclude the patient for a medical reason. You should then select "No-Medical Reasons".	X	X	X
108	2/20/2014	For CAD-7, can the acceptable diagnoses for "No-Medical Reasons" be documented anytime in the patient's history? Would this meet criteria to answer "No-Medical Reasons"?	The medical reason used to exclude a patient from CAD-7 needs to be documented in the current medical record.	X	X	X

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109	2/20/2014	For CAD, if you cannot confirm LVSD because there are no cardiac reports available, what should we select?	You would answer "No".	X	X	X
110	2/20/2014	For CAD-7, when a patient is not on an ACE/ARB due to a valid medical exclusion, should this patient be excluded from the denominator for this component of the CAD module, or included in the numerator for this component of the CAD module?	That patient would be excluded from the denominator of the component measure.	X	X	X
111	2/20/2014	For CAD-7, if a cancer patient is undergoing cancer treatment and not on ACE/ARB therapy, would this be considered a medical reason?	If the documentation in the medical record states ACE/ARB therapy was not prescribed due to cancer treatment this would be considered an acceptable medical reason to exclude the patient from CAD-7.	X	X	X
112	2/27/2014	For CAD-7, does Amlodipine alone (not mixed with another drug) count as an ACE/ARB (calcium channel blocker)?	No, Amlodipine alone does not count as an ACE/ARB. Please review the CAD Drug Codes tab of the 2013 GPRO Web Interface CAD Supporting Document for Amlodipine combinations acceptable for CAD-7	X	X	X
113	2/27/2014	To confirm whether a CAD patient also has DM, what is the timeframe of the DM diagnosis? Does the DM diagnosis need to present in 2012 or 2013 or anytime in the history?	The patient should have a documented history of diabetes in the measurement period or the year prior to measurement period.	X	X	X
		CARE-1: Medication Reconciliation				
114	FAQ	For medication reconciliation, what exactly needs to be stated in the note for a post acute care visit?	Guidance is provided in the Narrative Specification, Supporting Documents and CARE-1 performance calculation flow. There is not an exact note required, however the medical record must indicate the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications. Also, if someone besides the PCP (physician PA, NP) or a clinical pharmacist performs the medication reconciliation there must be documentation that the PCP or clinical pharmacist is aware of the review.	X	X	X

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115	FAQ	For CARE-1, we have implemented a process by pharmacists to ensure that a patient's medication list is reconciled on the day of discharge. Is this acceptable?	In addition to having the reconciliation at discharge, you would also need to follow-up with a discharge or office visit reconciliation within 30 days of the inpatient facility discharge. When CMS looks for patients who are eligible for this measure we look in the claims data for the office visit to have occurred at least one day after and within 30 days of the discharge.	X	X	X
116	FAQ	Regarding CARE-1, how are we to handle instances when a patient is re-admitted before their required 30-day follow-up? How is the provider able to reconcile medications from the first hospitalization when those medications would likely be changed within 30 days?	The 30-day follow-up office visit is part of the sampling process for 2013 CARE-1. Therefore, if a patient has two discharges, medication reconciliation will be based on the follow-up visit in an office within 30 days of the inpatient facility discharge. If two inpatient facility discharge dates are pre-filled in your Web Interface and the office visit is within 30 days of both discharge dates you may use this follow up visit to determine medication reconciliation for both discharges.	X	X	X
117	FAQ	If a patient is in the hospital for rehabilitation, is that considered an inpatient status?	Yes, as noted in the Data Guidance tab of the CARE Supporting Documents rehabilitation, psychiatric, skilled nursing or acute care stay is used to define an inpatient facility discharge for the purposes of this measure.	X	X	X
118	FAQ	Regarding CARE-1, we understand that this needs to be linked to a specific discharge date; is the implied date or timeframe acceptable for reporting?	When confirming the discharge date for 2013 reporting of CARE-1, the date used for verification can be plus or minus two days on either side of the pre-filled discharge date. The office visit where medication reconciliation was accomplished must be within 30 days of the discharge date.	X	X	X
119	FAQ	For medication reconciliation, in order to be counted in the denominator do the following three criteria need to be met: 65 or older AND Discharged from an inpatient facility AND seen within 30 days? Or is this also measuring the compliance of following up within 30 days?	It is important to remember that the three criteria mentioned were used by the CMS contractor preparing the data files for inclusion in the Web Interface. Your task is to confirm there is documentation to support the claims on which the data files were based. On the Web Interface, you will have a table with your discharge dates and the confirmation that the patient was discharged on that date. (+/- 2 days). If you confirmed the discharge date, then you must confirm they had an office visit within 30 days. If they had an office visit within 30 days, then you need to answer the medication reconciliation question. **They are not included in the denominator if you cannot confirm the discharge date and that an office visit occurred.** We are not aware that the intent of the measure steward is to measure the compliance of following up within 30 days post hospitalization.	X	X	X

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120	FAQ	For CARE-1,,can you please define clinician. Physician, PA, NP?	There is a note within the data guidance that says the intent of this measure is to ensure that the PCP (Physician, Physician Assistant, Nurse Practitioner) or a clinical pharmacist (pharmacist who has the authority to prescribe medications) reviewed the discharge medications from the inpatient facility. If others, such as a nurse, perform the medication reconciliation there must be documentation that the primary care physician or clinical pharmacist is aware of the review.	X	X	X
121	FAQ	For CARE-1, do we meet the measure if the EP went over discharge meds with the patient and recommends discontinuing (name of drug) or continuing all meds as documented on med list? Or, do we have to have the actual d/c sheet with meds listed in chart?	Numerator compliance for CARE-1 is met if the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications.	X	X	X
122	FAQ	For CARE-1, does it include all discharges in 2013 or only until a certain date in 2013?	The claims data used for sampling is provided to CMS' contractor at the end of October. Any claims noting discharges processed by that date are included that also have office visits within 30 days of the inpatient facility discharge. **All discharges the ACO is responsible for reporting on are included in the Web Interface.**	X	X	X
123	FAQ	For CARE-1, when looking for a hospital discharge should we only be looking at inpatient admissions, or would observation admissions also be included?	CARE-1 discharges are identified by inpatient discharge day management codes found in Physician claims. Observation admissions should not use these discharge codes and therefore should not be included in this measure.	X	X	X
124	FAQ	For CARE-1, how do we handle patients who are discharged from an acute care hospital to a skilled nursing facility? Is the skilled nursing facility physician visit the office visit?	No, if the patient is also discharged from the skilled nursing facility and has a single office visit within 30 days of the discharge from the inpatient facility, the office visit medication reconciliation will count as the office visit for both the inpatient and skilled nursing facility discharges. If there is no office visit found in claims within 30 days after an inpatient discharge (inpatient facility and skilled stays) there will not be a pairing (inpatient discharge and office visit dates) to populate in the Web Interface.	X	X	X

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125	FAQ	For CARE-1, does the reconciliation process from the provider need to include medications such as eye drops (Over-the-counter as well as prescription) or milk of magnesia, etc.?	Yes, all medications whether prescription or over-the-counter should be reconciled.	X	X	X
126	FAQ	CARE-1: Medication Reconciliation, if the hospital discharge follow-up visit provider note documents the end of visit medications and the provider has signed the note, would this count as discharge medication reconciliation, or does the note specifically need to state discharge reconciliation?	Yes, this would count as medication reconciliation as long as the following information is included per the data guidance : "Medical record must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications".	X	X	X
127	FAQ	If the medical note states the medications were reconciled at a post discharge office visit but it does not specify if the medications were changed, kept, or discontinued, does this count as medication reconciliation?	The CARE-1 data guidance states that the "Medical record must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications."	X	X	X
128	FAQ	For the collection of the CARE data - where must the assessment need to happen? PCP office, hospital, nursing home, over the phone, etc.?	Assuming this question is regarding CARE-1 and where the medical record information is coming from, the medical record must indicate that the clinician is aware of the inpatient facility discharge medications and they will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications. All locations mentioned are appropriate as long as the medication reconciliation was reviewed by a PCP (physician, PA, or NP) or clinical pharmacist.	X	X	X
129	FAQ	If we do not have access to our patient's discharge information (e.g., no information at all or only the date of admission), how do we validate the discharge date that is prefilled in the GPRO Web Interface?	It is the ACO's or GPRO's responsibility to obtain this information to the best of its ability to account for the patient's care. If the documentation in the patient's medical record, registry, or other information (e.g., a list received from the hospital) does not reflect an inpatient hospital discharge on this date, **or within 2 days prior or after this date**, then you would need to answer "No". This will disable the medication reconciliation question. If the medical record documentation reflects a different discharge date, again answer "No".	X	X	X

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130	FAQ	If a patient is discharged once and has three office visits within 30 days, will the patient appear in the denominator three times?	No. The patient would appear in the denominator once (for one discharge). In order to meet the numerator criteria, medication reconciliation would need to have been performed at one or more of the office visits.	X	X	X
131	FAQ	If a patient is discharged from a hospital to a skilled nursing facility (med rec performed) and then to a long term care facility (med rec performed), what should we report?	Patients who were sampled into this measure had evidence of a primary care visit within 30 days of their inpatient facility discharge. In these cases, a primary care encounter in the SNF or LTC setting can be considered an outpatient encounter.	X	X	X
132	FAQ	When the discharge dates pre-populated are a discharge from hospital to SNF and then back to hospital, is it correct to mark "No" for these discharges until the patient actually leaves the inpatient setting?	For each discharge that is pre-populated in the GPRO Web Interface, the abstractor is required to confirm whether or not a discharge occurred on that date and if so, whether or not a visit occurred within 30 days. In the situation you describe, where you are able to confirm both discharges occurred, you would mark "Yes" under "Discharge" and then move on to confirm whether or not an office/clinic visit occurred within 30 days.	X	X	X
133	FAQ	Are patients only counted as numerator compliant for medication reconciliation if, after each discharge, their medications were reconciled?	Each of the patient's discharges is counted as a single observation. For each patient/discharge combination in the GPRO Web Interface, you will need to confirm the discharge, confirm an office visit within 30 days, and confirm that medication reconciliation was done. For example, if a patient has two discharges (each with an office visit within 30 days), but medication reconciliation was only done at one office visit after the first discharge, then the patient will contribute two observations to the denominator, but only one to the numerator.	X	X	X
134	FAQ	Can medication reconciliation be performed over the phone?	As long as all of the criteria are met, the reconciliation does not need to be a traditional encounter. For example, telephone encounters are acceptable.	X	X	X
135	1/27/2014	CARE-1: If a patient has an office visit status post discharge and the progress note states the medication list was reviewed, even if it doesn't specifically state medication reconciled after discharge, does this comply with the measure?	As long as the provider is aware of the discharge medication and will either keep or change the discharge medication, this would be acceptable.	X	X	X

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136	1/27/2014	CARE-1: If the hospital discharge date is pre-populated in the Web Interface, and we cannot find evidence of that discharge in our EHR, should we select "No" for patient discharge from an inpatient facility on this date?	You would select No if you cannot find a discharge at all. If you find a discharge within one or two days of the pre populated discharge date prefilled, then you can select Yes.	X	X	X
137	1/27/2014	If the patient has 3 discharge dates and we were only able to document the med reconciliation for the last 2 discharge dates, do we get credited for this measure?	If there are three discharge dates but only 2 medication reconciliations you would pass performance on 2 of the 3 discharges. The only exception is if one of the medication reconciliations meets the time requirement for more than one discharge and the medication reconciliation performed covers both discharges. Documentation in the medical record should substantiate the quality action you report.	X	X	X
138	1/27/2014	Which measures are required to be done in the office only, as opposed to being able to find the data elsewhere? I was only able to see that CARE-1 & Depression screening has to be done in the office is that correct?	CARE-1 can be done in other settings - as long as documentation of the medication reconciliation ends up in office visit medical record. This measure requires the screening to be completed in the office of the provider filing the code.	X	X	X
139	1/27/2014	For CARE-1, EHR states "Meds reviewed and reconciled with pt" and is signed by the doc. Does this meet med rec = Y? What about same, but in cases where the progress note also indicates meds to change?	Follow the guidance that's given in the Data Guidance tab. It's very specific to what is required to be considered a medication reconciliation which includes whether or not changing, keeping, adding, or changing dosage. Please follow the data guidance for further information.	X	X	X
140	1/27/2014	Our EMR is shared IP and OP. If the patient has an office visit post IP DC, the med list is the hospital DC med list. The provider will reconcile these meds using the EMR. Can we count this as medication reconciliation?	Yes, you can count it as medication reconciliation as long as the medical record includes the information that's included in the inclusions and synonyms tab of the data guidance.	X	X	X
141	1/28/2014	A number of our patients have more than one discharge date listed. Do we need to confirm all of the dates or how is this to be handled?	The ACO or PQRS GPRO need to confirm the discharge(s) that are prefilled in the Web Interface.	X	X	X

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142	1/28/2014	Can we get a data extract of every medication reconciliation date after discharge for every patient in our CARE-1 measure?	You are able to download the CARE-1 patients and the discharge dates in the Patient Discharge XML file.	X	X	X
143	1/28/2014	CARE-1: If the patient was hospitalized for a short time to observe for bleeding and no medication changes were made at all and therefore not addressed on the next visit, do we have to answer no to reconciliation when there was nothing to reconcile?	As long as you have documentation that the medications have been reviewed and it has the elements of that review (i.e. medications do not need to be changed), then that should be pass for medication reconciliation. However, if it was billed as an observation stay, it would not have been included in your sample.	X	X	X
144	1/28/2014	CARE-1: Our EHR application is programmed to compare the patient discharge list with the current medication list. When the provider completes the reconciliation task as programmed, the note documented in the EHR application indicates 'Medication Reconciliation Complete', but the words 'against the inpatient facility discharge medication list' or similar does not appear in the application. Must these words be included or dictated, or does the functionality in the EHR application that facilitates the comparison to the discharge medication list meet the measure when the provider has completed their task?	In terms of being audited, we are looking for who has taken responsibility for the medication reconciliation. We need to see if it was performed by one of the approved types of persons and if the person doing it has access to the discharge medication list and the list of medications the patient was on in the outpatient setting.. If this was handled with a checkbox, as long as the GPRO/ACO is able to provide their written process that occurred, that should be appropriate.	X	X	X

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145	1/28/2014	CARE-1: We have found office visits w/in 30 days of discharge. However the provider is simply checking a paper template stating that meds were reviewed, but not documenting that the meds were changed or remained the same, does this meet the measure?	If the GPRO was audited it would be required that the documentation include "The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications."	X	X	X
146	1/28/2014	In the discharge XML file, a single patient can have multiple discharge dates that are less than 30 days apart. Do we need to upload a medication reconciliation date for all 3 dates? Or if one discharge has a medication reconciliation within 30 days, are we compliant?	For sampling purposes, if an office visit occurs 30 days after multiple discharges, all the discharges will be included in the Web Interface. Use one encounter date to reconcile medications for each of them but be sure to reconcile each discharge date. When this measure is calculated, it's based on how many discharges occurred for the number of patients you have and are added together for your denominator.	X	X	X
147	1/29/2014	Do all the discharged medications need to be listed on the office visit notes?	All of the medications should be listed.	X	X	X
148	1/29/2014	For CARE-1, if a doctor makes changes to some medications on the medication list but does not comment on the remaining medications except to say "medications reconciled with patient", does this scenario qualify for meeting medication reconciliation?	Yes, it would count as medication reconciliation because it is evident that the physician is looking at whether the patient's medications are still needed or need to be discontinued.	X	X	X
149	1/29/2014	For CARE-1, the physician has access to hospital record from the office but is not permitted to print due to HIPAA restrictions. If he states he has reviewed the record online and reconciled medications in relation to, can we consider the measure completed?	Yes, as long as the documentation indicates that medication reconciliation was performed. All components of reconciliation must be completed as per the CARE-1 data guidance. (i.e. The medical record must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of inpatient facility discharge medications.)	X	X	X

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150	1/29/2014	For CARE-1, there are multiple discharge dates pre-filled by CMS. What if the follow-up/medication reconciliation happened in another office outside of our practices? How do we document this?	Your group sampling group has been deemed the patient's "home". It would be your responsibility for you to attempt to find this information or if not possible, then your only other recourse would be to answer "No".	X	X	X
151	1/29/2014	If a patient's primary care provider makes a home visit to reconcile medications rather than seeing the patient in office will that still satisfy the measure. Is the patient required to be seen face-to-face in the office if a home-visit is made?	The CARE-1 measure requires an office visit within 30 days of the discharge. Note that patients are only sampled if they have an inpatient discharge with an office or clinic visit within 30 days of the discharge. However, medication reconciliation can be performed in any type of setting as long as it is documented in the office record.	X	X	X
152	1/30/2014	For CARE-1, are we to use the first office visit after discharge to answer the medication reconciliation question or can we use any office visit within the 30 days?	You can use any office visit within 30 days of the discharge data during which medication reconciliation was accomplished.	X	X	X
153	1/30/2014	We have a federally funded program called Independence at Home, which allows us to conduct home visits in general. Documentation is in the EMR. For CARE-1, will a home visit count as an office visit?	Documentation needs to be available that the appropriate provider completed the medication reconciliation including all applicable components within the 30 day time period post discharge.	X	X	X
154	1/31/2014	CARE-1: If the patient has 2 discharge dates 1/25 and 1/26/13 prefilled and there is only one discharge noted on the patient's record what should we do?	In that case, you would only confirm the discharge in which you have recorded in the patient's medical record.	X	X	X

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155	1/31/2014	For CARE-1: If an office visit is found within 30 days of discharge however the visit does not mention discharge or Hospitalization but does say Medication Reconciliation clearly. Is that visit acceptable?	No, you need to treat each element separately. You first need to verify the discharge date. If you cannot verify that the patient was discharged from an inpatient facility (plus or minus 2 days) you would stop abstraction. If you can verify this information then you go on to your office visit. Both of these are verified before you get to the reconciliation instruction noted below: From the Supporting Documents Data Guidance: Instruction: Determine if discharge medications were reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge	X	X	X
156	1/31/2014	For CARE-1, what do we do when the discharge date in the Web Interface does not match the discharge dates in our records. For example, the Web Interface shows a discharge date of 10/10/13 but our records only has date 7/13/13.	In this instance, if the discharge is pre-filled to yes, then you would change the yes to no. However, if this is the patient's first visit and there were no visits between October 2012 and March 2013, then this wouldn't be acceptable.	X	X	X
157	2/6/2014	CARE-1: Is medication reconciliation required when the discharging physician who wrote the discharge prescriptions is the primary care provider?	Yes, medication reconciliation would still be required in this scenario.	X	X	X
158	2/6/2014	CARE-1: The electronic medical record states during a visit following a hospital discharge, a list of all the medications and then stated that the medication list was reviewed and reconciled with patient. The following procedure code is also documented in the record: 1111F DISCHARGE MED/CURRENT MED MERGE. Does this meet the measure?	Yes, this would meet the measure.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
159	2/6/2014	CARE-1: We have a prefilled discharge date of 1/10/13; however, no discharge summary was found. The office visit note from 1/16/13 indicates "The patient has done quite well since she was released home from Providence Saint Joseph Med Center". Can we accept this as discharge confirmed?	No. The office visit note does not provide confirmation of the 1/10/13 discharge. If the note had referenced a date or Tuesday of the prior week, this documentation would have been considered confirmation.	X	X	X
160	2/20/2014	Are we held responsible for medication reconciliation 30 days after discharge when the individual did not become our patient until months after the discharge? They had a doctor outside of our organization within 30 days of the discharge.	Yes, please note the Assignment and Sampling section of this document for further information.	X	X	X
161	2/20/2014	Can we use a discharge note written by one of our physicians at an extended care facility discharge as evidence of medication reconciliation (if it covers all of the required elements)?	The discharge note may be used if it was documented in the office visit within 30 days of the inpatient facility discharge.	X	X	X
162	2/20/2014	For CARE-1, if 4 dates are listed and we can only confirm 3 dates, will this count as a completed measure or would this be considered a skip?	This is a measure that we need to think of at the discharge level rather than at the patient level. For the three discharge dates you can confirm you would answer the remaining data elements. You would not skip this patient and therefore, would not need to replace the patient with another one.	X	X	X
163	2/20/2014	For CARE-1, our sample includes what we believe to be discharges from our Senior Diagnostic Center which has restricted access to records. We have not confirmed discharges for these. Is that correct (IP/Psych)?	If you cannot confirm the discharge date of a patient (plus or minus 2 days) you will answer "No" and will not need to continue to answer any additional elements for that discharge/visit pairing.	X	X	X

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164	2/27/2014	For CARE-1, the date of discharge listed is after the physician left the practice. The medical record up to the time that the physician was with our ACO/GRPO, but after that we do not have the information. How do I answer the questions in CARE-1?	If you have a medical record, then you are responsible to answer these in the best way that you can. When possible, you should collaborate with the physician so that the medical record is complete. If the information is not available, then you will have to select "No" for the patient.	X	X	X
		CARE-2: Screening for Future Fall Risk				
165	FAQ	For CARE-2, is documentation of "No Walking or Balance Issue" or "has walking or balance issues" in measurement year sufficient for screening for future fall risk or just answering "Have you had a fall in the past 12 months"?	In the Data Guidance for CARE-2 a fall is defined as screening for future fall risk can include documentation of no falls within the last year **OR** documentation of one fall without injury in the past year **OR** documentation of two or more falls in the past year **OR** any fall with injury in the past year.	X	X	X
166	FAQ	For CARE-2, please advise who may perform the fall screening (who is considered qualified).	The 2013 Narrative Specifications indicate a clinician with appropriate skills and experience may perform the screening. This would include physicians and other healthcare professionals such as a physical therapist.	X	X	X
167	FAQ	For CARE-2, can we count screenings for future fall risk regardless of the setting where they were performed, outpatient or inpatient?	Yes, that is correct. The 2013 GPRO Web Interface Falls assessment screening in CARE-2 must be completed at least once within 12 months, but does not have to be completed in the office. Some examples of where the falls assessment can be completed are over the phone, during a hospitalization, at a home health visit or a PT visit. Documentation needs to be reflected in the office record however.	X	X	X
168	FAQ	For CARE-2, if we cannot find any 2013 encounters for a ranked patient, can we assume no fall screening was performed?	In order for a patient to be attributed to your GPRO or ACO, the patient must have had 2 primary care visits with your GPRO or ACO during 2013. Use all available information to determine if the medical record can be found and if fall screening occurred.	X	X	X
169	FAQ	If the physician has documented for the patient questions on the patient's environment (rugs, etc.) does that satisfy the measure, or does history of past falls or injury have to be used?	Documentation of patient environment does not satisfy CARE-2. The following is taken directly from the CARE Data Guidance: Screening for future fall risk may include: Documentation of no falls in the past year or only one fall without injury in the past year or documentation of two or more falls in the past year or any fall with injury in the past year.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
170	FAQ	For screening for Future Fall risk, should we look for a screening during the 12-month measurement period, or 12 months from the last visit?	The screening must be done during the measurement period in order to be included in the numerator.	X	X	X
171	1/27/2014	CARE-2: Is it acceptable for the fall screening to be performed during an acute care visit?	Yes.	X	X	X
172	1/29/2014	Does the CARE-2 fall screen apply to all patients or only patients having had a previous fall?	This screen applies to all patients.	X	X	X
173	1/29/2014	For CARE-2 Screening for future fall risk, what reasons documented by the provider (other than patient not ambulatory) would count as "medical reasons" for not completing fall risk screening?	If you have a question regarding a specific reason you believe could be a medical reason for not completing falls risk, please submit it.	X	X	X
174	1/30/2014	For CARE-2, if the patient is being seen in the office due to an injury and the provider documents "bruising on left buttock, denies fall", is this acceptable fall risk screening?	Yes, this would be acceptable.	X	X	X
175	1/30/2014	For CARE-2, is the "Timed Up and Go" test (used to assess patient mobility) or the Morse Fall Risk acceptable as a fall risk screening?	It would count as a future fall risk screening if it includes documentation of no falls in the past year, only one fall with no injury in the past year, or documentation of 2 or more falls within the past year or any fall with injury in the past year. Please refer to the data guidance for CARE-2.	X	X	X
176	1/31/2014	CARE-2: Does a note that indicates no falls but does not specifically state "in the last year" qualify as a fall screening?	This would only qualify as a CARE-2 falls screening if the note indicating no falls in the last year occurred during the measurement period.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
177	1/31/2014	For CARE-2, does a formal falls screening tool not have to be completed on each patient to meet the measure? Are we only documenting that there are no falls in the past year or only one fall without injury in the past year, or documentation of two or more falls in the past year?	Yes, that is correct. This measure is not dictating how you assess the patient per se. It is looking for a history of falls documented in the medical record.	X	X	X
178	1/31/2014	For CARE-2, does the screening question, "have you fallen in the last 12 months" meet the definition of screening for falls risk?	Yes, it does.	X	X	X
179	1/31/2014	For CARE-2, if the answer to "if you have fallen in the last 12 months" is yes, is there a requirement to ask if they have fallen more than once resulting in an injury?	While there is not a formal requirement, if the provider asks a patient if they have fallen and the patient responds that they have, then the provider would most likely want to follow-up with further questions.	X	X	X
180	1/31/2014	Does a formal fall screening tool NOT have to be completed on each patient to meet the measure? ONLY documenting if no falls in the past year or only one fall without injury in the past year or documentation of two or more falls in the past	That is correct. A formal falls screening tool is not a necessary component of CARE-2.	X	X	X
181	2/6/2014	CARE-2: If a patient is confined to a wheelchair, does it have to be the entire measurement year or only part of it to be excluded?	The measure owner hasn't addressed this situation specifically. If the patient is non-ambulatory at the time of the encounter, then you can exclude them.	X	X	X
182	2/6/2014	CARE-2: If we have a patient with no office visits, how do we answer the confirmation & future fall risk?	Unless you are unable to find the medical record, of if the patient is not qualified for the sample, select, "No."	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
183	2/20/2014	For CARE-2, can an acute-setting falls risk assessment - which includes asking if the patient has had a fall in the last 3 months - count?	The following is taken directly from the CARE Data Guidance and is required for Falls Risk Assessment: Screening for future fall risk may include: Documentation of no falls in the past year or only one fall without injury in the past year or documentation of two or more falls in the past year or any fall with injury in the past year. A key component your example appears to be missing is that the patient or the patient's caregiver should be queried about the patient's fall history for the past year, not just for a 3-month period of time.	X	X	X
184	2/27/2014	For CARE-2: A chart note reads "Patient falls at home when she does not use her assistive device." Does this qualify as a falls screening?	If there is documentation of a falls risk assessment as defined in the 2013 GPRO Web Interface Narrative Specifications and 2013 GPRO Web Interface CARE Supporting Document, specifically located in the Data Guidance tab, this would be appropriate.	X	X	X
COMPOSITES						
185	FAQ	Calculation of the measures when part of a composite: Will we submit the measures separately and CMS will calculate the performance for the composite **OR** Will we provide the Pass/Fail result directly to CMS?	The GPRO/ACO will enter in data that is relevant to individual measures (component measures) that comprise the composite. The Web Interface will calculate the composite rate.	X	X	X
186	FAQ	The Diabetes composite measures specify that patients must have "Two or more face-to face visits for diabetes" to qualify for the denominator. Can CMS provide any guidance on what qualifies as a visit for diabetes?	This is available in the Supporting Documents for the Diabetes Mellitus (DM) module. Several tabs in this excel spreadsheet are referred to by us as the Downloadable resources as they contain codes that may be downloaded and used to assist in creating your XML. In the tab labeled DM Evaluation Codes, there is a set of codes in a section that is highlighted in gray. These are the codes CMS uses to identify the sample for the DM module. This has already been accomplished for you and you are not to further perform this analysis on your sample. It is provided for your information so that you are aware of how the sample was created.	X	X	X
DIABETES MELLITUS MODULE						
187	FAQ	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?	This is a module where CMS does look back to the prior year for a diagnosis in the administrative claims in addition to the measurement year.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
188	FAQ	If a patient does not have diabetes but is in the sample and meets other measures, do we include this patient, or do we add an additional diabetic patient to the numerator?	The first thing you'll need to do is confirm the diagnosis of diabetes mellitus. If you cannot do that, you'll select no to the confirmation element and move on to the next patient.	X	X	X
189	1/27/2014	Can we confirm the Diabetes diagnosis if a patient has documented history of Diabetes in 2011?	Within the data guidance it states that you must confirm the patient has a documented diagnosis of Diabetes in the measurement period or year prior (2013 or 2012).	X	X	X
190	1/27/2014	Is it a requirement that to confirm a DM patient that they have two visits for DM during the measurement year and year prior and one visit for any reason in the measurement year OR is it acceptable to confirm at least one visit with a diagnosis of DM?	When you're confirming, you just need to have documentation that patient has DM anywhere in your medical record anytime within the measurement year or year prior to the measurement year.	X	X	X
191	1/29/2014	For the DM composite module, most of our patients do not have an IVD diagnosis. Will this mean the patient is excluded from the entire DM composite measure?	No, if the patient is excluded from denominator of an individual measure within the composite, you automatically get a pass for that patient for that piece of the composite. Example: There are 5 component measures in the DM composite measure. Since Daily Aspirin-IVD has denominator exclusions, you may have several patients that are omitted from the denominator for the Daily Aspirin –IVD component, but the patient may be meeting performance on all other component measures and could still be included in the numerator of the composite.	X	X	X
192	1/29/2014	The 2013 Supporting Documents for DM says to treat exclusions for polycystic ovaries (PCO) differently than gestational/steroid diabetes. However, the measure flow document treats them the same. Which is it?	Please refer to the data guidance for more detail. All three diagnoses, if present result in an exclusion from the denominator of all diabetes mellitus (DM) measures. However, when you are looking for documentation of steroid induced and gestational diabetes you are restricted to the measurement period or year prior. You can resource the entire patient history to determine if they have polycystic ovary disease. All three diagnoses must be documented no later than the end of the measurement period.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
193	2/6/2014	We have a history and physical for a patient that was diagnosed with DM during an acute care stay out of town for knee surgery; however, the primary care provider has not confirmed this diagnosis in the patient's electronic medical record. How would we confirm this DM diagnosis?	Select "Yes" if the patient has a documented history of DM in the medical records. Documented history of DM must be during the measurement period or year prior to the measurement period.	X	X	X
194	2/20/2014	In the DM module, if a patient was noted to no longer have diabetes due to pancreas transplant as documented in 2011, and a 2013 note indicated the history of diabetes, should the DM diagnosis be confirmed in the abstraction?	This would be a valid example of when to request a CMS approved reason. "Other CMS Approved Reason" within the Web Interface requires actual CMS approval. CMS requires the PQRS GPRO/ACO to submit an incident to the QualityNet Help Desk requesting an approval. You would be notified via Help Desk incident resolution if your request was approved.	X	X	X
195	2/20/2014	If I have a patient with polycystic ovaries and diabetes in the same problem list (in the measurement year) do I say "confirmed" for DM but "excluded for medical reasons"?	You would answer - "Not Confirmed - Medical Reasons: select this option if the patient has polycystic ovaries, gestational diabetes or steroid induced diabetes or steroid induced diabetes".	X	X	X
196	2/20/2014	In the DM Drug Code downloadable resource list, we're seeing a number of patients with "metformin" listed on their medication lists, not as "metformin hcl/pioglitazone, etc." as are listed on the resource list. Should these patients be considered eligible for DM?	Yes, you may use these listed medications to support the confirmation of the diabetes mellitus diagnosis..	X	X	X
197	2/20/2014	If a patient has pre-diabetes or hyperglycemia, can we confirm a diagnosis of diabetes for such patients?	These diagnoses are not synonymous with diabetes mellitus. In instances where you cannot confirm diabetes, please select - "Not Confirmed: Select this option if you are unable to confirm the diagnosis of DM for this patient".	X	X	X
198	2/27/2014	Is pre-diabetes, impaired glucose and hyperglycemia considered diabetes for inclusion?	If a patient is pre-diabetic or hyperglycemic, they are not considered as diagnosed with diabetes.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
199	2/27/2014	Are you using these codes to include patients in the DM measure: 790.29, 790.21, 790.11?	No, these codes are not used. 790.29, 790.21, and 790.11 are not included in the DM Evaluation Codes tab of the DM Supporting Document and are therefore not included for sampling purposes.	X	X	X
DM-2: HbA1c Poor Control (>9) and DM-15: HbA1c Control (<8)						
200	FAQ	Regarding DM-2 (HBA1c Poor Control), which is considered satisfactory reporting: 1) patients with DM HgbA1c <20.9 or 2) patients with DM HgbA1c >9?	This measure is an inverse measure. To pass the measure, the patient would need to have HgbA1c > 9. This means that individual patient is in poor control as indicated by their HbA1c. Please reference the measure flows to better understand all instances where a patient will end up being counted in the numerator of this measure since inverse measures are more complex analytically.	X	X	X
201	FAQ	Regarding DM-2 and DM-15, patients aren't allowed to have a HbA1c value of >8 and <9 to succeed in either measure. They fail performance on both measures. Is that correct?	Yes, that's correct. They would fail performance on both measures remembering that "failing" DM-2 is actually clinically a good thing as the patient is not exceeding the parameter for poor control. The 2013 performance calculation flows will be helpful in clarifying passing and failure in performance for these measures.	X	X	X
202	FAQ	For DM-2 and DM-15, if an A1c is pre-populated from an unknown source, and you cannot find evidence within your system, you don't have to change this to "No". There is a claim for the test-- you just didn't provide it. You would not get credit for the value.	Yes, that's correct except you will have only pre-filled dates and "Yes" options if there was a claim found for a HbA1c during 2013 for your patient. If you have a prefilled date and "Yes" option and you didn't want to change it to "No" you can leave it as "Yes" and fill in a "0" in the result field. However, essentially they are the same answer if you don't perform the test or if there is a 0 for your performance.	X	X	X
203	FAQ	For an A1c or Blood Sugar result, does the entry into the interface need to be a "draw" from a lab or may a Point of Care result be used for reporting?	The requirements for this element do not include a specific location for the drawn sample. The A1c result should be included in the medical record or be available to the practitioner at the point of care.	X	X	X
204	1/27/2014	DM: I notice that some of the A1Cs dates are filled out. What if we don't find that information when we abstract? Do we abstract on top of it? For the patient I'm abstracting, no A1C was performed for the year. How would I record this?	In this case, you would select "0" in the results field.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
205	1/28/2014	DM-2: Regarding HbA1c and LDL values, the data guidance says there must be a note in the record. Does the actual lab report showing the data and value count as the note, or is a specific progress note entry required?	The date and the value are the two components needed. They can either be in a dated note or be present as part of the dated laboratory report.	X	X	X
206	1/28/2014	DM-2: The flowchart document says that if a patient is tested for HbA1c, put the patient in the numerator. But the Data Guidance says NOTE: must state date of test and result to count as compliant. Which is correct?	You do need the date of the test and the level. We don't give all the details in the flow chart documents as we do within the data guidance. For purposes of providing data in the Web Interface, please use the data guidance. Use the flowcharts for the purpose of determining your performance rates.	X	X	X
207	2/6/2014	If an A1c date is prefilled and we can only find an A1c value that was done prior to the prefilled date, do we change the date or should we answer "no"?	If a value for the pre-filled date or more recent test cannot be found in the patient record, the pre-filled date may be replaced with the most recent date of the test found in the medical record within the measurement period. If the GPRO cannot find any test within this allotted period, leave the "Yes" and use a zero for the value within the Web Interface.	X	X	X
DM-13			**DM-13: High Blood Pressure Control**			
208	FAQ	On the specs it does not specify if you can take inpatient data for measures that have a BP component; example, Preventive BP, HTN and diabetes. Can we take a BP from inpatient records?	The diabetes blood pressure measure (DM-13) and Hypertension (HTN-2) requires that the BP be obtained during a visit to the practitioner's office or other non-emergency outpatient facility. The blood pressure can be taken from any setting when reporting PREV-11. However, you may use your clinical judgment in PREV-11. When the encounter is for an acute event that would reasonably alter the BP, i.e., fractured arm, chest pain, select "No – Medical Reason.	X	X	X
209	FAQ	DM-13: High Blood Pressure Control, if the patient has multiple Systolic and Diastolic blood pressure values for their most recent date, are we permitted to take the lowest Diastolic and lowest Systolic as outlined in HEDIS specifications?	The DM data guidance states, "Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP." Please use GPRO Web Interface measure specifications that are located on the CMS website.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
210	FAQ	For the most recent blood pressure documentation, does the data need to be pulled from a Primary Care Visit or would a Specialty office visit be ok to use for the data?	As long as the blood pressure is documented in the medical record, it can be either a primary care visit or a specialty office visit.	X	X	X
211	2/6/2014	DM: Only patients without a DM rank have a blood pressure date entered. Is this correct?	There are no prefilled dates associated with blood pressure readings.	X	X	X
212	2/20/2014	In the DM module, if the most recent blood pressure assessed is in association with an office visit for acute pain, can the blood pressure from that visit be excluded?	With the information provided the answer is no; it would not be excluded.	X	X	X
DM-14: LDL-C Control						
213	FAQ	Regarding the DM-14 component of the Diabetes Composite measure for LDL control, if the chart documentation reveals that the LDL has been controlled < 100 mg/dL throughout the last 12-24 months, but the "most recent" LDL is > 100, has the measure been met?	You must answer using the most recent test in the measurement period and provide the date and value for that test.	X	X	X
214	FAQ	Follow up question regarding Diabetes Composite measure and the most recent" LDL > 100. If the documentation shows that patient is non-compliant with the plan of care, is there an exception or exclusion available?	There is no requirement for a plan of care based on an elevated LDL-C and there are **NO** exclusions available for this measure.	X	X	X
215	FAQ	How does a result of 0 (zero) for "unable to calculate LDL-C due to high triglyceride affect the performance calculation?	For this measure you would fail performance if you enter "0" (zero). For questions such as this we recommend you take a look at the measure flows that are available on the CMS website. These measure flows can help you determine performance rates for all the measures.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
216	FAQ	In DM-14, the eligible age range is 18-75 years old. However, the average age of our population is much higher (i.e. 80-90 years old) and would be excluded. What should we do?	When sampling patients for the diabetes modules, we only sample patients within the eligible age range. So you should not find patients outside of the age range. Depending on the age range of your patient population, your sample for this measure may not include 616 patients if you are an ACO or a PQRS GPRO with 100 or more EPs. The maximum sample size for a PQRS GPRO with 25-99 EPs is 327.	X	X	X
217	2/27/2014	For the DM measures, are we able to use the total cholesterol value for LDL?	DM-14 requires the LDL-C result. Synonyms for LDL-C testing are included in the Inclusions/Synonyms column of the Data Guidance tab of the DM Supporting document. A calculated LDL may be used for LDL-C screening and control indicators.	X	X	X
DM-16						

