CMS Web Interface Measure Documentation

Reference Guide for Performance Year 2019

Intended to be used as a supplemental resource in conjunction with the 2019 Web Interface measure specifications posted in the online CMS QPP Resource Library.

WHY DO I NEED TO HAVE SUPPORTING DOCUMENTATION?

Medical record documentation that supports the action reported in the CMS Web Interface should be available upon request.

Claims data may be used to prepare the CMS Web Interface excel. However, supporting medical record documentation will be required to substantiate all data submitted (including a diagnosis if applicable) in the event of an audit.

WHAT DOCUMENTATION DO I NEED FOR EACH CMS WEB INTERFACE MEASURE?

This *Reference Guide* outlines the documentation requirements for each of the 2019 CMS Web Interface quality measures. Data collection for these measures occurs in early 2020. More details related to the documentation requirements specific to each measure can be found in the Guidance section of the measure specifications. It is recommended that you become familiar with these details, as this guide is only an outline of the documentation requirements and does not contain these details.

WHY ARE TIMEFRAMES APPLICABLE TO INDIVIDUAL MEASURES?

Some measures have specific look-back periods that apply to numerator, denominator, or applicable exclusion/exception criteria. When timeframes differ from the “measurement period” (January 1, 2019–December 31, 2019), they are noted within the Documentation Requirements and Guidance sections.

WHAT ARE THE DOCUMENTATION REQUIREMENTS APPLICABLE TO ALL MEASURES?

In some cases, you may be asked to provide documentation that does not refer to a specific measure component. These documents may be requested in order to substantiate instances where the ACO indicated a beneficiary was not qualified for the sample or where *Other CMS Approved Reason* was selected to skip a beneficiary for a given measure. The table below contains documentation requirements should you need to provide documentation for one of these selections.

CMS Web Interface Entry	Documentation Required
Not Qualified for Sample	Specific reason a beneficiary is not eligible for the sample (e.g., In Hospice, Moved Out of Country, Deceased, or non-FFS Medicare enrollment) documented in the medical record.
Other CMS Approved Reason	The Quality Payment Program Service Desk Inquiry Number supplied with response.

WHAT ARE THE DOCUMENTATION REQUIREMENTS APPLICABLE TO EACH SPECIFIC MEASURE?

Below are the documentation requirements for each measure. Specific examples of the kinds of documentation that may satisfy these requirements are included. Please note the examples provided are a selection of acceptable documents but does not include all acceptable documentation. Please refer to the Guidance section of the measure specifications for more details.

CARE-2 (ACO-13): Falls: Screening for Future Fall Risk

Measure Description:
Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

Denominator:
Patients aged 65 years and older with a visit during the measurement period

Denominator Exclusions:
Exclude patients who were assessed to be non-ambulatory during the measurement period

Denominator Exceptions:
None

Numerator:
Patients who were screened for future fall risk at least once within the measurement period

Documentation Required:

- Documentation of assessment of whether the patient has experienced a fall or problems with gait or balance performed during the measurement period. Documentation of no falls is sufficient.
  - ***Example:*** Office visit note dated March 21, 2019 indicating the patient's gait/balance was assessed.

or

- Documentation of exclusion criteria.
  - ***Example:*** Office visit note dated October 1, 2019 stating the patient is wheelchair bound.

DM-2 (ACO-27): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Measure Description:
Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

Denominator:
Patients 18–75 years of age with diabetes with a visit during the measurement period

Denominator Exclusions:
None

Denominator Exceptions:
None

Numerator:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Documentation Required:

- A diagnosis of diabetes (active or history of) during the measurement period or year prior to the measurement period.
  - ***Example:*** Problem list dated December 10, 2018 indicating a diagnosis of diabetes.

  and

- The date and value of the most recent HbA1c test performed during the measurement period.
  - ***Example:*** Laboratory report dated June 10, 2019 indicating most recent HbA1c value of 9.2%.

HTN-2 (ACO-28) Controlling High Blood Pressure

Measure Description:
Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period

Denominator:
Patients 18–85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Denominator Exclusions:
Patients with evidence of end stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period
OR
Patients age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 any time during the measurement period
Denominator Exceptions:
None

Numerator:
Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

Documentation Required:

- A diagnosis of essential hypertension within the first six months of the measurement period (prior to 07/01/2019) or at any time prior to the measurement period.
  - ***Example:*** Problem list dated March 14, 2019 indicating the patient has essential hypertension.

  and

  - The date and value of the most recent systolic and diastolic blood pressure readings during the measurement period. If there are multiple blood pressure readings on the same date of service, use the lowest systolic and lowest diastolic reading as the most recent blood pressure reading.
    - ***Example:*** Office visit note dated December 1, 2019 indicating the most recent blood pressure was 117/64.

    or

- Documentation of exclusion criteria.
  - ***Example:*** Problem list dated August 8, 2019 indicating the patient has ESRD.

