Quality Payment PROGRAM

2020 Centers for Medicare and Medicaid Services (CMS) Web Interface Frequently Asked Questions

How to Navigate This Resource

Purpose

This resource focuses on the Centers for Medicare and Medicaid Services (CMS) Web Interface and provides a general overview of information regarding the CMS Web Interface measures and reporting requirements for the Quality performance category under the Quality Payment Program (QPP).

This resource was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary for the 2020 performance period. It is not intended to take the place of the written law or regulations. Readers are encouraged to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents. Other materials available to assist groups, virtual groups, and Accountable Care Organizations (ACOs) are mentioned throughout this document.

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Quality Reporting for the 2020 Performance Period: Overview

Activity	Estimated* Timeline
Groups, virtual groups, and ACOs participating in the Shared Savings Program or the Next Generation ACO Model provide care to patients during the 2020 performance period.	January 1, 2020–December 31, 2020
CMS Application Programming Interface (API) available for testing in the developer preview environment.	August 19, 2020
Patients are assigned and sampled for groups, virtual groups, and ACOs reporting via the CMS Web Interface. CMS generates a sample of patients for each CMS Web Interface measure that is pre-populated in the CMS Web Interface.	November 2020–December 2020
Submission Period Starts: CMS Web Interface opens for data entry.	January 4, 2021
Groups, virtual groups, and ACOs attend Support Calls.	January 27–March 24, 2021
Submission Period Ends: Last day for groups, virtual groups, and ACOs to report data; data abstraction will not be permitted once the submission period closes.	March 31, 2021
After submission closes, users can view your reports on the Reports page. The Reports page is located in the main left navigation after logging in to the QPP Portal.	April 1, 2021

2020 CMS Web Interface Resources

The resources below are currently available on the QPP Resource Library:

2020 CMS Web Interface Measure Specifications and Supporting Documents
The 2020 CMS Web Interface Measure Specifications and Supporting Documents is a zip file containing the following documents:

- **Measures List** – Contains the list of CMS Web Interface measures, including the CMS Web Interface measure number, title, alternative measure identifiers for other collection types or programs, and measure steward contact information.
- **Measure Specifications and Performance Calculation Flows** – The Measure Specifications contain detailed instructions for each measure and should be used in conjunction with the applicable Coding Document. These documents also contain Measure Flows with Sample Calculations for Performance Rates and Downloadable Resource Mapping Tables, meant to assist users with identifying the proper variable names for the measure within the Coding Documents.

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- **Coding Documents** - An Excel workbook that lists codes that may be used to guide reporting of each measure. The documents contain the appropriate codes to use to satisfy the Denominator, Encounters, and the Numerator.
- **Submission Release Notes** - Includes the list of changes to the Measure Specifications made since the release of the 2019 CMS Web Interface Measure Specifications.
- **Coding Release Notes** - Includes the list of changes to the Coding Documents made since the release of the 2019 CMS Web Interface Coding Documents.

2020 CMS Web Interface Quick Start Guide

The 2020 CMS Web Interface Quick Start Guide provides CMS Web Interface users with information needed to understand and report data via the CMS Web Interface.

2020 CMS Web Interface Telehealth Guidance

The 2020 CMS Web Interface Telehealth Guidance outlines how telehealth relates to the reporting of measure data within the CMS Web Interface for the 2020 performance period.

2020 CMS Web Interface User Guide

The CMS Web Interface User Guide shows users how to access the CMS Web Interface, report data, view data reporting progress, and access other CMS Web Interface resources. Topics covered include the following:

- Viewing and downloading your patient sample.
- Managing clinics and providers.
- Reporting data.
- Viewing progress and reports.
- Additional instruction for:
    - Reporting consecutive and confirmed reporting requirements.
    - Reporting when you have less than 248 patients consecutively ranked for a measure.
    - Skipping a patient in your sample (including submitting an “Other CMS Approved Reason”).
    - Updating demographic information.

2020 CMS Web Interface Sampling Methodology

The 2020 CMS Web Interface Sampling methodology explains the sampling methodology for the 10 clinical quality measures reported via the CMS Web Interface.

2020 MIPS Assignment for CMS Web Interface and CAHPS for MIPS Survey

The 2020 Merit-based Incentive Payment System (MIPS) Assignment Methodology for CMS Web Interface and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey describes the process for assigning Medicare patients to a group and virtual group participating in MIPS for the 2020 performance period.2020 CMS Web Interface Excel Template

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The 2020 CMS Web Interface Excel Template is a pre-formatted Excel Template allows users to input submission data for the CMS Web Interface.

2020 CMS Web Interface Excel Template with Sample Data

The 2020 CMS Web Interface Excel Template with Sample Data provides an example of the latest CMS Web Interface Excel Template populated with sample data that allows users to understand the 2020 performance period changes to the measures and template prior to the submission period.

2020 CMS Web Interface Data Dictionary

This lists elements from the CMS Web Interface Excel Template to assist users as they prepare to report data using the 2020 CMS Web Interface Excel Template.

2020 CMS Web Interface User Demo Videos (Playlist)

The series of demo videos will help CMS Web Interface users with quality data submission for the 2020 performance period.

Note: For Shared Savings Program resources, please visit the Shared Savings Program Guidance and Specifications page.

2020 CMS Web Interface Measures

CMS Web Interface Measure Identifier (ID)	Measure Name
CARE-2	Falls: Screening for Future Falls
DM-2	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
HTN-2	Controlling High Blood Pressure
MH-1	Depression Remission at Twelve Months
PREV-5	Breast Cancer Screening
PREV-6	Colorectal Cancer Screening
PREV-7	Preventive Care and Screening: Influenza Immunization
PREV-10	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PREV-12	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
PREV-13	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

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How to Get Started

- Review the 2020 CMS Web Interface Measure Specifications and Supporting Documents and familiarize yourself with each of the 10 measures included in the 2020 CMS Web Interface:
    - The Measure Specifications and coding Excel spreadsheets are your source documents.
    - If you submitted quality data to CMS through the CMS Web Interface for the 2019 performance period, review the 2020 Measure Specification Submission Release Notes and the 2020 Coding Release Notes (found within with Measure Specifications and Supporting documents zip file) to identify measure changes and updates that were made from the 2019 performance period to 2020 performance period.
- Review the 2020 CMS Web Interface Measure-Specific Frequently Asked Questions (FAQs) within this document, which are intended to supplement the Measure Specifications.
- Use the posted educational resources to prepare for data submission and understand reporting requirements for the CMS Web Interface.

