

# **ONCOLOGY CARE MODEL**

## **OCM Data Registry**

### **User Manual**

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 **SECTION  
508**





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# 1. Introduction

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The Oncology Care Model (OCM) is a payment model designed to test the effect of better care coordination, improved access to practitioners, and appropriate clinical care on health outcomes and costs of care for Medicare fee-for-service (FFS) patients with cancer who receive chemotherapy. OCM encourages participating practices (OCM Participants) to improve care and lower costs through episode-based payments that financially incentivize high-quality, coordinated care. CMS expects that when OCM Participants make these changes, it will result in better care, smarter spending, and healthier people.

The OCM Data Registry (OCMR) is a web-based tool used to collect clinical and quality data from OCM Participants. Data includes staging information and quality measures that span several domains of patient care. This user manual is a resource to support practices in utilizing the Data Registry.

This user manual provides OCM Participants with the information described below:

- Details around the reporting and submission periods are included in Section 2. This section provides a table of reporting requirements and submission deadlines, for user convenience.
- Section 3 provides guidance on how to access the Data Registry. This section specifically walks through:
  - Registering for an EIDM Account
  - Requesting Access to the CMS Innovation Center
  - Requesting Access to the Data Registry
  - User Roles
  - Logging In
- Section 4 specifically provides guidance on how to navigate the Data Registry. The section is divided into several subsections which include:
  - Data Registry Overview: includes a summary of the different tabs in the Data Registry.
  - Data Registry Functionality: this section walks through the steps to use the Data Registry, including:
    - Viewing patients in the Staging tab: Patient Grid and Patient List Export.
    - Reporting Staging and Clinical Data: This includes updating patients from HICN to MBI, updating Staging and Clinical Data to current clinical reporting requirements, and detailed step-by-step instruction on manual data entry and file upload.
    - Resolving duplicate patient records: This includes the steps to identify the duplicate record for the patient to be kept for future reporting, with the other duplicate record(s) for the patient being deleted.
    - Reporting Aggregate Measure Results.
    - Instructions on using the Submission Tab, Completeness File, and OCM Lab.
- Section 5 provides an overview of error and warning messages functionality.



- Section 6 provides answers to frequently asked questions and is divided into the following:
  - Data Registry Access (Section 6)
  - Data Upload and Submission (Section 6.2)
  - MBI Transition (Section 6.3)



## 2. Overview

Episodes of chemotherapy care are organized by performance periods, which are six-month periods of time during which a group of episodes terminate. Table 1 shows the frequency of reporting, deadlines for submission dates, and the data that must be submitted for the submission deadlines.

OCM aggregate quality measure results are reported semiannually for six-month measurement periods (January – June and July – December each year). Aggregate quality measure results are required to be reported and submitted to the OCM Data Registry no later than three months after the end of each measurement period. The aggregate measure submission deadlines for each measurement period are March 31<sup>st</sup> for the July – December measurement periods and September 30<sup>th</sup> for the January – June measurement periods.

Staging and clinical data for attributed beneficiaries for each performance period is required to be reported to the OCM Data Registry within 30 days of the attributed beneficiary data being available in the Registry.

For more information on the reporting requirements for each reporting period, see the OCM Clinical Data and Quality Measures Guide and the OCM Quality Measure Aggregate Reporting Criteria.