DM-16: Daily Aspirin or Antiplatelet Medication for Patients with IVD

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
218	FAQ	Regarding the measures requiring the use of aspirin (ex. DM-16), does aspirin need to be on the medication list or does the aspirin actually have to be prescribed in 2013?	As long as there is evidence in the medical record that the patient is taking daily aspirin, that is sufficient.	X	X	X
219	FAQ	Is there a reason that the diagnosis list for IVD confirmation is different for the DM module than the IVD module?	There is a difference, because the measures are developed by different measure owners. The measure owner for IVD is National Committee for Quality Assurance (NCQA) and the measure owner for DM is Minnesota Community Measurement (MNCM).	X	X	X
220	FAQ	For DM-16, if a patient has IVD, we are only able to select "Yes" or "No" for daily ASPIRIN use. If the patient is on another antiplatelet medication, does it qualify?	Please refer to the DM drug code list in the supporting documents. The measure looks for Aspirin or another Antithrombotic, which includes: Aspirin, clopidogrel, or a combination of Aspirin and extended release Dipyridamole	X	X	X
221	FAQ	Just to clarify the expectation that if they are on Coumadin for IVD/DM then they should also be on aspirin?	For DM-16, Warfarin is listed as an exclusion. Warfarin and enoxaparin are considered anticoagulant antithrombotics while aspirin and clopidogrel are considered antiplatelet antithrombotics. Please refer to the Exclusions column within the Data Guidance tab for details relating to drug exclusions located within the 2013 GPRO Supporting Documents found under the Downloads section on the GPRO Web Interface page of the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
222	FAQ	DM-16: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease, ASA or antiplatlet use includes exclusions of Coumadin or Lovenox use. It does not state the newer anticoagulants: Eliquis (apixaban), Pradaxa (dabigatran), and Xarelto (rivaroxaban). Are these appropriate exclusions?	The newer medications are also appropriate exclusions. We have received additional measure owner clarification regarding the exclusion of the newer medications listed: Eliquis (apixaban), Pradaxa (dabigatran), and Xarelto (rivaroxaban) are all appropriate exclusions.	X	X	X
223	1/29/2014	For the DM-16 measure, where can we find a list of non-steroidal anti-inflammatory agents (exclusion for patients not prescribed aspirin or antiplatelet)?	The accepted contraindications for DM-16 are listed in the Data Guidance tab of the 2013 DM Supporting Document in the Exclusions column. Additional guidance has been provided by the measure owner including Eliquis (apixaban), Pradaxal (dabigatran), and Xarelto (rivaroxaban). A comprehensive list is found on the DM Drug tab.	X	X	X
224	2/27/2014	Regarding DM and history of IVD, the 414.00 code is not included in the evaluations codes in the data guidance. Should we select yes if 414.00 is the only code found?	Yes you can use 414.00 for confirming of IVD.	X	X	X
			DM-17: Tobacco Non-Use			
225	FAQ	In relation to the measures that diabetes – non-tobacco use and Prevention – screening for tobacco use, how are we to answer these questions in relation to electronic cigarettes?	The measure owner does not consider e-cigarettes tobacco use.	X	X	X
226	FAQ	Please confirm the tobacco use measures: On DM tobacco use - "yes" means tobacco non-user; in PREV 10 does yes mean tobacco user?	DM-17 "yes" means tobacco non-user. PREV-10 "yes" means tobacco user.	X	X	X
227	FAQ	Please clarify the definition for Former Smoker that is addressed in PREV-10 and DM-17.	If you can show documentation that they are not a current smoker, you can mark them as "nonsmoker" regardless of former smoker status. Please also note that tobacco use also includes forms of smokeless tobacco.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
228	FAQ	Tobacco use: If you look at an EHR and notice that the patient is listed as "non-user" but there is no date listed is that acceptable or do we need to find office notes to make sure that the patient was questioned within the appropriate time period?	Both PREV-10 and DM-17 require that the patient was screened for tobacco use within a specific time period, therefore a screening date would be required.	X	X	X
229	FAQ	On the documentation for proving a beneficiary is no longer a smoker, please define "documentation" - lab test?	If the lab test somehow identifies that the beneficiary is no longer a smoker that's fine. All that is really required is that the provider asks the patient if they're a smoker and they write it down to document that the patient is not a smoker.	X	X	X
		HF-6: Beta-Blocker Therapy for Patients with LVSD				
230	FAQ	The description for HF-6 states within a 12-month period when seen in an outpatient setting OR at EACH hospital discharge. Will the GPRO Web Interface be configured like CARE-1, i.e. there is a discharge date where we could have many to one person encounters?	HF-6 is not configured like CARE-1. The Web Interface will not list all of the patients' discharges for the measurement period. The question has a yes/no answer unless the patient is excluded for medical, patient or system reasons.	X	X	X
231	FAQ	For HF-6, supporting documents list metoprolol tartrate as one of the acceptable beta blockers. However, the narrative specifications list metoprolol succinate. Is either one acceptable?	For this Heart Failure beta-blocker measure, there are three generic beta-blockers that are allowable to meet the measure's numerator criteria. The medication that was just listed is not recognizable as one of those medications. We went to the measure steward, the AMA, and asked for clarification. The medications are coded in RxNorm which is the standard clinical terminology used to report medications. Within the RxNorm terminology, metoprolol succinate extended release is identified as metoprolol tartrate extended release. Metoprolol tartrate alone, meaning not the extended release form, is not included on the medication list. In order to meet the measure, it needs to be the extended release form. The AMA has been assured by their pharmacy experts who helped them develop the value sets of the allowed medications that the metoprolol tartrate extended release maps to the metoprolol succinate extended release. **Brand names that map to these three generic medications are acceptable to use to satisfy the numerator for this measure.** We will be posting this answer on CMS's website as part of the frequently asked questions shortly.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
232	FAQ	For the Heart Failure measure regarding the LVEF (HF-6), it states that if the ejection fraction is ever less than 40, how far back do we reasonably need to go to find this information?	You may go back as far as necessary in the patient's medical record to determine if the patient ever had an LVEF <40% or documentation of moderate or severe left ventricular systolic dysfunction.	X	X	X
233	FAQ	For HF-6, if the patient is allergic to one of the beta-blockers, are they excluded for medical reasons, or do we have to show allergies to all three medications (carvedilol, bisoprolol fumarate, metoprolol)?	It would be acceptable to medically exclude a patient based on an allergy to any beta-blocker.	X	X	X
234	FAQ	For HF-6, we don't currently capture LVEF discretely, and we're finding only a handful of patients where anyone has ever charted the relevant HCPCS code. Thus our denominator is extremely small. Is this okay?	Yes, this is acceptable. If you have confirmed a diagnosis of heart failure but cannot determine if the patient has LVSD (LVEF < 40% or documented as moderate or severe) you will select "No: Select this option if the patient does not have LVSD". However, you can also use documented LVEF if a code is not available.	X	X	X
235	FAQ	In HF-6, does the reason for not prescribing beta-blocker therapy need to be documented during the measurement period to count or does it count if it was documented anytime in the patient's history?	You may find documentation of a medical reason for not prescribing beta-blocker therapy at any time in the patient's history.	X	X	X
236	FAQ	Is a clinical diagnosis sufficient to confirm the diagnosis? If not, what are acceptable methods for confirmation of diagnosis?	Yes, clinical diagnosis is sufficient as long as it is documented in the records. For acceptable diagnosis, please refer to the Data Guidance Inclusions/Synonyms and the downloadable evaluations tab for this measure.	X	X	X
237	FAQ	HF-6: When will we receive the brand names that map to the 3 generic medications acceptable to use as noted in the Q&A?	Brand name medications are provided by measure stewards at their discretion.	X	X	X
238	FAQ	How will you identify denominator patients for the Heart Failure measure who have LVEF<40% as you only have claims data only	When sampling patients for heart failure, we do use claims to identify those with a diagnosis of heart failure. When you go into the web interface you have an option to indicate whether the patient has LVSD and if they do, continuing to determine if a beta-blocker has been prescribed.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
239	FAQ	What if a patient recovers from previous LVSD?	For the HF-6 measure the data guidance refers to verification of LVSD if the patient ever had an LVEF less than 40% or has had a documented LVEF as moderate or severe. The reason for that is that the patient could have been on long term beta-blocker therapy and it could have inched back up over that threshold.	X	X	X
240	1/27/2014	HF: Can an exclusion be added for patients who had a heart transplant (i.e. had a diagnosis of heart failure prior to the transplant but no current heart failure with new heart)?	For specific cases such as this one, please open help desk ticket and provide the patient's rank, module and reason for requesting "Other CMS approved reason".	X	X	X
241	1/27/2014	HF: We have several patients with a heart failure diagnosis and are on one of the approved beta-blockers but we are unable to find an ejection fraction of less than 40. Many have a recent ejection fraction of greater than 40, but must have had a lower one earlier in life. Can we count it without seeing the actual ejection fraction?	You would have to find the LVEF result < 40% or a narrative description of the result that describes the LVSD as moderate or severe in the medical record.	X	X	X
242	1/28/2014	HF-6: If the patient had more than one hospital admission, do we need to look at EACH admission in the measurement year for a discharge beta-blocker?	For this measure, there question has a yes/no answer. Unless the patient is excluded for other medical patient or system reasons, you would answer yes or no.	X	X	X
243	1/28/2014	HF-6: We reviewed the Q & A form 1/9/2014 and it is still not clear; the question is can metoprolol tartrate bid count as the required beta blocker, there is no metoprolol tartrate Extended that we locate. Please clarify.	Only the metoprolol tartrate extended release or metoprolol succinate would count.	X	X	X
244	1/28/2014	When will we receive brand name drug list for medications for HF-6?	Brand name drug lists are not provided unless the measure steward included them as part of their specification. Drug lists provided are typically generic. Brand name drugs can be mapped to the generics listed.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
245	1/28/2014	When you are talking about limiting Measure 31 to the three Beta Blocker meds, you are talking about ACO correct? Not GPRO HF-6, which has more than these three?	ACO Measure #31 and HF-6 is the same Web Interface measure. The same Web Interface is being used for both the PQRS GPRO and ACO programs (SSP and Pioneer) for program year 2013.	X	X	X
246	1/29/2014	For HF, does Cardiomyopathy exclude the patient from heart failure even if the provider lists congestive heart failure as another diagnosis?	Note that different types are cardiomyopathy are considered as inclusions or exclusions. The data guidance states synonyms for heart failure may include: Congestive heart failure, CHF, left ventricular failure, biventricular failure, cardiac failure, pump failure, cardiac decompensation, Kerly B lines, pulmonary vascular congestion, ischemic cardiomyopathy, venous congestion, dilated cardiomyopathy, pulmonary edema, lung edema, interstitial edema, perihilar edema/fluid, fluid or volume overload, perihilar congestion, interstitial congestion, cephalization or alveolar edema, left-sided heart failure, right-sided heart failure, systolic heart failure, diastolic heart failure, rheumatic heart failure. Exclusions in the data guidance include: Pleural effusions, pleural fluid, cardiomegaly, enlarged heart, cardiomyopathy, hypertrophic cardiomyopathy, nonrestrictive cardiomyopathy.	X	X	X
247	1/30/2014	For HF, does a current LVEF>60% supersede a previous LVEF<40%? Or does a beta blocker still need to be prescribed?	If you can determine the patient EVER had an LVEF < 40% select "Yes". Then determine if the patient was prescribed beta-blocker therapy.	X	X	X
248	2/6/2014	HF: The exclusions include pleural effusions. Can we only exclude a patient if this is an active problem during 2013?	Transient conditions that are listed as exclusions that may be due to causes other than heart failure should be restricted to documentation within the measurement period.	X	X	X
249	2/6/2014	HF-6: If an echo report showing mild to moderate LV dysfunction, an ejection fraction 40-45%, does the patient <u>not</u> meet the measure?	Select "Yes" if the patient has ever had an LVEF < 40% or has had a documented LVEF as moderate or severe. In this case you would select "No" because the ejection fraction does not fall below the 40% threshold.	X	X	X
250	2/6/2014	HF-6: If we can't find an ejection fraction <40%, but the patient does have ejection fraction at 50% and is on a Beta Blocker, do we still answer "no"? If we answer "no", how is our performance rate impacted?	Select "No" if the patient does not have LVSD as defined in the instructions of the Data Guidance tab of the HF Supporting Document. This patient would <u>not</u> be considered denominator eligible for HF-6. Please review the 2013 GPRO Web Interface Flows for more details specific to anticipated performance rates.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
251	2/6/2014	If a heart failure patient has a heart failure exclusion diagnosis, do we enter "Not Confirmed" for the HF diagnosis confirmation question?	The diagnoses listed in the Exclusion column of the Data Guidance tab of the Heart Failure Supporting Documents are for your use in selecting the "Not Confirmed" option when medical documentation supports their presence.	X	X	X
252	2/6/2014	Pacemaker (V4501) is an exclusion for HF-Beta Blocker. If patient has a Biventricular ACID which is a Defibrillator (V4502), is this considered an exclusion for beta-blockers?	If documentation in the medical record indicates the patient is not prescribed a beta-blocker due to a Biventricular ACID this would be considered acceptable as a medical exclusion.	X	X	X
253	2/20/2014	For HF-6, a patient had an ejection fraction of 40% by echo (33% by cardiac MR). Cardiac MR is not listed in the hierarchy of diagnostic studies to determine if LVSD is present. Can we use cardiac MR results?	Confirming with AMA (measure owner) that a cardiac MR is an acceptable diagnostic tool	X	X	X
254	2/20/2014	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 answer "No" if the beta-blocker is not one of the three generic beta-blockers listed for this measure or one of the brand name beta-blockers equivalent to one of the three generics.	X	X	X
255	2/20/2014	For HF, if a patient has a documented diagnosis of CHF but also has one of the exclusions (cardiomyopathy, cardiomegaly etc) would the appropriate answer be "No- Other CMS Approved Reason" since there is not a choice available relating to medical exclusions?	If a patient has one of the exclusions shown in the Data Guidance tab of the 2013 GPRO Web Interface HF Supporting Document, the appropriate selection would be "Not Confirmed" if you are unable to confirm the diagnosis of heart failure.	X	X	X
256	2/20/2014	For the denominator for HF, must the documentation for the LVEF <40% come from an EKG? Can we confirm with diagnosis alone for the denominator?	No both heart failure and either a quantitative or qualitative description of LVSD are required. The denominator is "All patients aged 18 years of age and older with a diagnosis of heart failure with a current or prior LVEF < 40%."	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
257	2/27/2014	For HF, to confirm LVSD, if the documentation in the chart notes "variable ejection fraction - restrictive LV function", Does this suffice to confirm LVSD?	You need to either document that the ejection fraction is moderate to severe or the specific value of the ejection fraction less than 40%. Refer to the LVSD Synonyms tab provided in the HF Supporting Document.	X	X	X
258	2/27/2014	Does Atenolol qualify for a beta blocker?	Atenolol does not qualify for a beta blocker for reporting purposes of 2013 GPRO Web Interface HF-6. Please use one of the 3 drugs specified in the HF Supporting Document, Data Guidance tab and HF Drug Codes tab.	X	X	X
259	2/27/2014	Which beta blockers qualify for heart failure, LVSD?	From the Inclusions/Synonyms column of the HF Supporting Document, Data Guidance tab; Note: Bisoprolol, carvedilol, or sustained release metoprolol succinate are the ONLY beta-blockers allowed for this measure.	X	X	X
260	2/27/2014	Is Systolic Dysfunction or Diastolic Dysfunction a confirmation for Congestive Heart Failure?	No, not by itself. Please refer to the LVSD Synonyms tab of the HF Supporting Document.	X	X	X
261	2/27/2014	For Congested Heart Failure, if the patient has a confirmed diagnosis of CHF but an ejection fraction cannot be verified, is it appropriate to document "LVSD" as "No"?	Yes, that's correct.	X	X	X
262	2/27/2014	If a patient diagnosed with both heart failure and cardiomyopathy considered "not confirmed" because cardiomyapthy is an exclusion?	Yes, if the patient is diagnosed with both heart failure and cardiomyopathy select "Not Confirmed".	X	X	X
263	2/27/2014	If a patient has an included and an excluded diagnosis for heart failure, should they be excluded from the measure? Many patients have several exclusions which may have resulted from their diagnosed heart failure.	If you are referring to the exclusions column included in the HF Supporting Document, Data Guidance tab, then you would select "Not Confirmed". Examples include a patient with a documented diagnosis of heart failure but also having pleural effusions, pleural fluid, cardiomegaly, etc.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
HTN-2 header						
264	FAQ	On the specs it does not specify if you can take inpatient data for measures that have a BP component; example, Preventive BP, HTN and diabetes. Can we take a BP from inpatient records?	The diabetes blood pressure measure (DM-13) and Hypertension (HTN-2) requires that the BP be obtained during a visit to the practitioner's office or other non-emergency outpatient facility. The blood pressure can be taken from any setting when reporting PREV-11. However, you may use your judgment in PREV-11 and refrain from using BPs when the encounter is for an acute event that would reasonably alter the BP, i.e., fractured arm, chest pain.	X	X	X
265	FAQ	Does a hypertension diagnosis need to be documented in 2013? The technical specifications state any time in patient's history; the same is true for all at-risk measures other than diabetes.	For HTN-2, the diagnosis can be anytime documented in the patient's medical record up through the last day of the measurement period (December 31, 2013). Please refer to the data guidance for other measures.	X	X	X
266	FAQ	For the most recent blood pressure documentation, does the data need to be pulled from a Primary Care Visit or would a Specialty office visit be ok to use for the data?	As long as the blood pressure is documented in the medical record, it can be either a primary care visit or a specialty office visit.	X	X	X
267	FAQ	Regarding the medical reason for not including BP, is this a pregnancy any time in 2013, or only if still pregnant at last office visit?	This is referencing anytime within 2013.	X	X	X
268	FAQ	For HTN-2, should we use encounters related to the following specialties: Cardiology, Internal Medicine, Family Medicine, Geriatrics, Nephrology, or Endocrinology?	You should take the most recent blood pressure reading of the measurement period regardless of provider type, as long as the blood pressure isn't taken in an emergent or emergency or surgical setting.	X	X	X
269	1/30/2014	Are pulmonary hypertension and chronic heart disease considered heart failure? If not, what are they classified as?	Neither of these conditions are listed as a synonym for heart failure. You may also resource the code descriptions in the Evaluation tab of each of the Supporting Documents.	X	X	X

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270	1/31/2014	HTN-2: When examining exclusions for this measure and the measure flow, it is evident that exclusions for medical reasons can only be applied if a BP was not recorded during 2013. Shouldn't patients with exclusions be excluded from performance?	Patients who are medically excluded from HTN-2, as well as other GPRO Web Interface measures/modules, are removed from both the numerator and the denominator when calculating performance.	X	X	X
271	1/31/2014	When examining exclusions for HTN-2 and the measure flow, it is evident that exclusions for medical reasons can only applied if the blood pressure was not recorded during 2013. Should these patients with exclusions be excluded from performance even if a blood pressure was supported? For example, a pregnancy exclusion should occur even if a provider took a blood pressure in 2013.	You would want to exclude the patient for a medical reason. For the purposes of reporting HTN-2 in the GPRO Web Interface you would not answer "Yes", a blood pressure was documented. The intent of HTN-2 does not include analyzing high blood pressure control for a patient who is pregnant or who has ESRD.	X	X	X
272	2/6/2014	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 has to say "Hypertension"?	Yes, this is an accepted abbreviation for a diagnosis of high blood pressure.	X	X	X
273	2/6/2014	HTN-2: Is the patient's position during the blood pressure reading taken into account? Would we use the lowest systolic and lowest diastolic regardless of sitting, standing, or laying down?	You would use the lowest values regardless of position.	X	X	X
ISCHEMIC VASCULAR DISEASE MODULE						

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
274	FAQ	Is there a reason that the diagnosis list for IVD confirmation is different for the DM module than the IVD module?	There is a difference, because the measures are developed by different measure owners. The measure owner for IVD is the National Committee for Quality Assurance (NCQA) and the measure owner for DM is Minnesota Community Measurement (MNCM).	X	X	X
275	FAQ	For IVD measures, if our supporting chart documentation does not contain any of the CPT codes for IVD how can we be certain to include or exclude a patient? Chart notes may sometimes use the verbiage 'CAD' 'stroke' 'CABG.'	The codes are provided in order to facilitate use of creating a XML directly from your EHR if that's your chosen method. If you are supplementing with some manual review, you can certainly utilize any verbiage that is written in the chart. That language would be appropriate to use as synonyms for IVD.	X	X	X
276	1/27/2014	IVD: Code 414.00 is not included in the documentation, but it is a code for CAD. Can we use that code?	Yes, it would be acceptable to use ICD-9 code 414.00 as it is located within the downloadable resource table for IVD.	X	X	X
IVD-1: Complete Lipid Profile and LDL Control						
277	FAQ	Just to clarify the expectation that is if they are on Coumadin for IVD/DM then they should also be on aspirin?	For DM-16: Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease - Warfarin is listed as an exclusion. Warfarin and enoxaparin are considered anticoagulant antithrombotics while aspirin and clopidogrel are considered antiplatelet antithrombotics. Please refer to the Exclusions column within the Data Guidance for details relating to drug exclusions located within the 2013 GPRO Supporting Documents found under the Downloads section on the GPRO Web Interface page of the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
278	1/27/2014	IVD: Can we use a LDL Direct result if a LDL-C is unavailable?	Yes, you can use an LDL Direct as one component of the lipid panel that is required.	X	X	X
279	1/27/2014	IVD: Regarding LDL-C, if we can use an LDL direct does that need to be done on the same day as the other components of the lipid profile? If an LDL direct is done a different day during the measurement period which day to we use for the result date.	You need to use the most recent date that blood was drawn for the lipid profile or LDL direct.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
280	1/30/2014	For IVD - 1, if high triglycerides prevent an LDL from being calculated, what do we put into the field for LDL?	We have a question with the measure owner regarding the LDL Direct value. For LDL-C, if you can't get a value, enter "0" (zero).	X	X	X
281	1/30/2014	For IVD, the LDL is yes and date include as done outside our group, however, there is no value and we don't have that value. Can we enter zero?	Working on documentation to clarify.	X	X	X
282	1/30/2014	Is an LDL alone sufficient to answer "yes" for the Lipid Panel performed question for both IVD-1 & DM?	No, an LDL is not sufficient for IVD-1 as all components of the lipid panel need to be obtained; however, LDL Direct or calculated can be used for DM.	X	X	X
283	2/6/2014	IVD: If a lipid panel date is pre-populated that we cannot confirm in the patient's chart, nor can we find a different LDL date, do we select "No"?	Correct, you would select "No", patient did not have at least one lipid profile (or ALL component tests) during the measurement period.	X	X	X
IVD-2: Aspirin or Other Antithrombotic						
284	FAQ	IVD-2: Use of Aspirin or Another Antithrombotic, is Pradaxa considered an antithrombic	No, Pradaxa (dabigatran) is not considered an antithrombotic and would be excluded. Prasurel (Effient) however is on the medication list in the data guidance for IVD-2 as an antithrombotic.	X	X	X
285	1/27/2014	Are we restricted to select an aspirin or another antithrombotic medication from the list of IVD drug codes provided in the supporting data guidance documents?	IVD-2; Aspirin or Other Antithrombotic, is limited to the coding provided in the IVD Drug Codes tab of the IVD Supporting Document. If you are questioning the appropriateness or a medication not on the list please open a QualityNet Help Desk inquiry and we can research further.	X	X	X
286	1/28/2014	IVD-2: Is Coumadin considered an antithrombotic?	No.	X	X	X
287	1/30/2014	For IVD-2, are there any medical reasons we can use to explain why a patient is not on medications? Does patient refusal count?	No, there are no exclusions for IVD-2.	X	X	X
288	1/30/2014	For IVD-2, how do we handle where provider indicates patient is allergic to ASA?	There are no exclusions for this measure, so you would have to answer "no".	X	X	X

