2022 Centers for Medicare & Medicaid Services (CMS) Web Interface Frequently Asked Questions

How to Navigate This Resource

Purpose

This resource focuses on the Centers for Medicare & 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 isn't intended to grant rights or impose obligations. The information provided is only intended to be a general summary for the 2022 Merit-based Incentive Payment System (MIPS) performance period. It isn't 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 Alternative Payment Model (APM) Entities (including Medicare Shared Savings Program Accountable Care Organizations (Shared Savings Program ACOs)), are referenced throughout this document.

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Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to the additional information and resources.

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Overview: Quality Reporting for the 2022 Performance Period

Activity	Estimated* Timeline
Groups, virtual groups, and APM Entities (including Shared Shavings Program ACOs) provide care to patients during the 2022 performance period.	January 1, 2022 – December 31, 2022
CMS Application Programming Interface (API) available for testing in the developer preview environment.	August 2022
Patients are assigned and sampled for groups, virtual groups, and APM Entities (including Shared Savings Program ACOs) reporting via the CMS Web Interface. CMS generates a sample of patients for each CMS Web Interface measure that is prepopulated in the CMS Web Interface.	December 2022
Submission Period Starts: CMS Web Interface opens for data entry.	January 3, 2023
Groups, virtual groups, and APM Entities (including Shared Savings Program ACOs) attend Support Calls.	January 25 – March 22, 2023
Submission Period Ends: Last day for groups, virtual groups, and APM Entities (including Shared Savings Program ACOs) to report data; data abstraction won't be permitted once the submission period closes.	March 31, 2023

2022 CMS Web Interface Measures

CMS Web Interface Measure Identifier (ID)	MIPS Quality ID	Measure Name
CARE-2	318	Falls: Screening for Future Fall Risk
DM-2	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
HTN-2	236	Controlling High Blood Pressure
MH-1	370	Depression Remission at Twelve Months
PREV-5	112	Breast Cancer Screening
PREV-6	113	Colorectal Cancer Screening
PREV-7	110	Preventive Care and Screening: Influenza Immunization
PREV-10	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
PREV-12	134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
PREV-13	438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

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2022 CMS Web Interface Resources

The resources below are currently available on the QPP Resource Library. For Shared Savings Program resources, please visit the Shared Savings Program Guidance and Specifications page and the QPP Resource Library.

2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP)
The 2022 CMS Web Interface Measure Specifications and Supporting Documents is a ZIP file that contains 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.
- **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 2022 CMS Web Interface Measure Specifications.
- **Coding Release Notes** - Includes the list of changes to the Coding Documents made since the release of the 2022 CMS Web Interface Coding Documents.

2022 CMS Web Interface Quick Start Guide (PDF)
The 2022 CMS Web Interface Quick Start Guide provides CMS Web Interface users with information needed to understand and report data via the CMS Web Interface.

2022 CMS Web Interface Telehealth Guidance (PDF)
The 2022 CMS Web Interface Telehealth Guidance outlines how telehealth relates to the reporting of measure data within the CMS Web Interface for the 2022 performance period.

2022 CMS Web Interface User Demo Videos (Playlist)
This series of demo videos will help CMS Web Interface users with quality data submission for the 2022 performance period.

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2022 CMS Web Interface User Guide (PDF)
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.

2022 CMS Web Interface Excel Template (XLXS)
The 2022 CMS Web Interface Excel Template is a preformatted Excel Template that allows users to input submission data for the CMS Web Interface.

2022 CMS Web Interface Excel Template with Sample Data (XLXS)
The 2022 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 2022 performance period changes to the measures and template prior to the submission period.

2022 CMS Web Interface Data Dictionary (PDF)
This lists elements from the CMS Web Interface Excel Template to assist users as they prepare to report data using the 2022 CMS Web Interface Excel Template.

2022 CMS Web Interface Sampling Methodology (PDF)
The 2022 CMS Web Interface Sampling methodology explains the sampling methodology for the 10 clinical quality measures reported via the CMS Web Interface.