**Table 1: Registry Reporting Requirements**

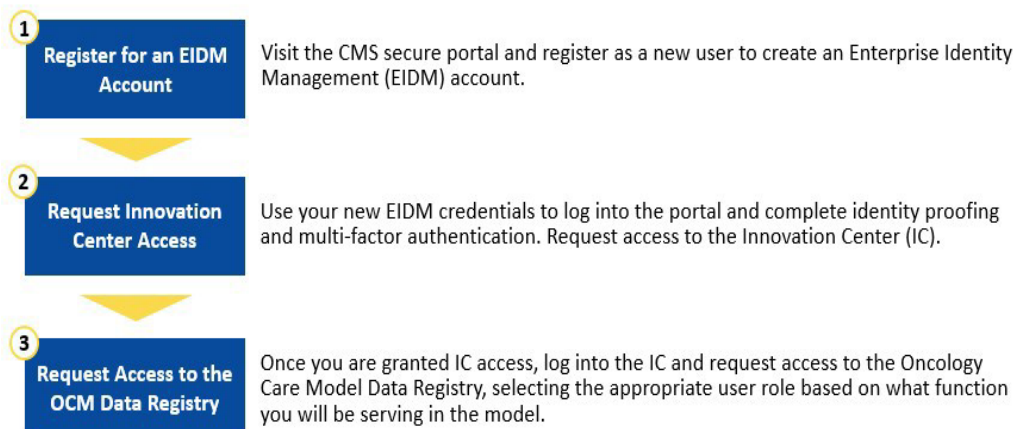
<b>Frequency of reporting:</b>	Semiannual
<b>Deadline for aggregate measure results submission:</b>	Within 3 months after the end of each measurement period
<b>Deadline for staging and clinical data submission:</b>	Within 30 days of attribution data being available in the OCM Data Registry



## 3. Accessing the Data Registry

Accessing the Data Registry is a multistep process (Figure 1). For detailed instructions on requesting access for first time users, review the Data Registry Quick Reference Guide, Data Registry Access FAQ, and the OCM Data Registry Guide to Accessing the Registry and Selecting User Roles (all available on OCM Connect)

Figure 1: Steps to Access the Registry



### 3.1 Registering for an EIDM Account

CMS uses one set of accounts, security features, and webpages to serve many applications, including the Data Registry, called the CMS Enterprise Identity Management (EIDM) system. If you already have an EIDM account for other CMS applications, you can use it for the purposes of OCM as well.

If you don't already have a CMS EIDM account, create a new account in the CMS Secure Portal.

- Link to [CMS Secure Portal](#)
- Refer to the “OCM Data Registry Access Quick Reference Guide” available on OCM Connect for detailed instructions.

**Note:** When registering for an EIDM account users are not able to use a public domain email address, such as Gmail, as it is not supported by OCM. Users must provide a business account.

#### 3.1.1 Requesting Access to the CMS Innovation Center

Use your EIDM credentials to login to the CMS Secure Portal and request access to the Innovation Center (IC). To access the Data Registry, the user must request the IC Privileged User Role. This step includes remote identity proofing and multi-factor authentication (MFA).

#### 3.1.2 Requesting Access to the Data Registry and User Roles



After gaining access to the IC, the user must log in and request access to the specific application (Oncology Care Model), selecting the appropriate user role based on what function the user will serve in the model. A summary of the permissions in the Data Registry allotted to the Data Registry Point of Contact (POC) and Practice Administrator roles can be found below (Figure 2).



Generally, it is expected that:

- The Data Registry POC role will have the same user permissions as individuals with the Practice Administrator Role **and will also have the responsibility to approve access for other users at the practice.** Individuals who expect to manage data for multiple providers and access practice-wide data will serve in the Practice Administrator role. Requests for this role are approved by the Data Registry POC.
- For users who wish to access multiple practices, the user must have the same role at each practice. For example, if a user wants to access two practices then they either need to be a POC at both or a Practice Administrator at both.

Figure 2: Data Registry User Roles

OCM Data Registry User Roles	Data Registry POC	Practice Administrator
Which Team Members should have these User Roles?	 OCM Point of Contact	 Administrative Staff and Practice POCs
Approve access for other users at the practice	✓	
Report staging and clinical data through manual entry or file upload	✓	✓
Modify or delete staging and clinical data before it is submitted	✓	✓
Report aggregate measure results	✓	✓
Submit aggregate measure results and staging and clinical data to CMS	✓	✓

Users who need to change from a Practice Administrator role to a Data Registry POC role, or from a Data Registry POC role to a Practice Administrator role, must first remove their current role and then request the new role in the OCM Data Registry. Users are not permitted to have more than one user role at a time. Once the current role is removed and the new role is requested, the user must contact their Registry POC for approval.