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289	1/30/2014	For IVD-2, is the Aspirin/Anti-platelet list all-inclusive? Would Warfarin be an acceptable antithrombotic medication for IVD-2?	There are no exclusions for this measure so Warfarin isn't acceptable.	X	X	X
290	2/6/2014	What is considered an anti-thrombotic medication?	For the purposes of reporting IVD-2, Oral Antithrombotic therapy includes: aspirin, clopidogrel or combination of aspirin and extended release dipyridamole.	X	X	X
291	2/20/2014	For antithrombotics, is clopidogrel, xarelto or coumadin alone okay (without aspirin)?	For the purposes of 2013 GPRO Web Interface IVD-2, oral antithrombotic therapy includes aspirin, clopidogrel or combination of aspirin and extended release dipyridamole. Xarelto and Coumadin are not acceptable.	X	X	X
292	2/27/2014	For IVD-2, would "buffered aspirin" count?	Yes.	X	X	X
293	2/27/2014	What antithrombotic are considered for the IVD modules?	There is a list provided within the Inclusions/Synonyms column for IVD-2. Plavix is included. Xarelto, Pradaxa and Coumadin are not included.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
			PREVENTIVE CARE			
294	FAQ	Will the reported QM through claims be included in the numerator?	Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). **For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you.** In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. If you are an ACO and are selected for audit, you will also be required to provide this supporting medical record documentation following the data collection period. This is not the case if the WI has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: • A note indicating the date the breast cancer screening was performed AND • The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the ACO be selected for audit.	X	X	X
295	FAQ	What are we confirming for the PREV measures? Since most of these are not gender specific, would we just be confirming they are the correct age?	For every patient you confirm the existence of their medical record and verify the date of birth is correct. We only remove a patient if they are not qualified for a specific PREV measure.	X	X	X
296	1/27/2014	In addition to the pre-populated data, if we can pull additional PREV data from our database, does it still need to be confirmed in the medical record?	If the provider has access to this information at the point of care, and you can speak to it if it were ever requested, then yes, it's acceptable. However, we suggest that you find the information in the medical record.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
297	1/27/2014	PREV-5 and PREV-6: Some of our patients do not receive mammography or colorectal cancer screening because they are too old and their physicians do not believe it is necessary. Can we select "No-Medical Reasons"?	For PREV-5: Breast Cancer Screening, the only reason to select "No Medical Reason" is there was any documentation the patient had a bilateral mastectomy or two unilateral mastectomies. The age parameter for this measure is 40-69 so if any patients are in your sample that exceed this age, please ensure the birth date is accurate. If it is not, you should alter the birth date. The age pre-filled in the Web Interface is the age of the patient on the first day of the measurement period. For PREV-6: Colorectal Cancer Screening, there are specific reasons in the data guidance to select "No Medical Reason" including: Diagnosis of colorectal cancer, total colectomy, terminal illness, other reason documented by practitioner for not performing colorectal cancer screening PREV-6 specified reasons to select no medical reason. If a provider has specifically documented a reason for not performing the screening, select other reason. The age parameter for this measure is 50-75. The same instruction as noted above is appropriate.	X	X	X
298	1/28/2014	Why for the influenza screening is there an option to select "No-Patient Reasons" if patient refuses, but in the Pneumonia (pn) screening we would need to answer this differently to "No"?	PREV-8, Pneumococcal Vaccination does not include a patient and system reason to exclude a patient based on measure owner direction. However, a medical reason is provided for this measure. PREV-7, Influenza Immunization is stewarded by a different measure owner. This measure contains medical, patient and system reasons for exclusion.	X	X	X
299	1/28/2014	If just the year of screening (mammography or colonoscopy) is written as a part of patient HISTORY, without full date or results will this be acceptable for measure compliance or should we need to go after full date and results?	PREV-5 requires the results of the mammography and the exact date. PREV-6 does not require a date or result. PREV-6 requires documentation in the medical record indicating colorectal screening is "up-to-date" or "current".	X	X	X
300	1/29/2014	For PREV-5 and PREV-10, the 2013 Narrative Specification states that the screening would be valid if done within 24 months. When does the 24 month date look back to? Is it the first day of the measurement year?	24 months refers to the current measurement period and the year prior.	X	X	X
301	2/6/2014	Is every provider responsible for the preventive measures if they have only see the patient once a year?	Yes, the ACO or PQRS GPRO is responsible for reporting on any patient attributed to their sample regardless of measure/module.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
302	2/20/2014	For clarification, for some patients the only visits have been to specialist such as dermatology and orthopedist who do not typically measure BP, BMI etc. For the preventive measures, would you consider this as "not confirmed" or "no medical record found"?	For the purposes of reporting 2013 GPRO Web Interface PREV-11, neither option, "not confirmed" or "no medical record found" is appropriate based on visits to the specialist. Select "No" if patient was not screened for high blood pressure within the measurement year, Jan 1, 2013 through Dec 31, 2013. It is the GPROs responsibility to obtain this information to the best of their ability to account for the patient's care.	X	X	X
			PREV-5: Breast Cancer Screening			
303	FAQ	Previously the speaker mentioned the mammogram measure as it relates to patient reporting. Is it acceptable if the patient reports the date and the results and it's recorded in the medical record, but there is no report?	The measure owner requires both the date of the mammogram and the results be documented. The Data Guidance for PREV-5 includes the following NOTE: Documentation in the medical record must include both of the following: A note indicating the date the breast cancer screening was performed AND The result of the findings	X	X	X
304	FAQ	If our ACO can prove via claims data that breast cancer screening or colorectal cancer screening was performed but the results are not in the medical record, will this count as a numerator hit? For example, another provider outside the ACO ordered the test.	For PREV-5 Breast Cancer Screening, you have to have the date and result in the medical record. Even if it is pre-populated from claims in the Web Interface, you need to ensure that this information is also included in the medical record. For PREV-6, Colorectal Cancer Screening, the Data Guidance says that you need to have documentation in the medical record that screening is up to date or current.	X	X	X
305	FAQ	What is the proper age calculation for PREV-5: Breast Cancer Screening? The NQF specification has notes that imply it starts at 42 because of the two-year look back period. I thought the rule is the age is 40 on January 1st of the measurement year.	The 2013 denominator age requirement for PREV-5, Breast Cancer Screening, is 40 years of age as of the first day of the measurement period or Jan 1, 2013. Please do not refer to the NQF specifications for purposes of 2013 GPRO Web Interface reporting. Instead, please use the specifications specifically created for the GPRO Web Interface program.	X	X	X
306	FAQ	PREV-5: Breast Cancer Screening, are we only going to see females within the correct age range?	Yes, based on the assignment and sampling process, you should only see females. If you see otherwise, please open a help desk ticket and we will work with CMS for a "CMS approved reason to exclude the patient.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
307	FAQ	PREV-5: Breast Cancer Screening, how should we answer if the patient refused the screening?	In this instance you will have to select "no" in the Web Interface and it would be a performance failure for the measure.	X	X	X
308	FAQ	PREV-5: Breast Cancer Screening, is the period of 24-month look back period January 1, 2012 - December 31, 2013?	Yes, that's correct. For this data collection period (reporting year 2013), a mammography performed between January 1, 2012 through December 31, 2013 (24 months) will be included in the numerator. For this measure, you should have both the date and results of the screening documented.	X	X	X
309	FAQ	PREV-5: We have noticed there are a few patients that are eligible for this measure who were 70 years old on 1/1/13 - would we answer "no - other CMS approved reason"?	If you believe a patient is attributed to your sample mistakenly you can open a QualityNet Help Desk Incident to request an "other CMS approved reason". Please make sure you include the patient rank, module/measure, and reason for request. CMS will approve or deny the request in the resolution of the incident.	X	X	X
310	FAQ	Will PREV-5: Breast Cancer Screening and PREV-6: Colorectal Cancer Screening measures be among those prefilled in GPRO?	Yes, this will be pre-populated when available in the claims. We won't pre-populate the date. Please note, it's only pre-populated if the answer is yes for mammogram screening.	X	X	X
311	FAQ	If we are unable to find the *result* of a mammogram in the patient record, do we need to change the response to "No"? What if we can't find documentation of any mammogram in the past two years?	That is correct. The measure steward's specifications indicate that a mammogram must be accompanied by the results/findings of the mammogram. Because the record of the mammogram was not accompanied by the results/findings of the mammogram, then you would need to answer "No" in the GPRO Web Interface and this case would not be included in the numerator.	X	X	X
312	FAQ	For the mammogram measure, will an MRI count for patients with implants? Will a sonogram count for patients with dense breast tissue?	The measure steward has not included any provision for including MRI or ultrasound testing as a substitute for mammography. We will share your comments with the measure owner for future evaluation.	X	X	X
313	FAQ	Are breast implants an approved medical reason for not having a mammogram? What about terminal illness? What if the patient is currently undergoing treatment for breast cancer?	No. None of the listed are currently approved medical reasons for not having a mammography. We will bring these suggestions to the measure steward for consideration.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
314	1/27/2014	PREV-5: Breast Cancer Screening, I understand that the date and result are required to be documented in the medical record. If this is patient reported in the chart, does the exact date need to be recorded, or would 'April 2013', for example, count?	No, the measure requires that the date and results of the screening be included in the outpatient medical record.	X	X	X
315	1/28/2014	PREV-5: If it is marked as "O" indicating this is pre-filled data from outside our TIN, do we need to have documentation present in our medical record stating the date of the outside mammogram and the results?	Yes, you would need both the date and results from the mammogram.	X	X	X
316	1/28/2014	PREV-5: If the patient refused the mammography, do we select no or should we submit a help desk ticket to request No - Other CMS Approved Reason?	You would select "No".	X	X	X
317	1/30/2014	For PREV-5, if a patient is not qualified for the measure, it states to select No-Other CMS approved reason. What are these other CMS-approved reasons?	If you want to select Other CMS approved reason you must open a Quality Net help desk ticket specifying the patient rank and reason to receive approval.	X	X	X
318	1/30/2014	For PREV-5, we found a note documented that the provider spoke with the oncologist that the patient had a mammogram and documented the results. However, the provider did not document the date of the mammogram. How do we handle this?	If the patient's Mammogram element was pre-filled with a "Yes" you would have to change your "Yes" to a "No" unless you reach out to determine the date.	X	X	X
319	1/31/2014	For PREV-5, breast cancer screening, does thermal gram count?	No, this does not count.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
320	2/6/2014	PREV-5: What if a patient had a unilateral mastectomy and has metastatic disease and, therefore, receives PET scans and CTs rather than a mammogram?	If the patient had a unilateral mastectomy and has metastatic disease and now a screening mammography is no longer performed it would be appropriate to request "Other CMS Approved Reason" to exclude the patient. However, approval should not be considered automatic. More details may be required in order to receive approval from CMS for an "Other CMS Approved Reason".	X	X	X
321	2/6/2014	PREV-5: What should we put if a patient refuses a mammogram?	You would have to answer "no" if the mammogram was not performed. This measure does not include a patient reason for refusal.	X	X	X
322	2/20/2014	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 is met?	For PREV-5, documentation in the medical records needs to include both of the following: A note indicating the date the breast cancer screening was performed AND the results of the findings. Patient reported findings are not appropriate.	X	X	X
323	2/27/2014	Can we accept a progress note where a patient informed the doctor of the result of her mammogram, such as "she notes that her mammogram 10/25/12 is negative"?	Patient reported results aren't acceptable for PREV-5.	X	X	X
324	2/27/2014	For PREV-5, if we see in the progress notes "Mammo one year ago within normal limits", can we accept it?	Documentation in the medical records must include the date the breast cancer screening was performed AND the result of the findings, per the Instructions column of the PREV Supporting Document, Data Guidance tab.	X	X	X
PREV-6: Colorectal Cancer Screening						
325	FAQ	If our ACO can prove via claims data that breast cancer screening or colorectal cancer screening was performed but the results are not in the medical record, will this count as a numerator hit? For example, another provider outside the ACO ordered the test.	For PREV-5 Breast Cancer Screening, you have to have the date and result in the medical record. Even if it is pre-populated from claims in the Web Interface, you need to ensure that this information is also included in the medical record. For PREV-6, Colorectal Cancer Screening, the Data Guidance says that you need to have documentation in the medical record that screening is up to date or current.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
326	FAQ	For GPRO PREV-6 Colorectal Cancer Screening--Is the FIT (Fecal immunochemical test) considered to be an FOBT in your definitions. It is not listed in the Data Guidance information under Inclusions/Synonyms.	No, that information is not provided by the measure owner. Anything you do not see in the Inclusions or Synonyms column would not be acceptable. **UPDATE:** Post support call, PMBR contacted NCQA (measure steward for PREV-6). The Fecal Immunochemical Test (FIT) would be considered an FOBT. The FIT will be included in the 2014 PREV-6 Data Guidance, inclusions/synonyms tab.	X	X	X
327	FAQ	Colon Cancer Screening: Is one FOBT ok for reporting or do you need 3 FOBT results?	Yes, one FOBT would be acceptable for the purposes of this measure. If you look within the Data Guidance it provides you with other tests and associated timing that would be considered "current" screening.	X	X	X
328	FAQ	Colon Cancer screening: Must there be documentation of procedure or is physician notation in the chart sufficient?	The physician notation within the medical chart would be sufficient.	X	X	X
329	FAQ	PREV-6: Colorectal Cancer Screening, is it true that if a patient refused a colo-rectal screen that this is now considered a "No" response?	Within the data guidance, the only acceptable reason for exclusion is medical reason. The patient record would fail the measure if the patient refused the screening.	X	X	X
330	FAQ	If we have documentation that a colonoscopy was performed in 2009, would that count toward the numerator of the colorectal cancer screening measure?	Yes. You will need to indicate that there is documentation in the medical record of a colonoscopy being performed during the measurement year or during the nine years preceding the measurement year. Note that patient reported testing is allowable.	X	X	X
331	FAQ	If the physician recommends a colonoscopy, but the patient states they wish to receive the test elsewhere, can that be counted as a "yes"? What if the patient fails to follow up?	In neither of those cases will the patient "count" toward the numerator. The patient needs to have had the colonoscopy during the measurement period or during the 9 years prior to the measurement period, or a flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period, or an FOBT during the measurement period.	X	X	X
332	1/28/2014	If there is a pre-filled date for a colorectal cancer screening, must we follow-up to verify that it is up to date in the medical record?	The data prefilled will be a "Yes". Final determination regarding required verification in the medical records will be addressed in the Prefilled Elements document to be provided shortly.	X	X	X

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333	1/28/2014	PREV-6: If the claims data pre-filled in the Web Interface says "Yes" and the physician's EMR shows notes of the GI screening done and notes, but does not contain the actual GI report, does this qualify as enough documentation to say "Yes"?	Yes.	X	X	X
334	1/28/2014	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?	Yes, it's acceptable. Within the data guidance under the inclusions and synonyms column, there is a section that states colorectal cancer screening is current may include documentation in the medical record indicating the colorectal screening is up-to-date or current.	X	X	X
335	1/29/2014	For PREV-6, how is "terminal illness" defined for answering "No - Medical Reasons"? What are some of the conditions that would count? What are other medical reasons for not completing the colorectal cancer screening?	Terminal illness is defined at the discretion of the provider. You may select "No - Medical Reasons" for the following conditions: Diagnosis of colorectal cancer, total colectomy, terminal illness, other reason documented by practitioner for not performing colorectal cancer screening. Other reasons documented by the provider can be accepted if the provider includes clear written documentation that they are not ordering screening for a particular medical reason.	X	X	X
336	1/30/2014	For PREV-6, can we accept a virtual colonoscopy?	No, based on measure owner input a virtual colonoscopy is not acceptable for reporting PREV-6. They based their decision on the USPSTF Guidelines.	X	X	X
337	1/30/2014	For PREV-6, does the record have to have a note stating "up to date" or similar for screening, or is it sufficient to have a copy of the screening report in the medical record but not referred to in a progress note?	If you have a copy of the screening, you don't necessarily need "up to date" in the medical record.	X	X	X
338	1/30/2014	If a provider states that a patient had a colonoscopy in 2011 but does not give specific date, what would the default date be?	This measure does not require a date. Because the reference in the record ensures the reader that a colonoscopy was performed during the measurement period or the nine years prior to the measurement period, a "Yes" answer is appropriate to signify the patient is current.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
339	1/31/2014	Does barium enema count as colorectal screening?	We would want to look back at the coding and see if it's already been addressed. Within the supporting document, if the coding is already there it can be used. Otherwise, it cannot be used as the measure specifications are pretty specific about what is acceptable for colorectal screening.	X	X	X
340	1/31/2014	What do we do when a patient has been ranked for PREV-6: Colorectal Screening and the patient is less than 50 or greater than 75 years of age?	Please note that patients are sampled based on age calculated at the beginning of the measurement period, January 1, 2013. If you find that the difference in age makes the patient fall out of the measure, please contact the help desk for another CMS approved reason. When you confirm the patient in the Web Interface, you would select No, Other CMS Approved Reason. This will leave the patient eligible for other measures for which they are qualified.	X	X	X
341	2/6/2014	If a fecal occult blood test (FOBT) is ordered and discussed or billed in the last 12 months, do we have to have the results documented in the chart to select "yes" or is billing and discussion enough?	If the information is available to the provider that's providing the care at the point of care, then it's okay. But if the FOBT is only listed in the billing system and is not available to the provider, then it's not sufficient.	X	X	X
342	2/6/2014	PREV-6: A patient didn't receive a colonoscopy because he could not comply with the prep instructions and his primary care provider decided to use fecal immunochemical tests as an alternative, can we select "yes" for screening? Would ColoVantage have been appropriate to meet the measure?	You can select "yes" for the FIT test. However, ColoVantage is not considered acceptable for Colorectal Cancer Screening.	X	X	X
343	2/6/2014	PREV-6: If the brother of a patient with Down Syndrome declines the patient's colonoscopy, would we select "No -Medical Reasons"?	If the provider has specific written documentation stating that the patient is foregoing the procedure due to his Downs diagnosis, then you would select "No - Medical Reasons".	X	X	X
344	2/20/2014	How do we address PREV-6 when the only provider listed for the patient is an ENT doctor and we have no Primary Care records in our EHR?	The patient is attributed to your group based on the fact the plurality of care were billed by your organization. Therefore you are responsible for reporting on the patient. If you cannot find the information, you would answer "No" for that question.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
			PREV-7: Influenza Immunization			
345	FAQ	For the influenza vaccine exclusion what qualifies as an "other system reason" and "vaccine not available"?	For example, if there was a vaccine shortage like we had a few years ago - that would be a system reason.	X	X	X
346	FAQ	For PREV-7, please explain the reference to Previous Receipt in the 2013 specification manual.	2013 PREV-7: Influenza Immunization - As long as the patient reports they previously received a flu shot, that would be acceptable. Accurate and complete information would indicate the vaccine occurred during the flu season dating back to August 1, 2013.	X	X	X
347	FAQ	If a claim for a service (such as flu vaccine) can be identified in claims data but it is not in the patient record because the vaccine was given at a location other than the ACO (such as Walgreens) can the ACO enter this in GPRO and receive credit?	If a claim for an influenza immunization was pre-filled in the Web Interface (a "Yes" answer) you do not need to have supporting documentation in the patient's medical record. If the influenza immunization field is blank (null) when you look in your Web Interface you can select the "Yes" option if you have supporting documentation in your patient's medical record indicating their receipt of the immunization during the flu season (October 1, 2012 – March 31, 2013) or "Prior receipt" (back to August 1, 2012). You are able to take patient report of this immunization being received. An exact date is not needed if you can support it was provided during the 2012/2013 flu season (dates above).	X	X	X
348	FAQ	Influenza: Confirm that an influenza vaccine received Sept 2013 meets PREV-7 measure.	No, September 2013 would be the flu season for 2014. You may look back to 2012 for the 2013 reporting. Please review the data guidance as those dates are specified. For 2013 reporting, the flu season would be from October 2012 - March 2013 with a look back or report of prior receipt back to August 1, 2012.	X	X	X
349	FAQ	In PREV-7, does an influence vaccine given in September 2012 count?	Yes you may look back as far as August 2012 for the influenza vaccine.	X	X	X
350	FAQ	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the immunization measures?	If that information is available at the point of care, then that information can be used.	X	X	X
351	FAQ	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 measurement specifications.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
352	FAQ	Do we only include vaccinations administered between January and March 2013? Or can we look back into 2012 for documentation of an influenza immunization?	The influenza immunization measure is one of the measures that allow you to look back to before 1/1/2013. If your medical record contains documentation that the patient was administered the influenza immunization between October 1, 2012 and March 31, 2013 OR if there is documentation that the immunization was done prior to October 1, 2012 (by a provider or at another setting), then you can select "Yes" to indicate that an influenza immunization was received. You do not have to verify that patient received influenza vaccine if this information is pre-populated into the Web Interface.	X	X	X
353	FAQ	If the medical record does not indicate that the patient has been vaccinated for influenza and/or pneumonia and the patient is unable to recall, how would you recommend answering PREV-7 and PREV-8?	In this situation, you would answer "No" for both, unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.	X	X	X
354	1/27/2014	Can we use data from an immunization registry if we have access to the registry?	Yes, you can use data accessed from an immunization registry.	X	X	X
355	1/27/2014	PREV-7: If pre-populated date is found are we required to verify in our EMR or can we take that date as meeting the measure.	We only pre-populate this field with a "yes" when a claim is found. We do not pre-populate a date in the flu shot.	X	X	X
356	1/28/2014	During the 1/27/14 Q&A call, you said documentation of vaccines given in an outside data registry would be sufficient to count it as done. What if it was not documented in the medical record during the measurement period? Can we still count it?	If audited the GPRO would be required to substantiate the quality action reported. You would need to be able to access documentation to verify the influenza vaccination was given. It would be anticipated that the information would be available to caregivers at the point of care.	X	X	X

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357	1/30/2014	For PREV-7, the flow does not indicate need for office visit to meet measure however the data guidance refers to an office visit between 10/1 and 3/31. Is an office visit required during the date range to meet the measure if patient has reported without a visit?	A visit is required as part of the sampling process. The 2013 PQRS GPRO and ACO Assignment and Sampling Overview may be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
358	1/31/2014	During a physical exam with a primary care provider on June 10, 2013, the patient gave the information that he received his flu shot on January 1, 2013 from Walgreen's. Is this acceptable?	If this patient had a visit between October 1, 2012 and March 31, 2013, then yes, this is acceptable.	X	X	X
359	2/6/2014	PREV-7: Is there an allowable patient reason in instances where the patient has refused the flu immunization?	Yes. Please refer to the 2013 PREV Supporting Documents, Data Guidance tab for all applicable exclusions.	X	X	X
360	2/20/2014	If the patient is not seen in the flu season, how do we answer the influenza question? Are they "Yes, confirmed" or "No for Other CMS Approved Reason"? These are the only options available.	When CMS does the sampling, they have identified if the patient had a visit during the flu season, although it may not be with your practice. If you are the primary care physician, documentation in the patient's record should note the patient received the immunization even if your organization did not provide the immunization. If this element was pre-filled with a "Yes", you do not need to have supporting documentation in the patient's medical record.	X	X	X
361	2/27/2014	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 medical record should confirm that influenza vaccination was received.	X	X	X
362	2/27/2014	For PREV-7, if we don't have record of an office visit during 10/1/2012-3/31/2013, should the patient be excluded from the measure, or are they non-numerator?	No, this is not an acceptable exclusion.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
			PREV-8: Pneumococcal Vaccination			
363	FAQ	For the pneumonia vaccination measure, does the eligible exclusion need to be noted in the measurement period in order to exclude the patient from the measure, or can the exclusion be noted anywhere in the patient's history?	That can be noted anywhere in the patient's history.	X	X	X
364	FAQ	For pneumococcal vaccination, the specs do not mention patient reported data. Since it is unlikely the pt received the vaccination during the Measurement Year, we assume we should be counting patient reported data? Is this acceptable?	Yes, for PREV-8 it would be acceptable to count patient reported data assuming it is documented.	X	X	X
365	FAQ	If the medical record does not indicate that the patient has been vaccinated for influenza and/or pneumonia and the patient is unable to recall, how would you recommend answering PREV-7 and PREV-8?	In this situation, you would answer "No" for both, unless documentation reflected a query of a caregiver that you consider to be a reliable historian for the patient.	X	X	X
366	1/31/2014	For PREV-8, can you clarify the 1P and 8P modifiers? 1P is vaccination not administered/not previously received for medical reason. 8P is vaccination no administered/not previously received for reason unknown. Is this correct?	Yes, that's correct. This is the information included in the individual measure specifications. These are included in the specifications as this may be the only coding that a provider can map to. The 8P modifier is not included in any of the 2013 GPRO Web Interface measure/module Downloads.	X	X	X
			PREV-9: BMI Screening and Follow-Up			
367	FAQ	For the BMI follow-up plan; is the documentation of a future visit enough to satisfy the measure? Does is 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 2013 measure.	X	X	X

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368	FAQ	Back to the BMI follow-up visit - how does this need to be linked?	The follow up visit needs to be linked in some manner to the abnormal BMI visit. It would be anticipated that documentation would be available to establish the required link. Documentation stating that progress with the patient's diet or exercise plan would be assessed at the upcoming visit is one example.	X	X	X
369	FAQ	For the BMI Screening measure, the description reads "Percentage of patients aged 18 and older with a calculated BMI in the past six months or during the current visit…" What does this mean in context of the measurement year?	For this measure, you are asked to look at calendar year 2013 (the measurement period) and find the last visit for that patient. You should then determine if a BMI was calculated at this visit. If a BMI was not calculated at this visit, then you should look back 6 months (from the most recent visit) to determine if a BMI was calculated. When you find a visit where the BMI was calculated, you will need to determine if it is normal or abnormal. If it was normal, then no further abstraction is necessary. If it was abnormal, then there needs to be documentation that a plan of care was in place. If you are unable to find a visit and recorded BMI within the 6 months preceding the most recent visit, you would indicate that a BMI was not calculated.	X	X	X
370	FAQ	BMI: If the only office visit was March 2013 and there was no BMI recorded, can we look back 6 months into 2012 to a visit where the BMI is recorded? Or is this a failed measure?	Yes, if the most recent office visit was March 2013 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 2012.	X	X	X
371	FAQ	For PREV-9, if the patient has no visits with our organization during the calendar year, are they automatically part of the numerator? Or can we look at that most recent visit and see if BMI was charted then or 6 months prior?	If the patient has no visits in the reporting year, then the patient should not be included in your group's sample. If you find a patient that did not have an office visit at your group in the reporting year, please contact the QualityNet Help Desk.	X	X	X
372	FAQ	Will we need to actually enter the patients calculated BMI into the portal? Or do we need to say yes a BMI was completed or no a BMI was not completed?	You do not need to enter the calculated BMI into the Web Interface. Please see the Supporting Documents, the GPRO Online Help, the videos imbedded in the GPRO online help, or the GPRO XML Specifications for the allowable answers for this measure. The allowable answers for all measures can be found in these documents or videos.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
373	FAQ	Can we use a reported BMI that is in a specialty note but without a height and weight noted?	No, the measure requires the height and weight be measured by an eligible professional or their staff (see Data Guidance). Height and weight alone are not sufficient and the BMI needs to have been calculated based on this height and weight.	X	X	X
374	FAQ	Please clarify what "calculated within the past six months or during the current visit" means when auditing this measure.	If there was documentation on weight and height in a patient's medical record without an actual calculation of a BMI that would not be sufficient. We need to see in the medical record that those numbers were used to calculate the BMI and the plan that came from that result if it was abnormal.	X	X	X
375	FAQ	Can you please clarify again what types of visits count for assessing whether the BMI was recorded at the most recent visit? (i.e. all outpatient visits including specialists, ED, urgent care, hospital stay?)	PREV-9 does not specify what type of visit, only that an eligible professional or their staff needs to have measured the patient's height and weight that is used for the calculation of the BMI.	X	X	X
376	FAQ	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 and a follow-up plan is documented within the last 6 months or during the current visit if the BMI is outside normal parameters (see Narrative Specifications).	X	X	X
377	FAQ	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 in a wheelchair.	X	X	X
378	FAQ	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. We would expect it to be documented for that physician's knowledge or the knowledge of other caregivers in the future.	X	X	X
379	FAQ	Please clarify if you mean to say the BMI look back is from 12/31/2013 and that 2014 services / visits should not be included for data abstraction.	Correct. 2014 Services/visits should not be included for data abstraction for the 2013 GPRO Web Interface submission. However, if the most recent BMI is abnormal it is acceptable to show a note in the chart for a recommended follow up visit within 6 months, which could be a follow up scheduled in 2014.	X	X	X

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380	FAQ	For PREV-9, can a measured BMI in the patient's record from an encounter in any setting be used (e.g. outpatient, inpatient, ED, etc)?	As long as you can find the most recent BMI you can use that. In the narrative specification for the BMI measure there is a numerator note that indicates the calculated BMI or follow up plan for BMI outside of normal parameters that is documented outside of the medical record may be reported if done in the providers office or facility or if obtained by the provider from outside medical records within six months.	X	X	X
381	FAQ	For PREV-9, when should BMI follow up plan provided: on the date of the encounter which has an out-of-range BMI or should we look back 6 months from the most recent out-of-range BMI encounter?	If the patient has an abnormal BMI, a follow-up plan at that current visit or within the past 6 months of the visit should be documented.	X	X	X
382	FAQ	If a patient's medical record contains height and weight but not BMI, would we need to indicate that a BMI was not calculated? Similarly, what if the weight was measured during the measurement year, but the height was measured in February 2012?	This would not meet the BMI measurement requirements, which requires that both components of the BMI be measured during the measurement year.	X	X	X
383	FAQ	Is there any exclusion for patients whose BMI cannot be calculated (e.g., paraplegia)?	Paraplegia would be considered a medical reason for not calculating a BMI.	X	X	X
384	FAQ	One of our terminally ill patients has a BMI outside of normal parameters, but there was no follow-up plan. How do we complete this patient?	Terminal patients are excluded from this measure. The BMI measurement screen of the Web Interface is where you are able to indicate Not Screened for Medical Reason. Because you will have completed available fields for this patient for this measure, you will have completely reported on this patient for this measure.	X	X	X
385	1/27/2014	Can we use the documentation for the BMI measure from the nursing home facility chart if a provider sees patients at those facilities?	Yes, you can use documentation for PREV-9 from the nursing home facility chart.	X	X	X

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386	1/27/2014	PREV-9: Many of our patients are Chinese and generally have lower BMIs than non-Chinese patients. Particularly among the elderly, some patients have BMIs below 23 and yet are still healthy. Can we indicate that the BMI is normal?	No you can't indicate that BMI is normal, but it is possible that the provider follow-up could be that the provider is going to monitor the BMI as it seems to be normal for that particular patient. Please follow the data guidance. If the provider has anything written in the record even if they simply monitored the BMI that would constitute a follow-up.	X	X	X
387	1/27/2014	PREV-9: The provider documents the BMI number, documents that he found it to be abnormal and documents "follow up plan", but does not specify what the follow-up plan is, but did bill the G-code. Does this count as yes for a follow-up occurred?	Yes, this counts as follow-up for an abnormal BMI.	X	X	X
388	1/28/2014	PREV-9: Can we exclude a patient from if a provider documents "obesity, Cerebral Palsy, Paraplegic, etc..." but no calculation of BMI is documented in a patient's chart?	Medical exclusions for not calculating a BMI when reporting PREV-9 may include: Patient is pregnant, patient is receiving palliative care, or patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. Patient exclusions for not calculating a BMI may include: Patient refuses BMI measurement or if there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.	X	X	X
389	1/29/2014	For PREV-9, a patient goes from a normal BMI, but then has gained weight that makes her most recent BMI abnormal. The doctor mentions it is due to the medication she is on. Should we exclude her due to medical reasons or count the comment as a plan?	The patient cannot be excluded for a medical reason as the abnormal BMI still needs to be addressed. Also, this would not count as a plan of care.	X	X	X
390	1/29/2014	For PREV-9, is the timeframe a strict 6 months from the most recent visit for a BMI to have occurred? What if the most recent visit occurred in late November, and the BMI is from early May?	Yes, the six months from the most recent visit to calculate the BMI is a strict time frame. If the most recent visit occurred in late November, you will use that date to look for a BMI and if that BMI was outside of normal parameters, a follow-up plan should also be documented at the November visit.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
391	1/29/2014	For PREV-9, we have patient with a history of Alzheimer's that had a BMI in the chart that was out of range, the doctor documented that there was no follow-up plan for out-of-range BMI but did not specifically link it to the Alzheimer's diagnosis. Can we count this patient?	To exclude a patient, documentation in the medical record needs to explain that the lack of follow-up for an abnormal BMI was as a result of the Alzheimer's diagnosis.	X	X	X
392	1/30/2014	For PREV-9, if the BMI was documented and the provider discussed and documented various options to treat obesity but the patient declined all options, is this enough to report that the provider formed a follow up plan?	As long as you have documentation that the provider had a follow-up plan documented, this would be sufficient.	X	X	X
393	1/30/2014	Will a BMI of 31 be considered passing?	The normal parameters for the BMI are in PREV data guidance inclusion synonyms column for age 65 and older $23 \geq BMI < 30$ are considered normal. For ages 18-64 years of age $18.5 \geq BMI \geq 25$ are considered normal.	X	X	X
394	1/31/2014	PREV- 9: Is the most recent BMI/office visit was in Jan 2013 and out of range can we look back 6 months into 2012 for a documented follow up plan? OR does all documentation have to occur in 2013?	You may look back 6 months into 2012 for a follow-up plan.	X	X	X
395	1/31/2014	PREV-9: BMI is abnormal, documentation states continue low carb low fat diet, and provided education materials but does not specifically mention abnormal BMI, does that meet criteria for follow up plan?	A BMI must be documented at the most recent visit or within the past 6 months.	X	X	X
396	2/6/2014	PREV-9: Can the patient be referred to a PA or NP for the follow-up plan?	It would be anticipated the medical records would include the reason for referring a patient with an abnormal BMI to a PA or NP.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
397	2/6/2014	PREV-9: If a patient had an emergency visit on 12/31/13 and no BMI was calculated, would we be required to look 6 months back from that emergency visit? Is visit defined as any visit or outpatient only visits?	If the emergency room visit is considered an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status, the BMI would not have to be calculated at that visit. Then the next most recent visit could be used to determine if there was a calculated BMI and if not you could look back 6 months from that date.	X	X	X
398	2/6/2014	PREV-9: If a patient has a BMI value below the accepted parameters, but is described as "well-nourished" within the visit note, would this be an acceptable explanation as to why the patient is "Not Eligible/Not Appropriate for BMI Follow-Up?"	No. It would be anticipated the medical records would indicate a follow up is not necessary and the reasoning for that determination.	X	X	X
399	2/6/2014	PREV-9: If a patient has an abnormal BMI on 6/1/13 in an outpatient clinic, then has a follow-up appointment on 6/30/13, would we select "Yes"?	It would be appropriate to answer "Yes" the patient had an abnormal BMI and "Yes" there was a follow-up plan documented if the follow up visit can be linked to the abnormal BMI by the documentation in the record.	X	X	X
400	2/6/2014	PREV-9: If the patient comes in for a B12 injection delivered by a nurse in December 2013, does this start the 6-month look back or does the 6-month look back start with a visit with the primary care provider?	The visit for an injection should not be used for determining the BMI.	X	X	X
401	2/20/2014	For BMI, if a patient is over 65 years old and has a BMI lower than normal parameters, what should be selected for follow-up since follow is for BMI higher than normal parameter?	A follow up would be required as the BMI is outside of normal parameters rather it be below or above those listed. 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, referral to a registered dietician, or referral to online resources among others that the physician may determine appropriate for that individual.	X	X	X
402	2/20/2014	For PREV-9, can you clarify the follow-up "documentation of a future appointment"?	For PREV-9, documentation of a future appointment is documentation in the medical record of a future appointment to address the abnormal BMI. This appointment is not limited to a physician referral. They may be referred to a dietician, a support group, or a health coach.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
			PREV-10: Tobacco Screening and Cessation Intervention			
403	FAQ	Please clarify the definition for Former Smoker that is addressed in PREV-10 and DM-17.	If you can show documentation that they are not a current smoker, you can mark them as "nonsmoker" regardless of former smoker status. Please also note that tobacco use includes forms of smokeless tobacco.	X	X	X
404	FAQ	Tobacco use: If you look at an EHR and notice that the patient is listed as "non-user" but there is no date listed is that acceptable or do we need to find office notes to make sure that the patient was questioned within the appropriate time period?	Both PREV-10 and DM-17 require that the patient was screened for tobacco use within a specific time period, therefore a screening date would be required.	X	X	X
405	FAQ	On the documentation for proving a beneficiary is no longer a smoker, please define "documentation" - lab test?	If the lab test somehow identifies that the beneficiary is no longer a smoker that's fine. All that is really required is that the provider asks the patient if they're a smoker and they write it down to document that the patient is not a smoker.	X	X	X
406	FAQ	In relation to the measures that diabetes – non-tobacco use and Prevention – screening for tobacco use, how are we to answer these questions in relation to electronic cigarettes?	The measure owner does not consider e-cigarettes tobacco use.	X	X	X
407	FAQ	For PREV-10 when it says screening should be at least once within 24 months would it be accurate to tell our abstractors that screening must be in the record either in 2012 or 2013? If a patient is assessed and identified as a smoker at the current visit, does smoking cessation counseling done at a previous visit within the 24 month look back period count?	Yes, this is correct in both instances. The 2013 PREV-10 Data Guidance defines "Within 24 months" as: The 24-month look-back period of time from the measurement end date.	X	X	X
408	FAQ	Please confirm the tobacco use measures: On DM tobacco use - "Yes" means tobacco non-user; in PREV-10 does yes mean tobacco user?	DM-17 "Yes" means tobacco non-user. PREV-10 "Yes" means tobacco user.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
409	FAQ	In PREV-10 would a note by the physician in the plan section of the chart "Quit Smoking" satisfy the follow-up requirement?	Yes, it would.	X	X	X
410	FAQ	When using an EHR, can you use the answer to tobacco use listed in social history as an appropriate answer? It is listed in an office visit, has a date; but can we use this as a screening since it might be an on-going response from previous office visits?	PREV-10: Determine if the patient was screened for tobacco use at least once within 24 months AND identified as a tobacco user. The response you use must meet the time parameters specified in the PREV-10 Data Guidance and Narrative Specification. If audited, it should be determined that the quality action can be substantiated.	X	X	X
411	FAQ	If the medical record only indicates "smoking", will that patient be numerator compliant for PREV-10?	We can deduce from this entry in the medical record that the patient was asked that they were a smoker and they answered positively. However, in order to be numerator compliant, there also needs to be indication that the patient received tobacco cessation counseling. In this case, there is no indication of tobacco cessation counseling, so the patient would not be numerator compliant.	X	X	X
412	FAQ	If a patient quit smoking in the last 3 months, will the patient be considered to be a non tobacco user?	Yes, they would be identified as a non-user of tobacco if they quit smoking in the last 3 months of the measurement period.	X	X	X
413	FAQ	Many of our patients have prescriptions for Bupropion SR 150 mg Extended Release and for Bupropion SR 200 mg Extended Release. The PREV Drug Code list of tobacco cessation agents includes Bupropion SR 150 mg Extended Release but NOT Bupropion SR 200 mg Extended Release. Could we answer "Yes" to the question determine if intervention was received when they are taking the 200 mg one?	Yes, this would be acceptable.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
414	1/28/2014	For the ACO-PREV-10: Tobacco Use: Screening and Cessation Intervention measure, does Chantix (Varenicline Tartrate) count as a medication for Tobacco use intervention for patients identified as smokers? This medication was not listed on the med list.	Yes, Chantix Varenicline Tartrate is acceptable.	X	X	X
415	1/28/2014	PREV-10: Does intervention need to occur on same day of positive assessment or can it be done at any point in the measurement year? (i.e. assessed in November and the patient was a smoker, but cessation intervention did occur earlier in the measurement period.)	These don't have to occur on the same day. In the data guidance, the instructions column asks you to determine if the patient was screened for tobacco use at least once within 24 months AND identified as a tobacco user. If found to be a tobacco user, then determine if cessation intervention was accomplished.	X	X	X
416	1/29/2014	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 measure assuming that all required documentation is in medical record.	X	X	X
417	2/6/2014	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.	X	X	X
418	2/6/2014	PREV-10: Would a previous smoker now using e-cigarettes meet the tobacco screening and cessation measure? Is it the same case for DM?	For PREV-10, in 2013, e-cigarettes are not considered tobacco use. As long as patient was screened and they are only using e-cigarettes, this would classify as a "non-user". It would be the same for the DM measure.	X	X	X
419	2/20/2014	For PREV-10, if the notes state "Status Unknown" and the member has Alzheimer's, would this be a medical reason for exclusion?	Yes - as long as there is documentation from the provider linking this diagnosis to the reason the patient was not screened.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
420	2/20/2014	For PREV-10, is a tobacco screening/intervention that is done during a hospitalization rather than in the PCP office setting acceptable for meeting measure requirements?	Yes - the setting is not specified for this measure.	X	X	X
		**PREV-11: Screening for High Blood Pressure and Follow-Up**				
421	FAQ	For PREV-11, are all patients with an active diagnosis of hypertension excluded as a "No-Medical Reasons" for this measure even if a BP is taken at the visit?	Yes, that's correct. The patient would be excluded from PREV-11 for medical reasons if there is an active diagnosis of hypertension.	X	X	X
422	FAQ	Can you please show us PREV-11? This is a complicated measure with various follow-up options.	Please refer to the 2013 GPRO measure flows and 2013 Supporting Documents found under the Downloads section on the GPRO Web Interface page of the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html There is also a video in the Quick Start Guide that will go into more the available answers for this measure. The Quick Start Guide is accessible via the PQRS Portal: http://www.qualitynet.org/PQRS.	X	X	X
423	FAQ	On the specs it does not specify if you can take inpatient data for measures that have a BP component; example, Preventive BP, HTN and diabetes. Can we take a BP from inpatient records?	The diabetes blood pressure measure (DM-13) and Hypertension (HTN-2) requires that the BP be obtained during a visit to the practitioner's office or other non-emergency outpatient facility. The blood pressure can be taken from any setting when reporting PREV-11. However, you may use your judgment in PREV-11 and refrain from using BPs when the encounter is for an acute event that would reasonably alter the BP, i.e., fractured arm, chest pain.	X	X	X
424	FAQ	Can we use ambulatory blood pressure monitor readings for the screening blood pressure?	Ambulatory blood pressure monitor readings from the patient are not acceptable. Eligible professionals who report this measure must perform the blood pressure screening at the time of the qualifying visit and may not obtain measurements from external sources.	X	X	X
425	FAQ	In PREV-11 the specifications state to select no medical reason if the patient has an active diagnosis of HTN. How do you define "active"? Documented in 2013?	Patient is under medical management for hypertension. Documentation of medical management should be indicated in the medical records during 2013.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
426	FAQ	For PREV-11, is a patient reported BP acceptable for BP rescreen if the one taken at the office was elevated?	No, patient reporting for this measure is not acceptable.	X	X	X
427	FAQ	For PREV-11, should we really exclude patients who already have a diagnosis of hypertension? We are worried this will lead to too many skipped patients for this module.	Yes you should remove patients who have a current diagnosis of hypertension. We are aware that this may make your denominator smaller and we are prepared to see this, although the majority of hypertensive patients should be remove during assignment and sampling.	X	X	X
428	FAQ	In PREV-11, to qualify as a second hypertensive reading, must the readings be consecutive and within the measurement period?	They do not have to be consecutive readings; however, both reading should occur during a 12 month period to be considered a second hypertensive reading for purposes of recommending appropriate follow-up.	X	X	X
429	FAQ	For PREV-11, what type of follow up plan for hypertension should be reported for the out-of-range patient?	The data guidance (a tab in the PREV Supporting Documents) outlines the different information that should be documented depending on whether the patient is pre-hypertensive; the first hypertensive blood pressure reading is recorded, or if there has already been a second hypertensive blood pressure reading during the measurement period.	X	X	X
430	FAQ	What type of follow-up plan for hypertension should be reported for the out of range patient?	HTN-2 does not require documentation or reporting of a follow-up plan. PREV-11 requires a follow-up plan and recommendations for the appropriate follow-up plan are included in the PREV Data Guidance. The follow-up plan required for PREV-11 should be documented in the medical records.	X	X	X
431	FAQ	For documenting the follow-up visit for the Screening for High Blood Pressure measure, is a future appointment sufficient to satisfy the documentation follow-up?	In order for a future appointment to satisfy the follow-up requirement, there would need to be documentation that links the appointment to the fact that the patient has an elevated blood pressure and requires monitoring of this elevation. In addition, recommended lifestyle modifications, referrals to alternative/primary care provider, anti-hypertensive pharmacological therapy, laboratory tests, or an electrocardiogram are considered recommended follow-up depending on the BP reading. Specific direction is provided in the 2013 GPRO Preventive Care Data Guidance document.	X	X	X
432	FAQ	For 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.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
433	FAQ	Are blood pressure readings done during a stress test acceptable?	A blood pressure taken under more normal circumstances would be more clinically appropriate.	X	X	X
434	1/27/2014	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 f/u plan was not directly linked?	Correct, the follow-up recommended should be appropriately linked to blood pressure management when reporting PREV-11.	X	X	X
435	1/27/2014	PREV-11: The provider documented blood pressure of 122/60 as well as an abnormal BMI. In the section for follow-up plan, he documented that he counseled the patient to reduce salt and to diet to lose weight. Does this meet the follow-up for both measures?	Yes, this would count for 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. | X | X | X |
| 436 | 1/29/2014 | For PREV-11, a patient has a blood pressure > 120/80 with recommendation stated to return in 6 months, not 12 months. Does the return to office need to be 12 months out? | If a patient was screened and has an SBP ≥ 120 and ≤ 139 or DBP ≥ 80 and ≤ 89, the following Follow-Up is recommended: Rescreen BP within a minimum of one year AND Recommend Lifestyle Modifications OR Referral to Alternative/Primary Care Provider. We aren't looking to see if the follow-up office visit actually occurred. We want to determine if the patient was screened for high blood pressure and if a follow-up was recommended as appropriate. | X | X | X |
| 437 | 1/29/2014 | For PREV-11, when a patient has a blood pressure reading out of range and our medical record indicates "continue with a heart healthy diet", does that satisfy the lifestyle modifications defined in the data guidance? | Yes, this satisfies the measure as long as it is documented in the patient's medical record. | X | X | X |

