CMS Web Interface FAQs

Updated 7/13/2020

*CMS is implementing multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. Refer to the **Quality Payment Program COVID-19 Response Fact Sheet** for more information.*

Quality Reporting for Calendar Year 2019: Overview

Activity	Estimated* Timeline
ACOs, MIPS groups, and virtual groups provide care to patients during the performance period	January 1, 2019–December 31, 2019
API available for testing in the developer preview environment	August 14, 2019
CMS assigns beneficiaries to the ACO, MIPS group, or virtual group, samples them into the CMS Web Interface for data collection, and prefills some beneficiary information	November 2019–January 2020
CMS Web Interface opens for data entry by ACOs and applicable MIPS groups and virtual groups	January 2, 2020
ACOs, MIPS groups, and virtual groups attend weekly Q&A sessions	January 15–March 25, 2020
CMS Web Interface closes to data abstraction by ACOs and applicable MIPS groups and virtual groups; no more abstraction possible	**March 31, 2020** ***Closes at 8:00 p.m. EDT / 7:00 p.m. CDT / 6:00 p.m. MDT / 5:00 p.m. PT***
Continued access to CMS Web Interface to generate, view, and print reports (all other functionality disabled)	Through spring of 2022

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Activity	Estimated* Timeline
ACOs selected for audit are notified by CMS**	April 2020
ACOs' audit materials due to CMS	May 2020
Quality scores reported to ACOs	Late Summer/Early Fall 2020

*Dates may be subject to change.
**Applicable to Shared Savings Program ACOs only. All Next Generation ACO Model ACOs are selected for the audit.

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Beneficiary Sample Without Data File

ID	Question	Answer
1.	What information will be provided in the Beneficiary 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 Beneficiary Identifier (MBI)) • Beneficiary first name • Beneficiary last name • Gender • Birth Date • Beneficiary 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 ACO, MIPS group, or virtual group who provided the highest number of primary care services to the patient
2.	What are we supposed to do with the beneficiary sample files?	The beneficiary sample files give the ACOs, MIPS groups, and virtual groups a list of the assigned beneficiaries who have been sampled for CMS Web Interface data collection, the TIN or CCN at which the beneficiary received the most primary care services, and the names and NPIs of up to three providers who provided the plurality of primary care services visits to the beneficiary—all based on Medicare claims data from within and outside of the ACO, MIPS group, or virtual group. The purpose of this list is to assist the ACOs, MIPS groups, and virtual groups in finding beneficiary records. However, it is possible that the beneficiary's record is located with none of these providers. If that is the case, the ACO, MIPS group, or virtual group should make every effort to locate the beneficiary's record to collect data on this beneficiary.

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Sampling and Prepopulation

ID	Question	Answer
1.	Will all of our assigned/aligned beneficiaries be populated into the CMS Web Interface?	No. Beneficiaries will be sampled randomly (for ACOs it is based on third quarter assignment/ alignment) into the CMS Web Interface using the specifications in the 2019 Web Interface Sampling Methodology document, posted in the QPP Resource Library.
2.	In the CMS Web Interface, what makes the patient "confirmed and complete"?	Confirmed and complete means that for each patient you have confirmed the disease diagnosis (where applicable), indicated whether or not you have found the medical record, confirmed the patient is qualified for the measure, and provided all the required information.
3.	What is the significance of a beneficiary's rank?	Each sampled beneficiary in a CMS Web Interface measure is randomly assigned a rank order number for that measure. Beneficiaries will be ranked 1-616 (or 750 for PREV-13), or to the maximum number of eligible beneficiaries 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 beneficiaries for each measure (excluding beneficiaries meeting criteria to be skipped). For more information on consecutive completion, please see Appendix A: Consecutively Confirmed and Completed Requirement.
4.	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-level. The samples on which ACOs will need to submit clinical quality data will be drawn from all assigned/aligned beneficiaries across the entire ACO; that is, all participant TINs. 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, not for each participant TIN in the ACO.
5.	What if one or more of our CMS Web Interface measures contain fewer than 248 ranked beneficiaries?	Not every CMS Web Interface measure may have a sample of 248 patients; this is particularly true in measures for diseases that have low prevalence rates. If CMS was unable to identify a minimum of 248 beneficiaries who met the sampling criteria, then all beneficiaries who meet the criteria will be sampled. If fewer than 248 beneficiaries are found eligible for a CMS Web Interface measure, then the ACO, MIPS group, or virtual group should report on all eligible beneficiaries.