**Note:** users may experience a gap in OCM Data Registry user access during this switch since approvals are completed manually.

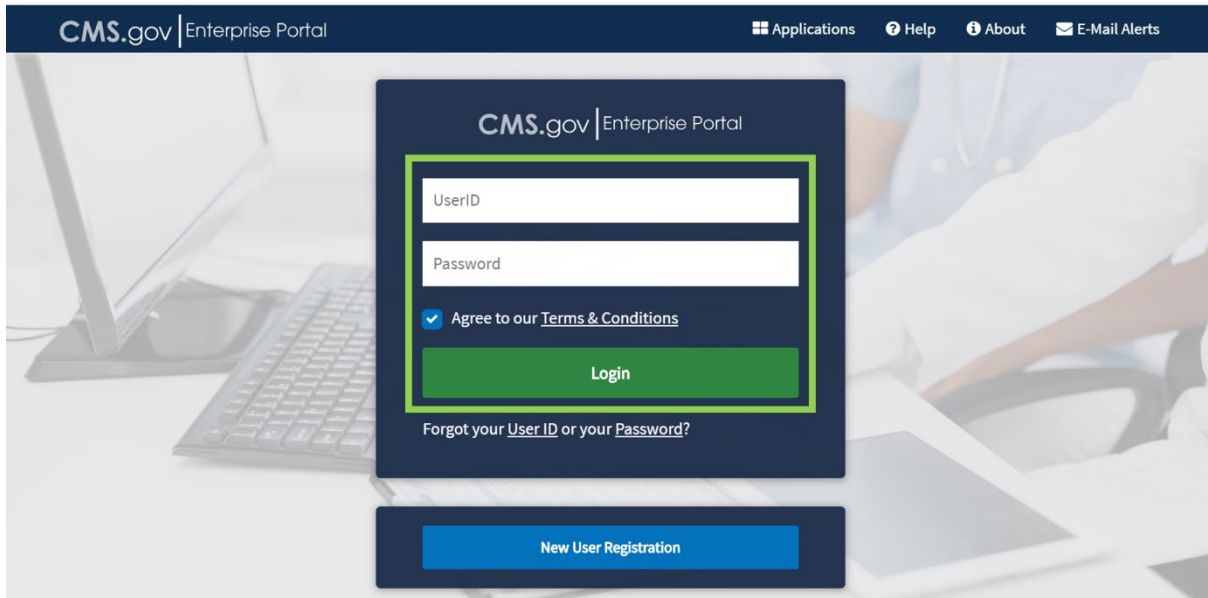


### 3.1.2.1 Logging In

Step 1: Enter the CMS website to access the CMS Secure Portal.