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
438	1/29/2014	For blood pressure, at appointment #1, blood pressure was high, and follow-up was completed and lifestyle modification changes implemented. When the patient returns for appointment #2, the BP is still high but now only in pre-hypertensive range. Does the previously documented lifestyle modification change still count for the second blood pressure?	Notation regarding continuing the plan of care, ie, life style modifications and rescreen in one year, should be documented. Please refer to the Data Guidance tab of the Preventive Care Supporting Documents for further detailed information.	X	X	X
439	1/29/2014	Does a patient's follow-up visit for high blood pressure have to be attached to a billable visit?	No, this can be a follow-up for blood pressure check by the nurse in the office with physician involvement if remains elevated.	X	X	X
440	1/30/2014	For PREV-11, can you please clarify the and/or instructions for pre, first and second hypertension reading?	The recommended follow up information in the Inclusions/Synonyms column of the PREV-11 Data Guidance is clinical recommendations for follow up due to BP classification. The Narrative Specifications contain a table that outlines the expected follow-up for each category and may be the most comprehensive source for you.	X	X	X
441	1/30/2014	For PREV-11, if the last two blood pressure readings are within normal range and there is no recommended follow-up documented, should I report "no" that the patient was not screened for high blood pressure or yes for patient was screened for high blood pressure?	If the patient was screened for high blood pressure, you would answer "Yes".	X	X	X
442	1/30/2014	For PREV-11, the data guidance states to take the most recent blood pressure reading. Can we use documentation that has follow up plans prior to the most recent reading in the patient's record and during the reporting period?	No, you need to use most recent BP. If the most recent BP is outside normal parameters, determine if a follow up plan is documented.	X	X	X
443	1/31/2014	If a patient is ranked in PREV-11 but has a diagnosis of hypertension, should the confirmation be no for other CMS-approved reason?	The correct option to select is "No-Medical Reasons". This will exclude the patient from the measure because they have an active diagnosis of hypertension.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
444	1/31/2014	PREV-11: Screen for HBP- If provider documents that they discussed Lifestyle Modifications but does not list those modifications (and meets all other measure criteria for follow up), does this meet the measure?	Yes, that would meet the measure.	X	X	X
445	2/6/2014	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 has to say "Hypertension"?	Yes, this is an accepted abbreviation for a diagnosis of high blood pressure.	X	X	X
446	2/6/2014	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 medically excluded from PREV-11. This would indicate the patient is being medically managed for hypertension. During the sampling process patients with a submitted claim with the hypertension diagnosis are not included in the sample.	X	X	X
447	2/6/2014	PREV-11: Does starting the patient on an antihypertensive medication (without lifestyle modifications) with a follow-up screen satisfy the measure?	If documentation in the medical record substantiates the use of antihypertensive medication and a follow-up screen as the recommended follow up plan for an abnormal BP, this would be acceptable.	X	X	X
448	2/6/2014	PREV-11: How do we handle patients that have an elevated blood pressure due to White Coat Syndrome?	If the BP is considered abnormal, it would be expected that a follow up plan would be recommended.	X	X	X
449	2/6/2014	PREV-11: If the patient is screened for blood pressure and it's found to be abnormal but there is no documented follow-up, should we select "Yes" or "No"?	Select "No" if the patient was screened, had an abnormal BP and there was no follow up recommended.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
450	2/6/2014	PREV-11: If we are looking at the most recent blood pressure, what is meant by the second hypertensive reading?	The Hypertensive BP Readings included in the inclusions/synonyms column of the Data Guidance tab are to assist in determining the most appropriate follow up. The most recent BP is used, but the medical records might indicate the most recent reading is a second hypertensive reading and therefore the follow up documented should be based on a second hypertensive reading.	X	X	X
451	2/6/2014	PREV-11: In the data guidance, it states "use latest BP". What does this mean if the measure only needs to be done "at least once per measurement period"?	The measure only has to be reported once, but the most recent BP should be used if there is more than one reading documented during the measurement period.	X	X	X
452	2/6/2014	PREV-11: 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 for medical reasons. Select, "No-Medical Reasons".	X	X	X
453	2/20/2014	For PREV-11, is a patient with a diagnosis of Pulmonary Hypertension, (ICD 416.8) eligible for the measure?	Please refer to the Supporting Documents Exclusions tab for a specific code list of exclusions.	X	X	X
454	2/20/2014	For PREV-11, if a patient is already on hypertensive medication but hypertension is not on the official diagnosis list and the patient has only one hypertensive reading in 2013, does patient meet the measure?	Although receiving anti-hypertensive medication is not a medical exclusion, a diagnosis of hypertension, as you noted, is a medical exclusion. Please proceed with data collection for this patient using the most recent blood pressure following the Data Guidance as noted in the PREV Supporting Documents.	X	X	X
455	2/27/2014	For PREV-11, if the patient's blood pressure has fluctuated during the year but the last blood pressure is within normal levels, can we select yes that screening was performed?	Yes, this is acceptable because you are using the most recent BP. We do not expect to see a follow-up plan if the most recent blood pressure is normal.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
456	2/27/2014	For PREV-11, if the blood pressure is not normal, and no plan is noted, is the correct answer "No" even though the blood pressure was taken? To answer "Yes", is it correct that both the blood pressure and follow-up plan must occur?	If the blood pressure is abnormal and there is no follow-up plan, select "No".	X	X	X
		PREV-12: Depression Screening				
457	FAQ	We have a question regarding 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 does include all patients 12 years and older. Yes, this measure does comply with the latest guidance from the US Preventive Services Task Force which does recommend depression screening for those 12 years old and older.	X	X	X
458	FAQ	If a patient completes the depression screening questionnaire on the patient portal a day or more before the office visit and the provider reviews and follows up at the visit (days later), can this scenario be counted for the numerator of this measure?	According to the Inclusions/Synonyms tab of the PREV-12 Data Guidance, screening includes the following statement: This measure requires the screening to be completed in the office of the provider filing the code.	X	X	X
459	FAQ	For PREV-12, please advise who may perform the depression screening (i.e. who is considered qualified to perform it)?	The depression screening for PREV-12 must be completed in the office of the provider filing the code. The measure owner does not specify the credentials of the qualified professional that is administering the age appropriate standardized depression screening tool.	X	X	X
460	FAQ	If we are not billing a code for depression screening and fall screening, can the screening be done over the telephone?	Depression screening required for PREV-12 cannot be performed over the phone. The depression screening must be completed in the office of the provider filing the code. However, for further clarification the falls screening required for CARE-2 can be accomplished over the phone.	X	X	X
461	FAQ	For PREV-12, if a completed PHQ-9 form is in the medical record, does that count?	PHQ-9 is an acceptable screening tool for PREV-12. The Data Guidance states, "Examples of depression screening tools include but are not limited to" in reference to the screening tools. The critical element to remember is that the screening tool must be age appropriate and standardized.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
462	FAQ	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?	If there is a positive screen documented during the measurement period a follow-up plan must also be documented on the date of the positive screen (see Narrative Specifications).	X	X	X
463	FAQ	In PREV-12, can it be a talk with the provider about the feelings to screen for depression?	The provider must substantiate the quality action being reported. Talking with the patient about their general mood is not considered a depression screening using a standardized age appropriate tool. The following is provided in the PREV Data Guidance: Standardized Clinical Depression Screening Tool: A normalized and validated depression screening tool developed for the patient population where it is being utilized.	X	X	X
464	FAQ	In PREV-12, , the specifications state "No-Medical Reasons" can be selected if the patient has an active diagnosis of Depression or Bipolar Disorder diagnosed prior to the first day of the measurement period. How far back prior to 2012 can we look for the diagnosis to be considered active?	There is no specific timing requirement for this measure. The active diagnosis must occur prior to the first day of the measurement period.	X	X	X
465	FAQ	For PREV-12, does the depression screening have to be done in a face-to-face encounter?	Yes, it does. Please see the Inclusion/Synonym column of the Data Guidance for this measure which states, "This measure requires the screening to be completed in the office of the provider filing the code."	X	X	X
466	FAQ	When a measure states that screening tools include, but aren't limited to (such as PREV-12), how do we know what screening tools other than those mentioned will be allowed?	For the PREV-12 measure a standardized and age-appropriate depression screening tool is acceptable.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
467	FAQ	What documentation is needed for depression screening?	The screening component of the measure is looking at whether or not an age-appropriate standardized screening tool was used. Although the specification provides examples of tools that can be used, use of a specific standardized tool is not required. If the tool used indicates a potential diagnosis of depression, the second part of the measure will require documentation of a follow-up plan. Please note that documentation from the provider that the patient does not have depression is not sufficient evidence of a screening. Note that the medical record does not need to include a copy of the standardized tool that was used.	X	X	X
468	FAQ	If there is a notation in the patient record (in 2013) that the patient is under care of a mental health professional sufficient to exclude the patient from the depression measure?	If there is an indication that treatment by a mental health professional **for depression or bipolar disorder** began or a diagnosis was made prior to the measurement period, then yes, the patient may be excluded from the measure.	X	X	X
469	1/27/2014	Does a diagnosis of depression without documentation of Depression screening, allow for marking the patient as medically excluded?	Yes, as long as the diagnosis of depression occurred before the first day of the measurement period. For 2013 submission diagnosis of depression needs to occur before Jan 1, 2013.	X	X	X
470	1/27/2014	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 the diagnosis of depression occurred on or after Jan 1, 2013 there needs to be evidence of a depression screen in the measurement period, Jan 1, 2013 to Dec 31, 2013.	X	X	X
471	1/27/2014	How do we handle a depression diagnosis first made in 2013, but without screening tools?	If no depression screening tools are documented, then you would have to answer "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 2013.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
472	1/28/2014	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. We will explore your suggestion with our Technical Expert Panel for its annual measure review. In order to meet the current measure, the results of the depression screening and follow-up plan (if positive depression screen) must be documented at the time of the encounter (i.e. the appointment with the provider). Although the patient may have access to the depression screening tool in advance of the appointment, the depression screening results need to be documented on the date of the encounter (date of the appointment). If it is evident the eligible provider documented/verified the results of the depression screen in the medical records on the date of the encounter, this would meet the screening portion of this measure. But please note; if the depression screening was positive, a follow-up plan must be documented.	X	X	X
473	1/28/2014	Depression screenings are often done with the Medicare Wellness visits which occur before the doctor visit, and then the provider reviews the results at the visit. Does that count?	If the visit and the screening are occurring at that office visit, then it would count.	X	X	X
474	1/29/2014	Do PHQ's only need documented review by the provider if the responses cascade into a PHQ9?	The PHQ is standardized tool for screening and the provider would indicate if it's a "+/-" screen and if a follow-up plan is needed.	X	X	X
475	1/29/2014	For PREV-12, there is documentation of no depression in the notes however there is no way to know if the PHQ2 or 9 is embedded in their EMR. Would the documentation qualify for measure?	This would not qualify for measure because there is no indication that a standardized age appropriate depression screening tool was used.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
476	1/29/2014	For PREV-12, for patients with documented dementia or Alzheimer's, would "No-Medical Reasons" be the appropriate answer?	Yes in this instance no for medical reasons would be acceptable because we would assume that the provider considers this a situation where the patients functional capacity or motivation to improve may impact the accuracy of results and that is listed as an under the exclusion section of no medical reasons. Not screened for medical reasons may include: *Patient has an active diagnosis of Depression or Bipolar Disorder, (diagnosed prior to the first day of the measurement period) * Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status * Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of the standardized depression assessment tools. For example: certain court appointed cases or cases of delirium	X	X	X
477	1/29/2014	For PREV-12, if there is a note on the patient's chart regarding patient doing well on a depression medication for depression/anxiety but no screening was done for this measurement period, does this qualify as No - Medical Reason?	Patients with an active diagnosis of Depression (diagnosed prior to the first day of the measurement period) are excluded.	X	X	X
478	1/30/2014	For PREV-12, is clear documentation of patient's current function/ limitations in 2013 enough for exclusion or does the provider have to specifically document that the patient was not screened for depression because of their these limitations?	Documentation should substantiate the quality action reported.	X	X	X
479	1/30/2014	For PREV-12, what PHQ-9 value do we need to report on? Does it have to be the most recent one or is it any value throughout the reporting period?	PREV-12 does not stipulate the GPRO must use the most recent value from a clinical depression standardized tool only to report whether the score represents depression or not.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
480	1/30/2014	Is traumatic brain injury an exclusion for PREV-12, depression screening?	If the physician decides this is a situation in which the patient's functional capacity or motivation to improve may impact the accuracy of the results of the standardized depression assessment tool, then yes. But it really 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.	X	X	X
481	2/6/2014	PREV-12: If a patient is seeing a psychiatrist for anxiety, would that count as a medical reason for not doing a screening? Would dementia be considered limited functional capacity and qualify as a medical reason for not conducting a screening?	Yes, the patient would qualify if the EP has it documented in the medical record as a medical reason for excluding.	X	X	X
482	2/6/2014	PREV-12: Is it acceptable to use depression screening and follow-up that was performed during a hospital inpatient stay?	That would be acceptable as long as the screening follows the parameters outlined in the Data Guidance.	X	X	X
483	2/20/2014	Can you 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 tool be used during the measurement period for depression screening.

You need to have documentation that the age appropriate standardized depression screening tool was used, but the actual screening tool does not need to be present in its entirety, just the result of whether it revealed the patient to have depression. | X | X | X |
| 484 | 2/20/2014 | In answering the depression screening question the options are not available to select "No" for a screening performed that was not positive. What's the appropriate answer to this scenario? | If the patient has a positive screen, select "Yes" indicating that the patient's screen was positive for clinical depression using a standardized tool. If the screen was positive, select "Yes" follow-up documented or "No" follow-up not documented. If the screen was negative, "No", patient's screen was not positive for clinical depression using a standardized tool. If "No" selected, do not answer Follow-Up Plan. | X | X | X |
| 485 | 2/20/2014 | If the documentation states that a depression screening was performed and then states the patient is not depressed, does that qualify for the measure? | This would qualify as a depression screen as long as an age appropriate standardized screening tool was used. | X | X | X |

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
486	2/20/2014	If a patient has a depression diagnosis and treatment is discussed in notes, is that a "Yes" for depression screening?	If the patient has an active diagnosis of depression or bipolar disorder prior to the first day of the measurement period, select "No - Medical Reasons".	X	X	X
487	2/20/2014	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 patient was documented as being screened. Then select "No", patient's screen was not positive for clinical depression using an age appropriate standardized tool. If you selected "No", then you do not answer the follow-up plan questions.	X	X	X
488	2/20/2014	For PREV-12, if a patient was screened and found positive for depression but DENIED depression when it was discussed (Thus, no follow up was done.) Does this count as No-patient reasons/refusal? If no follow up was done because of the denial does that mean the patient should be excluded?	If a patient was screened for depression and found positive for depression there must be a follow-up plan documented. There is not a patient exclusion reason available to exclude a patient from the required follow-up plan for a positive depression screening. In this scenario you would need to select "No" for the follow-up plan documented.	X	X	X
489	2/27/2014	If the active diagnosis of depression was mentioned in the progress note for 2011 but no documentation was provided in 2012 and "depression" was mentioned again in 2013 with no mentioned of medical management, would this qualify for "No-Medical Reason"?	For depression screening, the exclusions column for medical reasons in the PREV-12 data guidance include: Not screened for medical reasons may include: • Patient has an active diagnosis of Depression or Bipolar Disorder, (diagnosed prior to the first day of the measurement period) • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of the standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.	X	X	X
490	2/27/2014	Do selecting "No - Medical Reason" for PREV-12 "Active depression", mean the patient needs to be currently on anti-depression medications?	No, the measure is not limited to the being on an anti-depression medication as confirmation of an active diagnosis of depression. A patient is considered to have an active diagnosis of depression as long as they are currently being medically treated for depression. In order to medically exclude the patient with an active diagnosis of depression, the diagnosis is required to have occurred prior to the first day of the measurement period.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
491	2/27/2014	For PREV-12, the physical exam states "Psy: Alert & oriented, time, place, person. No evidence of clinical depression." Different patient, review of systems says "Psy: No homicidal or suicidal ideations." "Over the past 2 weeks, has not felt down, depressed or hopeless, Over the past 2 weeks, has not felt a lack of interest or pleasure in doing things"? Do any of these meet the criteria for depression screening?	An age appropriate standardized depression screening tool must be used.	X	X	X
492	2/27/2014	If a patient is seen by an annual wellness nurse who performed a GDS depression screening which was negative, can we use that as screening, even though patient did not see the clinician that day?	Yes, this would count as screening as long as it is documented in the medical record.	X	X	X
493	2/27/2014	If PHQ 2 is positive and we continue to use PHQ 9, does this meet the measure?	No, because the PHQ9 is considered an additional depression screening tool, not a recommended follow-up.	X	X	X

ASSIGNMENT & SAMPLING

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	How is patient age determined for who is in the measures?	Age is calculated on the first day of the measurement year. For this measurement period, it is January 1, 2013.	X	X	X
2	FAQ	If a patient dies in November 2013, can the patient be sampled for the quality measures?	We are using data through the end of October 2013; it is possible that the patient would be sampled if they died after that date or if their date of death was not updated in CMS' enrollment database prior to sampling. However, you do have an option in the Web Interface to indicate that the patient is not actually qualified for the sample because the patient is in hospice, has moved out of the country, is deceased, enrolled in an HMO, or for another CMS approved reason. See the 2013 Supporting Documents and Release Notes for ACO and PQRS GPRO Web Interface Users posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. Note that if a patient dies after the measurement period (i.e. after December 31, 2013) you may not select "Not Qualified for Sample – Deceased"	NA	X	X
3	FAQ	What is the definition of a primary care service visit?	There is more information on the primary care service visit on the CMS website and the YouTube videos. A list of primary service codes is available in the 2013 GPRO Sampling Supplement posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
4	FAQ	Several providers left our ACO effective12/31/2013, but claims billed to them will still be used for sampling; how should we handle sampled patients who saw these providers?	From the point of care coordination, the Medicare beneficiaries assigned to your ACO did have the plurality of visits at your ACO, albeit the physicians may have left your practice. Additionally, we do have documentation on the SSP website about the effects of dropped or added TINs. Those providers that are participated, but left their ACO will receive a PQRS incentive if the ACO satisfactorily reports quality measures. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Updating-ACO-Participant-List.html for more information.	NA	X	X
5	FAQ	Must a patient have had claims for 2 primary care encounters at our ACO in order to be eligible for sampling?	Yes, this is correct. The list of HCPCS codes used to identify claims for primary care encounters are presented in Appendices A and B in the 2013 GPRO Sampling Supplement posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
6	FAQ	Can you provide us with the physician/practice name for the various providers sampled patients visited during the measurement year?	ACOs will receive the list of beneficiaries prior to the Web Interface opening. The list will include top TIN or CCN and up to three top NPIs based on the number of visits to each provider.

Note that this information will also be available in the GPRO Web Interface when it opens. | NA | X | X |
| 7 | FAQ | Are mental health provider visits included in the sampling methodology? What other specialties are used in assignment and sampling? | In both the 2013 PQRS GPRO Assignment Specifications and the Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology documents posted on the CMS website, tables 2, 3, and 4 provide list of specialties that are included in each assignment methodology. Mental health professional are included in the list of specialties used for assignment and sampling purposes, in particular geriatric and general psychiatry. | X | X | X |

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
8	FAQ	How will patients be selected for quality reporting? Is it random?	Patients are randomly sampled into each module in the GPRO Web Interface. For more information, please see the Assignment and Sampling slide presentation at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html and the accompanying Assignment and Sampling YouTube video at http://go.cms.gov/GPROPlaylist	X	NA	NA
9	FAQ	Why won't the Web Interface patient list for PQRS GPROs be released until January 27th?	ACOs receive the patient list prior the opening of submission because they are multi-TIN organizations, meaning that one ACO is made up of multiple group practices from multiple TINs across a wide variety of practice areas. They are given their patient sample in advance so they can gather the information needed for submission. PQRS GPROs are group practices comprised of only one TIN. Additionally, the ACO program has separate contracts with their groups and is able to provide this information securely whereas PQRS GPRO is not set up in the same way.	X	NA	NA
10	FAQ	What was the logic behind choosing 411 patients for submission?	A sample size 411 has been used historically in other programs such as HEDIS and the Physician Group Practice (PGP) Demonstration. It yields a 95% confidence interval, which is why we have continued to use it. To account for cases in which a patient must be skipped for a valid skip reason, whenever possible CMS will provide a 50% oversample. Therefore 616 patients will be populated into each module, or all eligible patients if fewer than 616 are available.	X	X	X
11	FAQ	What happens if we can't find a sampled beneficiary in any of our medical record systems?	You are able to skip patients if you cannot find them in the medical records as long as you completely report on 411 consecutively ranked patients in total per module. For example, if you skip one patient, you will need to report on an additional patient, patient 412.	X	X	X

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12	FAQ	What is meant by "consecutively ranked"?	When patients are sampled into a module, they are assigned a rank based on the order in which they were sampled. Consecutive means you start at the patient with rank #1 in that module and complete all the patients in the module ranked from 1-411. If you must skip a patient for one of the valid skip reason, you must complete additional patients on a one-to-one basis for each skipped patient. Each module will have a patient with a rank, and you will complete the patients ranked 1-411 in that module. It is possible that each patient will have a different rank throughout different modules. However, the sampling methodology that CMS will use increases the likelihood of a patient having a similar rank in each module into which they are sampled. In other words, a low ranked patient in one module is likely to have a low (though not identical) rank in other modules.	X	NA	NA
13	FAQ	If we do not participate in the elective ranking, do we need to include rank in our submission?	Patients are ranked in each module automatically as they are sampled into each module in the Web Interface for your group. They will already be ranked when you log into the Web Interface and you cannot change the rank order. Note that you do not need to enter data in the order the patient is ranked, as long as you ultimately consecutively complete the required number of patients.

If you are referring to the elective quality tiering under the Physician Value Program, please submit your question to the QualityNet helpdesk. | X | X | X |
| 14 | FAQ | Is a "not-eligible beneficiary" considered a "skipped" beneficiary? | Yes, this is correct. You must enter all required information to confirm that a patient is not eligible for a particular module or measure. | X | X | X |

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15	FAQ	Can you explain the 10% skip threshold?	If you find patients that you are unable to find medical records for or the proper diagnosis or another appropriate reason for skipping, you need to skip the patient and report on another patient. Once you run a report, you will see the skip rate in addition to how many patients you skipped and the reason. You will still have a successful submission as long as you complete additional patients. If you exhaust your list of eligible patients and report on 100%, you will be considered complete.	X	X	X
16	FAQ	Do each of our EPs need to have seen at least one sampled beneficiary in order to satisfy PQRS requirements?	The sampling is not done at an EP level, but rather at the ACO level. There could potentially be EPs in your organization who do not have patients attributed to them in the sample. For SSP ACOs, all of the EPs under an ACO participant TIN satisfy PQRS requirements by virtue of the ACO successfully reporting ACO GPRO Web Interface measures. "Full" Pioneer participant TINs (participant TINs under which all providers participate in the ACO) will satisfy PQRS requirements by virtue of the ACO successfully reporting ACO-GPRO Web Interface measures.	NA	X	X
17	FAQ	Are ACOs encouraged to search providers outside of the given TIN and NPIs for quality measures on assigned beneficiaries?	Yes, the information CMS provides on the top TIN and top NPIs is to guide you in looking for patient records; however, as an ACO you have agreed to be accountable for you assigned beneficiaries. You will need to do your due diligence to find records.	NA	X	X
18	FAQ	We have 29 PCP in our ACO and just completed PY 2012. Some of them are already reporting on PQRS. Does this mean that their patients will not appear in the list of 411?	Since they have enrolled in ACO, they can only participate through the ACO if we are talking about a SSP ACO. Therefore, any reporting they have been doing as individuals through other methods (claims, registry, EHR) will not count for PQRS incentive or avoiding the payment adjustment. They must report through the ACO.	NA	X	X
19	FAQ	If we have a patient in our sample that was attributed by a physician who was rounding in a skilled nursing facility but who left and has provider outside of our ACO, do we use the SNF records for the data and is this acceptable?	In order for the patients who have been assigned to your ACO, the plurality of their primary care services would have been attributed to your ACO. If you are able to access the medical record, you should report on this patient.	NA	X	X

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20	FAQ	Are the GPRO patients provided from CMS determined by encounter claims submissions so we would be able to find a patient by encounter for the measures?	Yes, patients are initially identified and assigned to the ACO or GPRO based on primary care service encounters provided by the organization. For GPROs, it is for primary care services under their specific TIN and for ACOs; it's for services under their participating TINs. We require a minimum of 2 visits at the TIN during the measurement year to be identified as eligible for quality sampling. Encounter codes for individual measure denominator criteria are available in the measure supporting documents.	X	X	X
21	FAQ	Would patients who have only seen an Urgent Care provider within our TIN still be required to report on, or would this be an eligible skip?	Based on assignment and sampling methodology the patient was assigned to your TIN. If you have the patient's medical record you must report on them.	X	X	X
22	FAQ	If a provider leaves the ACO, do we still need to report on one of their patients?	Patients are assigned to an ACO, not to individual providers. If you have access to the patient record, you should report data for the patient.	X	X	X
23	FAQ	Will beneficiaries who decline to share data be included in the sample?	Yes, they would be included in your sample.	NA	X	X
24	FAQ	How are we going to know if a patient/beneficiary is a HMO Medicare enrollee during the measurement year?	When we are sampling, if we find HMO enrollment as a primary payer, we will not sample those patients. However, if you find this information, then you can indicate that the patient is Not Qualified for Sample and provide a Reason of HMO Enrollment with a Date.	X	X	X
25	FAQ	What is the file type of the beneficiary file that will be sent to ACOs on January 13th?	The beneficiary file that will be sent to ACOs only will be delivered via your ESP or MSP mailbox as an Excel file (.xlsx).	NA	X	X
26	FAQ	If we select medical record found "NO" will the patient be considered skipped in all the modules/measures?	Yes, Selecting "No" will skip the patient in all modules and measures. If the Medical Record Found is set to "Not Qualified for Sample" and a valid Reason and Date are provided, the patient will also be skipped in all modules. You will need to complete data for an additional patient in the affected modules See the Patient Confirmation tab in each of the Supporting Documents as well as the Medical Record Found video embedded in the GPRO Online help for more information on skipping a patient.	X	X	X

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27	FAQ	Do we complete 411 consecutive patients overall or in each module?	You need to complete data for 411 consecutive patients in each module.	X	X	X
28	FAQ	When the beneficiary list is provided, will it be in the format of the measures as well? If not, for those ACOs who are uploading data via XML, is there a specific format that we need to have it in?	The beneficiary file that will be sent to ACOs only will be delivered via your MFT mailbox as an Excel file (.xlsx). If you are uploading XML files you must use the format specified in the GPRO XML Specifications. The XML Specifications are available on the CMS GPRO Web Interface page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html If you export your patient data or patient discharge data in an XML file from the Web Interface it will be in the same format that is required for an XML upload.	NA	X	X
29	FAQ	Will the random sample be available in the MFT 1/13/14 in the morning?	Each ACO received a Beneficiary-Provider Supplemental Information File on 1/13/14 as planned. The file was delivered to each ACO's MFT mailbox, and will be available for download until February 11, 2014. Groups will be able to access the beneficiary information when the Web Interface opens on 1/27/14.	NA	X	X
30	FAQ	Do I need to confirm the diagnosis for each patient or just use the provided patient list as the denominator?	The samples are selected using claims data submitted with the appropriate G-code. For example, the sample for diabetes would be pulled using claims data with diabetes G-code included on the claim. We ask that you then confirm that the patient does have diabetes documented in the medical record to complete the remaining data.	X	X	X
31	FAQ	How should the three primary care physician names be used?	The physician name is provided to help you as a point of reference to help you find patient medical records, however the physician list is not exhaustive and you should look for all data on the patient.	NA	X	X
32	FAQ	If the ACO reports on a deceased, HMO, or hospice patient unintentionally, does this count against the ACO completely reporting on 411 beneficiaries?	If you reported on a patient as deceased, HMO, or hospice, you would be able to go back into the Web Interface and fix it.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
33	FAQ	If the patient is attributed to a psychiatrist and does not have any other office visits with a Primary Care Physician, can we exclude this patient as we cannot go through these charts?	No, if you have a situation such as this, please open a help desk ticket. We will work with you to find the visits that attributed the patient to your group. As needed, we will work with CMS to provide a "CMS approved reason". Please note that the assignment and sampling process is at the TIN level, not the provider level.	X	X	X
34	FAQ	In our patient list, there patients that are not part of the ACO, i.e. not in the latest assignment list. Do we need to provide PQRS info for those patients?	All patient samples for the GPRO WI were based on a third quarter assignment for MSSP ACOs. For Pioneer ACOs we use data available as of the third quarter which was exclusions through the second quarter.	NA	X	X
35	FAQ	Last year, we had some patients attributed to our ACO that had not activity in our medical record during the measurement period. Would we be able to say could not find medical record since there is absolutely no activity?	Due to differences in the patient attribution methodologies for Pioneer ACOs and MSSP ACOs it may be possible that an assigned or aligned beneficiary was not treated within the medical year. To address the situation we require two visits at one of the ACO participant TINs during the measurement year. According to the claims, we have found the patients to be associated with your ACO during the measurement year so this should not be an issue.	NA	X	X
36	FAQ	What is the significance of a patient's rank?	Each sampled patient in the module/measure is randomly assigned a rank order number for that module/measure. Patients will be ranked 1-616 for an ACO or PQRS GPRO with 100 or more EPs, or the maximum number of eligible beneficiaries if fewer than 616 are eligible for a given module. The purpose is to facilitate completion of 411 cases in consecutive order. For PQRS GPROs with 25–99 EPs, patients will be ranked 1–327 to facilitate completion of 218 cases in consecutive order.	X	X	X

