2023 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. The CMS Web Interface is an available collection type for Medicare only Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) meeting the reporting requirements under the Alternative Payment Model (APM) Performance Pathway (APP) and isn't an available collection type for any other Quality Payment Program participants.

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 2023 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 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: CMS Web Interface Reporting for Shared Savings Program ACOs for the 2023 Performance Period

Activity	Estimated* Timeline
Shared Savings Program ACOs provide care to patients during the 2023 performance period.	January 1, 2023 – December 31, 2023
CMS Application Programming Interface (API) available for testing in the developer preview environment.	August 2023
Patients are assigned and sampled for Shared Savings Program ACOs reporting via the CMS Web Interface. CMS generates a sample of patients for each CMS Web Interface measure that is pre-populated in the CMS Web Interface.	December 2023
Submission Period Starts: CMS Web Interface opens for data entry.	January 2, 2024
Shared Savings Program ACOs attend Support Calls.	January 10, 2024 – March 6, 2024
Submission Period Ends: Last day to report data; data abstraction won't be permitted once the submission period closes.	April 1, 2024

2023 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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2023 CMS Web Interface Resources

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

2023 Performance Year APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs (ZIP, 6 MB)

The 2023 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 2023 CMS Web Interface Measure Specifications.
- **Coding Release Notes** - Includes the list of changes to the Coding Documents made since the release of the 2023 CMS Web Interface Coding Documents.

2023 CMS Web Interface User Demo Videos (Playlist)

This series of demo videos will help CMS Web Interface users with quality data submission for the 2023 performance period.

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2023 CMS Web Interface User Guide (PDF, 4 MB)
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

2023 CMS Web Interface Data Dictionary (PDF, 659 KB)
The CMS Web Interface Data Dictionary lists elements from the CMS Web Interface patient sample to assist users as they prepare to report data using the 2023 CMS Web Interface Excel Template.

2023 Shared Savings and Losses, Assignment and Quality Performance Standard Methodology Specifications (Version #11) (PDF, 1,943 KB)
This document describes the specifications for beneficiary assignment and the shared savings and losses calculations under the Shared Savings Program codified at 42 CFR part 425. 2023.

2023 Performance Year APM Performance Pathway: CMS Web Interface Measure Benchmarks for ACOs (PDF, 286 KB)
This document describes methods for calculating the CMS Web Interface benchmarks for Shared Savings Program ACOs reporting the CMS Web Interface measures for the 2023 performance year. The benchmarks for the 10 CMS Web Interface measures are displayed in Appendix A of this document.

2023 CMS Web Interface Sampling Methodology (PDF)
The 2023 CMS Web Interface Sampling Methodology will be published no later than the first week of January 2024. The 2023 CMS Web Interface Sampling Methodology explains the sampling methodology for the 10 clinical quality measures reported via the CMS Web Interface.

2023 CMS Web Interface Telehealth Guidance (PDF)
The 2023 CMS Web Interface Telehealth Guidance will be published no later than the first week of January 2024.This guidance explains to clinicians that are reporting CMS Web Interface measures for Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) how telehealth may relate to reporting measure data within the CMS Web Interface.

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How to Get Started

- Review the 2023 CMS Web Interface Measure Specifications and Supporting Documents and familiarize yourself with each of the 10 measures included in the 2023 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 2022 performance period, review the 2023 Measure Specification Submission Release Notes and the 2023 Coding Release Notes (found within with Measure Specifications and Supporting documents ZIP file) to identify measure changes and updates that were made between the 2022 performance period and the 2023 performance period.
- Review the 2023 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 the reporting requirements for the CMS Web Interface.

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Extreme and Uncontrollable Circumstances Exception