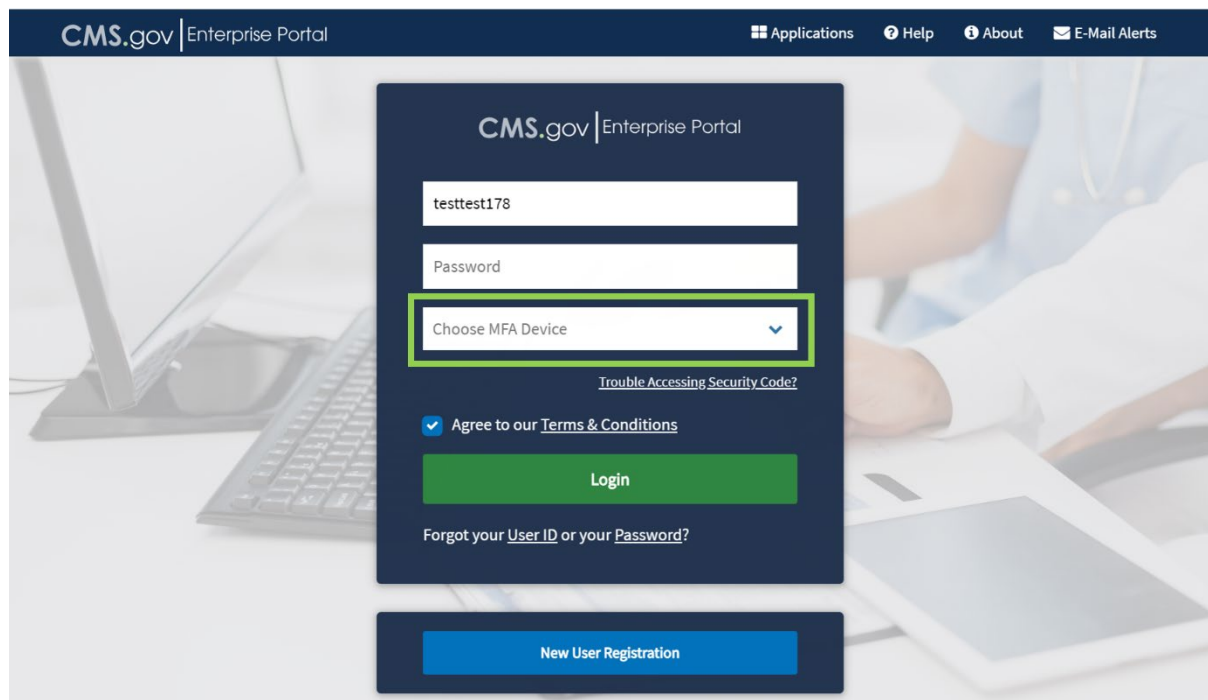
Step 2: Provide credentials, agree to the Terms & Conditions, and select 'Login' (Figure 3). If User ID/Password has been forgotten or new registration needs to occur, select either 'Forgot User ID/Password' or 'New User Registration.'

Figure 3: Login to CMS Secure Portal



Step 3: If MFA is configured on your profile, upon entering a username that is configured with MFA, an additional 'Choose MFA Device' field drop-down is displayed (Figure 4). If MFA is not configured on your profile, you will be taken directly to your My Portal page.