2022 CMS Web Interface and CAHPS for MIPS Survey Assignment (PDF)
The 2022 MIPS Assignment Methodology Specifications for the CMS Web Interface and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey outlines the assignment methodology process for groups, virtual groups, and APM Entities reporting data for the quality performance category via the CMS Web Interface and/or administering the CAHPS for MIPS Survey.

Performance Year 2022 APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs (PDF)

This document describes the methods for calculating the performance year 2022 CMS Web Interface measure benchmarks for the Shared Savings Program. The benchmarks established for the Shared Savings Program are adopted for purposes of MIPS.

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How to Get Started

- Review the 2022 CMS Web Interface Measure Specifications and Supporting Documents and familiarize yourself with each of the 10 measures included in the 2022 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 2021 performance period, review the 2022 Measure Specification Submission Release Notes and the 2022 Coding Release Notes (found within with Measure Specifications and Supporting documents ZIP file) to identify measure changes and updates that were made from the 2021 performance period to the 2022 performance period.
- Review the 2022 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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Extreme and Uncontrollable Circumstances Exception

ID	Question	Answer
1	Can I apply for a MIPS Extreme and Uncontrollable Circumstances Exception?	Yes. If you believe you have been affected by an extreme and uncontrollable circumstance (such as the public health emergency triggered by the COVID-19 pandemic), you can apply for this exception regardless of whether you report traditional MIPS or APM Performance Pathway (APP). Extreme and uncontrollable circumstances are defined as rare events entirely outside of your control and the control of the facility in which you practice. These circumstances would: • Cause you to be unable to collect information necessary to submit for a MIPS performance category; • Cause you to be unable to submit information that would be used to score a MIPS performance category for an extended period of time (for example, if you were unable to collect data for the quality performance category for 3 months), and/or; • Impact your normal processes, affecting your performance on cost measures and other administrative claims measures.

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ID	Question	Answer
2	Does the 2022 MIPS Automatic Extreme and Uncontrollable Circumstances Exception Policy apply to CMS Web Interface submitters?	No. The automatic Extreme and Uncontrollable Circumstances Exception policy only applies to MIPS eligible clinicians participating as individuals. The automatic Extreme and Uncontrollable Circumstances Exception policy doesn't apply to groups or virtual group participation. However, groups and virtual groups have an opportunity to submit an Extreme and Uncontrollable Circumstances Exception Extreme and Uncontrollable Circumstances Exception (PDF) application requesting reweighting for any or all performance categories for the 2022 performance period. The deadline to submit an Extreme and Uncontrollable Circumstances Exception application for the 2022 performance period is January 3, 2023, at 8 p.m. ET. The Extreme and Uncontrollable Circumstances Exception application deadline pertaining to the COVID-19 public health emergency (PHE) has been extended to March 3, 2023, at 8 p.m. ET. A group that chooses to submit data at the group level for the 2022 performance year will be scored as a group according to the existing and applicable 2022 MIPS scoring policies. All CMS approved virtual groups will be scored as a virtual group according to existing MIPS scoring policies, regardless of whether they submit data or not.
3	Where can I find information about how to submit a 2022 MIPS Extreme and Uncontrollable Circumstances Exception Application?	You can find information about the 2022 Extreme and Uncontrollable Circumstances Exception application in the 2022 MIPS Extreme and Uncontrollable Circumstances Exception Application Guide (PDF).
4	Does the Shared Savings Program Extreme and Uncontrollable Circumstances Policy apply to Shared Savings Program ACOs for Performance Year (PY) 2022?	All ACOs and their beneficiaries are impacted by the public health emergency (PHE) under the Shared Savings Program Extreme and Uncontrollable Circumstances Policy for Performance Year (PY) 2022 (reference Medicare Shared Savings Program: CMS Flexibilities to Fight COVID-19). ACOs that report quality data via the APP and meet MIPS data completeness and case minimum requirements will receive the higher of their ACO's MIPS quality performance category score or the 30th percentile MIPS quality performance category score. ACOs that are unable to report quality data via the APP will have their ACO quality performance score set equal to the 30th percentile MIPS quality performance category score.