ID	Question	Answer
1.	Does the 2023 MIPS Automatic Extreme and Uncontrollable Circumstances Exception Policy apply to Shared Savings Program ACOs reporting via the APP?	No. The automatic MIPS Extreme and Uncontrollable Circumstances Exception policy doesn't apply to APM participation. However, APM Entities have an opportunity to submit an application requesting the reweighting of for any or all performance categories for the 2023 performance period. For more information, review the 2023 Extreme and Uncontrollable Circumstances Exception Application Guide (PDF, 1 MB). The deadline to submit an Extreme and Uncontrollable Circumstances Exception application for the 2023 performance period is January 2, 2024, at 8 p.m. ET.
2.	Where can I find information about how to submit a 2023 MIPS Extreme and Uncontrollable Circumstances Exception Application?	You can find information about the 2023 Extreme and Uncontrollable Circumstances Exception application in the 2023 Extreme and Uncontrollable Circumstances Exception Application Guide (PDF, 1 MB).
3.	Does the Shared Savings Program Extreme and Uncontrollable Circumstances Policy apply to Shared Savings Program ACOs for the 2023 Performance Year?	All Shared Savings Program ACOs and their beneficiaries are impacted by the public health emergency (PHE) under the Shared Savings Program Extreme and Uncontrollable Circumstances Policy for the 2023 Performance Year (reference Medicare Shared Savings Program: CMS Flexibilities to Fight COVID-19). Shared Savings Program ACOs that report quality data via the APP and meet MIPS data completeness and case minimum requirements will receive the higher of their Shared Savings Program ACO's MIPS quality performance category score or the 30th percentile MIPS quality performance category score. Shared Savings Program ACOs that are unable to report quality data via the APP will have their Shared Savings Program 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 Shared Savings Program ACOs, sampling is based on third quarter assignment) into the CMS Web Interface using the specifications outlined in the 2023 CMS Web Interface Sampling Methodology (PDF) document.
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 Shared Savings Program ACO (participant) Taxpayer Identification Number (TIN) receive its own set of samples?	No. Quality data collection, measurement, and reporting in the Shared Savings Program ACO program are conducted at the Shared Savings Program ACO Entity-level. The samples on which Shared Savings Program ACOs will need to submit clinical quality data will be drawn from all assigned patients across the entire Shared Savings Program 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 Shared Savings Program ACO Entity, not for each participant TIN in the Shared Savings Program ACO.
4.	Will the CMS Web Interface use a Health Insurance Claim Number (HICN) or a Medicare Beneficiary Identifier (MBI)?	The 2023 patient samples will identify patients using a MBI and won't use the HICN.

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ID	Question	Answer
5.	Is the Shared Savings Program ACO responsible for validating the data that is pre-populated into the CMS Web Interface?	Yes. The 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 pre-populated 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 pre-populated for a patient, it doesn't need to be validated. The Shared Savings Program ACO won't have to provide medical record documentation for pre-populated influenza immunization data. However, if influenza immunization data aren't pre-populated, the Shared Savings Program ACO should refer to the patient's medical record to determine if an influenza immunization was administered in accordance with the 2023 CMS Web Interface PREV-7 Measure Specification and must document their findings in the CMS Web Interface. The influenza immunization data that's obtained from the medical record (i.e., not pre-populated from claims data) is subject to the provision of supporting documentation.

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Abstraction into the CMS Web Interface

ID	Question	Answer
1.	How many unique patient medical records should we expect to need to reference for reporting?	There are 10 patient samples provided to each organization, one for each of the 10 CMS Web Interface measures. Each of these samples will have no more than 616 (or 750 for PREV-13) patients. Patients are sampled using a method that increases the likelihood that they'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 2023 CMS Web Interface Sampling Methodology (PDF) document available for download from the QPP Resource Library. 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 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 by one of our 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 Shared Savings Program ACO and must have had at least 2 eligible services with your 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 Shared Savings Program ACO's participant TINs (i.e., the 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 Shared Savings Program ACO between January 1, 2023, and October 31, 2023. Therefore, your Shared Savings Program ACO 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 one of our 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 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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2023 CMS Web Interface Measure Specification Guide

The information in this section is intended to supplement the Performance Year 2023 APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs (ZIP, 6 MB) 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 Performance Year 2023 APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs (ZIP, 6 MB). An option is available in the CMS Web Interface that allows 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's 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 2023 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 2023 CMS Web Interface measures?	Applicable coding associated with the denominator exclusion for “frailty” can be found within each applicable 2023 CMS Web Interface Coding Document. Refer to the Performance Year 2023 APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs (ZIP, 6 MB). 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 that 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 the 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 the year prior is required.
4.	The measure specifications state, "to assess the age for exclusions, the patient's age on the date of the encounter should be used." Which encounter should be used to make this determination?	The measure specifications don't define which specific encounter to use when determining a patient's age for the Frailty and Advanced Illness denominator exclusions. For this reason, 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. Allowing the age to continue to be assessed based on the patient's age on the last day of the measurement period aligns with the 2023 sampling process and is consistent with 2022 and prior years.