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ID	Question	Answer
6.	Where can I find more information on how to quality report patients receiving comfort care?	Please refer to the “Patient Confirmation” section of the 2019 Web Interface Measure Specifications.
7.	What will be populated into the CMS Web Interface?	The following information will be prepopulated by CMS using Medicare claims, enrollment, and provider information available in the Integrated Data Repository (IDR) between January 1, 2019 to October 31, 2019. • Medicare Number (either the HICN or MBI) of the beneficiary • First and last name of the beneficiary • Gender • Beneficiary date of birth • Beneficiary rank in each CMS Web Interface measure, if applicable • NPIs/Provider Names of up to 3 providers that provided the most primary care services to the patient • TIN or CCN at which the beneficiary received the most primary care services • Whether the influenza vaccine was received (PREV-7)
8.	Will the CMS Web Interface use a Health Insurance Claim Number (HICN) or a Medicare Beneficiary Identifiers (MBI)?	The 2019 beneficiary samples may include some beneficiaries 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 beneficiary has a HICN or MBI, so that you can locate the beneficiary records correctly and efficiently. Likewise, the API contains the same beneficiary sample using the HICN and MBI. It is important that you use the same beneficiary identifier included in the sample when uploading data to the CMS Web Interface via Excel or API.

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ID	Question	Answer
9.	What if prepopulated demographic information is not accurate?	While the CMS Web Interface user can modify the demographic information that is prepopulated into the CMS Web Interface from the Medicare beneficiary enrollment database, it is anticipated that there will be little need for ACOs, MIPS groups, and virtual groups to modify this information. However, if the beneficiary's demographic information in your records and in the CMS Web Interface does not match, then the CMS Web Interface user may need to correct the information. For example, Medicare claims may not have the accurate date of birth for a beneficiary. Your ACO, MIPS group, or virtual group should correct this information because it may affect that beneficiary's denominator eligibility for certain measures. Note that any demographic information you changed in the CMS Web Interface does not get reported back to the Medicare beneficiary enrollment database. You should encourage your patient to contact the Social Security Administration directly to have such information updated.
10.	Is CMS able to exclude beneficiaries from sampling who did not have Fee-For-Service (FFS) Medicare as their primary payer at some point during the measurement period, who entered hospice, or who died during the measurement period?	Yes. If Medicare data as of October 31, 2019 indicate that the beneficiary did not have Fee- for-Service (FFS) Medicare as their primary payer, died, or entered hospice at any time during the measurement period, then CMS will exclude them from the quality sample. However, the claims data we pulled in October may not have the most up-to-date information (same for 'deceased' or 'hospice'). If the CMS Web Interface user finds additional or more recent information that indicates the beneficiary did not have FFS Medicare as their primary payer, entered hospice, or died at some point during the measurement period, then it would be appropriate to select "Not Qualified for Sample" in the CMS Web Interface with the appropriate reason indicated.

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ID	Question	Answer
11.	Is the ACO, MIPS group, or virtual group responsible for validating the data that is prepopulated into the CMS Web Interface?	Yes. The ACO, MIPS group, or virtual group should validate each patient's demographic information, as changes to age and gender may affect a beneficiary'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 ACO, MIPS group, or virtual group. PREV-7 (influenza immunization) is the only instance where numerator-specific data are prepopulated. Note that influenza immunization data are not prepopulated for all beneficiaries ranked in PREV-7, but only those for whom an immunization could be identified in the claims data. If influenza immunization data has been prepopulated for a patient, the ACO, MIPS group, or virtual group does not need to validate that data. If the ACO, MIPS group, or virtual group is selected for an audit, the ACO, MIPS group, or virtual group will not have to provide medical record documentation for prepopulated influenza immunization data. However, if influenza immunization data are not prepopulated, the ACO, MIPS group, or virtual group 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 prepopulated from claims data) is subject to provision of supporting documentation.

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Skipping Beneficiaries

ID	Question	Answer
1.	When is it appropriate to skip reporting on a beneficiary?	Each measure in the CMS Web Interface has a sample of beneficiaries that is chosen from the pool of beneficiaries assigned to the organization according to the assignment methodology.[1] Medicare claims data are used to determine if a beneficiary meets the criteria to be included in a given CMS Web Interface measure's sample according to the sampling methodology.[2] However, due to the timing of quality sampling, a full 12 months of claims are not available for analysis when the quality samples are created. The result is that a beneficiary may lose eligibility for the quality sample in general, or a particular measure denominator, between the time the sample is generated and the end of the performance year. It is also possible that data derived from the claims cannot be substantiated by information in the medical record. For these reasons, as well as the possibility that a medical record cannot be located, the CMS Web Interface allows an organization to remove ("skip") a beneficiary from the sample if he/she does not meet one or more of the quality sampling and/or measure-specific criteria. Organizations can skip beneficiaries in the CMS Web Interface using one of several options. If an appropriate skip reason is entered for a sampled beneficiary, that beneficiary is considered completed, but not confirmed. This means the beneficiary will not be counted towards the reporting requirement to completely and accurately report on a minimum of 248 consecutively ranked and confirmed Medicare beneficiaries for each measure, and will be replaced with the next consecutively ranked beneficiary who in turn must be reported on. Some skip reasons remove a beneficiary from all CMS Web Interface measures, and other skip reasons only remove the beneficiary from that specific measure. Specific skip reasons are discussed in this document. They include: No - Medical Record Not Found, Not Qualified for Sample, Not confirmed - Diagnosis, measure-specific exclusion criteria, and No - Other CMS Approved Reason.