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Sampling and Pre-Population

ID	Question	Answer
1	Will all our assigned patients be populated into the CMS Web Interface?	No. Patients will be sampled randomly (for ACOs, sampling is based on third quarter assignment) into the CMS Web Interface using the specifications outlined in the 2022 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 for PREV-13) 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).
3	Will each ACO (participant) Taxpayer Identification Number (TIN) receive its own set of samples? Applicable to Shared Savings Program ACOs.	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 patients across the entire ACO; that is, all participant TINs. More specifically, samples will be drawn from third quarter assignment. In other words, there will be one set of one sample (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 Beneficiary Identifier (MBI)?	The 2022 patient samples will identify patients using a MBI and won't use the HICN.

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ID	Question	Answer
5	Is the APM Entity (including a Shared Savings Program ACO), group, or virtual group responsible for validating the data that is prepopulated into the CMS Web Interface?	Yes. The group, virtual group, or APM Entity (including a Shared Savings Program 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 aren't prepopulated for all patients ranked in PREV-7 (such data are pre-populated only for patients in which an immunization could be identified in the claims data). If influenza immunization data has been prepopulated for a patient, it doesn't need to be validated. The group, virtual group, or APM Entity (including a Shared Savings Program ACO) won't have to provide medical record documentation for prepopulated influenza immunization data. However, if influenza immunization data aren't prepopulated, the group, virtual group, or APM Entity (including a Shared Savings Program ACO) should refer to the patient's medical record to determine if an influenza immunization was administered in accordance with the Measure Specifications and must document their findings in the CMS Web Interface. The influenza immunization data that's obtained from the medical record (i.e., not prepopulated 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'll be sampled into multiple measures (if they were eligible for multiple measures). Although there's the potential to see 6,294 (9 samples × 616 patients and 1 sample × 750 patients) unique patients, we typically see sample sizes between 1,000 and 3,000 unique patients. The sampling methodology is described in the 2022 CMS Web Interface Sampling Methodology document available for download from the QPP Resource Library. Groups, virtual groups, and APM Entities (including Shared Savings Program 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 APM Entity (including a Shared Savings Program ACO) must confirm and completely report on 248 (or all eligible patients, if there are less than 248) consecutively ranked patients.
2	What if one of our sampled patients wasn't seen at our group, a TIN within our virtual group, or one of our APM Entity's (including a Shared Savings Program 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 APM Entity (including a Shared Savings Program ACO) and must have had at least 2 eligible services with your group, a TIN within your virtual group, or one of your APM Entity's (including a Shared Savings Program ACO) 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 APM Entity's (including a Shared Savings Program ACO) participant TINs, the group, or a TIN within the virtual group (i.e., patient moved or the provider is no longer with the Shared Savings Program ACO's participant TIN)?	Patients sampled into the CMS Web Interface had at least 2 primary care service visits with your APM Entity (including a Shared Savings Program ACO), group, or TIN within your virtual group between January 1, 2022, and October 31, 2022. Therefore, your APM Entity (including a Shared Savings Program 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.
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 APM Entity's (including a Shared Savings Program 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 APM Entity (including a Shared Savings Program ACO) at the time during which care was provided to the patient is eligible for use in data collection.

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2022 CMS Web Interface Measure Specification Guide

The information in this section is intended to supplement the 2022 CMS Web Interface Measure Specifications (ZIP) and shouldn't 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 2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP). An option is available in the CMS Web Interface that allows groups, virtual groups, and APM Entities (including a Shared Savings Program 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. There are 3 general categories of allowable reasons:

  - Medical.
  - Patient.
  - System.

  A denominator exception removes a patient from the performance denominator only if the numerator criteria aren't met, as defined by the exception. This allows for the exercise of clinical judgment 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's 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 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's 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's 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.