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Patient Sample Without Data File

ID	Question	Answer
1	What information will be provided in the Patient Sample file that will be available in the CMS Web Interface?	The file will include: • Medicare ID (either the Health Insurance Claim Number (HICN) or the Medicare Patient Identifier (MBI)) • Patient first name • Patient last name • Gender • Birth Date • Patient rank for each of the CMS Web Interface measures into which the patient was sampled • Clinic ID, which will be the Taxpayer Identification Number (TIN) or CMS Certification Number (CCN) that provided the patient with the most primary care service visits • Provider Names/National Provider Identifiers (NPIs): NPIs, first names, and last names of up to 3 providers within the group, virtual group, or ACO who provided the highest number of primary care services to the patient.

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Sampling and Pre-Population

ID	Question	Answer
1	Will all of our assigned/aligned patients be populated into the CMS Web Interface?	No. Patients will be sampled randomly (for ACOs, sampling is based on third quarter assignment/alignment) into the CMS Web Interface using the specifications outlined the 2020 CMS Web Interface Sampling Methodology document, posted in the QPP Resource Library.
2	What is the significance of a patient's rank?	Each sampled patient in a CMS Web Interface measure is randomly assigned a rank order number for that measure. Patients will be ranked 1-616 (or 750 for PREV-13), or to the maximum number of eligible patients if fewer than 616 (or 750) are eligible for a given measure. All organizations, regardless of size, are required to completely and accurately confirm and report on a minimum of 248 consecutive Medicare patients for each measure (excluding patients meeting criteria to be skipped). For more information on consecutive completion, please see Appendix A: Consecutively Confirmed and Completed Requirement.
3	Will each ACO (participant) TIN receive its own set of samples? Applicable to Shared Savings Program ACOs and Next Generation ACO Model ACOs only.	No. Quality data collection, measurement, and reporting in the ACO program are conducted at the ACO Entity-level. The samples on which ACOs will need to submit clinical quality data will be drawn from all assigned/aligned patients across the entire ACO; that is, all participant TINs. More specifically, samples will be drawn from third quarter assignment/alignment. In other words, there will be one set of 10 samples (one for each measure) drawn for the entire ACO Entity, not for each participant TIN in the ACO.
4	Will the CMS Web Interface use a Health Insurance Claim Number (HICN) or a Medicare Patient Identifiers (MBI)?	The 2020 patient samples may include some patients that are identified with a HICN, although the majority will be identified using an MBI. The CMS Web Interface and Excel template contain tips that indicate whether a patient has a HICN or MBI, so that you can locate the patient records correctly and efficiently. Likewise, the API contains the same patient sample using the HICN and MBI. It's important that you use the same patient identifier included in the sample when uploading data to the CMS Web Interface via Excel or API.

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ID	Question	Answer
5	Is the ACO, group, or virtual group responsible for validating the data that is pre-populated into the CMS Web Interface?	Yes. The group, virtual group, or ACO should validate each patient's demographic information, as changes to age and gender may affect a patient's denominator eligibility. Provider information populated in the CMS Web Interface is for informational purposes only, so validation of these data are at the discretion of the organization. PREV-7 (influenza immunization) is the only instance where numerator-specific data are pre-populated. Note that influenza immunization data are not pre-populated for all patients ranked in PREV-7, but only those for whom an immunization could be identified in the claims data. If influenza immunization data has been pre-populated for a patient, it does not need to be validated. If the group, virtual group, or ACO is selected for an audit, the group, virtual group, or ACO will not have to provide medical record documentation for pre-populated influenza immunization data. However, if influenza immunization data are not pre-populated, the group, virtual group, or ACO should refer to the patient's medical record to determine if an influenza immunization was administered in accordance with the Measure Specifications, and should document their findings in the CMS Web Interface. Should your organization be selected for an audit, the influenza immunization data that is obtained from the medical record (i.e., not pre-populated from claims data) is subject to the provision of supporting documentation.

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Abstraction into the CMS Web Interface

ID	Question	Answer
1	How many unique patient medical records should we expect to need to reference for reporting?	There are 10 patient samples provided to each organization, one for each of the 10 CMS Web Interface measures. Each of these samples will have no more than 616 (or 750 for PREV-13) patients. Patients are sampled using a method that increases the likelihood that they will be sampled into multiple measures (if they were eligible for multiple measures). Although there is the potential to see 6,294 (9 samples x 616 patients and 1 sample x 750 patients) unique patients, we typically see sample sizes between 1,000 and 3,000 unique patients. The sampling methodology is described in the 2020 CMS Web Interface Sampling Methodology document available for download from the QPP Resource Library. Groups, virtual groups, and ACOs are required to confirm and completely report on the first 248 consecutively ranked patients in each CMS Web Interface measure. The additional sampled patients allow for cases in which some patients may not be eligible for quality reporting. In such cases, the patient may be "skipped" and will automatically be replaced with the next patient, who must be reported on. The group, virtual group, or ACO must confirm and completely report on 248 (or all eligible patients, if there are less than 248) consecutive ranked patients.
2	What if one of our sampled patients was not seen at our group, a TIN within our virtual group, or one of our ACO participant TINs during the measurement period?	Though the patient may not have received care at your specific facility or practice, the patient was assigned to your group, virtual group, or ACO and must have had at least 2 eligible services with your group, a TIN within your virtual group, or one of your ACO's participant TINs during the measurement period to be chosen for inclusion in a CMS Web Interface measure sample. Since your organization is deemed accountable for such a case, you may not select 'not qualified for sample' under this circumstance.

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ID	Question	Answer
3	What if one of our sampled patients is no longer being seen at one of the ACO's participant TINs, the group, or a TIN within the virtual group (i.e., patient moved or the provider is no longer with the ACO participant TIN, the group, or a TIN within the virtual group)?	Patients sampled into the CMS Web Interface had at least 2 primary care service visits with your ACO, group, or TIN within your virtual group between January 1, 2020 and October 31, 2020. Therefore, your ACO, group, or a TIN within your virtual group is considered accountable for this patient's care, and you should do your best to obtain the necessary medical record information to complete the CMS Web Interface. Your medical record documentation should substantiate the information reported.
4	Can we exclude a sampled patient if they were only seen by a specialist within our group, a TIN within our virtual group, or one of our ACO participant TINs?	No. This patient was assigned to your organization and has at least 2 primary care service visits with your organization, so your organization is considered accountable for his/her care.
5	Is it possible to use data from multiple sources for abstraction?	Yes. Any medical record documentation available to the group, virtual group, or ACO at the time during which care was provided to the patient is eligible for use in data collection.

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2020 CMS Web Interface Measure Specification Guide

The information in this section is intended to supplement the 2020 CMS Web Interface Measure Specifications and should not be used as the sole resource for measure guidance. Please review the Measure Specifications thoroughly.