[1] For the Medicare Shared Savings Program, refer to the Shared Savings and Losses Assignment Methodology Specifications.
For Next Generation ACO Model, please refer to the Calculation of the Performance Year Benchmark: Performance Years 2019 and 2020.
For MIPS, refer to the 2019 Assignment Methodology Specification for the CMS Web Interface and CAHPS for MIPS Survey.
[2] 2019 CMS Web Interface Sampling Methodology for the Merit-Based Incentive Payment System, the Medicare Shared Savings Program, and the Next Generation ACO Model: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/0/2019CMSWISamplingDocument.pdf

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ID	Question	Answer
2.	If we skip a lot of beneficiaries in our sample, will we still be able to completely report?	Beneficiaries for whom the ACO, MIPS group, or virtual group has selected “No - Medical Record Not Found”, “Diagnosis Not Confirmed”, or “Not Qualified for the Sample” (for CMS approved reasons, deceased, entered hospice, Non-FFS Medicare, moved out of the country) are considered “skips.” As long as you have met the minimum requirement to confirm and report on a minimum of 248 consecutive Medicare beneficiaries for each measure or if the pool of eligible sampled beneficiaries is less than 248, then an organization is required to report on all eligible sampled beneficiaries, then you will have completely reported on the CMS Web Interface measures. If you do not meet the minimum requirement, then you will not have completely reported.
3.	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 beneficiary’s medical record. By virtue of being sampled into the CMS Web Interface, CMS has identified claims for this beneficiary submitted by your organization. CMS expects organizations to be able to obtain medical records for their assigned and sampled beneficiaries. This includes collaborating with physicians and/or other clinic staff both inside and outside the organization (including but not limited to the three NPIs provided in the 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
4.	When can I use “Not Qualified for Sample?”	CMS makes efforts to exclude beneficiaries that are not qualified for the sample, but because there are limitations in the claims data used to identify the sample, the CMS Web Interface allows a beneficiary to be skipped because they are not qualified for the sample. The beneficiary must meet one of the following criteria to be considered not qualified for the sample and will be removed from all CMS Web Interface measure samples: • In hospice[3] • Moved out of the U.S. • Deceased • Non Fee-for-Service (FFS) Medicare[4] If any of the above are true for a sampled beneficiary, at any time during the measurement period, that beneficiary is not qualified for the sample. If Not Qualified for Sample is selected, you must also select the specific reason from the menu provided (which matches the above stated list). The CMS Web Interface will also ask for a date that corresponds with the reason a beneficiary is not qualified for the sample. If the exact date is unknown (i.e., beneficiary date of death), you may enter the last day of the measurement period (i.e., December 31, 2019). Refer to Appendix B, Table B-2 for examples.
5.	When can I use “Not Confirmed - Diagnosis?”	Refer to the individual specification in the 2019 Web Interface Measure Specifications to determine when “Not Confirmed-Diagnosis” is appropriate to use. Refer to Appendix B, Table B-3 for examples.

[3] Hospice includes non-hospice beneficiaries receiving palliative goals or comfort care.
[4]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, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.

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ID	Question	Answer
6.	How do I know if a beneficiary meets measure-specific exclusion criteria?	Measure owners may specify a certain category of patient that should be excluded from a particular measure. The most common reason for this type of exclusion is that the quality intervention would not be appropriate for that patient population. Exclusions for a given measure are determined by the measure owner, and not all measures have exclusions. For measures where the measure owner has identified an appropriate exclusion category, this will be specified in the Narrative Specifications and the Supporting Documents. An option is available in the CMS Web Interface that allows organizations to indicate that a given beneficiary meets the exclusion criteria for a measure. Refer to Appendix B, Table B-4 for examples.
7.	Please define exclusion and exception.	Exclusions are a removal of the beneficiary from the denominator prior to looking for the numerator criteria; the beneficiary is skipped and replaced. Exceptions are a way to exclude the beneficiary from the denominator when they do not meet the numerator criteria for specified reasons; the beneficiary is not replaced. Not all measures have exclusions and/or exceptions. The exclusions and exceptions are only to be used as defined in the measure specifications.