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Frailty and Advanced Illness Exclusions

The Measure Specifications include exclusions for frailty and advanced illness for the following 2022 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	How is “frailty” defined within the applicable 2022 CMS Web Interface measures?	Applicable coding associated with the denominator exclusion for “frailty” can be found within each applicable 2022 CMS Web Interface Coding Document. Refer to the 2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP). The applicable codes can be found on the “Denominator Exclusion Codes” 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.

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ID	Question	Answer
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.
4	Can patients who are age 66 or older at any time during the measurement period be excluded regardless of their age when they meet the exclusion criteria?	To assess the age for the exclusion, the patient’s age at the end of the measurement period should be used. The patient must be age 66 at the end of the measurement period and meet criteria to be excluded. The patient doesn’t have to be age 66 when they meet criteria; they could be age 65.

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

The Measure Specifications include a denominator exclusion for patients age 66 and older in the 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 consecutive days during the measurement period for the following 2022 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 90 days must be consecutive days during the measurement period to meet the denominator exclusion criteria
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 at the end of the measurement period 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's 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 National Provider Identifiers (NPIs) provided in the CMS Web Interface), as well as with 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 A, Table A-1 for examples pertaining to the response of "Medical Record Not Found."
2	Is there a list of codes associated with hospice or palliative care?	No. There's 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.

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ID	Question	Answer
3	When can I use “Not Qualified for Sample?”	CMS makes efforts to exclude patients that aren’t 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 aren’t qualified for the sample. The patient must meet one of the following criteria to be considered “Not Qualified for Sample” and will be removed from all CMS Web Interface measure samples: • In hospice.[1] • Moved out of the U.S. • Deceased. • 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, 2022). Refer to Appendix A, Table A-2 for examples.

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

[2] This option is for patients enrolled in Non-Fee-for-Service (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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2022 CMS Web Interface Measure-Specific FAQs

CARE-2: Falls: Screening for Future Fall Risk

ID	Question	Answer
1	Who can perform the screening for future fall risk for the 2022 CMS Web Interface CARE-2: Falls: Screening for Future Fall Risk measure (2022 CMS Web Interface CARE-2)?	The measure isn't limited to a particular clinician type. 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 2022 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 2022 CMS Web Interface CARE-2 measure?	Yes. The screening for future fall risk may be completed during a telehealth encounter.
4	What documentation needs to be captured for this measure for non-ambulatory patients to be excluded from the 2022 CMS Web Interface CARE-2 measure?	The denominator exclusion for non-ambulatory patients was removed from the measure during the annual update and rulemaking cycle. The expectation is that a falls screening is completed during the measurement period for each eligible patient.

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ID	Question	Answer
5	What clinical information should the medical record reflect to meet the intent of the 2022 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 2022 CMS Web Interface DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (2022 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?	The patient must have an active diagnosis of diabetes during the measurement period OR an active diagnosis of diabetes during the year prior to be included in the measure.
2	For the 2022 CMS Web Interface DM-2 measure, do I use the date the bloodwas drawn or the date of the lab results?	It's appropriate to use the following priority ranking for the numerator of the 2022 CMS Web Interface DM-2 measure: • Lab report draw date. • Lab report date. • Flow sheet documentation. • Practitioner notes. • Other documentation.
3	Will HbA1c results from any setting be acceptable for the numerator for the 2022 reporting period?	Yes. The measure doesn't limit the numerator to a specific setting.
4	Is an HbA1c result reported during a telehealth visit acceptable?	Yes. Documentation of the 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 2022 CMS Web Interface DM-2 measure?	No. The 2022 CMS Web Interface DM-2 measure doesn't include CGM results to meet performance for the measure. Report the most recent HbA1c value documented in the medical record. Documentation must include a distinct numeric HbA1c result 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 2022 CMS Web Interface DM-2 measure?	No. Don't include HbA1c levels reported by the patient. The 2022 CMS Web Interface DM-2 measure doesn't allow patient reported HbA1c values to meet the numerator.