Measure-Level Exclusions and Exceptions

There are 2 options that will remove a patient either from the measure or measure's performance calculation. Measure owners may specify a patient should be excluded from the denominator of a particular measure (denominator exclusion) or from the calculation of performance for the measure (denominator exception). For measures where the measure owner has identified an appropriate denominator exclusion and/or denominator exception category, it will be specified within the 2020 CMS Web Interface Measure Specifications and Supporting Documents. An option is available in the CMS Web Interface that allows groups, virtual groups, and ACOs to indicate that a given patient meets the exclusion or exception criteria for a measure.

- **Denominator Exclusion** - Patients who should be removed from the measure population and denominator before determining whether the numerator criteria are met.

  If a patient meets the denominator exclusion criteria, they must be removed from the measure population. This patient will be replaced with the next consecutive patient sampled for the measure.

- **Denominator Exception** –When a patient is eligible for the denominator, but the Measure Specifications define circumstances in which a patient may be appropriately deemed as a denominator exception. Allowable reasons are categorized into 3 general categories:

  - Medical;
  - Patient; and
  - System.

  A denominator exception removes a patient from the performance denominator only if the numerator criteria are not met as defined by the exception. This allows for the exercise of clinical judgement by the MIPS eligible clinician. When a denominator exception is selected, the patient is considered completed for reporting.

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ID	Question	Answer
1	If a patient meets the performance for a measure, but there is an applicable denominator exclusion, which should be reported?	If a denominator exclusion applies to a patient, the exclusion should always be reported regardless of whether or not the quality action was completed for that patient. This ensures the intended denominator population is captured for the measure.
2	If a patient meets the performance for a measure, but there is an applicable denominator exception, which should be reported?	If there is documentation to support that the quality action was completed for the patient (i.e., the performance is met) AND the patient has an applicable denominator exception, it's appropriate to report "Performance Met." If the quality action wasn't completed for the patient and there is an applicable denominator exception, it's appropriate to report the denominator exception. This ensures that the eligible clinician is allowed the most advantageous outcome when calculating measure performance.

Frailty and Advanced Illness Exclusions

The Measure Specifications were updated to include exclusions for frailty and advanced illness for the following 2020 CMS Web Interface measures:

- DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- HTN-2: Controlling High Blood Pressure
- PREV-5: Breast Cancer Screening
- PREV-6: Colorectal Cancer Screening

These exclusions apply to the following:

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period

OR

Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness **OR** 2 outpatient, observation, emergency department, or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period.

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ID	Question	Answer
1	How is “frailty” defined within the applicable 2020 CMS Web Interface measures?	Applicable coding associated with the new denominator exclusion for “frailty” can be found within each applicable 2020 CMS Web Interface Coding Documents. Refer to the 2020 CMS Web Interface Measure Specifications and Supporting Documents. The applicable codes can be found on the “DenominatorExclusionCodes” tab within the appropriate Coding Document and are identified by the word "frailty" in the variable name.
2	The exclusion states a dementia medication must be “dispensed.” Does simply prescribing a dementia medication meet the intent of the exclusion?	No. The measure steward intentionally used the term “dispensed” in the denominator exclusion to ensure the patient had the medication, and it wasn’t simply prescribed. To meet the intent of the denominator exclusion, the dementia medication must have been active, that is, on the patient’s medication list sometime during the measurement period or the year prior. Or, there must be documentation within the medical record that the medication was dispensed to the patient during the measurement period or year prior.
3	If a patient has a claim with a diagnosis code, do they also need to have evidence of a qualifying dementia medication to use the exclusion: “Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period?”	Yes. The claim/encounter for frailty needs to be during the measurement period. In addition, documentation of a dispensed dementia medication during the measurement period or during the year prior is required.

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Institutional Special Needs Plan (SNP) or Long-Term Care Exclusions

The Measure Specifications were updated to include a denominator exclusion for patients age 66 and older in Institutional Special Needs Plan (SNP) or Residing in Long-Term Care with a Place of Service (POS) code 32, 33, 34, 54, or 56 for more than 90 days during the measurement period for the following 2020 CMS Web Interface measures:

- DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- HTN-2: Controlling High Blood Pressure
- PREV-5: Breast Cancer Screening
- PREV-6: Colorectal Cancer Screening

ID	Question	Answer
1	Does the Special Needs Plan (SNP) or long-term care exclusion have to be one stay totaling at least 90 days, or can it be multiple stays that total 90 days or longer?	The more than 90 days criteria may represent the total number of days a patient experiences care from a Long Term Care (LTC)/SNP during the measurement period and doesn't necessarily need to be representative of one continuous 90-day stay.
2	If a patient is younger than 66 years old and in Institutional SNP or Residing in LTC, can they still be considered for a denominator exclusion?	No. The patient must be 66 years or older to meet the intent of the denominator exclusion.

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Patient Confirmation

Patient confirmation is used to confirm a patient is eligible for submission, which includes the confirmation that the patient's medical record is found and the patient is qualified for the sample.

ID	Question	Answer
1	When can I use "No - Medical Record Not Found?"	The "No - Medical Record Not Found" option should be used only if there is truly an inability to locate and access the patient's medical record. By virtue of being sampled into the CMS Web Interface, CMS has identified claims for this patient submitted by your organization. CMS expects organizations to be able to obtain medical records for their assigned and sampled patients. This includes collaborating with clinicians and/or other clinic staff both inside and outside the organization (including but not limited to the 3 NPIs provided in the CMS Web Interface), as well as facilities both inside and outside the organization, with such collaboration attempts being repeated throughout the course of the data collection period, if needed. Refer to Appendix B, Table B-1 for examples pertaining to the response of "Medical Record Not Found."

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ID	Question	Answer
2	When can I use “Not Qualified for Sample?”	CMS makes efforts to exclude patients that are not qualified for the sample, but because there are limitations in the claims data used to identify the sample, the CMS Web Interface allows a patient to be skipped because they are not qualified for the sample. The patient must meet one of the following criteria to be considered not qualified for the sample and will be removed from all CMS Web Interface measure samples: • In hospice;[1] • Moved out of the U.S.; • Deceased; or • Non-Fee-for-Service (FFS) Medicare.[2] If any of the above are true for a sampled patient, at any time during the measurement period, that patient isn’t qualified for the sample. If Not Qualified for Sample is selected, you must also select the specific reason from the menu provided (which matches the above stated list). The CMS Web Interface will also ask for a date that corresponds with the reason a patient isn’t qualified for the sample. If the exact date is unknown (i.e., patient date of death), you may enter the last day of the measurement period (i.e., December 31, 2020). Refer to Appendix B, Table B-2 for examples.
3	Is there a list of codes associated with hospice or palliative care?	No. There is no list of codes for the CMS Web Interface measures to use for hospice or palliative care. Your medical record documentation should support that the patient was in hospice or was a non-hospice patient receiving palliative goals or comfort care.