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ID	Question	Answer
8.	When can I select “No - Other CMS Approved Reason?” How do you get approval to select “No - Other CMS Approved Reason” in the CMS Web Interface? Is there a list of Other CMS Approved Reasons to remove beneficiaries from any of the CMS Web Interface measures?	**Other CMS Approved Reason** is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting **Request Other CMS Approved Reason** in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface. To submit a skip request, follow these steps: 1. After confirming the beneficiary for the sample, scroll to the measure you would like to skip. 2. When confirming if the beneficiary is qualified for the measure, select **Request Other CMS Approved Reason**. 3. While making a skip request, review the organization you are reporting for and provide the submitter's contact information. CMS uses this email to send status updates and/or reach out if further information is needed to resolve the skip request. You also need to provide specific information about the beneficiary’s condition and why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case. Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as **Skipped** and another beneficiary must be reported in their place, if available. There is no list of “Other CMS Approved Reasons.” Requesting and approving removal of beneficiaries for an “Other CMS Approved Reason” is done on a case-by-case basis. Refer to Table B-5 for examples.

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Abstraction into the CMS Web Interface

ID	Question	Answer
1.	Do we have to enter our data in rank order? Or can we abstract information on beneficiaries out of rank order?	The actual order of data entry does not matter. However, by the end of the submission period, the ACO, MIPS group, or virtual group must have confirmed and completely reported on at least the first 248 consecutive beneficiaries (or all eligible sampled beneficiaries if fewer than 248 are sampled) and submitted the data to CMS in order to satisfy the reporting requirement for each measure.
2.	How many unique patient medical records should we expect we will need to reference for reporting?	There are 10 patient samples provided to each organization as follows: • One patient sample for the Care Coordination/Patient Safety measure (CARE-2) • One patient sample for each of the 3 disease measures (DM-2, HTN-2, and MH-1) • One patient sample for each of the 6 Preventive Health measures (PREV-5, PREV-6, PREV-7, PREV-10, PREV-12 and PREV-13). Each of these samples will have no more than 616 (or 750 for PREV-13) beneficiaries. Beneficiaries 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 potential to see 6,294 (9 samples x 616 beneficiaries and 1 sample x 750 beneficiaries), we typically see sample sizes between 1,000 and 3,000 unique beneficiaries. The sampling methodology is described in the 2019 Web Interface Sampling Methodology document available for download from the QPP Resource Library. ACOs, MIPS groups, and virtual groups are required to confirm and completely report on the first 248 consecutively ranked beneficiaries in each CMS Web Interface measure. The additional sampled beneficiaries allow for cases in which some beneficiaries may not be eligible for quality reporting. In such cases, the beneficiary may be “skipped” and will automatically be replaced with the next beneficiary, who must be reported on. The ACO, MIPS group, or virtual group must confirm and completely reported on 248 (or all eligible beneficiaries, if there are fewer than 248) consecutive beneficiaries.

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ID	Question	Answer
3.	What does “consecutively confirmed and complete” mean?	Beneficiaries are ranked 1-616 or 1-750 for PREV-13 (or 1 to the maximum number available if less than 616 or 750), and 248 of these beneficiaries- in consecutive order- need to be confirmed and completed in the CMS Web Interface. If you need to skip a beneficiary (i.e., 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 beneficiary, the final completed beneficiary should be ranked 249 instead of 248. For several examples, see Appendix A.
4.	What if one of our sampled beneficiaries was not seen at our MIPS group, TIN within our virtual group, or ACO during the measurement period?	Though the beneficiary may not have been seen at your specific facility or practice, the beneficiary was assigned to your ACO, MIPS group, or virtual group and must have been seen at least twice by participant TINs affiliated with your ACO, MIPS group, or virtual group 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. Please refer to your program’s assignment/alignment specifications for more information on how beneficiaries are assigned/aligned: • Medicare Shared Savings Program ACOs: Shared Savings and Losses and Assignment Methodology Specifications • MIPS Group and Virtual Groups: MIPS 2019 Assignment Methodology Specifications for the CMS Web Interface and CAHPS for MIPS Survey • Next Generation Model ACOs: NGACO Benchmarking Methodology

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ID	Question	Answer
5.	What if one of our sampled beneficiaries is no longer being seen at one of the ACO's participant TINs, at the MIPS group, or at a TIN within the virtual group (i.e., beneficiary moved or the provider is no longer with the ACO participant TIN, the MIPS group, or a TIN within the virtual group)?	Beneficiaries sampled into the CMS Web Interface had at least 2 Evaluation & Management (E&M) visits with your ACO, MIPS group, or TIN within your virtual group between January 1 and October 31, 2019. Therefore, your ACO, your MIPS group, or a TIN within your virtual group is considered accountable for this beneficiary's care, and you should do your best to obtain the necessary medical record information to complete the CMS Web Interface.
6.	Can we exclude a sampled beneficiary if they were only seen by a specialist at our facility?	No, this beneficiary was assigned to your organization and has at least 2 Evaluation & Management (E&M) visits with your organization so your organization is considered accountable for his/her care. Please refer to your program's assignment/alignment specifications for more information on how beneficiaries are assigned/aligned: • Medicare Shared Savings Program ACOs: Shared Savings and Losses and Assignment Methodology Specifications • MIPS Groups and Virtual Groups: MIPS 2019 Assignment Methodology Specifications for the CMS Web Interface and CAHPS for MIPS Survey • Next Generation Model ACOs: NGACO Benchmarking Methodology
7.	Where can we find a list of diagnosis, procedure, and exclusion/exception codes (i.e., denominator exclusions and reasons for denominator exceptions for "medical reason" or "patient reason") that can be used for reporting?	This information can be found in the 2019 CMS Web Interface measure specification documents and Release Notes, which are available for download from the QPP Resource Library in the "2019 CMS Web Interface Measure Specifications and Supporting Documents."