MH-1 (ACO-40) Depression Remission at Twelve Months

Measure Description:
The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

Denominator:
Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event

Denominator Exclusions:
Patients with a diagnosis of bipolar disorder
Patients with a diagnosis of personality disorder
Patients with a diagnosis of schizophrenia or psychotic disorder
Patients with a diagnosis of pervasive developmental disorder
Patients who were permanent nursing home residents

Denominator Exceptions:
None

Numerator:
Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve-month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five

Documentation Required:

- A diagnosis of major depression or dysthymia during the denominator identification period (11/01/2017 to 10/31/2018).
  - ***Example:*** Office visit note dated May 14, 2018 indicating the patient has major depression.

  and

- A PHQ-9 score *greater than* 9 between 11/01/2017 and 10/31/2018.
  - ***Example:*** Office visit note dated May 14, 2018 indicating a PHQ-9 score of 12.

  and

  - A follow-up PHQ-9 score *less than* 5 at 12 months (+/- 60 days) after the initial PHQ-9 score *greater than* 9.
    - ***Example:*** Office visit note dated May 30, 2019 indicating a PHQ-9 score of 4.

    or

  - Documentation of exclusion criteria.
    - ***Example:*** A nursing home visit note dated March 1, 2019 indicating the patient has been a resident of Shady Pines Nursing Home for 18 months.

PREV-5 (ACO-20): Breast Cancer Screening

Measure Description:
Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer

Denominator:
Women 51–74 years of age with a visit during the measurement period

Denominator Exclusions:
Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy
OR
Patients age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 any time during the measurement period

Denominator Exceptions:
None

Numerator:
Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period

Documentation Required:

- Date the mammogram was performed and results (October 1, 2017–December 31, 2019).
  - ***Example:*** A mammography report dated March 30, 2018 indicating a 3-D mammography was performed and the results were normal.

or

- Documentation of exclusion criteria.
  - ***Example:*** Procedure report dated July 19, 2011 indicating a bilateral mastectomy was performed on the patient.

PREV-6 (ACO-19): Colorectal Cancer Screening

Measure Description:
Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer

Denominator:
Patients 50–75 years of age with a visit during the measurement period

Denominator Exclusions:
Patients with a diagnosis or past history of total colectomy or colorectal cancer
OR
Patients age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 any time during the measurement period

Denominator Exceptions:
None

Numerator:
Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period (01/01/2019–12/31/2019)
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period (01/01/2015–12/31/2019)
- Colonoscopy during the measurement period or the nine years prior to the measurement period (01/01/2010–12/31/2019)
- CT Colonography during the measurement period or the four years prior to the measurement period (01/01/2015–12/31/2019)
- FIT-DNA during the measurement period or the two years prior to the measurement period (01/01/2017–12/31/2019)

Documentation Required:

- Indication of current colorectal cancer screening as evidenced by the completion of one of the above-mentioned tests or procedures within its corresponding timeframe, the date the screening was performed and the result.
    - ❖ ***Example:*** A colonoscopy report dated November 21, 2014 indicating an abnormal test result.

  or

- Documentation of exclusion criteria.
    - ❖ ***Example:*** Problem list dated February 1, 2019 indicating the patient had a total colectomy in 2011.

PREV-7 (ACO-14): Preventive Care and Screening: Influenza Immunization

Measure Description:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Denominator:
All patients aged 6 months and older seen for a visit during the measurement period

Denominator Exclusions:
None

Denominator Exceptions:

- Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reasons)
- Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reasons)
- Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reasons)

Numerator:
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Documentation Required:

- Indication the patient received an influenza immunization between August 1, 2018 and March 31, 2019 (not required if prefilled with "Yes" in the CMS Web Interface).
    - ***Example:*** An office visit note dated October 11, 2018 noting that the patient reported receiving an influenza immunization last week at Walgreens Pharmacy.

or

- Documentation of the reason why the Quality Action is not performed due to an exception.
    - ***Example:*** An office visit note dated December 1, 2018 indicating the patient refused an influenza immunization.

PREV-10 (ACO-17): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure Description:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Three rates are reported:

a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention
c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

NOTE: Within 24 months is defined as the 24-month look-back from the measurement period end date (01/01/2018–12/31/2019).