[1] Hospice includes non-hospice patients receiving palliative goals or comfort care.

[2] This option is for patients enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, Health Maintenance Organizations (HMOs), etc.) This exclusion is intended to remove patients for whom FFS Medicare isn’t the primary payer.

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2020 CMS Web Interface Measure-Specific FAQs

CARE-2: Falls: Screening for Future Fall Risk

ID	Question	Answer
1	Who can perform the fall screening for the 2020 CMS Web Interface CARE-2: Falls: Screening for Future Fall Risk (2020 CMS Web Interface CARE-2) measure?	The measure isn't limited to a particular clinician type. CMS does not dictate the internal workflow of clinicians or groups, virtual groups, and ACOs. The quality action can be completed by anyone the organization considers qualified.
2	Is documentation of an inpatient or emergency department falls screening acceptable for the 2020 CMS Web Interface CARE-2 measure?	Yes. The measure isn't limited to a particular setting.
3	Is a falls screening performed via telehealth acceptable for the 2020 CMS Web Interface CARE-2 measure?	Yes. The screening for future fall risk may be completed during a telehealth encounter.
4	If the patient is non-ambulatory at any time during the measurement period can they be excluded from the 2020 CMS Web Interface CARE-2 measure?	No. The patient would only be considered eligible for the denominator exclusion if they were non-ambulatory at the most recent encounter during the measurement period.

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ID	Question	Answer
5	What clinical information should the medical record reflect to meet the intent of the 2020 CMS Web Interface CARE-2 measure?	Screening for future fall risk is an assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool isn't required for this measure; however, potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test. Numerator Guidance: • Documentation of no falls is sufficient. • Medical record must include documentation of screening performed. • Any history of falls screening during the measurement period is acceptable as meeting the intent of the measure. • A gait or balance assessment meets the intent of the measure. If, after reviewing the medical record, you find supporting documentation that meets the numerator guidance criteria, then it would meet the intent of this measure.

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DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

ID	Question	Answer
1	For the 2020 CMS Web Interface DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (2020 CMS Web Interface DM-2) measure, will patients only be included in the measure 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?	"History" refers to the year before the measurement period. "Active diagnosis" refers to the measurement period. For the 2020 performance period, you would need to confirm the diagnosis of diabetes is documented in the medical record in 2019 or 2020.
2	For the 2020 CMS Web Interface DM-2 measure, do I use the date the blood was drawn or the date of the lab results?	It's appropriate to use the following priority ranking when considering performance of the numerator for the 2020 CMS Web Interface DM-2 measure: • Lab report draw date. • Lab report date. • Flow sheet documentation. • Practitioner notes. • Other documentation.
3	Will HbA1c values from any setting be acceptable for the numerator for the 2020 reporting period?	Yes. The measure doesn't limit the HbA1c to a specific setting.
4	Is an HbA1c reported during a telehealth visit acceptable?	Yes. Documentation of most recent HbA1c result may be completed during a telehealth encounter.

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ID	Question	Answer
5	Are Continuous Glucose Monitoring (CGM) system results acceptable for the numerator for the 2020 CMS Web Interface DM-2 measure?	No. The 2020 CMS Web Interface DM-2 measure doesn't include CGM results, whether patient reported or from the clinician. There must be medical record documentation of a distinct HbA1c value and the date the blood was drawn.
6	Some patients have at home HbA1c testing kits, meaning the patient is checking their lab values at home. Would this be allowed for the 2020 CMS Web Interface DM-2 measure?	Yes. Patient-reported HbA1c values are allowed as long as the date and most recent value are documented in the medical record.

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HTN-2: Controlling High Blood Pressure

ID	Question	Answer
1	If a clinician enters a blood pressure reading from a telehealth/telephone visit based on numbers from the patient's remote home blood pressure (BP) device, would this count?	A blood pressure taken by either a clinician, or a remote monitoring device (home device or a device brought by a visiting nurse or caregiver) and conveyed by the nurse or caregiver, or by the patient to their clinician, is acceptable for the numerator as long as it is the most recent blood pressure reading documented in the medical record for the patient during the measurement period.
2	Are home blood pressure monitors such as arm monitors, wrist monitors, and Apple Watch considered "remote monitoring devices?"	Since the measure guidance and specifications don't define what constitutes a remote monitoring device or methods of conveying the blood pressure from a remote monitoring device to the clinician, we are unable to provide guidance on specific devices or a specific workflow on how the clinician interacts with patients using remote monitoring devices during a telehealth encounter. It is the clinician's discretion as to whether the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable.
3	When we see both an inclusionary diagnosis and an exclusionary diagnosis, should the group, virtual group, or ACO continue to include the patient in the denominator?	It's the responsibility of the submitting group, virtual group, or ACO to work with the clinician to determine whether or not there is sufficient medical record documentation to confirm the patient's diagnosis. When submitting data through the CMS Web Interface, the expectation is that medical record documentation in addition to coding is available that supports the action reported in the CMS Web Interface. In the instance a patient meets the intent of the denominator exclusion, then it would be appropriate to remove the patient from the denominator.

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MH-1: Depression Remission at Twelve Months

ID	Question	Answer
1	The 2020 CMS Web Interface MH-1: Depression Remission at Twelve Months (2020 CMS Web Interface MH-1) Measure Specification states, "This 14 month measure assessment period allows for measurement of the patient's remission status at both six and 12 months." Does that mean that a patient must have a Patient Health Questionnaire-9 item version (PHQ-9) or Patient Health Questionnaire-9 Modified for Teens and Adolescents (PHQ-9M) score of less than 5 at both 6 and 12 months?	No. The intent of the measure is to evaluate how many patients reached remission at 12 months (+/- 60 days) after the index event.
2	A PHQ-9 has been completed for the patient on a paper form and scanned into the medical record, but the score wasn't totaled. Is it acceptable to calculate the score during abstraction?	No. If the score isn't totaled in the medical record documentation, you must select "No" when asked if the patient had one or more PHQ-9s or PHQ-9Ms administered during the denominator identification. Documentation of a follow-up PHQ-9 or PHQ-9M with a score less than 5 is also required to determine if the patient achieved remission for the numerator.
3	If a patient answers the first 2 questions of the PHQ-9 or PHQ-9M "not at all" and the rest of the questions are blank, is the depression screening considered numerator compliant?	No. All 9 questions must be answered to have a valid summary score for a PHQ-9 or PHQ-9M. There must be medical record documentation of the score and date completed.