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ID	Question	Answer
8.	Can we use NQF or HEDIS specifications for a measure when they are available?	No. Please follow the CMS Web Interface measure specifications as these specifications have been developed specifically for the CMS Web Interface reporting mechanism. They are available for download on the QPP Resource Library in the 2019 CMS Web Interface Measure Specifications and Supporting Documents. Additionally, these specifications are approved by the measure developer for use in the CMS Web Interface and reflect the intention of the NQF or HEDIS measures.
9.	Is it possible to use data from multiple sources for abstraction?	Yes, any medical record documentation the physician has available to them from the time at which care was provided to the beneficiary is eligible for use in data collection.

Care Coordination/Patient Safety

ID	Question	Answer
1.	For CARE-2: Falls: Screening for Future Fall Risk, where can I find more information including assessments that meet the numerator of the measure and who can perform the falls screening?	Refer to the CARE-2 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.

At Risk Populations: Diabetes

ID	Question	Answer
1.	For the DM2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) measure, where can I find if a diagnosis of impaired fasting glucose, pre-diabetes, or hyperglycemia is considered a diagnosis of diabetes?	These diagnoses are not synonymous with diabetes. In instances where you cannot confirm diabetes, please select “Not Confirmed-Diagnosis.” Please refer to the Denominator Codes in the 2019 CMS WI DM Coding Document for diagnoses included in the measure found in the 2019 CMS Web Interface Measure Specifications and Supporting Documents.

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ID	Question	Answer
2.	For the DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) measure, will beneficiaries only be sampled into 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?	CMS looks for an encounter with diagnosis of diabetes in the Medicare claims during the measurement year when populating the beneficiary sample. When confirming the diagnosis, organizations should also look at the measurement year and one year prior. Refer to the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library for more details.
3.	For DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), where can I find more information including the performance rate calculation and the documentation needed from the lab report for the date and value count?	Refer to the DM-2 Measure Specifications in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.

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At Risk Populations: Hypertension

ID	Question	Answer
1.	Where can I find more information on HTN-2: Controlling High Blood Pressure including if a beneficiary sampled will be excluded from the denominator and not included in the performance calculation if the beneficiary did not have a blood pressure reading? Where can I find more information on the types of visits that apply to this measure, the pregnancy exclusion, and the institutionalized beneficiary exclusions?	Refer to the sample calculations in the HTN-2 Measure Specifications in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.

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At Risk Populations: Mental Health

ID	Question	Answer
1.	For MH-1: Depression Remission at Twelve Months, where can I find information including the timeframe to determine if a beneficiary has a diagnosis of major depression disorder or dysthymia, the timeframe for the Denominator Exclusions, the definition of a “permanent nursing home resident” for purposes of reporting a Denominator Exclusion, and how to report if my organization does not use the PHQ-9 tool? Where can I find more information on if I can use any PHQ-9 with a score less than 5 obtained during the 10 and 14 month remission window?	Refer to the MH-1 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.

Preventive Health

ID	Question	Answer
1.	For PREV-5: Breast Cancer Screening, what if a beneficiary had a unilateral mastectomy and has metastatic disease and, therefore, receives PET scans and CTs rather than a mammogram?	In unique situations such as this, it would be appropriate to request “Other CMS Approved Reason” to exclude the beneficiary. However, approval should not be considered automatic.

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ID	Question	Answer
2.	For PREV-5: Breast Cancer Screening, where can I find information including if we should exclude institutionalized beneficiaries, and if digital breast tomosynthesis (3D) mammography counts as meeting the numerator criteria?	Refer to the PREV-5 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.
3.	For PREV-6: Colorectal Cancer Screening, where can I find more information including the documentation needed for colorectal screening and if we should exclude institutionalized beneficiaries?	Refer to the PREV-6 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.
4.	For PREV-7: Preventive Care and Screening: Influenza Immunization, will flu immunizations found in claims be included in the numerator?	Claims data is used when available to prepopulate the CMS Web Interface numerator for PREV-7 (influenza immunization). If influenza immunization data has been prepopulated for a patient, the ACO, MIPS group, or virtual group does not need to validate that data.
5.	For PREV-7: Preventive Care and Screening: Influenza Immunization, where can I find information on the timeframes when the flu vaccination can be administered to be included in the measure?	Refer to the PREV-7 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.
6.	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the PREV-7: Preventive Care and Screening: Influenza Immunization measure?	Any available medical record documentation, including immunization registry data, can be used to confirm the quality action.