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37	FAQ	Will each ACO child (participant) TIN receive its own set of samples?	No. Quality data collection, measurement and reporting in the ACO program are conducted at the ACO-level. The 15 samples on which ACOs will need to submit clinical quality data will be drawn across all assigned/aligned beneficiaries across all the child TINs of the ACO. In other words, there will be one set of 15 samples drawn for the entire ACO, not for each TIN in the ACO. The patients will be assigned to a clinic during the sampling. The Clinic IDs for an ACO will map to the participating ACO TINs. The Patient List can be sorted or filtered by the Clinic Name or ID to refine the list.	NA	X	X
38	FAQ	What if one or more of our modules contains fewer than 411 (for ACOs and PQRS GPROs with 100 or more Eligible Professionals (EPs)) or 218 (for PQRS GPROs with 25-99 EPs) ranked patients?	Not every module or measure will have a sample of 616 patients (or even 411 patients) for ACOs and PQRS GPROs with 100 or more EPs or 327 (or even 218) for PQRS GPROs with 25-99 EPs; this is particularly true in modules with diseases that have low disease prevalence rates. If CMS' contractor was unable to identify 616/327 patients that met the module sampling criteria, then all patients who meet the criteria will be sampled. In past experience, we have seen low numbers of patients sampled into the Heart Failure module. If you have fewer than the minimum number of patients in a module, you must confirm and complete or provide a valid skip reason for all the patients in the module.	X	X	X

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39	FAQ	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. Medicare HIC ID of the patient. First and last name of the patient. Gender Patient Date of birth Patient Rank in each module, if applicable The 3 Providers that provided the most primary care services to the patient Clinic at which the patient received the most primary care services Date of HbA1c test (DM module) Date of LDL-C test (DM module) Date of LDL-C test (IVD module) Mammogram (PREV-5) Colorectal Screening (PREV-6) Flu Shot (PREV-7) Pneumococcal Vaccination (PREV-8) Discharge dates (CARE-1)	X	X	X

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40	FAQ	What if pre-populated 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 GPROs to modify this information. However, if the patient's demographic information in your records and in the GPRO Web Interface does not match, then the abstractor may need to correct the information in the GPRO Web Interface. The most common issue may be a patient's date of birth. Medicare claims may not have the accurate date of birth for a patient, and your ACO or GPRO should correct this information since all measures have an age criteria for which the patient may be affected (e.g., patient may be removed from the denominator). If any changes to demographic information (such as age or sex) result in the patient no longer being qualified for the measure, you should select "Other CMS Approved Reason". Note that any demographic information you change in the GPRO Web Interface cannot be fed back into the CMS claims system. You should urge your patient to contact the Social Security Administration directly to have that information	X	X	X
41	1/16/2014	How should we handle discrepancies in HICs when the GPRO Web Interface has one HIC and our charts reflect a different number? How should this be documented in GPRO?	The Health Insurance Identification Numbers (HIC) is the patient's Medicare ID and cannot be changed in the Web Interface. The Medicare ID is the linking field for the patient. The Railroad Retiree Board or the Social Security Administration assign patient HIC. Patient's HIC#s may change over time as eligibility reasons change (for example, the last two digits of a patient's HIC# may change if the patient's eligibility status changes from spouse to widow or the entire HIC# may change if a patient changes eligibility from self to dependent status). Whenever possible you should confirm the patient based on other criteria (e.g., name, gender, date of birth).	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
42	FAQ	Is the ACO or GPRO responsible for validating the data that is pre-populated into the Web Interface?	You will need to look at the data guidance for specific measures to answer this question. For example, if an HbA1c lab test date is prefilled for a particular patient, the ACO or GPRO will need to identify the HbA1c value from that test. If, in your medical records, you do not find documentation of an HbA1c test performed on that date or cannot find an associated HbA1c value, you can then change the date to one that is within the measurement period for which you do have the HbA1c value. Claims data is used when available to pre-populate fields in Prev-5 (mammogram), Prev-6 (colorectal screening), Prev-7 (flu shot), and Prev-8 (pneumococcal vaccination). For the flu shot, colorectal cancer screening and pneumococcal vaccination measures you do not need to take any additional steps if the information has been pre-filled for you. In cases where the elements for these measures have not been pre-filled you will need to access the patient's medical record to determine if it supports that the quality action was completed in the respective timeframe, i.e., different for influenza immunization than for colorectal cancer screening. You will also be required to provide this supporting medical record documentation if your organization is selected for audit following the data collection period. This is not the case if the WI has been pre-filled with claims information. The breast cancer screening measure is treated differently because the measure requires that there be medical record documentation including both of the following: A note indicating the date the breast cancer screening was performed AND The result of the findings of the date of the mammogram and the results of the mammogram. The claims information will still be pre-filled; however, additional retrieval of information will be required to include these two components and that documentation will be required should the organization be selected for audit.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
43	FAQ	The data guidance states DM patients need 2 face to face visits for the denominator but the supplemental documents for GPRO do not ask for this information. Are 2 face to face visits necessary for the GPRO submission?	The required 2 face to face visits are addressed during the sampling process and therefore it is not necessary for you to confirm that the patient had two visits with the ACO our group during the measurement year. The Assignment and Sampling documents are located on the cms.gov website; http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. These documents are specifically located in the Downloads section at the bottom of the page.	X	X	X
44	1/27/2014	Have the discharge dates for CARE-1 and other pre populated data been posted on the CMS site for us to download? We just checked and we cannot seem to download.	Yes, this information is available in the Web Interface. If you cannot find this information once you log onto the Web Interface, please open a help desk ticket.	X	X	X
45	1/27/2014	I have a question about the claims data we received on the patients. If a patient does not fit within the requirements of the measure, are they still listed for that measure? For example, in PREV-5: Preventative Care and Screening: Breast Cancer Screening?	Patients that meet initial quality eligibility criteria are assessed for eligibility for each GPRO WI module based on individual module criteria. A random sample of eligible patients is drawn for each module of the Web Interface according to the sampling methodology. Therefore all patients sampled into each module met the module criteria based on Medicare claims data used to identify patients for sampling. You should use information in your patient's medical record to report in the Web Interface. The Assignment and Sampling documents are located on the cms.gov website; http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. These documents are specifically located in the Downloads section at the bottom of the page.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
46	1/27/2014	May we still abstract a patient who died or is in hospice when we have plenty of data to fully abstract this measure? For example if the patient died in 9/2013, but they had lots of office visits and data prior?	No, the patient must be alive during the entirety of the measurement period to be eligible for GPRO Web Interface reporting.	X	X	X
47	1/27/2014	The CARE-1 Discharge Dates are not posted yet under the MFT mailbox binary data. When will this be available? (We thought you said it was transferred.)	We submitted for ACOs to their MFT mailboxes on 1/13/2014 information on patients sampled in the Web Interface, but didn't include service dates on. Now that the Web Interface is open, you can access that information on each sampled patient in the Web Interface.	NA	X	X
48	1/27/2014	We are finding a number of beneficiaries who are outside the age ranges specified in the measure. What value should we report to exclude them from the measure?	Age is calculated as of first day of measurement period. If the patient met the measure's age requirement as of January 1, 2013, then the patient is eligible for sampling. You can correct a patient's date of birth if is it listed incorrectly in the Web Interface. If you are still finding issues with a patient's age, please submit a help desk ticket with the patient's rank in the module.	X	X	X
49	1/27/2014	We are finding many patients who do not have a specific diagnosis such as IVD or CAD but they are falling into that measure. Do we just make these as diagnosis not found? It seems like a lot more than last year.	Regarding sampling, we look for 2 claims with a diagnosis of the measure for each module. If you can't confirm, select no for patient confirmation. Please note we advise you to check all patient records including those that other providers may have.	X	X	X
50	1/28/2014	Because we are determining beneficiary for each individual PREV measure, does that mean that no parameters were used to select someone for a sample, i.e. men in the mammography sample?	Note that each PREV measure is a separate module and each has its own denominator. CMS samples patients using claims through 10/31/2013 and identified patients eligible for each module according to the module's denominator criteria. See the 2013 GPRO Sampling Supplement posted on the CMS Web Interface website, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html for more details on the criteria for each module.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
51	1/28/2014	CARE-1: Are we able to get a report that includes all of the discharge dates? We have looked at the patient discharge, patient ranking, and patient files and none of them include more than one discharge date.	For sampling, if you only see one patient discharge date that is the only date that is eligible for the denominator pending your confirmation of the data elements in the Web Interface.	X	X	X
52	1/28/2014	If in our auditing effort we find 50 ineligible patients of initial listing of 411 pts; do we proceed to report the subsequent 50 patients in the order submitted of the larger sample listing of 614 pts to complete the reporting for that measure?	Yes, The 50% oversample is provided whenever possible to allow for cases in which patients ranked in the first 411 or 218 patients must be skipped for valid reasons. For each patient that is skipped, an additional consecutively ranked patient, on a one-to-one basis, must be completed until the target sample size of 411 (for ACOs and GPROs with 100 or more EPs) or 218 (for GPROs with 25-99 EPs) is reached, or until the sample is exhausted.	X	X	X
53	1/28/2014	We have a high number of patients being skipped within DM due to not being able to confirm the diagnosis. Can you please explain how these patients were put into this module?	Please refer to the sampling documentation found on the GPRO Web Interface page of the CMS website under the 2013 GPRO Sampling Supplement header: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
54	1/29/2014	Because ACO measure 26 has a denominator of a diagnosis of diabetes AND IVD, should we assume that CMS put patients in the diabetes composite with IVD? We are not finding many diabetic patients with IVD. Will these patients be skipped for the entire composite?	No, it would not impact the composite score. CMS samples at the module, rather than measure, level. If a patient is confirmed and eligible for the DM module but does not meet the criteria for a particular measure, this patient will be considered to have passed the individual measure. Please note, however, that the patient will have to meet the numerator criteria for each measure to meet the numerator for the composite measure. Please review the 2013 Measures Flows for ACO GPRO and PQRS GPRO Web Interface Users, available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html for more information.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
55	1/30/2014	We have a patient is seeing an orthopedic specialist in our ACO, but her PCP is not in our ACO. Since she is ranked for DM, what shall we do for the information?	A patient is assigned to your ACO/GPRO based on plurality of primary care services. A patient must have a minimum of two visits for PCP in the measurement year with your organization. You should make your best effort to find the information needed for the module in which the patient is ranked. If cannot find the information, you would answer "no".	X	X	X
56	1/30/2014	We have a patient who has declined data sharing, but they are ranked in the patient sample in the Web Interface. What do we do in this case?	If the patient was assigned to your ACO, you should have access to the patient. Any information from the appointment of care is eligible for GPRO reporting.	NA	X	X
57	1/31/2014	If we have patients that records are in a nursing facility, do we have to get those records or can we skip?	From the perspective of assignment and sampling, we have been able to attribute those patients to your organization and therefore you have a responsibility to obtain those records and report on the patient.	X	X	X
58	1/31/2014	It was stated that a help desk ticket should be opened for instances where "No, other CMS Approved Reason" is selected. Is this for all reasons, such as those ranked for a measure that are not in the qualifying age range on 1/1/13?	Any time you feel like you have a request for another CMS approved reason you would want to submit a help desk ticket so it could be researched.	X	X	X
59	1/31/2014	Med Rec: If patient was discharged from hospital and admitted to SNF on the same day and in SNF or nursing home 30 days post IP DC, do we exclude them from the med rec requirement?	Yes, you can count it as med rec as long as medical record includes the information that's included in the inclusions and synonyms tab of the data guidance.	X	X	X
60	1/31/2014	We had a full sample of 616 patients ranked in the HF module last year. However, this year we only 517 patients in the HF module. Were there any issues with the HF samples this year?	The makeup of your assigned beneficiaries may be different this year, which means you may have fewer heart failure patients in the module. It is common for the heart failure measure, in particular to have fewer than 616 patients sampled. There may have also been slight changes in coding that could impact your sample.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
61	2/6/2013	Does Medicare Railroad Retirement qualify as standard Medicare?	Yes, Railroad Retirement patients are included in your sample if they have any months of Medicare Part A and B during the measurement period and meet other quality measurement criteria for PQRS reporting.	X	X	X
62	2/6/2013	For CARE-1, are discharge dates after an observation stay, ambulatory procedure or ambulatory surgery included in the discharge dates provided?	No, your patient sample should only include discharge date associated with inpatient stays.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
63	2/6/2013	For the DM measure, there were 100 patients for whom we could not confirm their diagnosis. Is this scenario possible and reasonable?	In order for the patient to be considered eligible for sampling into the diabetes module, CMS has identified claims indicating that the assigned beneficiary had: (1) At least two primary care services visits (for any reason) billed by an ACO participant TIN or group practice TIN during the measurement period AND Either: (2a): two face-to-face encounters with different dates of service in an outpatient setting or non-acute inpatient setting (not necessarily billed by an ACO participant TIN or group practice TIN) occurring during the measurement period or the year prior with a documented diagnosis of diabetes mellitus (DM) (type 1 or type 2); OR (2b) one face-to-face encounter in an acute inpatient or emergency department setting (not necessarily billed by an ACO participant TIN or group practice TIN) during the measurement period or the year prior with a documented diagnosis of diabetes mellitus (type 1 or type 2) Therefore, CMS has already confirmed that patients meet the initial sampling criteria for the diabetes module although it is possible that the claims used to identify diabetic patient came from outside the ACO or group practice. It is the ACO's or group's responsibility to confirm that the patient has a history of diabetes. If you are not able to confirm the diagnosis, then it is appropriate to select "Not Confirmed". For more information, you may find it helpful to review the 2013 PQRS GPRO and ACO WI Measures Part 2 slides, available for download on the GPRO Web Interface Web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
64	2/6/2013	How will additional patient are sampled to make up for skipped patients?	We provide a 50% oversample. As an ACO or GPRO with 100 or more EPs, you would have 616 patients in each measure. GPROs with 25-99 EPs would have 327 patients in each module. If you skip a patient, you would need to complete an additional patient to account for this skipped patient.	X	X	X
65	2/6/2013	If a patient is deceased, but we do not have a date documented in the record, what date should we use?	You would use 12/31/2013. You would need to be able know and show that the patient deceased on or before the end of 2013.	X	X	X
66	2/6/2013	If a patient is not a patient with our facility at the beginning of the reporting period, do we need to report on him or her?	Yes. By the assignment algorithm, the patient was assigned to your ACO or group as they were deemed to have the plurality of their Medicare services with your organization. Patients assigned to your ACO or group are considered eligible for quality measurement if they meet certain other quality measurement criteria and have at least two primary care service visits by an ACO participant TIN or group TIN during the measurement period. You will need to be accountable for this patient's care, and should contact the patient's other providers to obtain the needed quality of care information to complete the GPRO Web Interface. You should enter "Medical Record not found" only if you are unable to access the patient's Medical Record.	X	X	X
67	2/6/2013	If we can't confirm specific patient diagnosis, does the patient qualify? If not, how should we respond? If we skip the patient, what do we use as an indicator?	When you can't confirm a diagnosis, select "not confirmed" for the patient. You would then stop abstraction on that patient for that module. However, that patient may still be sampled for another module under a different rank.	X	X	X
68	2/6/2013	If we complete more than 411 patients per measure, how does that effect our measure compliance?	To satisfactorily report, you only need to complete 411 consecutively ranked patients per measure. The measure performance rate is based the total number of consecutively confirmed and completed patients, not including skipped patients. Your performance rate include Patient ranked #1 and includes all of your completed patients until we reach the first incomplete patient.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
69	2/6/2013	Should we be concerned if our sample size is less than 411?	In some cases, such as the heart failure (HF) measure, an ACO or GPRO may have less than the target sample size. If that's the case, you are responsible for reporting on all of the ranked patients in that module. If you are concerned about the sample, please submit a QualityNet Help Desk ticket.	X	X	X
70	2/6/2013	There are patients ranked for screening mammograms that are less than 50 years of age. Should we include them?	For 2013, the denominator criteria includes all female patients 40 to 69 years of age. Please refer to the 2013 GPRO Measure Specifications.	X	X	X
71	2/6/2013	When confirming if a patient is eligible for a module, should we be using the denominator criteria?	Yes, you want to look at denominator criteria. If feel the patient isn't eligible at that point in time, you can open a QualityNet Help Desk ticket and request an "Other CMS Approved Reason". In the QualityNet Help Desk ticket, please include the patient, module, rank and reason why you are requesting the other CMS approved reason. When CMS makes a decision, you will receive a resolution back from the QualityNet Help Desk and will be able to complete the patient appropriately.	X	X	X
72	2/6/2013	When determining if a patient is qualified for the sample, how should we treat patients that are in managed long-term care through an HMO? These patients are enrolled in Medicare as well as the HMO. Do they still qualify for the sample?	From a sampling perspective we look for Medicare Parts A & B activity; however, we aren't able to determine HMO patients from claims. However, you do have the option within the Web Interface to select not qualified if the patient is enrolled in an HMO, which you would select in this case.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
73	2/6/2013	When we downloaded our heart failure patient list, it only contained a rank for 433 patients where the others have 616? Why would that be?	As noted in the 2013 GPRO Sampling Supplement, whenever possible CMS will provide a 50% oversample of the target sample size. For ACOs and groups with 100 or more EPs CMS will sample up to 616 patients (50% more than the target sample of 411 patients). For groups with 25-99 EPs CMS will sample up to 327 patients (50% more than the target 218 patients). When fewer than 616 or 327 patients are available for a module, all of the available patients will be used. This can occur based on your patient population, so it shouldn't be concerning.	X	X	X
74	2/20/2014	If patients are seen only in specialist office, can they be excluded from rankings?	If your ACO or GPRO includes specialty providers, they are eligible for assignment as long as the bill appropriate E&M codes and therefore cannot be excluded.	X	X	X
75	2/20/2014	Is there any documentation about how the provider NPI's were assigned to our patient population? If so, where might we find it? If not, can you describe how they were assigned?	For ACOs, this information is documented in the supplemental file received prior to the opening of the Web Interface.	X	X	X
76	2/20/2014	This year, we are not showing any nursing home patients in our sample but last year there were quite a few. Is this due to a change in the sampling method?	No, the sampling method has not changed from last year other than changes to individual measures specifications. For clarification, the sampling method for ACOs has not changed. The PQRS GPRO method has changed somewhat to align with the ACO sampling method.	X	X	X
77	2/20/2014	If a patient is only seen by our GPRO by specialists, I understand the patient is attributed by plurality, but if attributed by this method, does this mean the patient did not see a primary care physician (internal medicine, family medicine, etc.) during the year anywhere?	We don't look at specialists or keep record of specialty codes for those beneficiaries assigned to your GPRO or ACO where they might have been seen. We don't have the information available if your patient has seen a primary care provider outside of your group.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
78	2/20/2014	Is there a rationale that within our sampling that when we get to the oversampling (rank 411) that it is not randomized, but it is starts by date of birth, and ranked by oldest to youngest?	Eligible patients were randomly sampled according to the methodology described in the 2013 GPRO Sampling Supplement available on the PQRS GPRO Web Interface page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. Please review this document for more information. This ordering is coincidental. If you have concerns about your sample please contact the QualityNet help desk.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
79	2/20/2014	Is every outpatient visit considered a primary care visit? Do the E&M codes determine primary care visit? We have patients that are being pulled into our sample who are listed under providers who work inpatient only. How is this taken care of?	All patients sampled into the Web Interface have been assigned to your ACO or GPRO by the program's assignment algorithm. Note that the assignment/alignment algorithms as well as the "2-visit rule" used to determine quality eligibility for GPRO sampling include domiciliary, rest home, and home services codes. For more information on GPRO assignment please see the 2013 GPRO Assignment Specifications at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_GPRO_Assignment_Specs.pdf. Information on the SSP assignment algorithm is available in the Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf . Detail on the Pioneer alignment algorithm is available in the Pioneer ACO Benchmark Methodology at http://innovation.cms.gov/Files/x/PioneerACOBmarkMethodology.pdf. The codes used in assignment/alignment are available in this document and also in the 2013 GPRO Sampling Supplement available on the PQRS GPRO Web Interface page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.

It is your responsibility to completely report on each sampled patient to the best of your ability to account for the patient's care. Note that the assignment/alignment algorithms include domiciliary, rest home, and home services codes. If, however, you are unable to obtain the medical record, it would be appropriate to select "No" under "Medical Record Found" in the Web Interface. | X | X | X |

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
80	2/20/2014	We have come to the end of our pre-populated list and are not seeing any additional names. Can we conclude that that is the total number of patients on whom we should be reporting? We have 308 patients, not 411 in the sample.	Yes, you can conclude that this is the total number patients available for Web Interface reporting. The target sample for ACOs and groups with 100 or more EPs is 411. Whenever possible, CMS pre-populates the Web Interface with a 50% oversample, for a total of 616 patients. For groups with 25-99 EPs, the target sample is 218 patients and a 50% oversample (327 patients) is provided whenever possible. When fewer than 616 or 327 patients are available, the Web Interface is populated with all of the patients eligible for the module. In this case you are responsible for reporting on 100% of the sampled patients.	X	X	X
81	2/20/2014	If a patient is enrolled in the Independence at Home CMS Demonstration project and visit data is in the EMR, then the patient cannot be included for submission because the care took place in the patient home. Is this correct?	Patients enrolled in the Independence at Home CMS Demonstration program are not eligible for assignment to MSSP ACOs or Pioneer ACOs. If you are an ACO and find a patient enrolled in this program please contact the QualityNet help desk. For group practices, these patients are eligible for assignment and therefore for quality sampling if they meet all quality eligibility criteria. As noted above, home care E&M codes are included in the assignment algorithm and those alone are not reason to exclude a patient from quality reporting.	X	X	X
82	2/27/2014	I have identified a patient from our sample that only has a first initial listed as their first name. I was able to find a patient matching by date of birth, yet the Medicare ID provided does not match our records. Is this patient eligible for reporting?	Yes, the patient is eligible if you can confirm enough information to successfully identify the patient. Note that Medicare IDs can change over time so it shouldn't be your only means of identifying patient.	X	X	X
83	2/27/2014	We have a persistent problem with sub-acute care or home care patients who have incomplete records flowing into our EHR chart or a primary care provider outside our GPRO (very often with sub-acute care patients.) Are sub-acute care facilities supposed to be included in our sample?	Any patient assigned to your GPRO/ACO has received the plurality of care for primary care services billed by your GPRO/ACO. We do include nursing home care and home care codes in our sampling process. There are supplemental documents on the CMS website that describe the assignment and sampling methodologies.

You need to use all of the information available to confirm and complete the patient. | X | X | X |

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
84	2/27/2014	Why are HMO patients not included in the sample? What is meant by "etc." in the below statement: HMO Enrollment: Select this option if the patient was enrolled in an HMO at any time during the measurement period (i.e., Medicare Advantage, non-Medicare HMOs, etc.)	Beneficiaries enrolled in a group health plan as their primary payer—including beneficiaries enrolled in Medicare Advantage (MA) plans under Part C, eligible organizations under section 1876 of the Social Security Act, and Program of All Inclusive Care for the Elderly (PACE) programs under section 1894—are not eligible for assignment. CMS uses claims submitted and paid through Medicare Part A (for inpatient and outpatient services) and Part B (for physician services) to assign beneficiaries to an ACO or GPRO and also for sampling purposes. The necessary data for determining module eligibility is not available in Part C claims or claims paid by other sources. The "etc." can refer to PACE plans as noted in the statement above.	X	X	X

PAYMENT ADJUSTMENT

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	We understand that we can submit one measure through the Web Interface for all our providers and that will satisfy the requirement for the PQRS and also the value based modifier to avoid the penalty. Is that correct?	There are two sets of criteria for reporting 2013 PQRS Web Interface reporting to avoid the 2015 PQRS and Value-based Payment Modifier (VM) adjustment: 1) Meet the criteria to avoid payment adjustment. To avoid the PQRS payment adjustment, your group must submit one valid measure through the GPRO Web Interface. Please note, if your group registered for the Value-based Payment Modifier (VM) quality tiering, then reporting only one valid measure may subject the TIN to a downward VM adjustment in 2015. Please also note that certain data for 2013 Web Interface reporting will be posted on Physician Compare. Additionally, CMS encourages all groups to learn how to satisfactorily report during the 2013 reporting period in order to prepare for participation in future program years. 2) Satisfactory report to earn the 2013 PQRS incentive by reporting on all measures included in the Web Interface and populate data for the first 218 consecutively ranked and assigned beneficiaries if you are a group of 25-99EPs or on the first 411 consecutively ranked and assigned beneficiaries if you are a group of 100+ EPs, or if there are less than that number, to report on 100% of assigned beneficiaries.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
2	FAQ	Is there another way that we can use to report one measure for one patient in order to avoid the 2015 PQRS payment adjustment? For example, is submitting via claims an acceptable way to report the one measure for one patient to avoid the PQRS payment adjustment?	There is no opportunity to change reporting methods since the registration period has closed. So, if you selected the GPRO Web Interface as your reporting mechanism, you must submit one valid measure for one patient in the Web Interface to avoid the payment adjustment. In order to earn the PQRS incentive in 2013 (and if applicable, to meet the Shared Savings Program Requirements), you must report on all measures/modules for your patient threshold (411 patients for ACOs and PQRS GPROs with 100 or more EPs, and 216 patients for PQRS GPROs with 25-99 EPs per measure/module). If you're a group practice, you cannot report via claims. Claims reporting is only for individual PQRS reporters.	X	X	X
3	FAQ	If an ACO completely reports, are the PQRS requirements satisfied for all of its participating TINs? What if one of the TINs has never seen any of the sampled patients	An ACO satisfactorily reporting will fulfill the PQRS requirements on behalf of the participating providers, regardless of their specialty.	NA	X	X
4	FAQ	While the ACO Quality Measures are Primary Care related, all participant TINs including Behavioral Health and Specialists who are in our ACO are eligible for the PQRS incentive and avoidance of penalty, right?	When the ACO satisfactorily reports quality measures, the ACO participant TINs with PQRS eligible professionals receive credit for PQRS reporting on behalf of all eligible professionals that are part of the TIN, PCPs and specialists. Please see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf for a list of EPs.	NA	X	X
5	FAQ	Are ACOs provided with the PQRS incentive payment amount paid to every TIN In the ACO?	Incentive payments are paid to the participant TIN not primary TIN.	NA	X	X
6	FAQ	How does the participant TIN within an ACO get the PQRS incentive bonus amount by individual NPI?	ACOs do not get PQRS feedback reports which provide an NPI break down.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
7	FAQ	When the physician receives the incentive payment for PQRS, will it state PQRS payment on it?	To clarify all payment are made at the TIN level. For PQRS GPROs the group will receive the payment. For ACOs each participant TIN under the ACO will receive the payment for the providers within that group. It will be one lump-sum payment made at the TIN level. Yes, it should state that it is a PQRS payment on the Remittance Advice with indicator of LE ("Levy") to indicate an incentive payment, along with PQ13 to identify that payment as the 2013 PQRS incentive payment.	X	X	X
8	FAQ	If our group reports only 1 measure, will we receive error messages because not all measures are submitted?	Yes, the Web Interface will show errors because it is missing data. However, if you are only submitting one patient for one measure to avoid the payment adjustment, this is acceptable. You must go to the Submit Screen on the Web Interface and click the Submit button to notify CMS that your submission is complete.	X	X	X
9	FAQ	If our organization did not choose quality tiering, is it possible for our organization to incur CMS penalties if our organization still submits everything required on the Web Interface?	For PQRS and Value-based Modifier (VM) purposes, if you submit satisfactorily in the GPRO Web Interface, your group will not be subject to a payment adjustment.	X	NA	NA
10	FAQ	It was stated the PQRS GPROs with 100 or more EPs have to report on all measures and all patients to meet requirements. In the 2013 Physician Fee Service final rule, it states you must report at least one measure. Which is the correct answer?	There are 2 criteria for PQRS reporting in the Web Interface: 1) In order to avoid the payment adjustment, the GPRO must report one patient on one measure and click "submit" in the Web Interface. 2) In order to receive the PQRS incentive, you must successfully report on greater than or equal to 411 consecutively ranked patients within the Web Interface for each module.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
11	FAQ	If a provider is listed under an ACO, they are covered under the GPRO incentive. Do they still have to report on their non-ranked Medicare patients through PQRS?	The ACO should only report on the assigned patients in each module. You will need to populate the data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or patient care measures. If the pool of eligible assigned beneficiaries is less than 411, then you will need to report on 100% of assigned beneficiaries.	NA	X	X
12	2/6/2013	We have successfully completed at least one measure and submitted it. How do we know we successfully met the requirement to avoid the adjustment for successfully reporting one patient one measure?	If you have a patient who shown as complete on the measures rate report and you have pressed the submit button, you have met the requirement to avoid the payment adjustment.	X	X	X

TIMELINE

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	We understand that we can submit one measure through the Web Interface for all our providers and that will satisfy the requirement for the PQRS and also the value based modifier to avoid the penalty. Is that correct?	There are two sets of criteria for reporting 2013 PQRS Web Interface reporting to avoid the 2015 PQRS and Value-based Payment Modifier (VM) adjustment: 1) Meet the criteria to avoid payment adjustment. To avoid the PQRS payment adjustment, your group must submit one valid measure through the GPRO Web Interface. Please note, if your group registered for the Value-based Payment Modifier (VM) quality tiering, then reporting only one valid measure may subject the TIN to a downward VM adjustment in 2015. Please also note that certain data for 2013 Web Interface reporting will be posted on Physician Compare. Additionally, CMS encourages all groups to learn how to satisfactorily report during the 2013 reporting period in order to prepare for participation in future program years. 2) Satisfactory report to earn the 2013 PQRS incentive by reporting on all measures included in the Web Interface and populate data for the first 218 consecutively ranked and assigned beneficiaries if you are a group of 25-99EPs or on the first 411 consecutively ranked and assigned beneficiaries if you are a group of 100+ EPs, or if there are less than that number, to report on 100% of assigned beneficiaries.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
2	FAQ	Is there another way that we can use to report one measure for one patient in order to avoid the 2015 PQRS payment adjustment? For example, is submitting via claims an acceptable way to report the one measure for one patient to avoid the PQRS payment adjustment?	There is no opportunity to change reporting methods since the registration period has closed. So, if you selected the GPRO Web Interface as your reporting mechanism, you must submit one valid measure for one patient in the Web Interface to avoid the payment adjustment. In order to earn the PQRS incentive in 2013 (and if applicable, to meet the Shared Savings Program Requirements), you must report on all measures/modules for your patient threshold (411 patients for ACOs and PQRS GPROs with 100 or more EPs, and 216 patients for PQRS GPROs with 25-99 EPs per measure/module).