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ID	Question	Answer
4	Since the age range for the 2020 CMS Web Interface MH-1 measure is 12-17 years old and 18 and older, can we use the PHQ-9 for all of our patients?	Yes. You may use either the PHQ-9 or PHQ-9M tool to meet the intent of the 2020 CMS Web Interface MH-1 measure.
5	Can a PHQ-9A be used for adolescents?	No. The only tools appropriate for indicating remission is a completed PHQ-9 or PHQ-9M.
6	Can the PHQ-9 or PHQ-9M be performed inpatient or should it be performed during outpatient encounters only?	The 2020 MH-1 Measure Specifications don't limit the PHQ-9 or PHQ-M screening to a specific setting.
7	Can the PHQ-9 or PHQ-9M be performed during a telehealth visit?	Yes. The PHQ-9 or PHQ-M may be performed using telehealth. PHQ-9 or PHQ-9M administration doesn't require a face-to-face visit; multiple modes of administration are acceptable (telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk).
8	Can you please clarify the timing used to identify denominator exclusions?	Patients with an active diagnosis of bipolar disorder, personality disorder, schizophrenia, psychotic disorder, or pervasive developmental disorder any time prior to the end of the patient's measure assessment period may be excluded. The index event date marks the start of the measurement assessment period for each patient, which is 14 months (12 months +/- 60 days). Patients who were a permanent nursing home resident any time during the denominator identification period (11/1/2018 to 10/31/2019) or the patient's measure assessment period (12 months +/- 60 days).

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PREV-5: Breast Cancer Screening

ID	Question	Answer
1	Does a unilateral mammogram count for the numerator?	A unilateral mammography counts only if there is medical record documentation of a mastectomy of the other breast. If only one breast is present, unilateral screening (one side) must be performed on the remaining breast.
2	Several numerator Current Procedural Terminology (CPT) codes were removed from the 2020 CMS Web Interface Coding Document for the 2020 CMS Web Interface PREV-5: Breast Cancer Screening (2020 CMS Web Interface PREV-5) measure leaving 3 Healthcare Common Procedure Coding System (HCPCs) codes to reference mammography screenings. However, there is CMS documentation that these 3 HCPCS-codes (G0202, G0204 and G0206) have been replaced with 77067, 77066, and 77065. Should we go ahead and use the “new” codes?	If mapping to an electronic health record (EHR), report based on the 2020 CMS Web Interface PREV Coding Document. The coding provided within the 2020 CMS Web Interface Coding Documents is considered to be all-inclusive for purposes of mapping to an EHR. If you’re not mapping to an EHR, the Coding Documents may be used as a guide to assist in reporting. CMS doesn’t dictate your internal workflow; therefore, other coding representative of the numerator quality action, denominator inclusion criteria or referenced exclusions/exceptions may be used to assist in locating the required medical record documentation.
3	The description in the 2020 CMS Web Interface PREV-5 Measure Specifications states "Women 50 - 74 years of age" while the initial population states "Women 51 - 74 years.” Which is correct?	The patient isn’t considered eligible for the denominator until age 51, but mammograms received beginning at age 50 can be used to satisfy the numerator. The lookback period allows for a mammogram during the measurement year, the year prior to the measurement year, and a 3-month grace period for a total of 27 months.

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ID	Question	Answer
4	Is it acceptable for the patient to report previous receipt of a mammogram and can it be done during a telehealth visit?	Yes. As long as the documentation includes the type of test AND result/finding. Documentation of 'normal' or 'abnormal' is acceptable. Documentation of screening for breast cancer may be completed during a telehealth encounter.
5	How is CMS handling gender identity in regard to quality metric inclusion? Do you only follow the legal sex or are any other identifiers considered?	Generally, CMS considers the patient's gender at birth for inclusion in the denominator. If there is an instance where a patient was sampled for the measure but you don't believe they should have been (i.e., they were born male but identify as or have transitioned to female), we suggest submitting a request for an Other CMS Approved Reason to skip the patient. CMS will evaluate each request on a case-by-case basis. In the instance a patient's demographic information is incorrect, it can be fixed within the CMS Web Interface. Note that any demographic information you changed in the CMS Web Interface doesn't get reported back to the Medicare patient enrollment database. You should encourage your patient to contact the Social Security Administration directly to have such information updated.

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PREV-6: Colorectal Cancer Screening

ID	Question	Answer
1	Does a Cologuard test count for the 2020 CMS Web Interface PREV-6: Colorectal Cancer Screening (2020 CMS Web Interface PREV-6) measure?	Yes. A Fecal immunochemical DNA test (FIT-DNA) during the measurement period or the 2 years prior to the measurement period is acceptable for the measure.
2	Does a FIT test (not FIT-DNA) count for 2020 CMS Web Interface PREV-6 measure?	Yes. A FIT test performed during the measurement period is acceptable for the measure.
3	If the FOBT is done in the office and sent to a lab, is this acceptable for this measure? If not, where must it be done to be valid?	No. Per clarification with the measure steward National Committee for Quality Assurance (NCQA), the intent is to exclude all FOBT tests performed in an office setting. Don't count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE. FOBT tests performed at home and brought to the office to be sent to a lab meet the intent and performance for the measure.

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ID	Question	Answer
4	The initial population in the 2020 CMS Web Interface PREV-6 measure states a visit is required during the measurement period. We know the data can be documented during a telehealth visit. Is an in-office visit required if a telehealth visit has been done during the measurement period?	The quality action isn't tied to a particular office visit or telehealth encounter the clinician may have with a patient. If there is medical record documentation to support that a colorectal cancer screening was completed within the appropriate timeframe specified for the type of screen, and results are documented, then performance of the measure is met. Appropriate screenings are defined by any one of the following criteria: • FOBT during the measurement period • Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period • Colonoscopy during the measurement period or the 9 years prior to the measurement period • FIT-DNA during the measurement period or the 2 years prior to the measurement period • Computed tomography (CT) Colonography during the measurement period or the 4 years prior to the measurement period
5	Will the newly approved Epi Pro Colon (r) Septin 9 be added to the list of acceptable colorectal screenings for the 2020 CMS Web Interface PREV-6 measure?	No. The Epi proColon blood test isn't considered numerator compliant for the 2020 CMS Web Interface PREV-6 measure.