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ID	Question	Answer
7.	For PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, where can I find information including if telephonic outreach for tobacco cessation counts as meeting the measure and if screening for tobacco use and cessation intervention have to occur on the same encounter?	Refer to the PREV-10 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.
8.	For PREV-12: Preventive Care and Screening: Screening for Depression and Follow-up Plan, what documentation is needed for depression screening?	Refer to the PREV-12 Measure Specifications in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.
9.	Where can I find more information about the PREV-12: Preventive Care and Screening for Depression and Follow-Up Plan measure including what beneficiaries can be excluded from the measure, what qualifies as a depression screen, and what qualifies as a positive depression screen?	Refer to the PREV-12 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.

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ID	Question	Answer
10.	Where can I find more information about PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease including what counts as a diagnosis of diabetes for Risk Category #3, information on the denominator exceptions, and information on if a beneficiary would qualify for denominator inclusion with the following terms: hyperlipidemia, dyslipidemia, and high cholesterol?	Refer to the PREV-13 Measure Specification in the 2019 CMS Web Interface Measure Specifications and Supporting Documents in the QPP Resource Library.

Performance Scoring and Benchmarks

ID	Question	Answer
1.	For ACOs that joined the Shared Savings Program or Next Generation ACO Model before 2019, a number of measures are Pay- for- Performance in 2019. Where can we find the benchmarks for the quality measures that are in Pay-for-Performance? **Applicable to Shared Savings Program ACOs and Next Generation Model ACOs only.**	The quality measure benchmarks for the 2019 reporting year are available on the Medicare Shared Savings Program website and on the Next Generation Model ACO Connect site.

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ID	Question	Answer
2.	Where can I find more information on how the benchmarks are used to determine our overall quality score in the Shared Savings Program or Next Generation ACO Model? **Applicable to Shared Savings Program ACOs and Next Generation Model ACOs only.**	*Shared Savings Program ACOs*: This information is presented in the Quality Measurement Methodology and Resources document. *Next Generation ACO Model ACOs:* This information is available on the Next Generation ACO Connect site.
3.	Which CMS Web Interface measures are pay-for-reporting for the 2019 performance period?	The following are pay-for-reporting measures and will not be scored: • MH-1: Depression Remission at Twelve Months • 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 Clinical Depression and Follow-Up Plan* • PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease *Measure was reclassified to pay-for-reporting after the start of the 2019 performance period.

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ID	Question	Answer
4.	Why was PREV-7 reclassified as pay-for-reporting after the start of the 2019 performance period?	In 2018, the Centers of Disease Control (CDC)/Advisory Committee on Immunization Practice (ACIP) updated clinical guidelines to include the recommendation that live attenuated influenza virus **was acceptable** for the 2018-2019 influenza season. The original guidance provided in the 2019 CMS Web Interface PREV-7 measure specification outlined the following clinical guidance: > As a result of updated CDC/ACIP guidelines which include the interim recommendation that live attenuated influenza vaccine (LAIV) should not be used due to low effectiveness against influenza A (H1N1) pdm09 in the United States during the 2013-14 and 2015-16 seasons, the measure specifications have been updated and no longer include LAIV or intranasal flu vaccine as an option for numerator eligibility. The guidance provided within the 2019 CMS Web Interface PREV-7 measure specifications does not align with the updated clinical guidelines from the CDC/ACIP. For instances in which significant changes to clinical guidelines impact measure specifications and the intent of the measure and/or occur between rulemaking cycles, clinicians are encouraged to adopt clinical processes that support the new guidelines. Changes to clinical guidelines may not be compatible with existing measures and could cause misleading results as to what is measured as good quality of care. CMS believes that adherence to the updated clinical guidelines versus the measure specification guidance for the 2019 CMS Web Interface PREV-7 measure could cause misleading results as to what is measured as good quality of care. Therefore, CMS is suppressing the scoring of the CMS Web Interface PREV-7 measure for the 2019 performance period. • CMS will suppress the measure for MIPS scoring in accordance with § 414.1380(b)(1)(vii)(A). • CMS is reclassifying the measure as “pay-for-reporting” in the Medicare Shared Savings Program as provided in § 425.502(a)(5). By suppressing the measure, CMS will reduce the denominator of available measure achievement points for the Quality performance category by 10 points (83 FR 59847). Although the CMS Web Interface PREV-7 measure is being suppressed for the 2019 performance period, MIPS groups, virtual groups, and APM Entities (Accountable Care Organizations (ACOs)) are still required to complete the reporting requirements for the measure.