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

The Measure Specifications include a denominator exclusion for patients aged 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 2023 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 actually 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 (or less) National Provider Identifiers (NPIs) provided in the CMS Web Interface, if available), 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 aims 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 CMSWeb 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, 2023). 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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2023 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 2023 CMS Web Interface CARE-2: Falls: Screening for Future Fall Risk (2023 CMS Web Interface CARE-2) measure?	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 2023 CMS Web Interface CARE-2 measure?	Yes. The measure isn't limited to a particular setting.
3.	Is a falls screening performed during a phone call with the patient where no encounter is billed acceptable for the 2023 CMS Web Interface CARE-2 measure?	Yes. The screening and documentation of results for future fall risk may be completed during a telehealth encounter. Telehealth encounters for the CMS Web Interface aren't limited to Medicare billable encounters (information may be obtained over the phone, email, etc.). Medical record documentation of any history of falls screening during the measurement period is acceptable to determine performance for the numerator.
4.	What documentation needs to be captured for this measure for non-ambulatory patients to be excluded from the 2023 CMS Web Interface CARE-2 measure?	Non-ambulatory patients aren't excluded from the measure. The expectation is that a falls screening is completed during the measurement period for each patient qualified for the measure.

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ID	Question	Answer
5.	What clinical information should the medical record reflect to meet the intent of the 2023 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 acceptableas 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 2023 CMS Web Interface DM-2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (2023 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 2023 CMS Web Interface DM-2 measure, do I use the date the blood was drawn or the date of the lab results?	It's appropriate to use the following priority ranking for the numerator of the 2023 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 2023 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 2023 CMS Web Interface DM-2 measure?	No. The 2023 CMS Web Interface DM-2 measure doesn't include CGM results as a way 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. Is this be allowed for the 2023 CMS Web Interface DM-2 measure?	No. Don't include HbA1c levels reported by the patient. The 2023 CMS Web Interface DM-2 measure doesn't allow patient-reported HbA1c values to meet the numerator.
7.	The 2023 CMS Web Interface DM-2 Measure Specification no longer contains the guidance that only Type 1 or Type 2 diabetes should be included in the denominator. Are patients with a diagnosis of secondary diabetes eligible for the denominator?	Yes. The 2023 CMS Web Interface DM-2 Measure Specification was updated to align with the intent of the measure, which is to ensure hemoglobin A1c control in all patients with any diagnosis of diabetes. Therefore, the guidance to only include Type 1 or Type 2 diabetes was removed.

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HTN-2: Controlling High Blood Pressure

ID	Question	Answer
1.	For the 2023 CMS Web Interface HTN-2: Controlling High Blood Pressure (2023 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 2023 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 BP readings taken by the patient using a non-digital device such as with a manual BP cuff and a stethoscope.
2.	What is the definition of a "remote monitoring device?"	The 2023 CMS Web Interface HTN-2 Measure Specification doesn'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 BP is considered acceptable and reliable.
3.	For the 2023 CMS Web Interface HTN-2 Measure Specification, is a BP reading taken during an urgent care visit acceptable?	Yes. Blood pressure readings from urgent care visits are acceptable for this measure if it's the most recent BP documented in the medical record. Urgent care visits are included in sampling based on the Encounter Codes tab of the 2023 CMS Web Interface HTN-2 Coding Document.
4.	Can we use a calculated average of multiple BP values taken over the course of a week via a remote monitoring device?	No, it isn't acceptable to submit a BP average (average of 2 or more BP readings). The measure requires the most recent BP documented within the medical record during the measurement period be reported for the numerator. If there are multiple BP readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent BP reading. Ranges and thresholds don't meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. Please ensure you're using the 2023 CMS Web Interface HTN-2 Measure Specification for the program for which you're reporting.

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MH-1: Depression Remission at Twelve Months

ID	Question	Answer
1.	For 2023 CMS Web Interface MH-1: Depression Remission at Twelve Months (2023 CMS Web Interface MH-1) measure, 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 or PHQ-9M. There must be medical record documentation of the score and date completed.
3.	Since the age range for the 2023 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 2023 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 2023 CMS Web Interface MH-1 Measure Specification doesn'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 (11/1/2021 to 10/31/2022) 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 (11/1/2021 to 10/31/2022). 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 2023 CMS Web Interface MH-1 Measure Specification.