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HTN-2: Controlling High Blood Pressure

ID	Question	Answer
1	For the 2022 CMS Web Interface HTN-2: Controlling High Blood Pressure 2022 CMS Web Interface HTN-2) measure, 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?	The measure allows for telehealth encounters. Please refer to the encounter codes found within the 2022_CMS Web Interface HTN Coding Document. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are acceptable. Don't include blood pressure readings taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope.
2	What is the definition of a "remote monitoring device?	The measure specifications don't define a remote monitoring device. It's the clinician's responsibility and their discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable.

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MH-1: Depression Remission at Twelve Months

ID	Question	Answer
1	For 2022 CMS Web Interface MH-1: Depression Remission at Twelve Months, 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.
2	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 follow-up PHQ-9 orPHQ-9M. There must be medical record documentation of the score and date completed.
3	Since the age range for the 2022 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 2022 CMS Web Interface MH-1 measure.
4	Can the PHQ-9 or PHQ-9M be performed inpatient or should it be performed during outpatient encounters only?	The 2022 MH-1 Measure Specifications don't limit the PHQ-9 or PHQ-9M screening to a specific setting.

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ID	Question	Answer
5	Can the PHQ-9 or PHQ-9M be performed during a telehealth visit?	Yes. The PHQ-9 or PHQ-9M 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).
6	Can you please clarify the timing used to identify denominator exclusions?	For denominator exclusions that require a specific diagnosis, the diagnosis must be active any time prior to the end of the patient's measure assessment period. 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 permanent nursing home residents any time during the denominator identification period (11/1/2020 to 10/31/2021) or the patient's measure assessment period (12 months +/- 60 days) are excluded.
7	Can you explain how to determine the index event date?	Verify the patient has an active diagnosis of major depression or dysthymia during the denominator identification period (11/1/2020 to 10/31/2021). Then look for the date of the first instance of a PHQ-9 or PHQ-9M greater than 9 during the same time period where the diagnosis is also present which would be the index event date. Refer to the step-by-step Submission Guidance and Measure Confirmation Flow in the 2022 MH-1 CMS Web Interface Depression Remission at Twelve Months measure specification.

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PREV-5: Breast Cancer Screening

ID	Question	Answer
1	For the 2022 CMS Web Interface PREV-5: Breast Cancer Screening (2022 CMS Web Interface PREV-5) measure, does a unilateral mammogram count for the numerator?	A unilateral mammography counts only if there's 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	The 2022 CMS Web Interface PREV-5 Coding Document only includes Logical Observation Identifiers Names and Codes (LOINC) codes to represent mammograms on the 'Numerator Codes' tab. Can Current Procedural Terminology (CPT) codes such as 77065, 77066 and 77067 that are billed on claims (with supporting documentation available) be used?	If you're mapping to an Electronic Health Record (EHR), you must use the coding within the 2022 CMS Web Interface PREV-5 coding document. The coding provided within the CMS Web Interface coding documents are considered all-inclusive when 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. 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 2022 CMS Web Interface PREV-5 Measure Specification 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 date, 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's 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 2022 CMS Web Interface PREV-6: Colorectal Cancer Screening (2022 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 2022 CMS Web Interface PREV-6 measure?	Yes. A fecal immunochemical test (FIT) during the measurement period would be acceptable based on the coding in the PREV-6 Coding Document numerator codes, based on the description of the FOBT_CODE variable.
3	If the fecal occult blood test (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.
4	Can we report FOBT results that are interpreted by our in-house labs? We understand the FOBTs obtained in the office or via DRE aren't accepted.	As long as the FOBT test itself wasn't performed in the office or performed on a sample collected via DRE, the test results are acceptable for the purpose of reporting the 2022 PREV-6: Colorectal Cancer Screening measure. The measure specifications aren't prescriptive on the type or location of a lab that can interpret an FOBT test. The type of colorectal cancer screening with the date it was performed AND the result or findings must be documented in the medical record to meet the intent of the measure.