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PREV-7: Preventive Care and Screening: Influenza Immunization

ID	Question	Answer
1	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the 2020 CMS Web Interface PREV-7: Preventive Care and Screening: Influenza Immunization (2020 CMS Web Interface PREV-7) measure?	Any available medical record documentation, including immunization registry data, can be used to confirm the quality action.
2	The numerator guidance states that Influenza immunizations during the flu season or report of previous receipt may or may not be completed during a telehealth encounter. What does may or may not mean?	The influenza immunization itself can't be completed during a telehealth encounter but a screening where the patient may report previous receipt of the influenza immunization between August 1, 2019 and March 31, 2020 can be and meets the intent of the measure.
3	Is a documented history of an egg allergy sufficient documentation to use the denominator exception for a medical reason?	No. A documented history of an egg allergy in the patient's medical record alone doesn't meet the intent of this denominator exception for the 2020 performance period. Documentation of an egg allergy must be during the measurement period and support that the allergy is still active during the appropriate timeframe (August 2019 – March 2020) for the flu season being reported to qualify as a denominator exception.
4	What are the documentation timing requirements for the 2020 CMS Web Interface PREV-7 measure?	The medical record should support that the refusal, exception, or receipt occurred during the appropriate time frame (August 2019 – March 2020) for 2020 reporting. PREV-7 documentation should be during the measurement period and be specific to the flu season being reported. As long as the medical record documentation supports that the quality action or exception submitted is relevant to the flu season being measured, it would be acceptable.

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PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

ID	Question	Answer
1	If we have a patient that states they are a non-smoker or a former smoker, is this acceptable for assessing a type of tobacco?	The intent of the Measure Specification is to determine if the patient was screened for tobacco use. Therefore, as long as a clinician has documented a status for any type of tobacco use (i.e., non-smoker, smokes, or uses smokeless tobacco), that meets the performance requirement for the screening component of the numerator.
2	There are 3 rate/population categories. Which rate (or criteria) is used for performance scoring for PY2020? Population 1, 2 or 3?	The rate for population 2 is used for consideration of performance of this measure.
3	Who is able to complete the cessation intervention within our organization (i.e., can a Medical Assistant provide counseling to the patients or does it need to be an eligible clinician)?	Cessation counseling can be provided by anyone your organization considers qualified.
4	Does a screening done in the emergency department or inpatient count?	Yes. The setting isn't specified for this measure. Use the most recent query during the 24-month period to determine tobacco status.

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ID	Question	Answer
5	Can the quality actions for the CMS Web Interface PREV-10 measure be done during a telehealth visit?	Yes. Both screening for tobacco use and tobacco cessation intervention may be completed during a telehealth encounter.

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PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

ID	Question	Answer
1	For the 2020 CMS Web Interface PREV-12: Preventive Care and Screening: Screening for Depression and Follow-up Plan (2020 CMS Web Interface PREV-12) measure, what documentation is needed for depression screening?	In regard to documentation submission for the 2020 CMS Web Interface PREV-12 measure, the following will apply: For CMS Web Interface users with an EHR that currently reflects the 2018 CMS Web Interface PREV-12 Measure Specifications, CMS will accept the same types of documentation those users submitted during the 2018 submission period for the 2020 performance period. CMS Web Interface users with an EHR that currently reflects the 2019 or the 2020 CMS Web Interface PREV-12 Measure Specifications, CMS will accept documentation that aligns with the 2019 or the 2020 CMS Web Interface PREV-12 Measure Specifications.
2	The 2020 CMS Web Interface PREV-12 Measure Specifications state that the screening results must be reviewed and verified and documented by the eligible professional in the medical record on the day of the encounter. What is the definition of an eligible professional?	The 2020 CMS Web Interface PREV-12 Measure Specifications state, “the results must be reviewed/verified and documented by the eligible professional in the medical record on the date of the encounter to meet the screening portion of this measure.” The intent of this statement is to clarify that the quality action should be completed by an eligible clinician; however, since CMS doesn’t dictate the internal workflow of eligible clinicians, groups, virtual groups, or ACOs, others within the organization may complete the action. The quality action can be completed by anyone the organization considers qualified.
3	Previously, a follow-up plan had to be documented on the date of positive screen but for 2020 the Measure Specifications state it must be documented on the date of eligible encounter. Is that correct?	For the 2020 CMS Web Interface PREV-12 measure, a follow-up plan can either be documented on the date of positive screen OR during a documented encounter (either telehealth or office visit).

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ID	Question	Answer
4	Does conducting a PHQ-9 after a positive PHQ-2 count as appropriate follow-up for the measure as it has in the past?	For the 2020 performance period, CMS is modifying the scoring of the 2020 CMS Web Interface PREV-12 measure. The coding changes that were made to the 2019 CMS Web Interface PREV-12 measure are the same coding changes that were made to the 2020 CMS Web Interface PREV-12 measure, which have been determined by CMS to be substantive changes to the measure. The modifications to the 2020 CMS Web Interface PREV-12 measure removed the Systematized Nomenclature of Medicine Clinical Terms (SNOMED) codes that recognized the rescreening of a patient using an additional standardized depression screening tool as a means of meeting the performance criteria for implementing an appropriate follow-up plan specific to a patient with a positive depression screening (as outlined in the 2020 CMS Web Interface PREV-12 Measure Specifications) when an adequate follow-up plan may not have been provided to the patient. As a result, the changes to the 2020 CMS Web Interface PREV-12 measure no longer allows clinicians to meet the performance criteria of implementing a follow-up plan without providing an appropriate follow-up plan to the patient (patient wouldn't be eligible for the measure numerator). The following will apply to the 2020 CMS Web Interface PREV-12 measure: • Reclassified to "pay-for-reporting" for the Shared Savings Program as provided in §425.502(a)(5); and • Excluded from MIPS scoring in accordance with §414.1380(b)(1)(i)(A)(2)(i) provided that the measure meets the data completeness requirement and the data applicable to the measure is reported via the CMS Web Interface.