If you're a group practice, you cannot report via claims. Claims reporting is only for individual PQRS reporters. | X | X | X |
3	FAQ	If an ACO completely reports, are the PQRS requirements satisfied for all of its participating TINs? What if one of the TINs has never seen any of the sampled patients	An ACO satisfactorily reporting will fulfill the PQRS requirements on behalf of the participating providers, regardless of their specialty.	NA	X	X
4	FAQ	While the ACO Quality Measures are Primary Care related, all participant TINs including Behavioral Health and Specialists who are in our ACO are eligible for the PQRS incentive and avoidance of penalty, right?	When the ACO satisfactorily reports quality measures, the ACO participant TINs with PQRS eligible professionals receive credit for PQRS reporting on behalf of all eligible professionals that are part of the TIN, PCPs and specialists. Please see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf for a list of EPs.	NA	X	X
5	FAQ	Are ACOs provided with the PQRS incentive payment amount paid to every TIN In the ACO?	Incentive payments are paid to the participant TIN not primary TIN.	NA	X	X
6	FAQ	How does the participant TIN within an ACO get the PQRS incentive bonus amount by individual NPI?	ACOs do not get PQRS feedback reports which provide an NPI break down.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
7	FAQ	When the physician receives the incentive payment for PQRS, will it state PQRS payment on it?	To clarify all payment are made at the TIN level. For PQRS GPROs the group will receive the payment. For ACOs each participant TIN under the ACO will receive the payment for the providers within that group. It will be one lump-sum payment made at the TIN level. Yes, it should state that it is a PQRS payment on the Remittance Advice with indicator of LE ("Levy") to indicate an incentive payment, along with PQ13 to identify that payment as the 2013 PQRS incentive payment.	X	X	X
8	FAQ	If our group reports only 1 measure, will we receive error messages because not all measures are submitted?	Yes, the Web Interface will show errors because it is missing data. However, if you are only submitting one patient for one measure to avoid the payment adjustment, this is acceptable. You must go to the Submit Screen on the Web Interface and click the Submit button to notify CMS that your submission is complete.	X	X	X
9	FAQ	If our organization did not choose quality tiering, is it possible for our organization to incur CMS penalties if our organization still submits everything required on the Web Interface?	For PQRS and Value-based Modifier (VM) purposes, if you submit satisfactorily in the GPRO Web Interface, your group will not be subject to a payment adjustment.	X	NA	NA
10	2/20/2014	What time on 3/21 does Web Interface close?	In the past, it has closed at 11:59:59 PM ET on the last day of submission.	X	X	X

2012 GPRO REPORTING

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	We submitted as a GPRO in 2012. We will know you received data because we received confirmation of transmission, and we have a QRUR report based on 2012 data, but we have no PQRS feedback report for 2012. Please explain.	The 2012 PQRS GPRO feedback on reporting information is combined in the 2012 QRUR report.	X	X	X
2	FAQ	Can you tell us how many groups used the XML Upload versus the Web Portal?	Based on our experience last year, we found that most of the ACOs and PQRS GPROs used a mixture of both XML upload and manual entry in the Web Interface. There are situations where it is possible to extract a date from an electronic health records system, but they might have to look up the value and we've heard examples of that. The majority of the patient updates were done with XML last year.	X	X	X
3	FAQ	The 2012 GPRO reports for groups with more than 100 providers stratify groups into low, mid, or high quality and low, mid, or high efficiency categories. One standard deviation is used for the cut points. Yet, we see about half of the expected number of groups.	This group should contact the QualityNet Help Desk for more information on their 2012 reports.	X	NA	NA

REPORTING REQUIREMENTS

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	Some of our EPs are participating in the CPC Initiative; can we still qualify for the 0.5% incentive payment if we submit data via the Web Interface?	If your group satisfactorily reports via Web Interface you will receive 0.5% PQRS incentive, but CPC providers in your group must also be sure to submit their data to the CPC program.	X	X	X
2	FAQ	What is the definition of a large GPRO? What is the definition of a medium GPRO? Are ACOs classified as medium or large? How does size determine GPRO Web Interface reporting requirements?	ACOs are not designated as medium or large. Medium GPROs are those with 25-99 eligible professionals. Large GPROs are those with 100 or more eligible professionals. There are 15 modules in the GPRO Web Interface and each organization is required to completely and accurately report on the target sample size for each module. ACOs and large GPROs are required to report on 411 consecutively ranked patients or if you have less than 411 patients sampled, then you will report on 100% of your patients for each module. Medium GPROs are required to report on 218 consecutively ranked patients for each module or 100% of your patients if there are less than 218 patients sampled.	X	X	X
3	FAQ	If many of our locales do not perform primary care does this mean this particular location needs to complete all measures on 100% of their patients for Web Interface GPRO over 100 providers?	CMS pre-populates the GPRO Web Interface with a sample of assigned patients who received at least two primary care services from an ACO participant during the measurement period. Each ACO needs to complete reporting on the first 411 consecutive patients in each of the 15 measures/modules. We have links to ACO GPRO reporting resources on the SSP website; this includes information on assignment and sampling. ACOs are neither required nor permitted to report on additional patients beyond those pre-populated into the GPRO Web Interface.	NA	X	X
4	FAQ	We are July 2012 starters and we have participants who will become effective January 1, 2014. Do these participants need to report through GPRO for 2013?	Participant TINs that become part of the ACO effective 2014 will need to report PQRS by another option for 2013 reporting period.	NA	X	X
5	FAQ	Our ACO went live in January 2013. Do we report on GPRO for the 2013 period?	ACOs that began their agreement period starting on 1/1/2013 will report via the GPRO Web Interface for the 2013 reporting period. This reporting period begins on January 27, 2014. ACOs that started after 1/1/2014 will begin reporting as an ACO in early 2015.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
6	FAQ	What happens if an ACO- participating physician reports PQRS outside of the ACO?	If an EP from a SSP ACO reports PQRS individually via claims or other method, we will not evaluate them separately from their SSP ACO PQRS participation. However, if a Pioneer ACO is part of a split TIN, then the group can participate as an entire group (both ACO and non-ACO participating providers) by reporting as a group in PQRS GPRO or the non-participating ACO EPs within the group can report PQRS individually via claims, registry or EHR reporting.	NA	X	X
7	FAQ	Are PQRS GPROs with fewer than 24 EPs eligible for reporting?	PQRS GPROs with 2-24 EPs cannot report via the Web Interface. They can however report via registry for the 2013 program year.	X	NA	NA
8	FAQ	If an EP joins an ACO after the participant list has been confirmed, does the ACO still need to report PQRS for the new EP since he/she is currently affiliated with the ACO TIN?	All TINs on the ACO participant list at the beginning of the reporting year will be included in quality reporting and eligible for the PQRS incentive if the ACO satisfactorily reports. If an EP joins a participant TIN and is billing under that TIN, then that EP will be part of reporting for those claims that were submitted under the ACO participant TIN.	NA	X	X
9	FAQ	We have two TINs registered under our ACO. Will the submission of data on the 411 satisfy reporting requirements for all providers, including those without specifically attributed patients?	Yes, it's 411 patients for each of the 15 measure modules. Sampling is completed for the entire ACO, so it is possible that an EP doesn't have any patients attributed in the Web Interface.	NA	X	X
10	FAQ	For a GPRO, if an EP reports via claims and the Web Interface but does not meet the incentive through the Web Interface, will the EP be eligible for an individual incentive?	No, PQRS GPRO will only be analyzed at the TIN-level for Web Interface reporting. If the GPRO doesn't meet the reporting requirements for incentive eligibility, even though the EP may have satisfactorily reporting via claims, they will not receive that incentive.	X	NA	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
11	FAQ	Will MU PQRS Measures need to be reported for 2013 if the group is reporting through GPRO? If so, will GPRO eventually take the place of all PQRS reporting?	For 2013, PQRS GPRO reporting will get you PQRS GPRO credit. There are additional steps the individuals NPIs within the group practice will need to take to meet all the requirements for MU. Web Interface reporting is not the same as reporting with Certified Electronic Health Record Technology (CEHRT). See the EHR Incentive Program website for information about Meaningful Use requirements at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MLN_MedicareEHRProgram_PQRS_eRXComparison.pdf.	X	NA	NA
12	FAQ	How many modules are there? Do we report on exactly 411 patients per module or greater than or equal to 411 patients per module?	There are 15 modules. Your organization will greater than or equal to 411 patients per module. 411 consecutively confirmed and complete patients per module (or 100% if fewer than 411 patients are available in a module) is the minimum to report to receive the incentive but you can report more than 411 as well. Skipped patients do not count toward the 411 count. When a patient is skipped for a valid reason, an additional consecutively ranked patient must be completed. If your group practice has 25-99 EPs they would be required to report on 218 consecutively ranked patients for each module or 100% of your patients if there are less than 218 patients sampled.	X	X	X
13	FAQ	As an ACO, will more than 411 patients be included in the denominator of the measures?	All patients who are consecutively confirmed and completed will be included in the measure denominator for performance rate calculation.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
14	FAQ	Can you define a small, medium and large GPRO?	A small GPRO has between 2 and 24 eligible professionals (EPs) and is not able to report via the Web Interface. A medium GPRO has been 25 and 99 EPs. Medium GPROs must populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 327) for each module or patient care measures. Large GPROs have greater than 100 EPs. Large GPROs must populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 616) for each module or patient care measures.	X	NA	NA
15	FAQ	How do we enter non-Medicare patients?	Only Medicare beneficiaries are entered into the web interface.	X	X	X
16	FAQ	I thought you only need to select one measure group to report, but it appears that all measures must be reported. Can you clarify?	Measures Group reporting is not a reporting option available to GPROs. The Measures Groups reporting option is only available to individual eligible professionals (EPs). This presentation was created for group practices that self-nominated to participate as a group via the Web Interface. Please contact the QualityNet Help Desk if you need additional assistance.	X	X	X
17	FAQ	Our ACO submission will count for PQRS submission for our participant TINs for 2013. Will this be the same for 2014?	Yes, for Shared Savings Program ACOs the ACO GPRO Web Interface submission will satisfy PQRS reporting requirements.	NA	X	NA

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
18	FAQ	How many unique patients should we expect to need to abstract?	There are 15 GPRO Web Interface modules, but many modules have similar criteria. For ACOs and GPROs with 100 or more EPs, CMS will sample no more than 616 patients for each of the 15 modules. For GPROs with 25-99 EPs, CMS will sample no more than 327 patients for each of the 15 modules. In 2012, patients were sampled using a method that would increase the likelihood that they would be sampled into multiple modules (if they were eligible for multiple modules). Typically we saw sample sizes between 4,000 and 6,000 unique patients, but ACOs or GPROs could potentially see over 9,000 (15 samples x 616 beneficiaries). We would expect a smaller number of unique beneficiaries for GPROs with 25-99 EPs. A similar sampling methodology will be used for 2013. The methodology is described in the 2013 GPRO Sampling Supplement available for download from the GPRO Web Interface Website. ACOs and GPROs with 100 or more EPs are required to completely report on the first 411 consecutively ranked patients in each module. GPROs with 25-99 EPs are required to completely report on the first 218 consecutively ranked patients in each module. The additional sampled patients allow for cases in which some lower ranked patients may not be eligible for quality reporting. In such cases, the patient may be "skipped" and an additional consecutively ranked patient must be reported for each "skipped" patient until the ACO or GPRO has completely reported on 411 (or all, if there are fewer than 411) consecutively ranked patients.	X	X	X
19	FAQ	For modules and measures in the Web Interface, what makes the patient "complete"?	Complete means that you have found the medical record, confirmed the disease diagnosis (for CAD, DM, HF, HTN, IVD samples) and provided all the required information under that module/measure (e.g., for a DM patient, that includes but is not limited to HbA1c value, most recent BP, tobacco use, etc.); or, for those measures that do not require confirmation of a diagnosis (CARE and PREV), that you have found the medical record, confirmed the patient is eligible for the measure, and provided all the required information (e.g., indicate whether or not the patient received a mammography screening).	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
20	FAQ	What does "consecutively complete" mean?	Patients are numbered 1-616 (or 1 to the maximum number available if less than 616), and 411 of these patients need to be completed in the GPRO Web Interface. 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 your final completed patient should be ranked 412 instead of 411. For several examples, see Appendix A. These numbers are for an ACO or PQRS GPROs with 100 or more EPs. See the examples for the number of patients for PQRS GPROs with 25-99 EPs.	X	X	X
21	FAQ	For GPRO submission, do you recommend only completing data on the number of consecutively ranked patients necessary to meet the required sample size or should we submit data for all eligible patients?	This is a personal preference for your group. For satisfactory reporting, we require that your group report 411 consecutive patients (for ACOs and PQRS GPROs with 100 or more EPs) or 218 consecutive patients (for PQRS GPROs with 25-99 EPs) for each of the 15 measures/modules. Some groups do choose to report on all patients eligible for their measures/modules. This could be for internal use for quality checking or for other group reasons.

Completeness is calculated in the first 411 consecutively confirmed and completed patients.

Performance is calculated on all consecutively confirmed and completed patients. Skipped patients are not included, and the denominator count stops at the first incomplete patient. If you submit data for all 616 patients for an ACO or a Large GPRO all confirmed and complete patients will be used to calculate the performance rate. If you are a Medium GPRO and submit data on all 327 patients, all confirmed and complete patients will be used to calculate the performance rate. | X | X | X |
| 22 | 1/27/2014 | If the sample beneficiary died during the reporting period but we do have the qualifying measures, can we complete this measure? | No, if the patient died during the measurement period, indicate this in the Web Interface. The patient cannot be confirmed. | X | X | X |

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
23	1/28/2014	If the ACO is new for 2013 is it correct that if we can validate the patient and find the record but don't have lab values in it when we enter "0", does this then satisfy the reporting requirement for that measure?	Yes, it would satisfy the reporting requirement. However, for the performance rate, it would be counted as a failure for performance.	X	X	X
24	1/28/2014	Is there a threshold of skipping patients where the percent skipped would affect payment?	The percent threshold of skipped patients that is 10 percent. Once you reach this threshold, you will receive a warning in the Web Interface. It won't necessarily affect payment as long as the skips are valid. However, CMS can choose to do a quality audit, during which your organization would have to provide information that would substantiate what your organization entered of did not enter for quality data.	X	X	X
25	1/29/2014	If we complete more than 411 sequentially RANKED beneficiary records for any sample module / measure (e.g. 520), will all the completed sequential records be used by CMS for calculating final performance rates, or will CMS truncate at the 411 threshold?	411 is used for calculating for completeness of module. If complete more patients, performance is based on number of total consecutively confirmed and completed beneficiaries.	X	X	X
26	1/29/2014	If we declined participation in the value based tier system, but report on all required GPRO elements successfully, is there any risk of penalties or adjustments if we don't meet measure benchmarks?	Please contact the QualityNet help desk at 1-866-288-8912 or qnetsupport@sdps.org for assistance.	X	X	X
27	1/30/2014	If we cannot confirm a patient has a measure/module for which we less than 411 patients, what can we do?	If you confirm fewer than 411 patients in a measure, then you must consecutively confirm and complete 100% of patients in your sample.	X	X	X
28	1/30/2014	What is the performance goal for each measure and how will this goal impact whether or not we receive financial penalty or reward?	Please view benchmarking guidance provided by ACO programs.	NA	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
29	1/31/2014	I need to know how I can separate a participant who does not want to be part of the ACO, and won't be submitting through GPRO any beneficiary measure sample. This will affect our weekly submission and how I can remove him from our ACO?	By ACO rules, any participating provider who leaves prior to the start of the measurement period is still counted and would still be eligible when sampling patients. Please do your best to work with this provider to obtain the medical information you need to report. However, if you can't obtain the medical record, you can select 'medical record not found' and move on to the next consecutively ranked patient.	NA	X	X
30	1/31/2014	If we do not have 411 patients listed in the module, are we required to fill in all patients for full reporting?	Yes, if you have fewer than 411 patients sampled for ACOs and large GPROs (218 for medium GPROs), you would need to complete 100% of your patients.	X	X	X
31	1/31/2014	We are required to complete 411 patients. Is this 411 patients total or 411 patients per module?	The reporting requirement is by module. So you will need to confirm and complete 411 consecutive patients of your sample (with an oversample of 616 patients) for each module. However, you do not need to complete your sample in the ranked order. Note that for CARE and PREV measures, there are 411 patients to complete for each individual measure.	X	X	X
32	2/20/2014	For DM, I have abstracted 189 patients and 112 (or 59%) of them did not have a diagnosis of diabetes. What will happen if we do not have 411 patients at the end of the 616 abstractions?	We encourage you to seek out the medical information from other providers as needed to confirm patients' diagnoses. If you are unable to do this, then you would select no for confirming diagnosis. You are responsible for reporting on 411 patients. If there are less than 411 eligible patients, then report on 100 percent of assigned patients.	X	X	X
33	2/20/2014	For those modules that have all 616 patients populated electronically, how can we indicate that we only want to submit 411 patients?	Even if the data is pre-populated, you still need to confirm that you found the information in medical record and confirm that the patient is eligible for the measure. You only need to do this for the 411 patients that you submit for in each measure.	X	X	X
34	2/27/2014	Our MSSP start date was 1/1/2013. For a few of our quality measures, we set up our EHR workflow to capture the data in a discrete reportable format after our MSSP start date. The data prior to the new EHR workflows is in the EHR but would need to be manually updated.	You are responsible for completely and accurately reporting your ACO's data. If you have access to this data, then you should complete it to the best of your ability.	NA	X	NA

WEB INTERFACE

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	Where is the ACO and PQRS GPRO Web Interface user manual for Program Year 2013 located?	There are a couple different user manuals. The manual that is posted on the portal (http://www.qualitynet.org/pqrs Physician and Other Health Care Professionals Quality Reporting Portal) will show you how to login to the Web Interface. The online help within the Web Interface has information on using the Web Interface.	X	X	X
2	FAQ	We are creating an information collection sheet for each measure. Will there be an opportunity to preview the Web Interface prior to the opening of submission? Is there currently a template available for viewing in the GPRO Web Interface?	Yes, there will be a high-level overview webinar that will be posted on the CMS YouTube website the next month. This will give a preview of how all of the data entry screens look. The Supporting Documents describe each of the measures and the measure components with the values that can be entered in the Web Interface. The Supporting Documents can aid in setting up the information collection sheet.	X	X	X
3	FAQ	Will the GPRO allow us to export the reports this year in either XML or CSV?	No, CMS security does not allow exporting the reports because they contain PHI and PII.	X	X	X
4	FAQ	Is there any possibility that the GPRO specs will be modified between now and the 2014 reporting period beginning January 27th?	No, the 2013 documents that include 2013 Narrative Specifications, Flows, and Supporting Documents, will not be modified between now and the submission period	X	X	X
5	FAQ	Will the test files in January be specific for each module and disease, so they will be a true test?	The file that will be provided in January prior to the Web Interface opening is the file of beneficiaries sampled into the ACO GPRO Web Interface and the top three TIN/NPI combinations where the beneficiary received care. It is not a test file.	NA	X	X
6	FAQ	Want to confirm that if we use the Web Interface do we still need to submit the QRDA XML files?	If you're submitting in the Web Interface, CMS allows manual entering of data in the Web Interface and XML uploads using the Web Interface XML format. If your question about QRDA relates to the EHR Incentive Program- Meaningful Use submission you will need to submit a QRDA file. QRDA submission is not related to Web Interface reporting. Contact the QualityNet Help Desk if you have additional questions.	X	X	X
7	FAQ	Are you going to have a test system to practice in for a week before go live?	No, there will not be a test system before going live.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
8	FAQ	Is there going to be an instruction document with screen shots from PQRS that we will have in advance of the go live date?	A high-level Web Interface training including screenshots has been posted on the CMS YouTube site: http://go.cms.gov/GPROPlaylist.	X	X	X
9	FAQ	To whom do the modules get sent when there are numerous submitters?	If your IACS account is tied to the TIN, you will be able to see that TIN when you log in to the Web Interface and you'll be able to see all modules and measures. When they log in to portal they will have access to all modules and patients for the TIN.	X	X	X
10	FAQ	We only have to report on 411 consecutive patients in each module. We manually abstract 100% of the patients so it's hard to carve out just the applicable ones (and we end up doing 100% of the sample, 616 patients). Are there any analysis implications for just doing the 411 as opposed to completing oversample too?	The Web Interface automatically consecutively ranks the sampled patients for each module. As you complete patients into the Web Interface, you can look at the Totals Report, which will tell which patients are completed for a module and the rank of the completed patients in that module. If you are doing Manual extraction, the patient list can be sorted by patients in rank order so you can easily identify the first 411 (or 218 for medium GPROs with 25-99 EPs) ranked patients in each module. As far as an impact on an analysis, it will not matter. When you complete 411 patients, you are finished in terms of satisfactorily reporting for PQRS.	X	X	X
11	FAQ	For pre-populated field data from CMS, can we update those fields with current information?	You should use the most recent data for the patient. The patient sampling goes through the end of October so if you have more recent data, you will want to update the Web Interface with that information. The supporting documents will provide additional information indicating when you should use the latest result for the patient. Any information documented in the patient's medical record should be used to update the Web Interface. The only exception to this will be CARE-1: Medication Reconciliation, where the information for this measure is pre-filled with the discharge date of any inpatient hospital stay for the patient who also had a visit within 30 days, so you do not add additional discharges that would have occurred late in 2013.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
12	FAQ	Is it possible that an ACO or GPRO would be asked to respond to a data request for a patient who is attributed to our organization but got the services in question from a provider who is not in our practice or ACO?	Yes. Patients are assigned to an ACO or GPRO if they received the plurality of their primary care services from that ACO or GPRO during the measurement period. Further, each patient who is sampled into the GPRO Web Interface was found to have at least 2 primary care service visits with an ACO or GPRO provider during the measurement period. However, particular services related to individual quality measures may have been obtained at an outside organization. In those cases, it may be necessary to look for information with providers outside of the ACO or GPRO.	X	X	X
13	FAQ	What version of Java is supported in the Web Interface?	The Web Interface is not Java dependent, so your Java version does not matter for the purposes of submitting your GPRO data.	X	X	X
14	FAQ	Is IE 8.0 still a requirement? Or can IE 9.0 and above be used? Are there any implications if our organization uses multiple versions of Internet Explorer?	This year we are recommending you use Internet Explorer (IE) 9.0. Although we have done some testing in IE 8.0, most of our testing and development tests have been done in IE 9.0. We don't know of any implications of using different versions.	X	X	X
15	FAQ	What data may be prefilled? Where can we find a list of prefilled elements?	We had a slide in the presentation that had a list of the prefilled elements. This information is also in Q&A and in the Web Interface presentation that is posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
16	FAQ	Will we be able to sort beneficiaries by TIN/EIN within the GPRO Web Interface?	For ACO the clinic ID is going to be your TIN/EIN.	X	X	X
17	FAQ	When we receive the beneficiary list to abstract, will it include the patient's rank or will we only be able to see that in the Web Interface itself?	Yes, you will be able to see the patient's rank. The patient will have a "0" in the Web Interface if he or she isn't ranked in the module. If the patient is not ranked in a module, the module data is not provided in the XML file. If he or she is ranked, there will be a "1" through "616" associated with the patient in both the Web Interface and in the XML file	NA	X	X
18	FAQ	Is the patient's medical record number from our system going to display in the Web Interface?	No, the medical record number is not included on claims, so it will not be pre-populated in the Web Interface. However, you can add it to the Web Interface using an XML upload or entering it manually in the Web Interface.	X	X	X

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19	FAQ	Is the patient list the same for all 22 measures?	You will have one overall patient list for your GPRO or Primary ACO; however a patient may or may not be ranked in each of the 15 modules. It is unlikely that a patient will be ranked for every module The list of patients included in each module will be different.	X	X	X
20	FAQ	If multiple red "X"s are listed per beneficiary, do we need to respond to each measure or merely one?	You will need to complete the data for each red "X". An exception would be if the patient is ranked high in one measure and very low in another module. If they are ranked high enough, you may be able to complete the module before abstracting the patient for that module. ACO or Large GPRO example: a patient is ranked 415 in PREV-5 and ranked 400 in HTN, you will need to complete the patient's data in HTN, but you may not need to complete the patient's data in PREV-5 unless you have skipped four lower ranked patients in PREV-5 to meet the minimum of 411 consecutively confirmed and completed patients in the PREV-5 module. Medium GPRO example: a patient is ranked 222 in PREV-5 and ranked 200 in HTN, you will need to complete the patient's data in HTN, but you may not need to complete the patient's data in PREV-5 unless you have skipped four lower ranked patients I nPREV-5 to meet the minimum of 218 consecutively confirmed and completed patients in the PREV-5 module.	X	X	X
21	FAQ	Once we complete the medical record number, can we drag and drop that column so it's further to the left on the patient list?	Yes, you can move the columns for the Patient List on the Home page to be in any order that you prefer. Note that the order will not save between log-ins. So you will need to reorder the patient list columns each time you log into the Web Interface.	X	X	X

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22	FAQ	Does the patient list include the provider's name or the provider's NPI?	The provider's name will be included in the Patient List displayed on the Home page of the Web Interface. However, both the provider's name and NPI will be listed in the Provider List displayed on the Edit Provider screen in the Web Interface. The provider's name and NPI are both listed in the XML file that can be exported from the Web Interface. See the GPRO XML Specifications for all fields included in the Provider XML file.	X	X	X
23	FAQ	Will CMS populate the clinic ID and the clinic name or is the ACO expected to populate these fields?	In most cases, the clinic ID and clinic name will be pre-populated; however if it is not pre-populated, you are able to add this information in the Web Interface.	NA	X	X
24	FAQ	Will the Web Interface be open prior to 1/27/14 for XML imports?	No, the Web Interface will not be accessible prior to 1/27/14.	X	X	X
25	FAQ	Once we have finished submission, are we able to retrieve a medical record number level report, listing all patients identified as a "1", "2", etc?	You can access this information in two ways prior to the close of submission (1/27/14): 1) Run the Detailed Totals report 2) Export your patients to an XML file and then follow the instructions in the XML specifications to import the data into Excel.	X	X	X
26	FAQ	Can you review again what the 10% threshold not exceeded means? Does it mean you haven't reported on enough patients?	The 10% threshold represents the percentage of patients that were skipped in a measure out of all of the patients that were consecutively completed.	X	X	X
27	FAQ	Can we only use the web interface to manually enter data and not use the XML upload at all? If yes, will we be penalized?	You may enter all your patient data manually. The XML uploads are an alternate method, so you will not be penalized if you do not use XML.	X	X	X
28	FAQ	Does the 100% complete mean that data is ready for submission?	100% complete means you have completed the required number of consecutively ranked patients and you are ready to submit the data to CMS. To submit your data, open the Submit screen and click the Submit button. This will provide your completed data to CMS. See the video imbedded in the GPRO online help for more information.	X	X	X

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29	FAQ	If prefilled data has a U or O, how would we verify that or do we need to say "No"?	Patients sampled into the Web Interface have had at least two primary care service visits at your practice or with an ACO participating provider. You should do your best to obtain the needed quality of care information to complete the GPRO Web Interface if it is not available in the patient's medical record.	X	X	X
30	FAQ	In PREV-11 it says 500 are complete so why isn't it a green check?	In the scenario shown during training, 500 patients were complete, but the patients ranked 14, 15, and 259 were incomplete. The "Analysis" line shows the number of consecutively confirmed and complete patients, excluding skipped patients. The count of Analysis patients stops at the first incomplete patient. The "Complete" line shows the number of complete patients in any order. The complete line excludes skipped patients, but does not stop at an incomplete patient. Once the patients ranked 14, 15, and 259 are complete, the number of consecutively confirmed and complete patients will change to 411 and PREV-11 will be marked as complete. The information available to determine skipped or incomplete patients is available in the Totals Report. The specific patient with the patient's rank in the module is shown on the Details page of the Totals Report.	X	X	X
31	FAQ	Is there a space to add multiple clinics for each patient? If 3 providers are listed, won't many patients have at least 3 clinic needs?	CMS provides information on the clinic and providers that provided the most care to each sampled patient. This information is provided to assist in the data collection process and help practices search more efficiently for patient medical records. In an effort to maintain user-friendly Web Interface we balance the amount of supplemental information such as this with the space available to provide that information. To that end we provide space for one clinic and up to 3 providers.	NA	X	X

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32	FAQ	We are required to report the value for control measures. If we don't have a record of the lab test, can we keep the date and put in a '0' for value?. If time allows, some groups might try to figure out where that A1C came from.	You may keep the pre-filled date, but provide a '0'. The performance will be calculated the same if you answer "No" or if you answer "Yes" and provide a '0'.	X	X	X
33	FAQ	Please explain the difference between the analysis column and the completed column	The "Analysis" line shows the number of consecutively confirmed and complete patients, excluding skipped patients. The count of Analysis patients stops at the first incomplete patient. The "Complete" line shows the number of complete patients in any order. The complete line excludes skipped patients, but does not stop at an incomplete patient.	X	X	X
34	FAQ	As an ACO, are we able to use a database that contains beneficiary information outside the medical record? For example, if we have partnered with a company (as an ACO) and a third party database is created, can we use that data to enter information into the Web Interface?	CMS holds the ACO accountable for reporting quality data in the GPRO Web Interface. If the ACO chooses to partner with a vendor to submit quality data on its behalf, such arrangements are between the ACO and the vendor.	NA	X	X
35	FAQ	Can we use claims data to answer the question even if it was performed and submitted by a provider outside of our ACO?	You can use claims data as long the information is documented in the patient's medical record. When confirming the diagnosis, we prefer that you use medical record data instead of claims data.	NA	X	X
36	FAQ	Can you please explain in detail where the discharge dates will be located in the Web Interface and if we will be able to export them out of the Web Interface?	The discharge dates are located on the CARE tab. If the patient is ranked in CARE-1, you would go to the CARE tab to enter the discharge dates.

There are videos located in the "2013 PQRS/ACO GPRO Web Interface User Manual" (which can be found at www.qualitynet.org/PQRS), that provide additional detail on discharge dates. On the Introduction page, there is a link to the online help, which contains all of the videos.

Yes, you can export the discharge dates. The XML specifications, available on the GPRO Web Interface page of the CMS website, detail how you can export this data. | X | X | X |

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37	FAQ	For the medications, the downloadable resources has an RxNorm code; but we have NDC codes... can you direct how I might be able to map the NDC codes with the RxNorm codes?	CMS does not provide mapping to NDC codes.	X	X	X
38	FAQ	If I download my data, then add MRNs to the file and upload it. Will a second download of data have those MRNS in the file?	Yes.	X	X	X
39	FAQ	If we have access to hospital records with EF, should we use these as well as our outpatient record when looking for LVSD or should we only count a patient as confirmed if this information is in our outpatient chart.	You can use any source of information that is available at the point of care for the primary care provider.	X	X	X
40	FAQ	If we use multiple medical records sources (specialist and PCP), where is the best place to note the source in GPRO and to include the notes in our extract? Last year comments were cut off at 20 characters vs. 140.	Comments may be entered in the General Comments text box on the Demographics tab for a patient. Comments may also be entered in the Comments box located on each of the module tabs. Comments may also be entered in the XML file, which has tags corresponding to the General Comments or module Comments text boxes. The limit on comments is 250 characters for 2014, as it was in 2013. The Other ID field is limited to 20 characters, but this field was intended to hold IDs such as insurance numbers or other values used to identify the patient. Comments should go in the Comments fields.	X	X	X
41	FAQ	Is there a "tool" we could use to have our providers/staff enter measure information into as they abstract information from patients charts and information?	There is no "tool" but the XML files may be imported into Excel which could be used to record data.	X	X	X
42	FAQ	Is there a need to secure a copy of proof of evidence for every element of MSSP abstraction in case of an audit?	The MSSP and Pioneer ACO program do have quality audits so we recommend retaining a record of all data that is reported in the Web Interface.	NA	X	X

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43	FAQ	On the Check Entries Report, can you explain warning versus error?	A warning is used when there is an inconsistency between similar elements and an error is used when there is missing or invalid data. You can find more information on the check entries report in the online help and also on the check entries.	X	X	X
44	FAQ	We did not see pre-populated data in sample file (e.g. discharge date from inpatient facility). Would that be in a separate file?	Yes, the Patient XML file contains all data except the CARE-1 measure data. The Discharge Dates are in the Patient Discharge XML file. Please see the XML Specifications available on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html for the layout of these files. The XML Specs may also be downloaded from the Web Interface Online Help.	X	X	X
45	FAQ	What happens if we cannot confirm a diagnosis for a patient? Is this patient considered a "skipped" patient?	If that's the case, you wouldn't be able to confirm diagnosis and you would select "no" in the Web Interface. The patient would be skipped in the module but may be eligible in other modules in which they are ranked.	X	X	X
46	FAQ	Where can we find a complete list of "CMS approved reasons" or "medical reasons" for patient exclusion?	There is not a complete list for either CMS approved reasons or medical reasons. These answers vary based on the measure. Within the data guidance, there is often an example provided for an acceptable medical reason. CMS approved reason is determined on a case-by-case basis.	X	X	X
47	FAQ	Why would "Unknown" be listed as the physician if attribution is based on paid claims?	It may be possible that the NPI is on the claim, but the provider name is not and the Web Interface couldn't identify the provider name. In this case, the physician name would be listed as unknown.	X	X	X
48	FAQ	Will sample files for each measure (not beneficiary information, just the column headers) be available prior to the 27th?	There are sample XML files on the CMS website. You can use these sample files and XSD's and import them into excel. There are no files with just column headers unless you were to use excel with the sample XML files.	X	X	X

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49	FAQ	Can you please clarify the terms "for analysis" means?	The **For Analysis** count on reports and screens reflects patients that are consecutively confirmed and completed. If some of your patients have not been consecutively confirmed and completed, you may see a different count of completed patients and For Analysis patients. The For Analysis line is on the Home page in the Group Status section. The 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 line the question refers to is in the Totals Report, which has a comment indicating whether or not they have met the minimum requirement.	X	X	X
50	FAQ	When should we click the "submit" button?	In order to be marked as complete for reporting, you do need to go to the Submit screen and press the "Submit" button. This will indicate to CMS that your data collection is complete. If you need to enter additional data after you have pressed "Submit", you may do so, but you will need to press "Submit" again once you have finished data collection.	X	X	X
51	FAQ	Do you lose data when the system logs you out after a period of inactivity?	Yes, if you are editing a patient and do not save the information, the edits on that patient will be lost if the system logs you out for inactivity. The system will also lock the patient with the user account that last updated the information. The Locked Records screen can be used to unlock a patient so any use can edit the patient.	X	X	X
52	FAQ	Can you edit information in the patient record after saving it?	Yes. The user can save the record multiple times and edit it at any time before the data collection period closes.	X	X	X
53	FAQ	Can we provide the data all modules for a given patient even if the patient is not ranked in all modules?	Yes, you could upload data for patients where it is not appropriate. Only the patients ranked in the module containing the measure will be updated. The data will be discarded for patients not ranked in the module containing the measure.	X	X	X
54	FAQ	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. The final percentage is calculated on consecutively confirmed and completed patients who meet the measure criteria.	X	X	X

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55	FAQ	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 that 411 or more patients for an ACO or PQRS GPROs with 100 or more EPs, or 218 or more patients for PQRS GPROs with 25-99 EPs, are considered "For Analysis", then you have successfully consecutively completed all necessary patients in the module. If you have fewer than the minimum number of eligible patients in the module and you have completed 100% of your sample, you also meet the reporting requirements. The comments on the For Analysis line will indicate "OK! Minimum Requirement Met". The Analysis line on the Group Status line on the Home page will have a green checkmark next to each module that satisfies the reporting requirements. Alternatively, the "Submit" screen and the "Submit Status Report" will indicate "OK! Minimum Requirement Met" for each module that has been satisfactorily reported. If you see this message for each of the 15 modules, then you have met the satisfactory reporting requirements.	X	X	X
56	FAQ	How do we export all pre-populated patient information?	Downloading the Patient file and the Patient Discharge file will contain all information that was pre-populated into the GPRO Web Interface.	X	X	X
57	FAQ	Which reports do you recommend we print and keep?	Though this is not required, you may want to print the Measure Rates Report (shows performance on each of the measures and modules) and the Totals Report, which will give you a sense of how many patients were skipped, etc.	X	X	X
58	FAQ	Does reporting on the GPRO Web Interface measures require manual chart abstraction? Is there any alternate method of data submission?	GPRO Web Interface measures must be reported via the Web Interface. However, some data can be uploaded from your EHR using XML. Training on this process will be provided prior to the start of the GPRO Web Interface reporting period.	X	X	X
59	FAQ	Can we use the GPRO Web Interface with Internet Explorer 7 or Google Chrome?	No, we recommend Internet Explorer 9, but you may use Internet Explorer 8 in order to use the GPRO Web Interface.	X	X	X
60	FAQ	Is it possible to use data from multiple sources for abstraction?	Yes, any documentation the physician has available to them at the point of care is eligible for use in data collection.	X	X	X

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61	FAQ	Do we have to enter our data in rank order? Or can we abstract information on patients out of rank order?	The actual order of data entry does not matter, however, the ACO or GPRO must consecutively report on at least the first 411 ranked beneficiaries (or all sampled beneficiaries if fewer than 411 are ranked) in order to satisfy the reporting requirement for each measure or module.	X	X	X
62	FAQ	What if one of our sampled patients was not seen at our facility during the measurement period?	Though the patient may not have been seen at your facility, the patient has to have been seen at least twice at one of the organizations (or facilities) affiliated with your ACO during the measurement period in order to be included in the samples. Specifically, beneficiaries were assigned to your ACO based on 3rd quarter 2013 assignment or alignment and must have had two or more primary care services visits at one of the ACO's Primary or Child TINs to be sampled into the module. Since your organization is deemed accountable for such a case, you may not select 'not qualified for sample' under this circumstance.	NA	X	X
63	FAQ	What are reasons to select "Not Qualified for Sample"?	An ACO or GPRO 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 had HMO Enrollment during the measurement period	X	X	X
64	FAQ	Some of our beneficiaries have opted out of data sharing. Will they be eligible for sampling into the GPRO Web Interface?	Quality data collection is not related to the data sharing processes that have been established for the Claims and Claims Line Feed data. A beneficiary opting out of data sharing does not exempt them from quality reporting.	NA	X	X