Updated 7/13/2020

ID	Question	Answer
5.	Why was PREV-10 reclassified as pay-for-reporting after the start of the 2019 performance period?	Within the CY 2020 Physician Fee Schedule Final Rule, CMS addressed concerns raised by stakeholders regarding the CMS Web Interface PREV-10 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure (PREV-10/ACO-17) that is included in the 2019 Merit-based Incentive Payment System (MIPS) performance period. Based on stakeholder feedback, CMS updated the 2019 CMS Web Interface PREV-10 measure specification by removing the numerator guidance that specified the following: "cessation intervention must occur during or after the most recent tobacco user status is documented." The guidance was determined to be inconsistent with the intent of the CMS Web Interface measure specifications and unduly burdensome for clinicians. The 2019 PREV-10 numerator guidance was updated to clarify that screening for tobacco use and tobacco cessation intervention do not have to occur on the same encounter, but must occur during the 24-month look-back period (1/1/2018 - 12/31/2019). The updated numerator guidance aligns with the clinical guidelines and will decrease burden for eligible clinicians performing tobacco screening and tobacco cessation intervention. The updated specification can be found within the 2019 CMS Web Interface Measure Specifications and Supporting Documents located in the QPP Resource Library. CMS will continue to require MIPS groups, APM Entities, and virtual groups reporting through the CMS Web Interface to meet the requirements for the 2019 CMS Web Interface PREV-10 measure; however, due to the mid-year change to the measure specification: • CMS is reclassifying the measure as "pay-for-reporting" in the Medicare Shared Savings Program as provided in 425.502(a)(5); and • CMS will exclude the measure from MIPS scoring in accordance with 414.1380(b)(1)(i)(A)(2)(i) provided it met the data completeness requirement and the measure was reported through the CMS Web Interface.

Updated 7/13/2020

6.	Why was PREV-12 reclassified as pay-for-reporting after the start of the 2019 performance period?	Stakeholders expressed concerns that the changes to the 2019 PREV-12 measure were substantive and would impact the reporting of data for the measure, which would have resulted in such modifications to be included in the rulemaking process. In the CY 2017 Quality Payment Program final rule (81 FR 77137), it was determined that substantive changes to measures (i.e., measure specifications, measure title, and domain modifications) would be identified during the rulemaking process while maintenance changes that do not substantively change the intent of the measure (i.e., updated diagnosis and procedure codes, definitions, and changes to patient population exclusions) would not be included in the rulemaking process. After the consideration of comments provided by stakeholders and the assessment of the coding modifications to the 2019 PREV-12 measure, CMS has determined that the changes to the 2019 PREV-12 measure are substantive. The modifications to the 2019 PREV-12 measure removed the 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 2019 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 2019 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 would not be eligible for the measure numerator). In order to promptly address the 2019 PREV-12 measure as having substantive changes, CMS is modifying the scoring of the 2019 PREV-12 measure given that the reporting of data via the CMS Web Interface is underway for the 2019 performance period. For the 2019 performance period, the following will apply to the PREV-12 measure: • Reclassified to “pay-for-reporting” for the Medicare Shared Savings Program as provided in §425.502(a)(5); and • Excluded from the Merit-based Incentive Payment System (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.

Updated 7/13/2020

ID	Question	Answer
		For the 2019 performance period, the following will apply: • CMS Web Interface users with an electronic health record (EHR) that currently reflects the 2018 PREV-12 measure specifications, CMS will accept the same types of documentation submitted during the 2018 submission period for the 2019 performance period. • CMS Web Interface users with an EHR that currently reflects the 2019 PREV-12 measure specifications, CMS will accept documentation that aligns with the 2019 measure specifications.

Interaction between CMS Web Interface and the Quality Payment Program

ID	Question	Answer
1.	How can I find out more information on the interaction between the Shared Savings Program and the Quality Payment Program?	For more information, please see the Medicare Shared Savings Program & Quality Payment Program Interactions for Performance Years 2019 document.

General

ID	Question	Answer
1.	You often reference the “Measures Steward” and “Measures Owner.” Can you explain who they are and what their roles are in quality measures reporting?	These terms refer to the organizations that create, test, and maintain quality measures. When more than one organization is involved, they must designate a *measure steward* during the NQF endorsement process. The measure stewards for each measure are listed on the cover page of each measure’s specification document as well as in the CMS Web Interface Measures List, which are available in the QPP Resource Library in the “2019 Web Interface Measure Specifications & Supporting documents.

Updated 7/13/2020

Version History Table

Date	Change Description
7/13/2020	Added information on CMS Web Interface measures PREV-7, PREV-10, and PREV-12 that were reclassified as pay-for-reporting after the start of the 2019 performance period.
4/27/2020	Added disclaimer language regarding changes to 2019 MIPS in response to COVID-19.
12/6/2019	Original posting

Updated 7/13/2020

Appendix A: Consecutively Confirmed and Completed Requirement

Question: How do organizations consecutively confirm and complete beneficiaries?