Denominator:
Population 1: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Population 2: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user
Population 3: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Denominator Exclusions:
None

Denominator Exceptions:
Population 1: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)
Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (eg, limited life expectancy, other medical reason)
Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (eg, limited life expectancy, other medical reason)

Numerator:
Population 1: Patients who were screened for tobacco use at least once within 24 months
Population 2: Patients who received tobacco cessation intervention
Population 3: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

NOTE: Screening for tobacco use and cessation intervention do not have to occur on the same encounter, but both must occur during the 24-month look-back period, and the cessation intervention must occur during or after the most recent tobacco user status is documented.

Documentation Required:

- The date and results of a query of the patient's use of tobacco.
  - ***Example:*** An office visit note dated September 23, 2019 indicating the patient is a tobacco user.
  - If identified as a tobacco user, documentation of cessation intervention.
    - ***Example:*** An office visit note dated September 23, 2019 indicating that the patient was counseled regarding tobacco use and prescribed Nortriptyline 10 MG Oral Capsule.

or

- Documentation of the reason why the Quality Action is not performed due to an exception.
  - ***Example:*** An office visit note dated August 24, 2019 indicating the patient was in the final stages of metastatic lung cancer.

PREV-12 (ACO-18): Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Description:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

Denominator:
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Denominator Exclusions:
Patients with an active diagnosis of depression or a diagnosis of bipolar disorder
Denominator Exceptions:
Patient Reason(s): Patient refuses to participate
OR
Medical Reason(s): 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
OR
Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Numerator:
Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

Documentation Required:

- The date and results of a named age appropriate standardized depression screening tool.
  - ***Example:*** An office visit note dated May 20, 2019 indicating the patient was screened for depression, that a PHQ-9 tool was used, and interpreted by the clinician as positive.
  - If screening results are positive, documentation of discussion of a follow-up plan on the date of the positive screen. The follow-up plan must be specified as an intervention that pertains to depression.
    - ***Example:*** An office visit note on May 20, 2019 (date of the positive screen) indicating the patient was referred to a behavioral health provider to address the positive depression screening.

  or

- Documentation of the reason why the Quality Action is not performed due to an exception.
  - ***Example:*** An office visit note dated June 10, 2019 indicates the patient refused depression screening.

  or

- Documentation of exclusion criteria.
  - ***Example:*** A problem list dated February 1, 2019 indicating the patient has an active diagnosis of depression.

PREV-13 (ACO-42): Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Measure Description:
Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:

- Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
- Adults aged ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR
- Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

Denominator:
All patients who meet one or more of the following criteria (considered at “high-risk” for cardiovascular events, under ACC/AHA guidelines)

- Patients aged ≥ 21 years at the beginning of the measurement period with clinical ASCVD diagnosis
- Patients aged ≥ 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia
- Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

Denominator Exclusions:
Patients who have a diagnosis of pregnancy
Patients who are breastfeeding
Patients who have a diagnosis of rhabdomyolysis
Denominator Exceptions:
Patients with adverse effect, allergy, or intolerance to statin medication
Patients with active liver disease or hepatic disease or insufficiency
Patients with end-stage renal disease (ESRD)
Patients with diabetes who have the most recent fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy (risk category 3 only)

Numerator:
Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period

Documentation Required:

- For Risk Category #1 only: An active diagnosis or history of clinical atherosclerotic cardiovascular disease (ASCVD).
    - ***Example:*** A problem list dated March 17, 2019 indicating that the patient has unstable angina.

  or

- For Risk Category #2 only: The date and value of a fasting or direct low-density lipoprotein cholesterol (LDL-C) level *greater than or equal to* 190 mg/dL (any time in the patient's history—but prior to the end of the measurement period) OR documentation of a history of or active diagnosis of familial or pure hypercholesterolemia.
    - ***Example:*** A problem list dated March 17, 2019 indicating the patient has a history of familial hypercholesterolemia.

  or

- For Risk Category #3 only: Adults aged 40-75 years with a documented diagnosis of diabetes and the date and value of a fasting or direct LDL-C level of 70-189 mg/dL (during the measurement period or two years prior to the beginning of the measurement period).
    - ***Example:*** A problem list dated March 17, 2019 indicating the patient has diabetes and a laboratory report dated September 3, 2018 indicating an LCL-C value of 152.

And for the corresponding risk category, documentation of:

- An active prescription for statin therapy anytime during the measurement period.
    - ***Example:*** Medication list dated June 16, 2019 indicating the patient is taking atorvastatin 20 mg.

  or

- Documentation of the reason why the Quality Action is not performed due to an exception.
    - ***Example:*** An office visit note dated April 1, 2019 indicating the patient has an allergy to statin medications.

  or

- Documentation of exclusion criteria.
    - ***Example:*** A problem list dated March 9, 2019 indicating the patient has a diagnosis of rhabdomyolysis.