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ID	Question	Answer
8.	Why was the Place of Service (POS) Exclusion [POS = 12 (home)] column included in the 2023 CMS Web Interface MH-1 Coding Document, Denominator Exclusion Codes tab?	Effective January 1, 2023, the American Medical Association (AMA) made significant changes to the Current Procedural Terminology (CPT) coding for evaluation and management (E&M) services. The codes for E&M in the home setting (99341 – 99350) were combined with the codes for E&M services in a domiciliary/rest home (99324-99340). The measure exclusion associated with these codes is specific to patients who were permanent nursing home residents any time during the denominator identification period or the measure assessment period. However, as part of the 2023 CPT updates, the AMA re-purposed the domiciliary/rest home CPT codes to represent both the home and domiciliary/rest home settings. In order to maintain the setting associated with denominator exclusion for MH-1, for the affected CPT codes, an exclusion of POS=12 (home) was added to prevent the home setting from being excluded.
9.	How should changes to Column G within the 2023 CMS Web Interface MH-1 Coding Document, Denominator Exclusion Codes tab be implemented?	When mapping to an Electronic Health Record (EHR), column G was added to identify a POS exclusion at the coding level. CPT Codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350 are exclusion codes except in cases where the POS 12 (home) = Y. If you aren't mapping to an EHR, CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350 can be used to identify encounters that may be applicable for the denominator exclusion when present **WITHOUT** POS 12. CPT Codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350 **WITH** POS 12 (home) shouldn't be excluded from the measure.

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PREV-5: Breast Cancer Screening

ID	Question	Answer
1.	For the 2023 CMS Web Interface PREV-5: Breast Cancer Screening (2023 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 2023 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 EHR, you must use the coding within the 2023 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 aren't 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 2023 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 2023 CMS Web Interface PREV-6: Colorectal Cancer Screening (2023 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 the 2023 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 (at the point of care) 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) or 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 2023 CMS Web Interface PREV-6 measure. The 2023 CMS Web Interface PREV-6 Measure Specification isn'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 2023 CMS Web Interface PREV-6 measure states “with a visit 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 ® Septin 9, ColoVantage (methylated Septin 9), Guardiant or other blood-based screenings be added to the list of acceptable colorectal screenings for the 2023 CMS Web Interface PREV-6 measure?	No. The numerator for 2023 CMS Web Interface PREV-6 measure doesn't include blood-based colorectal cancer screenings. The 2023 CMS Web Interface PREV-6 Measure Specification defines 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.	For the 2023 CMS Web Interface PREV-7: Preventive Care and Screening: Influenza Immunization (2023 CMS Web Interface PREV-7) measure, are we required to report a patient's influenza immunization status for 2 separate flu seasons, or do we have the option of reporting for only one of the flu seasons?	You must report immunization status specific to the flu season(s) for which the patient had a qualifying encounter. The flu season(s) in which the patient had a qualifying encounter will be noted in the CMS Web Interface. If the patient had a qualifying encounter during both flu seasons, you must report the patient's immunization status for both flu seasons.
2.	Our state has an immunization registry. Can this be used as an extension of the medical record to qualify for the 2023 CMS Web Interface PREV-7 measure?	Any available medical record documentation, including immunization registry data, can be used to confirm the quality action.
3.	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?	While the influenza immunization itself can't be received during a telehealth encounter, the patient may report previous receipt of the vaccine during a telehealth encounter. As long as there's medical record documentation that supports previous receipt for the flu season being reported it would be acceptable.

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ID	Question	Answer
4.	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 2023 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. Denominator Exception(s) must be documented during the measurement period and be specific to the flu season being reported.
5.	What are the documentation timing requirements for the numerator for the 2023 CMS Web Interface PREV-7 measure?	The medical record should support that the refusal, exception, or receipt occurred during the appropriate time frame for the flu season being reported. The 2023 CMS Web Interface 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.
6.	How is the flu season indicated in the patient sample files?	The patient sample files will contain the same set of variables included in prior years, with the addition of 2 new indicators that correspond to the 2 separate flu seasons (one for the 2022-2023 flu season and one for the 2023-2024 flu season). The indicator(s) will be checked if the beneficiary qualifies for the sample based on that timeframe. If the beneficiary qualifies based on both timeframes, then both indicators will be checked.