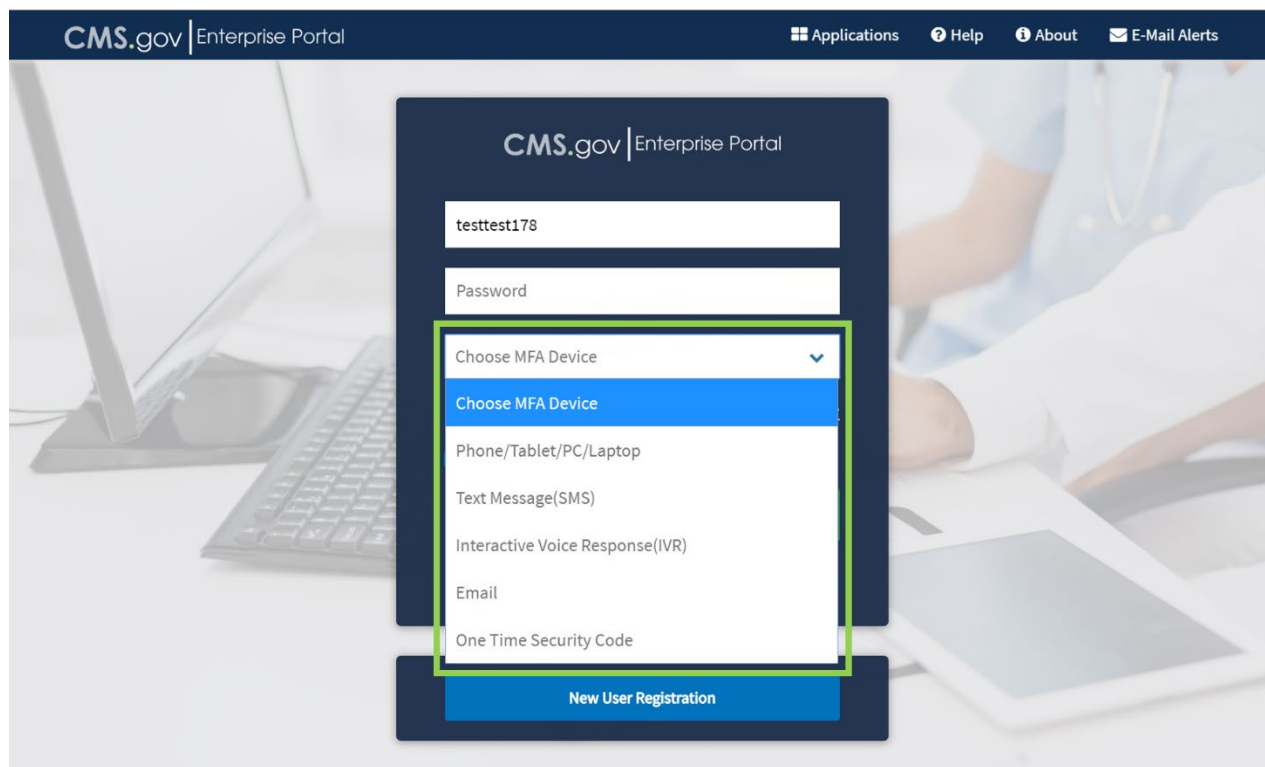
Figure 4: Choose MFA Device





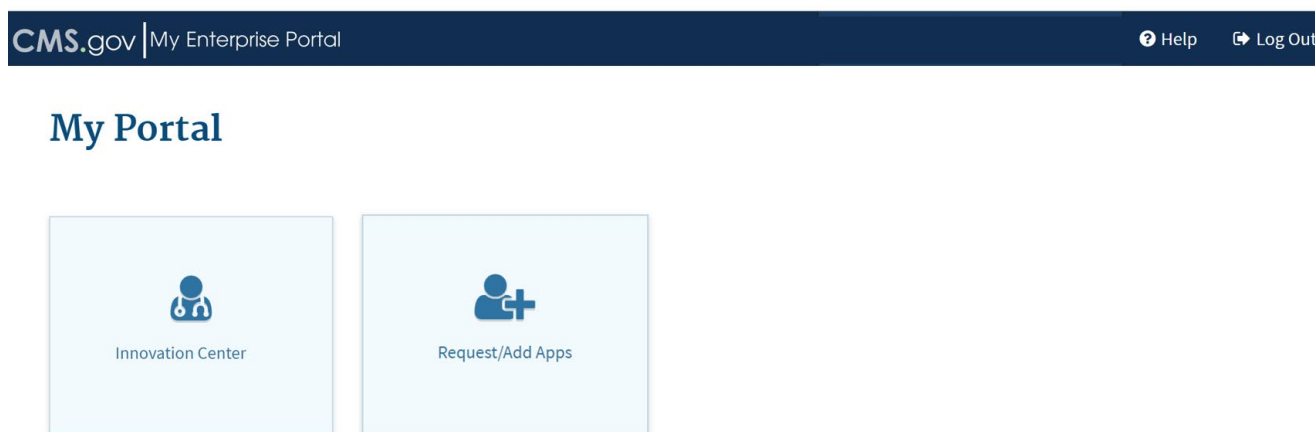
Step 4: Select your MFA Device, enter the security code, and select 'Login'. Depending on your selection, additional fields are displayed (Figure 5). Please refer to the Enterprise Portal User Manual for further information on MFA log-in.

Figure 5: MFA Device Options



Step 5: Upon log-in, users are directed to the My Portal page (Figure 6).