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ID	Question	Answer
5	Does a certain condition (intellectual disability, impairment, Alzheimer's, dementia, autism) qualify a patient for a denominator exception or exclusion?	A denominator exclusion would only apply to patients with an active diagnosis for depression or a diagnosis of bipolar disorder. The specification doesn't define denominator exceptions by specific diagnoses. If the patient qualifies for the measure and there is medical record documentation that the patient wasn't screened for depression due to, "Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools," then it would be appropriate to select the denominator exception. For this example, the denominator exception could be claimed if there is medical record documentation stating that the screening wasn't performed due to the patient's diagnosis, resulting in their inability to appropriately respond to the screening questions.
6	Can documentation of a follow-up plan be used to infer a depression screening was positive if no results were documented?	No. A clinician's interpretation of the results is required

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PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

ID	Question	Answer
1	Can the 2020 CMS Web Interface PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (2020 CMS Web Interface PREV-13) measure be completed via telehealth in light of the COVID-19 public health emergency?	No. The 2020 CMS Web Interface PREV-13 Measure Specifications state that documentation of statin therapy prescribed or being taken during the measurement period **can't** be completed during a telehealth encounter. It is the group, virtual group, or ACO's responsibility to make sure they can meet all other aspects of the quality action within the Measure Specification, including other quality actions that can't be completed by telehealth.
2	Should the 2020 CMS Web Interface PREV-13 measure be stratified as 3 measures for each denominator population or as single measure covering all 3 denominator populations?	The 2020 CMS Web Interface PREV-13 measure is a single measure. Each patient that has been determined to be denominator eligible will only be counted once. You should determine denominator eligibility by working sequentially through the denominator populations. Once you've determined a patient is denominator eligible, you would confirm if they received statin therapy. For more specific information, refer to the guidance provided on pages 7 and 8 of the posted Measure Specification.

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ID	Question	Answer
3	If a patient is on a combination drug, can we count the patient as being on a statin?	Any statin therapy, whether generic or brand name, is acceptable to meet the intent of the measure. The list of statins is available under the clinical recommendations section and isn't meant to be an all-inclusive list of acceptable statins. For more specific information, refer to the 2020 CMS Web Interface PREV Coding Document, "NumeratorDrugCodes" tab, for drugs that meet the numerator. Also, it's important to note that the coding within the 2020 CMS Web Interface PREV Coding Document is considered to be all-inclusive for the purpose of mapping to the EHR, If you're not mapping to an EHR, the Coding Documents may be used as a guide to assist in reporting. CMS doesn't dictate your internal workflow; therefore, other coding representative of the numerator quality action.
4	Is documentation of hypercholesterolemia alone sufficient to confirm the patient is denominator eligible for Population 2 in the 2020 CMS Web Interface PREV-13 measure?	No. If hypercholesterolemia alone is present and there is no other documentation to support "pure" or "familial," it wouldn't be appropriate to confirm the patient in the denominator of Population 2. On the contrary, if "hypercholesterolemia" is present in the medical record, along with documentation supporting "pure" or "familial," it would be appropriate to confirm the patient in the denominator of Population 2.
5	For population 2, is it acceptable to use any variation of the ICD-10 code E78 to confirm the diagnosis of pure or familial hypercholesterolemia?	Since the measure requires confirmation of a diagnosis of Familial or Pure Hypercholesterolemia, other cholesterol-related diagnosis aren't appropriate. ICD-10 diagnosis codes E78.00 and E78.01 are present in the PREV Coding Document and may be used to identify pure or familial hypercholesterolemia. Other variations of the E78 code aren't specific to pure or familial hypercholesterolemia. If you find other medical record documentation supporting the diagnosis of pure or familial hypercholesterolemia, then the diagnosis would be confirmed.

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ID	Question	Answer
6	When does the denominator exception (i.e., allergy or intolerance to statin medication) need to be documented in the medical record?	Medical record documentation should support that the denominator exclusion is active during the performance period. There are 2 numerator guidance notes that provide instruction regarding how to report an allergy to a statin and the timing requirement for the denominator exception. For more specific information, refer to page 17 of the posted Measure Specification.
7	If the clinician documents the patient is allergic/intolerant to one particular statin (i.e., Lipitor), is it acceptable to choose the denominator exception medical reasons or does the clinician need to say allergic/intolerant to statins for the 2020 CMS Web Interface PREV-13 measure?	A listing of drugs that may be used for the denominator exception can be found on the “DenominatorExceptionDrugCodes” tab of the 2020 CMS Web Interface PREV Coding Document. For mapping from the EHR when an accepted drug allergy is found, look for the drug classification with a "Yc" (Yes-conditional) in the “Drug EX” column of the “Denominator Exception Drug Codes” tab. These drugs may be used as a denominator exception if present in the patient's record accompanied by an appropriate conditional reason why the patient isn't taking the drug (i.e., adverse effect, allergy, or intolerance to statin medication).
8	Are patients aged 76 years and older still excluded from the 2020 CMS Web Interface PREV-13 measure for the 2020 performance period?	The 2020 CMS Web Interface PREV-13 measure denominator criteria for Population 1 and Population 2 is inclusive of patients aged 21 years and older. The denominator of Population 3 is limited to patients aged 40 through 75 years at the beginning of the measurement period. If a patient is out of the measure's age range, we will automatically pre-populate the response with "Not Confirmed – Age."

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Coding and Medical Record Documentation

When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the information submitted in the CMS Web Interface (i.e., medical record documentation is necessary to support the information that has been submitted).

ID	Question	Answer
1	Where do I find the 2020 coding for mapping quality measure data from my EHR?	Refer to Appendix II: Downloadable Resource Mapping Table in the Measure Specifications. Each data element within a measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2020 CMS Web Interface Coding Documents included in the 2020 CMS Web Interface Measure Specifications and Supporting Documents.
2	Can claims data be used to support the information reported or does it need to be sourced from the medical record?	Claims data can't be used to confirm a diagnosis used for sampling purposes as claims are the original source of the diagnosis sampling. Claims data can be used to assist in locating the required medical record documentation, but supporting medical record documentation will be required to substantiate what is reported. You may use any medical record documentation available as long as you can confirm the patient has an appropriate diagnosis as required by the measure.
3	Are we able to use codes that aren't within the Coding Documents?	When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported. CMS doesn't dictate your internal workflow; therefore, other coding representative of the numerator quality action, denominator inclusion criteria or referenced exclusions/exceptions may be used to assist in locating the required medical record documentation.

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Interaction between QPP and Medicare Shared Savings Program

ID	Question	Answer
1	How can I find out more information on the interaction between the Shared Savings Program and QPP?	For more information, please see the 2020 Medicare Shared Savings Program and Quality Payment Program Interactions document.

Where to Go for Help

- For additional questions related to the quality performance category, please contact the QPP Service Center at QPP@cms.hhs.gov or 1-866-288-8292 (Monday-Friday 8 a.m. - 8 p.m. Eastern Time (ET)). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.
  - Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- Connect with your local technical assistance organization. We provide no-cost technical assistance to small, underserved, and rural practices to help you successfully participate in the Quality Payment Program.

Version History

Date	Change Description
3/2/2021	Updated HTN-2: Controlling High Blood Pressure FAQs.
12/18/2020	Original version.

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Appendix A: Consecutively Confirmed and Completed Requirement

Question: How do organizations consecutively confirm and complete patients?