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ID	Question	Answer
5	The initial population in the 2022 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 encounter, including telehealth, the clinician may have with a patient. If there's 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.
6	Will Epi proColon (r) Septin 9, ColoVantage (methylated Septin 9), Guardiant or other blood-based screenings be added to the list of acceptable colorectal screenings for the 2022 CMS Web Interface PREV-6 measure?	No. The numerator for 2022 PREV-6 Colorectal Cancer Screening for the CMS Web Interface collection type doesn't include blood-based colorectal cancer screenings. The measure specifications define appropriate screenings as follows: • 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 • Fecal immunochemical DNA test (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

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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 2022 CMS Web Interface PREV-7: Preventive Care and Screening: Influenza Immunization (2022 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 the patient reporting previous receipt of the Influenza immunization 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, 2021, and March 31, 2022, 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 2022 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 2021 – March 2022) for the flu season being reported to qualify as a denominator exception.
4	What are the documentation timing requirements for the numerator for the 2022 CMS Web Interface PREV-7 measure?	The medical record should support that the refusal, exception, or receipt occurred during the appropriate time frame (August 2021 – March 2022) for 2022 reporting. PREV-7 documentation should be during the measurement period and be specific to the flu season being reported. If the medical record documentation supports that the quality action or exception submitted is relevant to the flu season being measured, it's acceptable.

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ID	Question	Answer
5	The codes for previous receipt of an influenza immunization were removed from the 2022 CMS Web Interface PREV-7 Coding Document numerator codes. Is it okay to use the codes provided last year for previous receipt?	If you're mapping to an EHR, you must use the coding within the 2022 CMS Web Interface PREV-7 coding document. The coding documents are considered all-inclusive when 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. 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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PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

ID	Question	Answer
1	For the 2022 CMS Web Interface PREV-10 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (2022 CMS Web Interface PREV-10) measure, what is needed to satisfy the screening portion of the measure?	The intent of the measure is to determine if the patient was screened for tobacco use at least once during the 2022 measurement period. Screening for tobacco use must occur during the encounter. Therefore, if 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	Does the measure include electronic cigarettes or vaping as tobacco use or tobacco cessation?	No. The intent of this measure is to screen for tobacco use for products that burn or use tobacco leaves. The United States Preventive Services Task Force (USPSTF) concludes that current evidence is insufficient to recommend electronic nicotine delivery systems for tobacco cessation.
3	There are 3 rate/population categories. Which rate (or criteria) is used for performance scoring for the 2022 performance period? Population 1, 2 or 3?	The rate for population 2 (Tobacco Users Received Tobacco Cessation Intervention) is used for consideration of performance of this measure.
4	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.

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ID	Question	Answer
5	What if the patient had more than one tobacco screening during the measurement period? Which one do we use?	In the instance there is more than one tobacco screening during the measurement period, use the most recent query during the measurement period to determine tobacco status. Patients identified as a tobacco user must receive tobacco cessation intervention on the date of the encounter or within the previous 12 months from the screening encounter date.
6	Does a screening that was done in the emergency department or inpatient count?	Yes. The setting isn't specified for this measure.
7	Can the quality actions for the CMS Web Interface PREV-10 measure be completed 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 2022 CMS Web Interface PREV-12: Preventive Care and Screening: Screening for Depression and Follow-up Plan (2022 CMS Web Interface PREV-12) measure, what documentation is needed?	When submitting data through the CMS Web Interface, it's expected that groups, virtual groups, and APM Entities (including Shared Savings Program ACOs) retain supporting medical record documentation demonstrating the following: • The patient met the denominator criteria; • The numerator quality action was performed; and/or • Any applicable denominator exclusions or exceptions existed. Due to the comprehensive and individual nature of patient medical records only available to CMS Web Interface users, CMS can't provide specific feedback regarding whether or not documentation in a patient medical record (including screenshots, scenarios, or internal policies) would meet the intent of the measure or suffice for a given measure in the event of an audit. In the event of an audit, auditors will review measure specifications in comparison to the patient medical record documentation provided by a group, virtual group, or APM Entity (including a Shared Savings Program ACO) for each patient sampled for the audit. We encourage you to review the 2022 PREV-12 measure specifications and ensure that your documentation supports that all components of the measure are met.
2	The 2022 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 2022 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, others within the organization may complete the action. The quality action can be completed by anyone the organization considers qualified.