Answer: The minimum number of beneficiaries 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 ACOs, MIPS groups, and virtual groups must confirm and complete data for 248 patients, starting with the beneficiary ranked #1 in each measure's sample. If you skip a beneficiary because (a) the medical record was not found, (b) the beneficiary is no longer qualified for the sample, (c) the beneficiary meets measure-specific exclusion criteria, (d) the diagnosis could not be confirmed, (e) the beneficiary age or date of birth has changed such that the patient is not eligible for the measure, or (f) an "Other CMS Approved Reason" then an additional beneficiary must be completed for each beneficiary that was skipped until 248 beneficiaries 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 beneficiary's medical record, confirmed the beneficiary is eligible for quality sampling, confirmed the disease diagnosis if applicable (for DM, HTN, MH), confirmed the beneficiary's age and sex, and confirmed that the beneficiary does not meet exclusion criteria for a given measure.
>
> **Complete** means that you have provided all the information required for a given beneficiary for the measure for which they were sampled.
>
> **Consecutive** means that you have completed the beneficiary that was ranked immediately after the previously completed (or skipped) patient.

Updated 7/13/2020

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

Table A-1. Example 1

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

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

No additional beneficiaries need to be abstracted.

Updated 7/13/2020

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

Table A-2. Example 2

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

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Beneficiary Rank	Consecutive	Confirmed	Complete	Beneficiary Confirmation Details	Beneficiary Completion Details	Will beneficiary count towards 248 required?
7–230	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes
231-232	Y	Y	Y	Yes—all relevant beneficiary data have been confirmed	Yes—all required numerator and denominator data have been entered	Yes—these two additional beneficiaries replace skipped beneficiaries #4 and #6

No additional beneficiaries are available for abstraction.

Updated 7/13/2020

In Example 3 (see **Table A-3**), laboratory result data for beneficiary rank #2 was not provided and 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

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

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

No additional beneficiaries need to be abstracted.

Updated 7/13/2020

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

Table A-4. Example 4

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

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

No additional beneficiaries are available for abstraction.

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Appendix B: Skipping Beneficiaries (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 cannot find either in the medical record you have, or through information obtained from other providers, you must answer the questions in the negative (i.e., that a diagnosis cannot be confirmed, or that a quality action was not performed).
2.	Dr. Banks can find the beneficiary's medical record, but can't find any of the information he needs in it.	No. A medical record is available. Dr. Banks is expected to use the data available to him, and coordinate with other providers for additional data where needed. If a specific piece of data needed to confirm a quality action was performed cannot be found, he must indicate that the quality action was not performed.
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.

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 2019.	Yes, this sampled beneficiary is not qualified for the sample because she did not have FFS Medicare as her primary payer during the measurement period.
2.	Mr. Bannister entered hospice care in December of 2019.	Yes, this sample beneficiary is not qualified for the sample because he entered hospice care during the measurement period.
3.	Mrs. Grey retired and moved to Argentina in November of 2019.	Yes, this sampled beneficiary now permanently outside of the United States.
4.	Ms. Smith died in April 2019.	Yes, this sampled beneficiary is deceased for part of the measurement period.

Updated 7/13/2020

ID	Example	Should I select "Not Qualified for Sample"?
5.	Mr. Skywalker lives in New Jersey, but takes an extended vacation in Costa Rica every winter.	No, this sampled beneficiary has not changed his residence to outside the United States.

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.

Table B-4: Meets Exclusion Criteria Examples

ID	Example	Should I select "Denominator Exclusion"?
1.	Mrs. Wagstaff is allergic to eggs and an influenza vaccination is contraindicated.	No. This allergy is specified as a measure exception—not a measure exclusion. You will be able to enter this data into the CMS Web Interface further into the abstraction process. Exception criteria is also clearly defined in the Supporting Documents.

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

ID	Example	Should I select "No - Other CMS Approved Reason"?
1.	Dr. Lorusso can find the medical record, but he can't find documentation of Mr. Miyagi's colorectal cancer screening.	No. Dr. Lorusso cannot select "No - Other CMS Approved Reason." He must indicate that Mr. Miyagi did not have a colorectal cancer screen.
2.	Ms. Lemon has located some beneficiaries that are outside of the age criteria for the measure they were sampled in.	No. You are able to correct a beneficiary's date of birth directly in the CMS Web Interface. If doing so causes the beneficiary to be outside of the age criteria for specific measures, the CMS Web Interface will automatically skip those beneficiaries.

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

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ID	Example	Should I select “No - Other CMS Approved Reason”?
3.	Ms. Anderson has identified a case that is unique, unusual, and not covered by any other skip reasons. An inquiry was submitted to the QPP Service Center, and CMS responded with an approval.	Yes. Because the process has been followed to obtain CMS review and approval, this reason can be selected.

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