Answer: The minimum number of patients that must be confirmed and completed for satisfactory reporting via the CMS Web Interface is 248 for each CMS Web Interface measure (or the maximum number available to you if less than 248). This means that groups, virtual groups, and ACOs must confirm and complete data for 248 patients, starting with the patient ranked #1 in each measure's sample. If you skip a patient because (a) the medical record was not found, (b) the patient is no longer qualified for the sample, (c) the patient meets measure-specific exclusion criteria, (d) the diagnosis couldn't be confirmed, (e) the patient's age or date of birth has changed such that the patient isn't eligible for the measure, or (f) an "Other CMS Approved Reason," then an additional patient must be completed for each patient that was skipped until 248 patients have been consecutively confirmed and completed or until the sample has been exhausted. Please see the Appendix tables A-1 through A-4 for examples.

Confirmed: means that you have obtained the patient's medical record, confirmed the patient is eligible for quality sampling, confirmed the disease diagnosis, if applicable, confirmed the patient's age and sex, and confirmed that the patient doesn't meet exclusion criteria for a given measure.

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

Consecutive: means that you have completed the patient that was ranked immediately after the previously completed (or skipped) patient.

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In Example 1 (see **Table A-1**), 3 patient ranks must be skipped and replaced. After patient rank #251, the CMS Web Interface measure is considered complete and no additional abstraction is required since 248 ranked patients were confirmed and completed.

Table A-1. Example 1

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

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Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
249–251	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes—these additional patients replace skipped patient #4, skipped patient #5 and skipped patient #6.

No additional patients need to be abstracted.

In Example 2 (see **Table A-2**), 2 patient ranks must be skipped, but there are fewer than 248 patient available for abstraction. After patient rank #231, the CMS Web Interface measure is considered complete since all available ranked patient have been consecutively confirmed and completed.

Table A-2. Example 2

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1-3	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes.
4	Y	N	Y	No—the diagnosis required for this measure can't be confirmed.	Yes—"Not Confirmed—Diagnosis" has been selected.	No—This patient isn't confirmed and must be replaced with another patient from the sample.
5	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes.

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Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
6	Y	N	Y	No—the patient isn't qualified for the sample because they are deceased during the performance period.	Yes—"Not Qualified for Sample" has been selected for this patient, and the date of death has been entered.	No—This patient isn't confirmed and must be replaced with another patient from the sample.
7–230	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes.
231-232	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes—these 2 additional patients replace skipped patients #4 and #6.

No additional patients are available for abstraction.

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In Example 3 (see **Table A-3**), laboratory result data for patient rank #2 wasn't provided, which causes the count of consecutively completed ranks to stop at rank #1. The CMS Web Interface measure is considered incomplete until Rank #2 is completed.

Table A-3. Example 3

Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
1	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes.
2	Y	Y	N	Yes—all relevant patient data have been confirmed.	No—lab test data required for the numerator wasn't provided. If this patient isn't completed, you will have only one patient counting towards your reporting requirement.	No—these patients aren't consecutive until rank #2 is completed.
3-4	N	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	No—this patient isn't consecutive until rank #2 is completed.
5	N	N	Y	No—the patient isn't qualified for the sample because they are deceased during the performance period.	Yes— "Not Qualified for Sample" has been selected for this patient, and the date of death has been entered.	No—This patient isn't confirmed and must be replaced with another patient from the sample. This patient also isn't considered consecutive until rank #2 is completed.

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Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
6–248	N	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	No—this patient isn't consecutive until rank #2 is completed.
249	N	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	No—this patient isn't consecutive until rank #2 is completed. Note this patient must be completed to replace skipped rank #5.

No additional patients need to be abstracted.

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In Example 4 (see **Table A-4**), 3 patient ranks must be skipped. While there are more than 248 patients in the original sample, there aren't enough patients sampled to replace those that were skipped. After patient rank #250, the CMS Web Interface measure is considered complete since all available ranked patients have been consecutively completed.

Table A-4. Example 4

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

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Patient Rank	Consecutive	Confirmed	Complete	Patient Confirmation Details	Patient Completion Details	Will patient count towards 248 required?
180–248	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes.
249	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes—this additional patient replaces skipped patient #4.
250	Y	Y	Y	Yes—all relevant patient data have been confirmed.	Yes—all required numerator and denominator data have been entered.	Yes—this additional patient replaces skipped patient #6.

No additional patients are available for abstraction.

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Appendix B: Skipping Patients (Examples)

Table B-1: Medical Record Not Found Examples

ID	Example	Should I select “No Medical Record Not Found?”
1.	Dr. Ruiz has Mrs. Liu’s medical record, but there isn’t a lot of information in it.	No. If you have a medical record you may not select “No - Medical Record Not Found.” You must complete reporting with the data available to you. If data are required that you can’t find either in the medical record you have, or through information obtained from other clinicians, you must answer the questions in the negative (i.e., that a diagnosis can’t be confirmed, or that a quality action wasn’t performed).
2.	Dr. Banks can find the patient’s medical record, but can’t find any of the information he needs in it.	No. A medical record is available. Dr. Banks is expected to use the data available to him, and coordinate with other clinicians for additional data where needed. If a specific piece of data needed to confirm that a quality action was performed can’t be found, he must indicate that the quality action wasn’t performed.
3.	There was a flood in our building just before the data collection period that destroyed many of our medical records.	Yes. This would be appropriate use of “No - Medical Record Not Found.” In this case your organization is unable to access the affected medical records.

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Table B-2: Not Qualified for Sample Examples

ID	Example	Should I select “Not Qualified for Sample?
1.	Ms. Alvarez had ABC Inc., a private insurer, as her primary payer through February of 2020.	Yes. This sampled patient isn’t qualified for the sample because she didn’t have FFS Medicare as her primary payer during the measurement period.
2.	Mr. Bannister entered hospice care in December of 2020.	Yes. This sample patient isn’t qualified for the sample because he entered hospice care during the measurement period.
3.	Mrs. Grey retired and moved to Argentina in November of 2020.	Yes. This sampled patient now permanently outside of the United States.
4.	Ms. Smith died in April 2020.	Yes. This sampled patient is deceased for part of the measurement period.
5.	Mr. Skywalker lives in New Jersey, but takes an extended vacation in Costa Rica every winter.	No. This sampled patient hasn’t changed his residence to outside of the United States.

Table B-3: Diagnosis Not Confirmed Examples

ID	Example	Should I select “Not Confirmed Diagnosis?”
1.	Ms. Stackhouse has diabetes listed in her medical record, but she gets all her diabetes treatment from her specialist.	No. The diagnosis is documented in the medical record. You are expected to coordinate care as needed to answer all diabetes related questions.

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