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ID	Question	Answer
7.	Can you please clarify how performance is calculated for this measure?	For patients sampled into one flu season (2022-2023 OR 2023-2024), performance will be calculated based on the numerator action reported for the applicable flu season. For patients sampled into both flu seasons, performance is aggregated based on the outcome reported for each: • **Performance Met** This is the outcome if the patient has documentation showing receipt of immunization for the 2022-2023 flu season AND the 2023-2024 flu season. **OR** If performance is met for one flu season and the patient had a documented denominator exception for the other flu season • **Denominator Exception** This is the outcome if there's a documented denominator exception for both flu seasons. • **Performance Not Met** This is the outcome when the patient doesn't receive the influenza immunization for one or both flu seasons. **OR** If the patient qualified for a denominator exception for one flu season and didn't receive the immunization for the other flu season, it would be considered performance not met (i.e., immunization wasn't administered for the 2022 – 2023 flu season and a denominator exception was documented for the 2023 – 2024 flu season).

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

ID	Question	Answer
1.	For the 2023 CMS Web Interface PREV-10 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (2023 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 2023 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?	Yes. The definition of tobacco use was updated for the 2023 measurement period. Use of any tobacco product includes “any product made or derived from tobacco intended for human consumption (except products that meet the definition of drugs). The 2021 United States Preventive Services Task Force (USPSTF) recommendation references the US Food and Drug Administration definition of tobacco, which includes e-cigarettes, hookah pens and other electronic nicotine delivery systems.” The intent of the screening portion of the measure has been met if the most recent tobacco use screening has a documented status of tobacco user or tobacco non-user.
3.	There are 3 rate/population categories. Which rate (or criteria) is used for performance scoring for the 2023 performance period? Population 1, 2 or 3?	The rate for population 2 (Tobacco Users Received Tobacco Cessation Intervention) is used for consideration of performance for this measure.

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ID	Question	Answer
4.	Who is able to complete the cessation intervention within our organization (i.e., can a Medical Assistant provide counseling to patients or does it need to be an eligible clinician)?	Cessation counseling can be provided by anyone your organization considers qualified.
5.	What if the patient had more than one tobacco screening during the measurement period? Which one do we use?	If there's more than one patient query regarding tobacco use, use the most recent query during the measurement period to determine tobacco status.
6.	When does tobacco cessation intervention need to be completed for patients identified as tobacco users?	Patients identified as a tobacco user must receive tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period. Please note that screening for tobacco use and cessation intervention don't have to occur on the same encounter.
7.	Does a screening that was done in the emergency department or inpatient count?	Yes. The setting isn't specified for this measure.
8.	Can the quality actions for the 2023 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.
9.	If there's a medical reason for not screening or providing tobacco cessation intervention to the patient, can we report an exception or exclude them?	No. The measure doesn't allow any denominator exceptions or exclusions. The expectation is that all patients qualified for the measure are screened for tobacco use and receive tobacco use cessation if identified as a tobacco user.

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

ID	Question	Answer
1.	For the 2023 CMS Web Interface PREV-12: Preventive Care and Screening: Screening for Depression and Follow-up Plan (2023 CMS Web Interface PREV-12) measure, what documentation is needed?	When submitting data through the CMS Web Interface, your medical record documentation should demonstrate 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 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. We encourage you to review the 2023 CMS Web Interface PREV-12 Measure Specification and ensure that your documentation supports that all components of the measure are met.
2.	The 2023 CMS Web Interface PREV- 12 Measure Specification states that “the depression screening results must be reviewed/verified and documented by the eligible professional in the medical record on the day of the encounter to meet the screening portion of this measure.” What is the definition of an eligible professional?	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.
3.	How is a “qualifying encounter” defined for 2023 CMS Web Interface PREV-12 measure?	A qualifying encounter is the encounter used to evaluate the numerator, which is the encounter associated with the most recent depression screening. The quality action isn't limited to a specific encounter type to meet the intent of the measure.