Figure 6: My Portal Page

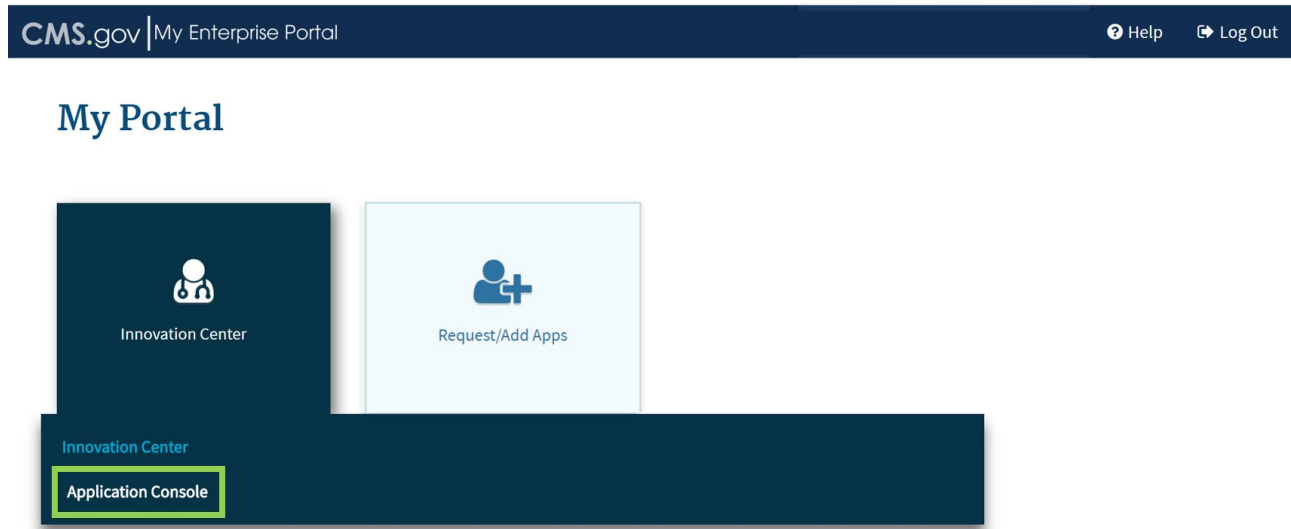


Step 6: On the My Portal page (Figure 7), hover over 'Innovation Center' and select 'Application Console' to launch the application. If you do not see the Innovation Center



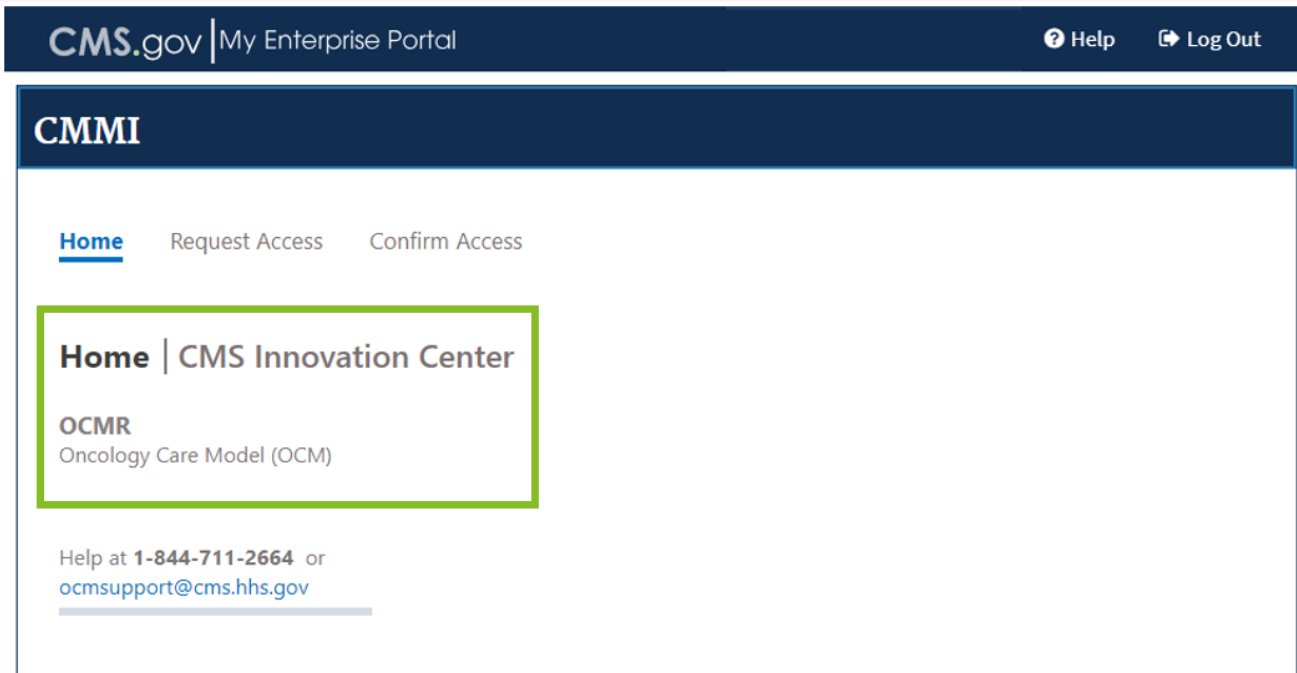
Application, you must request access by selecting 'Request/Add Apps'. For more information, see the Data Registry Access Quick Reference Guide available on OCM Connect.