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65	FAQ	Can we exclude a sampled patient if they were only seen by a specialist at our facility?	No, this patient was assigned to your ACO, so you will need to be accountable for his/her care. Please refer to the Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-v2.pdf) for more information on how beneficiaries are assigned to an SSP ACO. For Pioneer ACOs please see the Pioneer ACO Benchmarking Methodology.	NA	X	X
66	FAQ	Is there any benefit or harm to abstracting additional ranks in the module than what is required?	Some organizations may choose to upload more records for their own quality tracking or quality improvement efforts. If you enter the beneficiaries consecutively, only the first 411 patients will be used in the completeness determination, but all 616 beneficiaries will used in the measure rate calculations.	X	X	X
67	FAQ	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 GPRO has selected no medical record found, diagnosis not confirmed or not qualified for the sample (for CMS approved reasons, deceased, entered hospice, enrolled in an HMO, moved out of the country) are considered "skips". The GPRO Web Interface will produce a warning when 10% of a given sample has been skipped. However, this warning is only a system warning. ACOs and GPROs will not be penalized for skipping 10% of a module's sampled patients and as long as you have met the minimum requirement of 411 consecutively completed patients (or 100% of the sample if fewer than 411 are available), then you will have completely reported on the module. However, if there seems to be a consistent unexplainable pattern that CMS observes in your skips, then it may raise a flag, and that may be one of the selection criteria for a targeted audit or for targeted education with your ACO or GPRO.	X	X	X

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68	FAQ	Are there any requirements for who can enter data into the Web Interface?	While CMS does not require specific clinical backgrounds for clinical quality of care data abstraction, several factors should be considered when making this staffing decision. If information for certain measures is frequently stored in the same location and is a straightforward data collection, a non-clinical person is appropriate. An example of this would be the laboratory measures when you are looking for the most recent date and the corresponding value or result. If a measure has denominator exclusions that may require clinical knowledge to make the connection between the documentation and the reason for not providing a service or drug, then this needs to be considered as well, and a person with more solid clinical background may be better suited for abstracting this measure.	X	X	X
69	1/27/2014	DM Module - Are we allowed to abstract over the pre populated DM HbA1C test and date if there is another date?	Yes, you can change the date in the Web Interface as long as it's during the measurement period.	X	X	X
70	1/27/2014	Do we need to report on all hospital discharges for ranked patients? Or do we just report on the one aligned with the patient ranking number on the XML file?	You would report on all discharges for those patients ranked in the Web Interface. Discharge dates are prefilled for you so those are the only discharges you need to report on. You can export patient discharge dates to XML.	X	X	X
71	1/27/2014	For measures that require entry of an LDL-C test result, should we round any results that have a decimal even if it rounds up to 100?	Decimal places for the LDL-C value are not permitted in the XML file or the Web Interface. The only number that allows decimals places is HbA1c value. For this value, we suggest rounding down, if rounding up would make the value greater than 100 because the value is in fact less than 100.	X	X	X
72	1/27/2014	For the string length, is the length the number of characters it needs to be or is this the maximum length? For example, for Medicare ID number will we get an error if we have 9 digits instead of 15?	The string length specified in the Web Interface is the maximum number of characters allowed in the field. You may enter only the number necessary for your data.	X	X	X

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73	1/27/2014	If the LDL from the pre populated date in the GPRO Web Interface is not available in the PCP chart - can we use another value from a date earlier in the performance year and change the date in GPRO Web Interface?	Yes, you can change the date in the Web Interface as long as the date is during the measurement period and is considered the most recent value in the medical record.	X	X	X
74	1/27/2014	If the patient is < 18 yrs old (as of 1/1/2013), and the patient is not qualified for CAD calculations, would this be a case wherein we would have: <cad-confirmed>15</cad-confirmed>	The <cad-confirmed>15</cad-confirmed> is the appropriate tag and value to use when marking a patient as not qualified for the module for "Other CMS Approved Reason". Note that using "Other CMS Approved Reason" is done on a case-by-case basis and requires approval from CMS.	X	X	X
75	1/27/2014	In the pt discharge download, the patient name and the provider names are not showing. Should they be there?	No, the reason you only get the discharge date is because there were a lot of requests last year to have the discharges work with Excel. In order to do that, we had to make the file as flat as possible. If you want that same information on the providers, you can go to patient XML file and select only CARE-1 and you will get the information that way.	X	X	X
76	1/27/2014	Is there a list of qualified measures for each patient?	If you export the XML file from the Web Interface, it will give you your patient list and all data currently stored in the Web Interface. The measure data you need to provide for the patient is dependent on the modules in which the patient is ranked.	X	X	X
77	1/27/2014	Is there a way to download the discharge dates for CARE-1 for all patients identified at once?	Yes, you would select the "Patient Discharge" data set. Once you export it, the file would include all patients ranked in CARE-1 with all the patient's discharge dates.	X	X	X

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78	1/27/2014	Isn't there a section in the Web Interface where we can create predefined "Reports"? When I checked today that area was empty. To create patient or group or measure reports, must we export using an xml file?	Yes, you must push the "Generate Report" button, then your report will generate and the last 10 will be held on that screen for you to access later. You don't need to export patient data before you can generate a report. Note that these reports are static and do not update after they have been generated. After you upload an XML file or enter data manually you will need to generate a new report to reflect that data. Remember that these reports are only available to you during the submission period. Once the Web Interface closes on March 21, you will not be able to access these reports. The reports may be printed, so if you wish to retain a copy, print the report before March 21.	X	X	X
79	1/27/2014	We need to abstract if the discharge date does not match what we have in our EHR for CARE-1, correct? What if it is one or two days off? I notice a high percentage of the dates are incorrect.	If the dates of the prefilled discharge and the dates in your EHR are off by one to two days you may confirm the discharge.	X	X	X
80	1/27/2014	We want to make sure that we are able to submit ALL quality measures for each beneficiary via GPRO and if there are any known complications or issues with doing it this way?	If a patient is not ranked in a module, there is nowhere to store the data and; therefore, the data would be ignored in an XML upload. Please only upload data for a patient if they are ranked in a module. If you are manually entering data for your patients, the modules in which the patient is not ranked will not be available for entry. You will be unable to enter quality measure for that patient in those modules.	X	X	X

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81	1/27/2014	What if working on a patient you come across the doctor that its under is incorrect compared to what is in EMR system, can we still fill in the measures even though under wrong doctor?	If the providers listed for a patient do not match what is in the patient's medical record you should still fill in the measure values for the patient. The information CMS provides on the top TIN and top NPIs is to guide you in looking for patient records; however, this list may not be exhaustive or exclusive. You may also update the providers for the patient on the Demographics tab on the Home page of the Web Interface by selecting from the provider list that appears when you click the magnifying glass next to the provider's name. The patient's provider may also be updated in the XML file, but the NPI entered must exist for your group in the Web Interface. If the provider does not exist in the Web Interface, it may be added by clicking the "Add/Edit" link at the top of the screen and clicking "Provider" from the menu that appears.	X	X	X
82	1/27/2014	You should be aware that the Patient-Discharge XML file only includes the caremedcon-rank value for the first discharge for the each patient. It is not included on any other discharges.	That is correct. Please reference the presentation from the 1/31/2014 ACO and GPRO Daily Support Call posted on the CMS PQRS Web Interface website.	X	X	X
83	1/28/2014	Also, if we submit the completed discharge file with the confirmation for that module copied to each <patient> node, will that cause a problem?	No, it will not generate an error when the file format is validated. Note however, that if you duplicate the confirmation for each discharge, the answers provided for each of the confirmation tags should be the same. If they are different, the last tag processed will overwrite any other answer.	X	X	X
84	1/28/2014	Exported files only list one discharge date per patient and the portal has more than one. Is there a way for us to export a list from the portal that includes all of the discharge dates?	All the discharges for a patient are included in the Patient Discharge XML file. The first discharge will have the rank and confirmation tags, but the remaining discharges will only have the discharge data tags. Please reference the presentation from the 1/31/2014 ACO and GPRO Daily Support Call posted on the CMS PQRS Web Interface website.	X	X	X

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85	1/28/2014	How do we "get out" of a module without locking it in the Web Interface?	If you first go into the Web Interface and you are presented with the customization screen, where you select one or more modules. You can change the module selected by using the Preferences screen. If you are editing a patient and make a change to the patient's data, you either want to save the data or cancel any edits you made for the patient. You are then free to select another patient without the patient remaining locked.	X	X	X
86	1/28/2014	I noticed the fields in the discharge table for CARE-1 correspond to the data that needs to be entered for CARE-1. Should the discharge table get uploaded for the CARE-1 measure?	Yes, the Patient Discharge XML file should be used to upload CARE-1 confirmation and measure data.	X	X	X
87	1/28/2014	If CMS has no data (blanks) in the pre-filled data fields, will our data upload to the web interface override this information and populate the data based on what we send?	Yes, your uploaded data will populate the fields that were not pre-filled. Valid values in the XML file will overwrite blank values or previously entered values with the values in the XML file.	X	X	X
88	1/28/2014	In the PREV module, can you clarify what exactly we are 'confirming' in the individual measures in the Confirmation box?	For the PREV modules, you would be confirming that the patient is eligible for the module.	X	X	X
89	1/28/2014	In the Web Interface, if I add comments as a reference to where documentation was found in our EHR, will that data be available for use in any future audit that may be requested by CMS?	If you were to export your XML after you are finished with your upload, those comments will be included. You can also export to the patient summary report. This report is at the individual patient but you can batch the reports. Reports are not available once the submission period has closed so print them prior to the submission end date.	X	X	X

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90	1/28/2014	In the Web Interface, what does "add/edit" do? Could I use this feature to specify the name of the practice site a patient belongs to? All our practices (many sites) are in the same TIN, therefore sorting by TIN is not helpful in our case.	You can use the add/edit function to add additional clinics or providers. For clinics, you can add a TIN, CCN or other identifier useful for your group. Then you can go to the demographics screen and select that information and assign it to the patient or you may also do that association in your XML file. Once that's complete, the patient list on the homepage can be sorted by that clinic identifier.	X	X	X
91	1/28/2014	We were expecting to see pre-populated data in our XML exported files we downloaded individually such as ACO #14 PREV-7 - Influenza but are not seeing any. Is it likely that we do not have any pre-populated data or did we miss a step in the export?	To see pre-populated data you must select the modules that could be pre-populated to include in your XML export. If you did not select the PREV-7 module for the export, the pre-populated data will not be included in the file. It is unlikely that you do not have any patients with pre-filled data for PREV-7.			
92	1/28/2014	We were told that we should run the measure rates before we upload anything. The reports are still in a request received status. Is this expected?	The Measure Rate Report calculates performance on the data that has been entered into the Web Interface either manually or by an XML upload. Running the report before uploading data will generate a report with empty values. The network setting to generate the report was updated after this unexpected action was brought to our attention and all reports are now being generated on demand.	X	X	X
93	1/28/2014	What is the easiest way to capture what data has been pre-populated for our patient list before we upload our own XML file that overwrites pre-populated entries? Is there a measure-by-measure report?	There is not a measure-by-measure report. There are two ways see you could see your pre-filled data. There is a pre filled elements report that you could run for each of your patients, which shows you if the data was pre-populated and if it was populated from a claim originating from inside or outside your TIN. You can batch reports up to a couple hundred reports at a time. You can also export the patient data in the XML file and import that information into Excel and sort it using standard Excel features so it's easier to read.	X	X	X

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94	1/28/2014	Where can you find the written instructions for abstracting all the modules? What is the pathway to find the Supporting Documents for the HF module? For example synonyms for HF, beta-blocker list.	The location of the 2013 GPRO Web Interface Supporting Documents is: http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013SupportingDocumentsandReleaseNotesforACOandPQRS_GPROWebInterfaceUsers.zip.	X	X	X
95	1/28/2014	Would the cancel button at the top of the patient's module be the proper way to exit a patient and not save any data you have started to enter?	Yes, that would be the correct way to do it. If you push the Cancel button, any data entered since the last time you pressed the Save Patient button would be discarded.	X	X	X
96	1/29/2014	Can I create PDF's of the Patient Summary Report to print later?	No, you would need to print reports while submission is open	X	X	X
97	1/29/2014	If a patient is on their family member or spouse's HMO plan, and they use that HMO for their visits, would this count as 'Not qualified for sample'?	Yes, you can use the exclusions in the beginning in the Web Interface to exclude them from all modules. In the Web Interface, once you select a patient, you can choose Medical Record Found, but not qualified for sample. The reason would be HMO enrollment. You would input January 1, 2013 if the HMO enrollment covered the entire year.	X	X	X
98	1/29/2014	If there is pre-populated information in the Web Interface such as that a HgA1c was performed but you cannot find the labs in the patients chart, what should you do?	For the example provided: **DM-2 and DM-15** – If the HbA1c test was performed and can be found, it is pre-filled with a "Yes" to indicate the test was performed and the date of the test. The GPRO must add the value. In addition, if there is a more recent HbA1c test found in the patient record, the GPRO must utilize the more recent data and result when completing the measure. If the GPRO cannot find the additional information, the pre-filled date may be replaced with the most recent date of the test/examination found within the medical record (following the measure requirements [if the test must be performed within the measurement period, the date must be from the measurement period]). If the GPRO cannot find any test, the "Yes" should be changed to a "No" or for tests requiring a value, leave the "Yes" and use a zero for the value within the Web Interface.	X	X	X

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99	1/29/2014	In the Web Interface, I am able to sort patients for a measure and filter by clinic. Can I print that list?	The patient list cannot be printed. The measure rates report and the totals report allow you to select patients by measure and module. Within the details for each report, you can sort by provider.	X	X	X
100	1/29/2014	Is there a pre-filled guidance document available? Specifically can we just accept pre-filled pneumovax and flu vaccine without confirming in the chart?	The prefilled document is not available at this time. Yes, you can accept prefilled pneumovax and flu vaccinations.	X	X	X
101	1/29/2014	What do you do if the patient birthday is different from the record by 4 days?	If the change in the date of birth removes the patient from denominator eligibility; you can open a QualityNet Help Desk inquiry to request an "Other CMS Approved Reason" to remove the patient. The QualityNet Help Desk inquiry needs to include the patient rank, module/measure in question, and the reason for the request.	X	X	X
102	1/29/2014	When I print the patient summary report the measure is shown as incomplete even though the patient is ranked #567. Do I have to provide an answer even though the patient is not in the first 411 patients?	No, you don't need to provide the patient if he/she is ranked above 411. You need to complete the first 411 consecutively ranked patients in the order in which they appear in the group's sample. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In the patient summary report, the incomplete/complete is based on data provided regardless of rank. However, when you look at module completeness, the module will be marked complete if 411 consecutive patients are complete.	X	X	X
103	1/29/2014	For DM-13, we have successfully loaded a file. It indicates that 616 Total complete (column 11) and 411 Complete (column 7) and 100% completion rate (9). All other columns are 0, but the blood pressures are loaded. How do we troubleshoot?	The first way to trouble shoot would be to look at totals report. This report has details on each of the different lines items on the totals report. Each module will have several lines on the complete patients, incomplete patients, and skipped patients. This report is on the module level. You can also look at the measure rates reports. The measure rates report drills down into the individual measure level. The measures rates report also gives you information on which patients are complete or incomplete for each individual measure. These two reports should help you troubleshoot for which ones are showing up with a "0".	X	X	X

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104	1/30/2014	Can we upload an XML file while submitters are concurrently using the Web Interface?	Yes, you can, but it is not recommended. If a person is updated a patient and there is data in XML file for that patient, the data in the Web Interface would be overwritten. We recommend against someone updating the data while you're uploading a file.	X	X	X
105	1/30/2014	For the add/edit clinic name, does the Clinic ID have to be a valid TIN, or can any numerical entry be used to describe a clinic name within an existing TIN?	The ones that are pre-populated would be a valid TIN or CCN. The ones you add can be a numerical value for the ID and the name of the clinic to indicating something meaningful to you. One thing we would like to point out is if you TIN/CNN has a leading 0 you must add that leading 0 in your XML upload because the lookup for clinic validation requires an exact match.	X	X	X
106	1/30/2014	Is it correct that we are not required to fill in the Clinic fields if they are not pre populated?	Yes, that is correct. The Clinic ID is provided for your use in identifying the location where the patient was seen and is an optional field.	X	X	X
107	1/30/2014	The GPRO PC setup considerations specify that the internet option "show pictures" must be disabled. However, when we change the setting to disabled, we are unable to log on to the Web Interface.(There is no submit button showing after log in)	"Show pictures" option must be enabled to view the icons such as the checkmarks and "X" to indicate completeness, or the help icons. The Submit button should show on the Submit screen, but will be unavailable for selection until you check the box next to the attestation that you are authorized to submit the data.	X	X	X
108	1/30/2014	What report do we need to generate to show how many total patients we have to report on? That is, how can we monitor the number of patients we have completed, or how many are left to complete?	Use the Totals Report will show you how many patients are ranked in each module, how many patients are completed in any order, are completed in consecutive order, skips and total for each of the skip reasons. The Measure Rates Report will show you how you're doing in the individual measure.	X	X	X
109	1/30/2014	Why do I have to re-authenticate my computer at every login?	This is a CMS security policy. If you use a trusted computer frequently, you may check the lasts 12 hours, once that 12 hours is exceeded you will box "**Check this box if you trust this computer and want to register the computer for future account access**." Authentication need to enter the second factor code.	X	X	X

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110	1/30/2014	For CARE-1, are hospital discharge dates accessible in prefilled reports?	No, the Pre-filled Elements report in the Web Interface does not contain the Discharge Dates.	X	X	X
111	1/31/2014	Related to patient ranking, if we are manually entering data for more than measure for the same patient, is patient rank affected as far as entering consecutive patients for each measure?	If you were to have a patient ranked #1 in HTN and #7 in CAD, for example, you could enter the data for this patient in both modules. You don't need to complete patients in consecutive order as long as when you are finished abstracting patients, the first 411 patients in each measure are confirmed and completed.	X	X	X
112	1/31/2014	We have warnings "Minimum requirements not met" and "there is no record for analysis" on the Totals report. Can you please explain these warnings?	For a detailed answer, please go to the Online Help that can be accessed via the question mark on the Totals report page. When it says that minimum requirements are not met, it means that the number of patients required to meet satisfactory reporting has not been met. This is either 411 patients for ACOs and GPROs with 100 or more EPs or 218 patients for GPROs with 25-99 EPs, or 100% of patients if you have fewer eligible patients in your sample. There is no record for analysis means that you do not have any patients confirmed and completed starting at Patient #1 and going through consecutively. You will see this warning if you have not completed Patient #1 in the module.	X	X	X
113	2/6/2013	Can we overwrite prefilled values that can be overwritten?	The pre-filled values may be overwritten if the patient's medical record contains more current data and the values in the medical record are appropriate as per the Supporting Documents for the measure.	X	X	X
114	2/6/2013	Can we upload data by patient subset? We would like to upload patient subsets, one participating clinic at a time. Will the Web Interface accept multiple uploads from one clinic at a time?	Yes, you can upload data by patient subset. No, the Web Interface will only accept one Patient or one Patient Discharge file upload at a time. When the uploaded file has been processed, you may upload another file.		X	X
115	2/6/2013	Column "ns1:ivd-lipid-performed" contains numbers ranging from 1-113; however, I think it should only include 1s or 2s. Also, Column "ns1:care-comments" contains dates. Is this correct?	This happens when you import an XML file into Excel without adding the GPRO XML mapping (XSD) first. You need to use the XSD from the XML Specification and add it to your Excel file before you import the XML file. Otherwise, Excel tries to create the layout, which will not agree with the XML file.	X	X	X

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116	2/6/2013	How can the pre-populated data for HbA1c, IVD, and Mammography that are in the Web Interface be used?	Please review the 2013 GPRO Web Interface Pre-Filled Elements document to be provided shortly.	X	X	X
117	2/6/2013	How is the 'Total Eligible' value calculated in the Measure Rates Report? We have several measures that have over 100 patients completed but the total eligible only show 20 or less eligible encounters in the Measures Rate report.	The Total Eligible count is the number of patients meeting the measure criteria and consecutively confirmed and complete for all measures in the module. The Total Complete count is the number of patients complete for the measure in any order and the entire module does not need to be complete.	X	X	X
118	2/6/2013	I am unable to save the information for one specific patient for each module. Can I skip this patient or will the problem need to be resolved?	This needs to be resolved. Please check if the patient is locked by another user. You can check if the patient is locked on the Patient Status section on the Home page after selecting the patient. Or you can use the Locked Records screen. The online help provides information on these screens, If the patient is not locked, please open a help desk ticket so we can work with you to resolve the problem.	X	X	X
119	2/6/2013	If I choose to upload XML files module by module, is there anything I need to pay attention to? For example, when I upload PREV-5 will the null values for other modules overwrite what I have already uploaded?	Null values in the XML file will not overwrite values previously uploaded.	X	X	X
120	2/6/2013	If we submit data that we have entered thus far, are we allowed to go back and change a patient if we find further information?	Yes. You must Submit after updating the patient's data or the update will not be sent to CMS.	X	X	X
121	2/6/2013	Is a "13" for DM considered a skipped module as the Web Interface is marking it as a skipped patient?	The XML Specification indicates that you may skip a patient in the DM module for medical reasons using "13" in the DM Confirmation tag. If you use the "13" to indicate the patient is not confirmed for the DM module for medical reasons, the Web Interface will mark the patient as skipped.	X	X	X
122	2/6/2013	Is there an option to submit multiple files in the Web Interface at the same time?	Yes, you can upload 1 patient file and 1 patient discharge file at a time. You will have to wait until one file of each type is finished before starting another.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
123	2/6/2013	Our medical record and Web Interface match a patient's Medicare ID number and patient name, but the date of birth is different. Can we correct the date of birth to what our records reflect?	CMS does not maintain patients' dates of birth. Date of birth is maintained by the Social Security Administration (SSA). If you feel that it's wrong in the record, please encourage the patient to contact the SSA. Please note, you are able to change a patient's date of birth manually in the Web Interface by selecting the patient and updating the date of birth on the Demographics tab. You cannot update a patient's date of birth using XML. Lastly, if the birth date change is significant and it could change the patient's eligibility for a measure, please contact the QualityNet help desk to apply for another CMS approved reason to exclude that patient.	X	X	X
124	2/6/2013	The patient XML file has tags for CARE-1. When submitting data, should we just upload discharge xml to submit data on this module or do we need to include the CARE-1 tags in the patient XML as well?	The confirmation that the medical record was found, and if needed, the reason and date may be entered in either file. If you provide the values in the Patient Discharge file, you do not need to provide the values in the Patient file. The values are in the Patient file for use when the patient is ranked in other modules than CARE-1.	X	X	X
125	2/6/2013	The Web Interface does not give us a line for each discharge date. Can you please clarify?	The Web Interface CARE screen will display each discharge date on a separate line. The XML file will provide a set of tags for each discharge date, including the Medicare ID, discharge date, discharge confirmation office visit confirmation, and medication reconciliation. The first discharge date for the patient in the XML file will also contain the module rank and confirmation, which only needs to be provided once per patient. Information on XML Training can be located on the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. Scroll down to the "2013 Web Interface Training" section and view the XML training presentations from the 12/12/2013 and 1/31/2014 support calls.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
126	2/6/2013	What does the green 's' stand for in the patient status bar?	The green "S" indicates that the data you provided for the patient in that module meets the requirements for skipping the patient. If you move your cursor over any of the icons on the screen including the "S", a checkmark, or a red 'X' a tool tip with the full text for the icon is displayed. Information on the 'S' and other icons is also available in the online help topic and in the instructional videos in the online help.	X	X	X
127	2/6/2013	What method did completed ACOs use to complete submission, XML upload or manual abstraction?	For the GPROs and ACOs who are 100% complete, the method used was all manual abstraction, all XML uploads, or combination of both manual and XML.	NA	X	X
128	2/6/2013	When entering patient information into the Web Interface, I have noticed that the null value is not an option to select. Can you clarify?	When an answer is required for a measure component, a null value would not meet the reporting requirements for the patient. Only the valid values for the measure are listed on the pull-down menu.	X	X	X
129	2/6/2013	When uploading data to the Web Interface via XML, if we decide to upload the complete sample plus over sample (411+205 = 616) for a particular measure, what is our measure rate based on?	The measure rate would be based on 616 if all the patients are consecutively confirmed and completed. If somewhere between the 411 and 616 patients you have an incomplete patient in that module, then the measure rate is only up to the first incomplete patient and doesn't include skipped patients.	X	X	X
130	2/6/2013	Which report would I need to pull if I want a detailed list of patients that are passing/not passing/excluded/not eligible by measure once we have uploaded our data to the Web Interface?	The Measure Rates Report will give you the information you're looking for. If you need assistance running or reading the report, please refer to the Online Help or review the footnotes after you run the report.	X	X	X
131	2/20/2014	If a patient's first name is different than what was received in the file provided by CMS but all other identifying information is correct, can we change the first name?	Yes, you can go to demographics screen for that patient and update the patient's first name. Please be aware the update only saves in the Web Interface and does not get sent out to any other organization so the patient should follow normal channels for changing the name officially.	X	X	X
132	2/20/2014	What happens if you unknowingly submit measures for a deceased patient?	The data is stored, but will not be included in your performance calculations.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
133	2/20/2014	What does status "Skipped" mean?	You either indicated that you were unable to find medical record, could not determine the diagnosis, or the patient is not qualified for the sample (such as the patient is in hospice, enrolled in an HMO, deceased, or moved out of the country) Please note skipped patients are not included in your completeness or performance calculations.	X	X	X
134	2/20/2014	Can we download the patient list with the associated physicians? We need this to identify physician/patients for our off-site clinic where a separate EMR is in place.	The Patient Ranking and Patient XML files both include the NPIs associated with the patient.	X	X	X
135	2/20/2014	Can we submit more than once if desired?	You may submit more than once but note after you submit, this is the data that goes to CMS. If you update your patient's data after you submit, you need to submit again so the data CMS received the updated data.	X	X	X
136	2/20/2014	How do we uniquely update only one measure within a measure group, like PREV? We have noted that when data is uploaded for one PREV measure, that the numbers change for other measures within the PREV group even though we have not made any changes or updates.	Setting the Medical Record Found to "Yes" is global to all the modules in which the patient is ranked. You cannot indicate you have the medical record for one module, but not for another module in which the patient is ranked. After you set the Medical Record Found to "Yes", you must confirm that the patient is qualified for the PREV measures in which the patient is ranked. The PREV confirmation and associated measure data are treated as a module. You can confirm the patient is qualified for the PREV modules one at a time, and enter the associated measure data. If you confirm the patient is qualified for one of the PREV measures which has pre-filled data, the numbers can update based on the pre-filled answer without you providing an updated value.	X	X	X
137	2/20/2014	When I export the patient list from the Web Interface, the values for CARE-1 do not download into the file. Is this a known issue?	The Patient XML contains all measure data with the exception of the discharge dates. The Patient Discharge XML file contains the discharge dates.	X	X	X

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138	2/20/2014	If a pre-populated colorectal screening of "yes" is overwritten with a "no", does CMS use our uploaded NO or their pre-populated yes?	If the colorectal cancer screening was performed and can be found, it is pre-filled with "Yes" in the Web Interface. The group doesn't need to add or verify any additional information. If the group decides to change the "Yes" to a "No", CMS would use what was uploaded by the group. Pre-populated values are only used if the patient's Medical Record Found value is set to "Yes" and the confirmation of patient qualification for the module is also set to "Yes".	X	X	X
139	2/27/2014	If I have a patient that has an HMO for all visits in 2012 and 2013, would I enter the date as 1/1/2013? Or if I don't have any records from 2012 but our first visit was 3/12/13 that was billed to the HMO would I enter the date of 3/12/2013?	When we perform sampling, we exclude patients who have an HMO as their primary payer. Patients must be enrolled in Medicare Parts A & B during the measurement period to be eligible. Entering either date would be appropriate for this patient.	X	X	X
140	2/27/2014	The Web Interface shows that data is missing when I only report on the one CARE measure. What would I select under the other CARE measure that would allow me to submit the data?	The data for CARE-1 can be uploaded in XML using the patient discharge XML file. The data for CARE-2 can be uploaded in XML using the patient XML file. If you are using manual abstraction, you would need to enter the data manually in the Web Interface.	X	X	X

MISCELLANEOUS

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
1	FAQ	Will first year ACO 2013 Cohort scores be publically reported by individual ACOs?	ACO scores will be posted on Physician Compare by ACO.	NA	X	X
2	FAQ	Is there a plan to have a Q&A session where we can actually ask questions as opposed to just typing them in?	No, this is the format that will be used moving forward.	X	X	X
3	FAQ	Is the calculated performance rate publicly reported? Does is impact anything for SSP? I am asking because it was stated that if we report on all 616 patients all are used to determine the performance rate and we are trying to determine our best course of action.	For ACOs that began their agreement start date in 2012, there will be public reporting on Physician Compare website in early 2014. The diabetes component measures and CAB measures will be reported.	NA	X	X
4	FAQ	Are we being judged on performance for each module? What implications are there for a measure where we have a "0" for the numerator	ACO will need to completely and accurately report for 2013. This is the quality standard for the 2013 reporting period. In 2014, we move to pay for performance and you can find which measures go to pay for performance both in the SSP rule and supplement documents that are on the ACO quality page on the CMS website.	NA	X	X
5	FAQ	Will a list of questions and answers from this program be available for future reference, as well as the slides?	Yes, we will post the Q&A document and slides on the GPRO Web Interface page of the CMS website within two weeks of support calls: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
6	FAQ	What is the audit process after submission?	Additional information on the audit will be provided after the close of the reporting period to ACOs that are selected to participate in the Medicare Shared Savings Program quality measures validation audit.	X	X	X
7	FAQ	We have users who still need to be added to the listserv for all these notifications and meetings; how do we add people to the PQRS GPRO listserv?	If you are a PQRS GPRO, please send your request to: PQRS_Vetting@mathematica-mpr.com. If you are an ACO, you can update your contacts in HPMS.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
8	FAQ	By saying the PDF is "not 508 compliant" does that mean you would not recommend us printing them and using them to develop our XML?	No. You can still download the PDF and use it as a reference. However, a screen reader may not read the information accurately to a visually impaired user, and some of the built in navigational features (table of contents, bookmarks, and hyperlinks) may not be fully functional. If you click on the link, the online version is 508 compliant and the navigational features are fully functional.	X	X	X
9	FAQ	How do we access the EFT or MFT mailbox?	To access the MFT Internet Server, you must use the 4-character user ID and password assigned to you by the Center for Medicaid, CHIP and Survey & Certification (CMCS). For technical assistance, including issues with account passwords and the MFT web browser interface, contact the ACO Information Center at **1-888-734-6433**, option 2. TTY/TDD: 1-888-734-6563.	NA	X	X
10	FAQ	What is the exact title of the Supporting Documents that is referred to? I want a list of "other CMS approved reasons" for skipping a particular measure.	The Supporting Documents can be located on the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html Scroll to the bottom of the page to the "Downloads" section and select the first option; "2013 Supporting Documents and Release Notes for ACO and PQRS GPRO Web Interface Users". The Supporting Documents are Excel documents and are divided into 7 separate modules. A list of "other CMS approved reasons" is not available. This option must be requested by opening a QualityNet Help Desk incident and must include the measure/module, patient rank, and reason for the request. An example of a reason approved by CMS in the past is when a male patient has been attributed to PREV-5: Breast Cancer Screening.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
11	FAQ	Which of the YouTube videos provides the list of prefilled data?	The 2013 GPRO Web Interface Overview video on YouTube shows the Pre-filled Elements Report with the prefilled elements. The slides for this video, showing the Pre-filled Elements Report are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. The GPRO Online help available from a link in the 2013 GPRO Web Interface Quick Start Guide at https://www.qualitynet.org/portal. The Online Help will also be available from the application during the Submission period. See the information for the Online Help in the "Purpose" section of this document for details on how to access the Online Help outside the application.	X	X	X
12	FAQ	The SSP Quality Measure Benchmarks for the 2014 and 2015 Reporting Years: Appendix A listed several measures 7, 8, 19, 20, 21, 31 and 23 and 33 as Pay for Reporting in program year 2. We began participating as an ACO effective 1/1/2013.	ACOs with 2012 and 2013 start dates are pay-for-reporting for the 2013 reporting period that ACOs are currently reporting on. The benchmarks do apply to 2014 and 2015 reporting periods with data entry in early 2015 and 2016 respectively. For 2014 reporting with data entry in early 2015, the benchmarks will apply to ACOs with 2012 and 2013 agreement start dates for the measures that are pay-for-performance as outlined in table 1 in the Shared Savings Program rule. ACOs with 2014 agreement start dates will be pay-for-reporting for 2014.	NA	X	NA
13	FAQ	We are an anesthesiologist group of 100+ and does some pain management. Can we opted out and continue to bill EP PQRS via claim?	ACO Participant TINS can only participate in PQRS by the ACO satisfactory reporting via the ACO GPRO web interface. If EPs bill through non-ACO participant TINs, they may participate in PQRS in another way for the non-ACO billed charges. For groups reporting in the web interface via the traditional PQRS GPRO, the time period for changing your registration option has already passed.	X	NA	NA
14	FAQ	We require clarification regarding which NARRATIVE specs should be used to report 2013 Pioneer ACO CQMs. Are we to now use the PQRS GPRO NARRATIVE SPECS?	Yes, that's correct.	NA	NA	X

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15	FAQ	What does a 'termed' beneficiary mean? Should that beneficiary still be managed through care manager?	When we are talking about beneficiaries in terms of the Web Interface we are talking about the Medicare patients that have been assigned to your group or ACO that you would need to report on.	X	X	X
16	FAQ	What information will the Beneficiary Provider Supplemental File include? What is the purpose of this file?	The file will include a list of the assigned beneficiaries who have been sampled for GPRO data collection and the following information about those patients: • HICNO • Patient first name • Patient last name • Sex • Birth Date • Patient Rank for each of the samples • The TIN or CCN that provided the patient with the most primary care service visits NPIs, first names, and last names of the 3 providers who provided the highest number of primary care services to the patient. The purpose of this list is to assist the ACOs 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 should make every effort to search your own systems of network of providers to locate the patient's record in order to collect data on this patient.	NA	X	X
17	FAQ	Do we need to get a QualityNet account for the purposes of GPRO Quality Reporting?	No, you do not need a QualityNet account.	X	X	X
18	1/27/2014	For the 2013 GPRO Web Interface 0% performance is acceptable. Will the 2013 GPRO Performance rates be used to calculate Quality Tiering for the future?	Please contact the QualityNet help desk at 1-866-288-8912 or qnetsupport@sdps.org for assistance.	X	X	X
19	1/27/2014	If we get permission for "other CMS approved reason" do we need to include the QualityNet approval in the comments section?	No, groups and ACOs are not required to input any information in the comments section. Comments are to aid the groups/ACOs with their abstraction.	X	X	X