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ID	Question	Answer
4.	Previously, a follow-up plan had to be documented on the date of the encounter, but the 2023 CMS Web Interface PREV-12 the Measure Specification states that it may be documented up to 2 days after the date of the qualifying encounter. Is that correct?	Yes. For the 2023 CMS Web Interface PREV-12 measure, a follow-up plan must be documented by the date of the qualifying encounter (either telehealth or office visit) or up to 2 calendar days after the date of the qualifying encounter. However, the follow-up plan MUST still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator.
5.	Can documentation of a follow-up plan be used to infer a depression screening was positive if no results were documented?	No. The results must be reviewed/verified and documented by the eligible professional in the medical record to meet the screening portion of this measure.
6.	Should patients with **any** history of depression or bipolar disorder be excluded from the measure?	Yes. The intent of the measure is to screen for new cases of depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator. To implement this guidance, the qualifying encounter is the equivalent to the most recent depression screening. A patient should be excluded if they've **ever** been diagnosed with depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator.
7.	Does a certain condition (intellectual disability, impairment, Alzheimer's, dementia, autism) qualify a patient for a denominator exception?	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 (i.e., 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.
8.	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 2023 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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ID	Question	Answer
9.	Can we confirm the numerator if the medical record only contains the name of the tool and interpretation by the clinician?	Yes. At a minimum, you must document the tool's name and results of the screening with a score OR a clinician interpretation of positive or negative for depression.
10.	Why was POS Exclusion [Place of Service Code = 12 (home)] column included in the 2023 CMS Web Interface PREV-12 Coding Document, Encounter Codes tab?	Effective January 1, 2023, the American Medical Association (AMA) made significant changes to the CPT coding for evaluation and management (E&M) services. The codes for E&M in the home setting (99341 – 99350) were combined with the codes for E&M services in a domiciliary/rest home (99324-99340). In 2022 and in prior years, PREV-12 didn't include the CPT codes for E&M services in a home setting as denominator eligible encounters codes; however, the measure did include the CPT codes for E&M services in a domiciliary/rest home. As part of the 2023 CPT updates, the AMA repurposed the domiciliary/rest home CPT codes to represent both the home and domiciliary/rest home settings. In order to maintain the allowable settings for PREV-12, POS 12 (home) was added to the revised codes.
11.	Can you explain how to implement the POS Exclusion [Place of Service Code = 12 (home)] column included in the 2023 CMS Web Interface PREV-12 Coding Document, Encounter Codes tab?	The intent of the addition of Column G for these encounter codes is to indicate that these CPT Codes will only be included in the measure when they aren't associated with POS 12. Therefore, these encounter codes WITH a POS of 12 (home) are excluded from your patient sample. These updates reflect the AMA's revisions to CPT E&M coding, effective January 1, 2023.
12.	Can we meet performance for the 2023 CMS Web Interface PREV-12 measure using depression screenings conducted in a home setting?	Yes. While encounters associated with POS 12 aren't included in your patient sample, the 2023 CMS Web Interface PREV-12 Measure Specification doesn't limit the quality action for the numerator to a specific setting. If the most recent documented depression screening was completed during a home-based encounter, it would be acceptable to report the numerator as appropriate.

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

ID	Question	Answer
1.	Can the 2023 CMS Web Interface PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (2023 CMS Web Interface PREV-13) measure be completed via telehealth?	Yes. The 2023 CMS Web Interface PREV-13 Measure Specification allows 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 2023 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., muscle symptoms or an allergy to statin medication) need to be documented in the medical record?	Your medical record documentation should support that the denominator exception is active during the performance period and should support that a statin wasn't prescribed due to an applicable denominator exception. For more specific information, refer to the numerator submission guidance in the posted 2023 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 a patient allergy or statin-associated muscle symptoms 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/statin-associated muscle symptoms to statins for the 2023 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 2023 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., statin-associated muscle symptoms or an allergy to statin medication).
6.	What’s considered a medical reason for not taking statin therapy?	The 2023 CMS Web Interface PREV-13 Measure Specification isn't prescriptive as to what qualifies as a medical reason for not prescribing statin therapy. A clinician may use their discretion as to what constitutes a medical reason; however, there must be documentation supporting why the patient wasn't prescribed statin therapy.

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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 2023 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 2023 CMS Web Interface Coding Documents included in the Performance Year 2023 APM Performance Pathway: CMS Web Interface Measure Specifications and Supporting Documents for ACOs (ZIP, 6 MB).
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

Contact the QPP Service Center by email at QPP@cms.hhs.gov, create a QPP Service Center ticket, or by phone at 1-866-288-8292 (Monday-Friday, 8 a.m. - 8 p.m. ET). To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- People who are deaf or hard of hearing 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 2023.	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 2023.	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 2023.	Yes. This sampled patient moved out of the country during the measurement period.
4.	Ms. Smith died in April 2023.	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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