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ID	Question	Answer
3	Previously, a follow-up plan had to be documented on the date of positive screen but for 2022 the Measure Specifications state it must be documented on the date of eligible encounter. Is that correct?	Yes. For the 2022 CMS Web Interface PREV-12 measure, a follow-up plan must be documented by the date of the encounter (either telehealth or office visit).
4	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 and must be documented in the medical record.
5	Does a certain condition (intellectual disability, impairment, Alzheimer's, dementia, autism) qualify a patient for a denominator exception or exclusion?	The denominator exclusion only applies to patients who have been diagnosed with depression or bipolar disorder. The specification doesn't define denominator exceptions by specific diagnoses. If the patient qualifies for the measure and there's medical record documentation that the patient wasn't screened for depression due to a medical reason (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status) then it would be appropriate to select the denominator exception.
6	Does conducting a PHQ-9 after a positive PHQ-2 count as appropriate follow-up for the measure as it has in the past?	No. Per the 2022 CMS Web Interface PREV-12 measure specification, additional screening and assessment during the qualifying encounter doesn't qualify as a follow-up plan.

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

ID	Question	Answer
1	Can the 2022 CMS Web Interface PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (2022 CMS Web Interface PREV-13) measure be completed via telehealth?	Yes. The 2022 CMS Web Interface PREV-13 measure specification was updated to allow documentation of statin therapy prescribed or being taken during the measurement period to be completed during a telehealth encounter.
2	Is documentation of hypercholesterolemia alone sufficient to confirm a diagnosis of familial hypercholesterolemia for Population 2 in the 2022 CMS Web Interface PREV-13 measure?	No. If hypercholesterolemia alone is present and there's no other documentation to support "familial hypercholesterolemia," 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 "familial hypercholesterolemia," it would be appropriate to confirm the patient in the denominator of Population 2.
3	When does the denominator exception (i.e., allergy or intolerance to statin medication) need to be documented in the medical record?	Your medical record documentation should support that a statin wasn't prescribed due to an applicable denominator exception. Medical record documentation should support that the denominator exception is active during the performance period. For more specific information, refer to the numerator submission guidance in the posted 2022 CMS Web Interface PREV-13 measure specification.
4	For population 2, is it acceptable to use any variation of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) code E78 to confirm the diagnosis of familial hypercholesterolemia?	Since the measure requires confirmation of a diagnosis of Familial Hypercholesterolemia, other cholesterol-related diagnoses aren't appropriate. ICD-10 diagnosis code E78.01 Familial hypercholesterolemia is present in the PREV-13 Coding Document, Denominator Codes tab, along with other coding that may be used to identify familial hypercholesterolemia. Other variations of the E78 code aren't specific to familial hypercholesterolemia. If you find other medical record documentation supporting the diagnosis of familial hypercholesterolemia, then the diagnosis would be confirmed.

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ID	Question	Answer
5	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 2022 CMS Web Interface PREV-13 measure?	A listing of drugs that may be used for the denominator exception can be found on the “Denominator Exception Drug Codes” tab of the 2022 CMS Web Interface PREV-13 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).

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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 2022 coding for mapping quality measure data for 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 predetermined set of clinical codes. These codes can be found in the 2022 CMS Web Interface Coding Documents included in the 2022 CMS Web Interface Measure Specifications and Supporting Documents (ZIP).
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. 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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Where to Go for Help

- For additional questions related to the quality performance category, please contact the QPP Service Center at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET) or by email at: QPP@cms.hhs.gov. 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.

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Appendix A: Skipping Patients (Examples)

Table A-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 A-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 2022.	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 2022.	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 2022.	Yes. This sampled patient moved out of the country during the measurement period.
4.	Ms. Smith died in April 2022.	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 A-3: Diagnosis Not Confirmed Example

ID	Example	Should I select "Not Qualified for Sample?
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're expected to coordinate care as needed to answer all diabetes related questions.

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