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20	1/27/2014	Who can I talk to about CMS's policy for potential audits - how much documentation should we keep for potential audits?	Any medical record data used to populate the GPRO WI should be saved in the event of an audit.	X	X	X
21	1/28/2014	Will GPROs (non-ACO) using the Web Interface be audited? If so, when will this be scheduled?	As per the 2013 PFS Final Rule, CMS reserves the right to monitor data submitted, however at this time, we do not have a specific date or timeframe to announce for an audit.	X	NA	NA
22	1/31/2014	During last year's ACO quality audit, CMS provided appendix B which listed physician order for aspirin, clopidogrel, heparin, coumadin, or lovenox as use of aspirin or other antithromotic, but it was explained differently yesterday, please clarify.	Please contact QualityNet, so we can better understand the question and respond accordingly.	X	X	X
23	2/27/2014	For the DM Measure, we have 100 patients out of the 616 for whom we cannot confirm the diagnosis. We have done an extraction, and extensive manual chart audit and still have this gap. We are concerned about the skip threshold warning.	The threshold warning is only a warning, however please note that CMS may audit your data and review your skip threshold?	X	X	X

XML

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1	FAQ	If we upload data from the EMR into the portal, do we still need to go into the portal and choose the drop-down menu to select whether patient was eligible for the measure?	You must confirm whether the patient is eligible for the measure either on the screen using the drop-down menu or by including the confirmation value in the uploaded XML file. The XML specs define the tag and allowable values to confirm whether the patient was eligible for the measure. You may upload all required information using the XML files, which means you do not need to go into the portal and choose the drop-down menu. Any measure data that can be entered using the drop-down menu or text fields on the screen may also be uploaded in the XML file. You would only need to choose a value from the drop-down menu or enter data in a text field if you do not include the information in the XML file.	X	X	X
2	FAQ	If we upload data via an XML and the report or status screen shows that some measures are still incomplete, can we go into the GPRO Web Interface and update the information?	Yes, that is correct. Anything you upload, you will be able to view in the Web Interface and you can do additional entry if needed.	X	X	X
3	FAQ	Which measures, or portion of measures, that groups in general, were able to do auto downloads via XML back in GPRO (vs. manual collection and entry?) Labs, other?	All measure data in the Web Interface may be updated with an XML upload. The XML Specs provide the tags and valid values for each of the measure components. For the 2012 Program Year, some of the GPROs and ACOs updated all their measure data using XML uploads and others updated all their measure data using manual entry. The majority of the GPROs and ACOs used a mix of XML uploads and manual entry for all measures.	X	X	X
4	FAQ	When will the XML be provided by CMS to the GPRO submitters?	If you are referencing the XML sample files or XML specs, they are available and posted on the CMS website. They are located on the GPRO Web Interface page. This page can be located by typing in "GPRO Web Interface" into the search box on the CMS website or by referencing the link on slide 16 of this presentation. When the submission period is open, you will be able to export the XML files for your TIN's patients.	X	NA	NA

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5	FAQ	Was it just said that there is no option to export from GPRO? I believe this option was available last year.	XML files for the patient ranking, patient measure data, discharge data, clinics, and providers can be exported from the Web Interface.	X	X	X
6	FAQ	If we are making our submission through an XML upload file is it only the complete patient XML file that we upload or are there multiple XML files that need to be created and uploaded?	It is entirely up to how your organization would like to upload the XML files. The data can be in one submission or in multiple files. As noted in the question above, if you upload multiple XML files, the latest file will overwrite any previously loaded files. But again, you can upload one module at a time, one office's patients at a time, one measure at a time, etc. It really depends on what is best for your workflow.	X	X	X
7	FAQ	If you upload a file, do you have the capability to back out that file in case you upload incorrect data by error?	You do have the opportunity to correct an error. Backing out incorrect data, would essentially either overwrite the data with the new correct value or if you just put it in the wrong place, you could use a "-1" in your XML value. This is described as one of the valid values in the XML specification. A "-1" will blank out as a null the value that is currently in the database for the patient. For example you were only uploading dates for HbA1c and you accidently put them under LDL-C dates. If you wanted to remove the HbA1c dates from the LDL-C dates, you could modify the uploaded file to replace the dates with "-1" upload the file again. All dates with a "-1" in the XML file will now have a null in the database. Please use extreme cautious while doing this because it will remove data from the database, however we did put this option in just to cover this situation.	X	X	X

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8	FAQ	We were planning to use the Excel spreadsheet tool from last year to upload into the GPRO tool. Will this work or is there a new version, and if so, is it located on the above referenced cms.gov website?	If you used Excel last year, you can't use that same template this year because some of the measures and associated tags have changed for 2013. This especially goes for GPROs, as you will see significant changes in your measures. In addition, because the medical record found now applies to all of the modules in which the patient is ranked instead of being on a module by module basis, you can't use last year's template. We have given you instructions as to how to create a new template in Excel 2007, 2010, and 2013 with the supplied XSD files. The format for the template this year is not significantly differently from last year, but there are new and removed tags. Please use the format for this year or your tags will not be valid. The XML Spec contains a Release Notes section detailing the changes for this year.	X	X	X
9	FAQ	Are the NPI and Clinic IDs optional?	Yes, they are optional. You will have a pre-populated clinic and up to three NPIs. If you're happy with what you've got and you don't want to change them, you don't need to include them in the XML file.	X	X	X
10	FAQ	Is there a test system for us to upload a test patient's XML file?	No there is not a test system.	X	X	X
11	FAQ	If you submit an NPI that was not on the list of NPIs that was originally given to us for that beneficiary, will that be accepted?	An XML file containing an NPI that is not on the list of NPIs for your TIN will not be processed. Other valid NPIs will be processed. You will have a pre-populated list of NPIs and you can add NPIs in the Web Interface during the submission period. All NPIs associated to a patient will be pre-populated. All of the available NPI's will be available on a screen and drop down That will be demonstrated in January. If you want to use additional NPIs, you can go into the Web Interface and add new NPI's and then upload your XML files.	X	X	X
12	FAQ	If we change a patient's date of birth and the patient is no longer in age range for a measure, what do we do?	That may fall under other CMS approved reasons so we ask that you submit a QualityNet Help Desk ticket for this question.	X	X	X

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13	FAQ	How will CMS notify users of XSD updates? Or is the user responsible for checking the website and dates on documents	If we find any need to update the XSD, there are different avenues for updating the users. Should we need to change one, we will notify you immediately. How you will be notified depends on your program. It will not be your responsibility to check, we will ensure you are notified.	X	X	X
14	FAQ	As a follow up question to the XSD file change, will the sample files be updated as well?	The sample files did not need to be updated. What was found was that the version in the header did not match what was in the sample file. The sample file was correct which pointed out the difference in the XSD.	X	X	X
15	FAQ	What is the purpose of the clinic file?	This file is more useful for ACOs as they have a number of participating TINs. The information in the clinic file will help the organization see which participating TIN or CCN is associated to a patient. It can help them filter out their patients by each participating TIN.	X	X	X
16	FAQ	If you are new to the PQRS Web Interface, do you have to upload the HTML file in order to view the measures?	When the Web Interface opens, you will see the different measures. If you are new to the Web Interface, we suggest viewing the overview presentations that are available to you. These resources will show you what the different measures are. If you upload an XML file, the values that are uploaded will be visible in the Web Interface.	X	X	X
17	FAQ	When using the XML option, how can we ensure our patient sample stops at patient #411? In other words, if our file contains 616 patients, how can we ensure our performance is only tied to the first 411 patients via the file?	When you export your patients, either in the patient ranking or patient discharge file, the file will contain the patient's rank in all modules in which they were sampled. Depending on how you create your XML file, you would want to use that rank and only provide data for the first 411 patients. Just remember if you are uploading additional patients above 411, the count will stop at the first patient that is incomplete.	X	X	X
18	FAQ	If I am using XML and submit a different NPI, it sounds like from RTI's answer it would be accepted? What do the NPI's listed in the patient file represent?	As long as the NPI is already in the Web Interface when you upload the XML file you can submit a different NPI for a patient and it will be accepted. The NPIs for your TIN will be pre-populated and you can also add NPIs using the Web Interface. The top 3 NPIs for the patient are an additional way you can look up your patient, or filter your list of patients.	X	X	X

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19	FAQ	Will prefilled elements be included in the download export file?	Yes, when you first log on to the Web Interface, if you were to do an export of the patient and the patient discharge data it will contain all of the prefilled elements for you as soon as you log in to the Web Interface.	X	X	X
20	FAQ	If you substitute an NPI that differs from the three NPI's supplied. Does that work for TIN as well? Is there any benefit in submitting NPI's?	If you are changing an NPI for a patients, that's just going to be changing the association to that single patient in the Web Interface. The top three NPIs for a patient were provided to help you find a patient. The Clinic TINs or CCNs are provided to help you find patients. It is for your use and will not be submitted to CMS. CMS will not use the clinics or providers associate to a patient for calculations or measurements.	X	X	X
21	FAQ	Are there restrictions on how we upload XML files? Can we generate one XML file per measure and upload data using one XML file per measure? Can we test an upload with one patient?	Yes, you can upload data using one XML file per measure. Yes, once the Web Interface is open you may upload one patient as a test. Whatever data you enter will be saved for this patient.	X	X	X
22	FAQ	Is it acceptable if we don't include the "provider NPI", "patient first and last names", "gender", "birth-date", "clinic-identifier", "rank" in the XML file? Do we get an error by not using these elements?	Yes, this is acceptable. You won't get an error for not including this information in the XML file. The first/last name, gender, birth-date, and rank will all be pre-populated in the Web Interface. If you need to change any of the fields, you cannot do so in your XML file; you must update them directly in the Web Interface.	X	X	X
23	FAQ	Is an Excel template of the XML file is posted on the GPRO Web Interface website?	The XML specifications have been posted on the GPRO Web Interface page of the CMS website under the *2013 GPRO Web Interface XML Specification* header: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html. There are step-by-step instructions in the XML specifications for creating an Excel to XML template. The XSD files used to create the Excel template are included in the XML specifications.	X	X	X

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24	FAQ	Do you have a recommended workflow for a new group, with 4-5 staff performing data abstraction? Should we abstract by patient or by modules?	It's a personal choice. You may want to consider staff with particular expertise to complete certain modules. In addition, for the sampling of the Preventive Care measures, we tried to reuse patients as much as possible. So, it would make sense to complete these together at the patient level.	X	X	X
25	FAQ	Can you review the process for removing a value from a prior submission with a subsequent file submission (i.e. "removing" vs. "modifying" the previously submitted value)	Backing out incorrect data, would essentially either overwrite the data with the new correct value or if you just put it in the wrong place, you could use a "-1" in your XML value. This is described as one of the valid values in the XML specification. A "-1" will blank out as a null the value that is currently in the database for the patient. For example you were only uploading dates for HbA1c and you accidently put them under LDL-C dates. If you wanted to remove the HbA1c dates from the LDL-C dates, you could modify the uploaded file to replace the dates with "-1" upload the file again. All dates with a "-1" in the XML file will now have a null in the database. Please use extreme cautious while doing this because it will remove data from the database, however we did put this option in just to cover this situation.	X	X	X
26	FAQ	Is this XML tag correct: <submission> tag has attribute xmlns="gov/cms/pqrs/patient/v1"? Should it be ACO instead of PQRS?	The tag as written is correct. The ACO and GPRO measures were aligned for 2013 so there is only one submission attribute for PQRS reporting in the Web Interface.	X	X	X

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27	FAQ	Will you provide a checklist to ensure we don't miss anything on the Web Interface for submission?	If you are performing manual abstraction, when you save a patient, you will receive an errors/warnings message if applicable. If you are using XML, you can use the check entries report to check for inconsistencies and missing information.

The Totals Report will also help you make sure everything is complete in the Web Interface. It includes detailed information on the completeness of data shown in the Group Status section of the Home page.
This report helps you determine if the requirements for reporting have been met. If they have not been met, the report helps you determine which patients are missing and the data that is needed to qualify them for the reporting requirements. | X | X | X |
28	FAQ	When an ACO has multiple participant TINs do we need to upload one set of results (patient, patient discharge) per TIN?	You can choose to combine all of your TINs into one upload or multiple uploads. Whatever works best for you is how you should upload your patients. The Web Interface will allow multiple uploads.	X	X	X
29	FAQ	For first time data submitters, is there a test XML file we can download to see what it looks like?	Sample XML files are available in the "Downloads" section of the CMS Web Interface page http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html	X	X	X
30	FAQ	Is there any easy way of converting data captured in Excel using the patient xsd from cams into xml data? It has not been easy to achieve using Excel.	Answering this requires more information than is available here. Please open a help desk ticket and describe the problem you are having so we can make a recommendation.	X	X	X
31	FAQ	Can you please confirm that the tags should be in the same order as the Upload file as in the Download file.	The tags must be in the order specified in the XML Specification. See sections 4.2.5and 4.2.16 in the XML Specification where this is called out and see Appendix A for the Patient tag order and Appendix B for the Patient Discharge tag order.

The XML file that is exported from the Web Interface will contain the tags in the order indicated in the XML Specification. | X | X | X |

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32	FAQ	We're uploading a file with multiple providers. Am I correct in stating that the <group-tin> should be populated with the TIN from the ACO, while the provider's TIN should be placed in the <clinic-identifier>?	The ACO Primary TIN must be used in the <group-tin> tag. The <clinic-identifier> will be pre-filled for most of the patients. If you need to add a clinic identifier or update a clinic identifier for the patient you must use a clinic identifier that exists in the Web Interface. To obtain a list of the clinic identifiers that exist in the system view the Add/Edit->Clinics screen in the Web Interface or export the Clinics XML file. The clinic identifiers in the system represent the participating TINs or CCNs for the Primary ACO TIN. The clinic identifiers will be pre-populated and you may also add clinics if needed.	X	X	X
33	FAQ	When will the XML file be available for download? Will this be the 27th or the 13th?	XML files may be downloaded from the Web Interface when they submission period opens on January 27. You will be able to download XML files at any time during the submission period. Once the submission period closes on March 21, you will be unable to access the Web Interface or download XML files.	X	X	X
34	FAQ	Does the XML file name need to be the same file name for uploading and downloading?	No it does not. When downloading file, the system will generate a name for it. You can choose to save it under a different name and upload it.	X	X	X
35	FAQ	If an empty tag is used for some of the prefilled measures, would that throw an error during submission?	No empty tags do not throw errors in submission. It will be accepted but it will not be processed.	X	X	X
36	FAQ	What happens if an ACO reports on all 616 patients instead of 411? Will we see errors when uploading the XML document?	No, you will not get errors as long as the patients that you're reporting on are included. This may be easier for ACOs/GPROs that are extracting data from EHRs.	X	X	X
37	FAQ	What modules do I need to choose when exporting the XML files so that I will have the fields that match with the sample patient only prefilled that was provided by CMS?	The measures which may be pre-filled are DM-2, DM-15, IVD-1, PREV-5, PREV-6, PREV-7, PREV-8. You should select the DM, IVD, PREV-5, PREV-6, PREV-7, PREV-8 modules to get patients with pre-filled data.	X	X	X
38	FAQ	When would you have a null value in an XML file?	A null value means the answer has not yet been provided in the Web Interface. The only reason to use a null value in a XML file is if you entered a value in the XML file and you determined the value was an error.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
39	FAQ	Where can I download the .XSD files for the XML import?	The .XSD files can be downloaded from the XML specs.	X	X	X
40	FAQ	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.	X	X	X
41	FAQ	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, for example, if you entered "yes the patient had a mammography screening" in the Web Interface and then you upload an XML file that says "no the patient did not have a mammography screening," then yes, the XML file **will** overwrite what you originally entered into the Web Interface. If, however, you upload an XML file that does not contain the mammography screening tag or if you upload an empty mammography screening tag, then it will **not** overwrite what you have in the Web Interface.	X	X	X
42	FAQ	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 all of your sampled patients in one file.	X	X	X
43	FAQ	Does the XML upload automatically "save" the patient's information?	Yes. Uploading of the XML automatically saves the patient's information. Note that you still need to submit your data to CMS by going to the Submit screen and clicking the Submit button.	X	X	X
44	FAQ	Do you know which measures, or portion of measures, that groups in general, were able to do auto downloads via XML back in GPRO (vs. manual collection and entry?) Labs, other?	All measure data in the Web Interface may be updated with an XML upload. The XML Specs provide the tags and valid values for each of the measure components. For the 2012 Program Year, some of the GPROs and ACOs updated all their measure data using XML uploads and others updated all their measure data using manual entry. The majority of the GPROs and ACOs used a mix of XML uploads and manual entry for all measures.	X	X	X

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45	FAQ	The XML specifications do not indicate that the LDL date has to be during the measurement period. Is there a limit to the date range for that LDL?	All dates that are recorded in the Web Interface, other than date of birth, must be between January 1, 2013 and December 31, 2013. The XML Specification indicates the date must be in 2013, which is the measurement period. In the directions for DM-14, Determine Date Blood Was Drawn for the LDL-C Test and the directions for IVD-1 Determine Date Blood was Drawn for the Lipid Profile, the available values indicate "Valid date between 01/01/2013 and 12/31/2013 in format MM/DD/YYYY". Appendix A for the <dm-ldlc-date> and the <ivd-lipid-date> tags the Valid Values column indicates "Must be a valid date in 2013"	X	X	X
46	FAQ	For CARE-1 measure, patient rank in patient ranking file and in patient discharge file are going to be same?	The patient's rank in a module is a fixed value and will be the same in all XML files. It will also be the same value displayed in the Web Interface on the Patient List, in the Patient Status, and any reports in which the patient appears.	X	X	X
47	FAQ	CARE-1 Medication Reconciliation: Will the discharge dates be included in our exported patient list?	The Medication Reconciliation dates are exported separately from the patient list. There are 5 files you may export in the XML. Please reference the XML specs for details. The XML Specs are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
48	FAQ	Can you confirm that the Sample Beneficiary List will be downloaded from the GPRO site?	The Patient Ranking XML file will contain your Beneficiary List. This file contains the patients' Demographic information and the modules in which the patient is ranked. See the GPRO XML Specifications for all the values contained in this file.	X	X	X
49	1/27/2014	After we have downloaded the XML file and are ready to upload the med rec info, is there a format/layout identifying exactly what needs to be upload into each module/category - in other words, is there a "key" for responses to uploaded correctly?	Yes the key to the responses is the XML Specification. The XML Specification will give you the allowable answers for each of the tags in addition to the order the tags must in.	X	X	X

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50	1/27/2014	Can we export all patients & measures on an excel spreadsheet then complete and then upload into the web interface & submit?	You can do that but please see the Excel section in the XML Specifications. You will need to make minor modifications to the Excel sheet before you upload the file in the Web Interface. If you don't make those adjustments your file will be rejected.	X	X	X
51	1/27/2014	Do we have to download the XML files?	No, downloading the XML files is optional. Downloading the XML file provides you with a list of your patients as well the data currently in the Web Interface.	X	X	X
52	1/27/2014	Must we have a "GPRO-Abstract-Datatypes.xsd" to properly validate the XML? We had this file last time, but I don't see the link for it in the new specs.	No, the XSDs were separate file last year, but the 2013 XSDs available for download from the XML Specification contain all the necessary data types for validation.	X	X	X
53	1/27/2014	Please confirm that providing data (i.e. A1C and date) in our XML upload for a patient who cannot be confirmed is okay and won't impact upload or measure rate.	Yes, you can upload data for a patient that cannot be confirmed. You will not receive an error. This information will not be included in the performance calculation because the performance calculations first checks is the patient is qualified for the measure and will not include those patients that are not confirmed.	X	X	X
54	1/27/2014	The 2013 Web Interface XML Spec is labeled as "Version 1.3 w/Create Date: 12/10/2013. When you select the PDF on the Introduction Page, this spec states "Version 2.0 w/Create Date: 01/20/2013". Which is the correct version?	The online XML Specification is a link that will take you the same content as is included in the PDF. We have verified that they are the same versions and only the cover page is different.	X	X	X
55	1/27/2014	The CMS Excel spreadsheet has all the Quality Measures listed in one large spreadsheet. Do we upload it as one large sheet or do we break it up by measure?	This is the group's choice. The XSD mapping gives you all measures but you can select to only upload a smaller subset of measures at a time. If you break it up by measure, you will not need to include all the XML tags, the tags included in the file must be in the order specified in the XML Specification. Using the CSD provided in the XML Specification with Excel will ensure that the tags are in the correct order.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
56	1/27/2014	When downloading the Patients XML file and opening in Excel, the XML element order differs from the order required for upload in Appendix A of the XML Specifications Please confirm that the XML element order for upload should follow the XML specifications.	The XML element order must follow the XML Specification. Before you import the XML file into Excel, you must apply the XSD file. First, download the XML file and open your Excel program. Then you will import the XSD file followed by the XML file. The CSD files and the instructions for working with Excel are provided in the XML Specification.	X	X	X
57	1/27/2014	When using the XML file, are we supposed to use the Excel spreadsheet that has the CMS approved?	Excel is an option that you can choose to use. You must follow the format in the XML Specification and use the XSD files provided in the XML Specification.	X	X	X
58	1/27/2014	Where do we find the XML file to export within Web Interface?	To export data from the Web Interface, go to the blue navigation bar at the top of the page. There is a link called Export Data. Clicking on this link will take you to Export Data screen.	X	X	X
59	1/28/2014	For the med rec, we can only enter one date per patient in the xml so how can we report on multiple discharges?	You may enter multiple dates for a patient in the Patient Discharge XML file. You will enter the opening and closing <patient> tag along with the tags for the Medicare ID and the discharge data for each discharge.			
60	1/28/2014	For the pre-filled screening data, if we upload data in these fields in our XML file, will this be updated or ignored in the Web Interface? Will our data override any of this information?	Yes, any data in your XML file will overwrite data already in the Web Interface. If you upload an XML file with empty tags, the empty tags are ignored and they will not cause data to be overwritten.	X	X	X
61	1/28/2014	If we are planning on uploading data into GPRO via XML, is there a validation tool that we can run the data through to ensure it is in the correct format?	No, there is no external tool. You can validate your files internally using the XSD files provided or Excel. Files uploaded will be validated before they are sent to be processed for loading in the Web Interface. Any errors in the file will be available in the Upload Data Results table on the Upload Data screen.	X	X	X
62	1/28/2014	If we send data for patients who are not ranked for a module will this cause an error in the upload?	It will cause an error in the upload, but the data will be ignored and not stored in the Web Interface.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
63	1/28/2014	In the patient discharge XML file, the same patient identified by Medicare ID shows up several times. Is my observation that the module rank information is only included in one of the <patient> nodes, per Medicare-id, correct?	Yes, that is correct.	X	X	X
64	1/28/2014	Where do we find the XSD files for the export? Do we use the XSD files from the sample XML and XSD files?	The XSD files are available on the Introduction page of the XML Specification, which can be accessed from the CMS website or from the link in the Web Interface online help.	X	X	X
65	1/28/2014	Will using "-1" skip patients at all? When we do our initial file upload, is it better to use a "-1" as a NULL or report these as blanks? Will we receive an error for sending any blanks? If so, what fields will receive errors for blanks?	The value "-1" will not skip patients. "-1" is used to correct an error and will set the value back to null. You should only use "-1" if you need to correct an error. Empty tags or blanks values will not give you an error, and the tags will be ignored	X	X	X
66	1/29/2014	For any patient in the Patient XML file, can we not include those tags that we do not want overwritten? This would mean that number of items sent in for one patient will not be the same as that for another.	Yes, you can leave the optional tags empty in the XML file.	X	X	X
67	1/29/2014	If we are trying to upload data by module, do we include all of the tags and leave them empty?	Yes, you can leave the tags empty or not include them in the XML file.	X	X	X
68	1/29/2014	Our IT department has not been able to export the Medication Reconciliation file successfully with ALL discharge dates. Is the process different from last year? Have others experienced this problem?	The XML format has changed from 2012. All discharge dates are included in the XML file. Please reference the presentation from the 1/31/2014 ACO and GPRO Daily Support Call posted on the CMS PQRS Web Interface website.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
69	1/29/2014	What are the most common errors after uploading XML to the Web Interface and where can I find the instructions/guide to fix the errors?	The most common error that an invalid value is being used in a tag. For example, the date is not in correct format or an unallowable value is being used in the XML. Another error is that the XML file is invalid, either because it is saved with BOM, the header was copied from the XML Specification PDF, or it doesn't follow the specifications. Please refer to the XML Specification for the acceptable values for tags and correct order of tags.	X	X	X
70	1/29/2014	Will I get an error if I upload the XML data that provides information for patient who is not ranked in a specific rank? For example, if a patient is not ranked for mammogram, but we send data on mammogram, will we get an error?	No, you will not receive an error. The patient's data will not be saved in the Web Interface because the patient is not ranked.	X	X	X
71	1/29/2014	Will we be able to successfully upload the XML file if we have errors for "The value is missing" or will we need to correct these errors? Do we need to only correct critical errors to be successful in our file upload?	You would need to correct any validation errors before the file can be processed.	X	X	X
72	1/30/2014	For the XML file, do we need to include the following tags for all measures: medical-record-found, medical-not-qualified-reason medical-not-qualified-date?	The medical-record-found tag must be provided once for each patient. The medical-not-qualified-reason and medical-not-qualified-date are only required if you are skipping a patient because they are not qualified for the sample. The XML Specification provides information on when these tags are required to complete the patient's data.	X	X	X
73	1/30/2014	Is there a sample xml file for each measure available to double check the format/order against?	Yes, the sample XML files are located in the Download section of the Web Interface page of the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.	X	X	X
74	1/30/2014	Is this correct that not all discharge dates sent in the XML file are populated in the Web Interface?	No, that is not correct. The XML file is pulled from the database so all discharge dates in the XML file are pre-populated in the Web Interface.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
75	1/30/2014	What is the reference for the structure for the XML for patient records which have more than 1 discharge date?	Please refer to the XML Specification. As mentioned earlier on the call, you can reference the presentation from the 1/31/2014 ACO and GPRO Daily Support Call posted on the CMS PQRS Web Interface website to see what a patient with multiple discharges will look like when it's exported. You will see multiple discharges for a patient but the Medicare ID is repeated for the second discharge whereas the confirmation and rank are not included on the second or subsequent discharges.	X	X	X
76	1/30/2014	When I downloaded CARE-1, for patients with more than one discharge date to abstract only the first date shows up in my XML. How do I fix this?	All discharge dates for the patient are included in the Patient Discharge XML file.	X	X	X
77	1/31/2014	If we manually abstract data before the XML upload, will the data already entered into the Web Interface be affected or lost by subsequent uploads?	If the data manually updated is also in the XML file, then the XML file will overwrite that data already in the Web Interface. You can avoid overwriting the data by removing those tags or leaving the tags empty in your XML file.	X	X	X
78	2/6/2013	Can we test an XML upload? Can data uploaded from the XML file be overwritten?	There is no separate test system for XML. If you upload an XML file and then upload another XML with the same patients, it would overwrite data you previously uploaded.	X	X	X
79	2/6/2013	For CARE-1, how should we respond to the multiple discharge dates via XML upload for ranked patients?	Each discharge date should have an opening <patient> tag and a closing </patient> tag. The Medicare ID, discharge date, and associated measure answers for that date should be contained between the opening and closing tags.	X	X	X
80	2/20/2014	When I try to upload the XML file, which contains deceased patients, the interface expects us to fill in answer for the measures. It was my understanding that if the patient was deceased in the measurement period the patient would not qualify for the measure. Is this correct?	You do not need to provide data for deceased patients. If you are getting an error indicating you need to provide a tag for the measure it means your tags are not in the correct order as indicated in the XML Specification.	X	X	X
81	2/20/2014	For PREV-12, is it correct to use the same column to report that a depression screening was done as to report that a participant can be excluded from screening?	Please refer to XML specification which shows which XML tags should be used and which values are allowed. The column headers will match tags in the XML specification.	X	X	X

NO.	DATE OF SUPPORT CALL	QUESTION	ANSWER	PQRS GPRO	SSP ACO	PIONEER ACO
82	2/20/2014	I have a 3MB XML file to be uploaded. Is there a limit on the size of the XML file that can be uploaded?	3 MB is fine, limit is 80 MB, which far exceeds what a normal file would be.	X	X	X
83	2/20/2014	If an XML is submitted to the Web Interface that has additional information, will this produce errors? For example, if the patient is ranked for PREV-5 but we also include information for PREV-6, will this produce an error or will the file not be able to load?	The measure data for a module in which the patient is not ranked will be ignored.	X	X	X
84	2/27/2014	What report, if any, would help us retrieve a patient list if we were audited. Do I use our final XML download?	The final XML download would be a good way to obtain all of the patient information and would allow you to put it into an Excel spreadsheet easily.

The totals report lists each and every patient but doesn't provide information on each patient. You would need to look at the patient summary report for this information. | X | X | X |
85	2/27/2014	When exporting data, will this remove the patient from the sample list in the Web Interface or just create the XML document with no change to the Web Interface list?	When exporting data, it just creates the XML document with no changes to the Web Interface list.	X	X	X
86	2/27/2014	Is it correct that an ACO/GPRO can submit (via XML) data that exceeds the 10% skip threshold?	Yes, that is correct as long as you are using the appropriate skip reasons and have documentation in your records to back up the skip in case of an audit.	X	X	X
87	2/27/2014	In my XML file, <medical-record-found>2</medical-record-found> is listed, yet in Web Interface, the medical record found is not populated. Do I need to add something else to the tag?	Please open a help desk ticket to allow someone to work with you one-on-one to look at your XML file.	X	X	X

ADDITIONAL INFORMATION

PQRS GPRO

- 2013 PQRS GPRO information is available on the CMS PQRS website under the "Group Practice Reporting Option" page, or directly at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Selected-Group_Practice_Reporting_Option.html.
- 2013 PQRS GPRO Web Interface reporting information is available on the CMS PQRS website under the "GPRO Web Interface" page, or directly at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.
- Any questions regarding this document, PQRS or participation in the PQRS GPRO should be referred to the **QualityNet Help Desk** at desk at **866-288-8912**, TTY 877-715-6222, or via email at **qnetsupport@sdps.org**.

SSP

- 2013 SSP information is available on the SSP website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html.

PIONEER ACO

- Any questions regarding this document or participation in PQRS through the Pioneer ACO should contact the CMS at **PIONEERQUESTIONS@cms.hhs.gov**.

APPENDIX: CONSECUTIVE COMPLETION REQUIREMENT

Patients are numbered 1-616 (or 1 to the maximum number available if less than 616), and 411 of these patients need to be completed in the GPRO Web Interface by ACOs and PQRS GPROs with 100 or more EPs. For PQRS GPROs with 25-99 EPs, up to 327 patients will be ranked in a module and 218 must be completed. The 616 number represents a 50% oversampling to provide additional patients if you need to skip a patient in order to allow completion of 411 patients. Complete means that you have found the medical record, confirmed the disease diagnosis (for CAD, DM, HF, HTN, IVD), and provided all the required information; or, for those measures that do not require confirmation of a diagnosis (CARE and PREV), that you have found the medical record, confirmed the patient is eligible for the measure, and provided all the required information.

The minimum number for satisfactory reporting is 411 (ACO or PQRS GPRO with 100 or more EPs), or 218 (PQRS GPRO with 25-99 EPs) consecutively confirmed and completed patients, starting with the patient ranked #1 in the disease module or patient care/coordination measure. If you skip a patient because the medical record was not found, the patient is no longer qualified for the sample, the patient is not eligible for the disease module or patient care measure, **or** the diagnosis could not be confirmed then an additional patient, *on a one to one basis*, must be completed according to the criteria noted above. If the pool of eligible assigned beneficiaries is less than 411 for ACOs or for group practices participating in PQRS GPRO with 100 or more EPs, or less than 218 for group practices participating in PQRS GPRO with 25-99 EPs then report on 100% of assigned beneficiaries.

Following are three examples of completing patients in consecutive order in the Web Interface.

EXAMPLE #1

In this example, 2 patient ranks need to be skipped. An additional patient is eligible for a clinical exclusion per the measure specifications.

Patient Rank	Disease Confirmation (not applicable to all measures) or patient care eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes – confirmed	Yes – complete	Yes	
2	Yes – confirmed	Yes – complete	Yes	
3	Yes – confirmed	Yes – complete	Yes	
4	N/A	N/A	No	Medical Record not found
5	Yes – confirmed	Yes – complete	Yes	Patient was eligible for one of the clinical exclusions in the specifications.
6	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during 2013
7 through 411	Yes – confirmed	Yes – complete	Yes	
412	Yes – confirmed	Yes – complete	Yes	Must complete additional patient to make up for skipping Rank #4
413	Yes – confirmed	Yes – complete	Yes	Must complete additional patient to make up for skipping Rank #6

Note: No additional abstraction required: consecutively completed 411 ranked patients. Module considered complete.

EXAMPLE #2

In this example, 2 patient ranks need to be skipped, but there are fewer than 411 patients available for abstraction.

Patient Rank	Disease Confirmation (not applicable to all measures) or patient care eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes – confirmed	Yes – complete	Yes	
2	Yes – confirmed	Yes – complete	Yes	
3	Yes – confirmed	Yes – complete	Yes	
4	N/A	N/A	No	Medical Record not found
5	Yes – confirmed	Yes – complete	Yes	
6	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during 2013
7 through 386	Yes – confirmed	Yes – complete	Yes	
387	Yes – confirmed	Yes – complete	Yes	No additional patients available for abstraction.

Note: No additional patients available for abstraction: consecutively completed all available ranked patients. Module considered complete.

EXAMPLE #3

In this example, laboratory result data for patient rank #2 was not provided and causes the count of consecutively completed ranks to stop at rank #1.

Patient Rank	Disease Confirmation (not applicable to all measures) or patient care eligibility confirmation	Abstracted all information required in the module	Will patient count towards 411 required?	Notes
1	Yes – confirmed	Yes – complete	Yes	
2	Yes – confirmed	No – didn't abstract information on lab test	No	If this patient is not completed, you will have consecutively completed only 1 patient (Rank #1). Once Rank #2 is completed, it will be considered consecutively completed.
3	Yes – confirmed	Yes - complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
4	Yes – confirmed	Yes - complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
5	N/A	Yes (input date of death under "Not Qualified for Sample")	No	Deceased during 2013
6 through 411	Yes – confirmed	Yes - complete	No	Once Rank #2 is completed, this will be considered consecutively completed.
412	Yes – confirmed	Yes - complete	No	Must complete additional patient to make up for skipping Rank #5. Once Rank #2 is completed, this will be considered consecutively completed.

Note: Module considered incomplete until Rank #2 is completed.