Figure 7: My Portal Page - Application Console



Step 7: Users will be taken to the CMMI Application Selector table. Select 'OCMR Oncology Care Model (OCM)' tile to launch the application (Figure 8). If you do not see the OCM Application, you must request access under the 'Request Access' tab.

Figure 8: CMMI Application Selector





## 4. Navigating the Data Registry

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The Data Registry consists of the following six tabs:

1. Home – provides a welcome message and overview of OCM Data Registry Reporting Requirements.
2. Measures –primary location for aggregate measure result entry.
3. Staging – primary location for staging and clinical data entry and viewing historical patient attribution.
4. Submission –houses the ability to view pending submission periods, submit aggregate measure results, submit staging and clinical data, access the Completeness File and view submission history.
5. FAQ – provides users with responses to frequently asked questions to learn more about OCM or understand Data Registry functionality.
6. Support – location where users can send a message to the OCM Support Team, view quick links, and obtain information regarding system requirements.

All six tabs are essential to the Data Registry and this user manual will detail each of these tabs and its key functionalities.



## 4.1 Data Registry Overview

Users can navigate through the Data Registry by selecting through a series of tabs. Users can view all six tabs – Home, Measures, Staging, Submission, FAQ, and Support.

### 4.1.1 Home Tab

The Home tab provides users with a welcome message and an overview of the reporting requirements of the OCM Data Registry (Figure 9). Users may come here to be reminded of the upcoming submission deadline dates and the information that needs to be reported for each deadline.

The language on this screen will be updated over time with announcements and other helpful information.

Figure 9: Home Tab Screen



WELCOME TO THE  
**Oncology Care Model Registry**

- 1 Add staging and clinical data for your patients
- 2 Submit your staging and clinical data to CMS
- 3 Enter your aggregate measure results
- 4 Submit your aggregate measure results to CMS

Welcome to the OCM Data Registry!

Updated Reporting Requirements

Thank you for your participation in OCM. Please continue to reach out to OCM Support at [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov) for any questions regarding the OCM Data Registry, including updated reporting requirements and timelines listed below.

**Summary of New OCM Data Registry Reporting Requirements**

OCM Data Registry Aggregate Measure Reporting Requirements*	
Frequency of reporting	Semianual
Deadline for submission	3 months after measurement period ends
What must be submitted for the next aggregate measure reporting deadline*	7/1/2020 – 12/31/2020 Measure Results (Due March 31, 2021) <ul style="list-style-type: none"> <li>Aggregate quality measure result reporting:               <ul style="list-style-type: none"> <li>OCM FFS Beneficiary measures: OCM-4a, OCM-4b, OCM-5</li> </ul> </li> </ul>
What must be submitted for the subsequent aggregate measure reporting deadline*	1/1/2021 – 6/30/2021 Measure Results (Due September 30, 2021)

**Learn about the OCM**

For questions about the model, please visit our website or email us.

[Visit our website](#)

[CONTACT US](#)

**Technical Support**

For technical questions and support related to entering data, please email us.

[CONTACT US](#)



## 4.1.2 Measures Tab

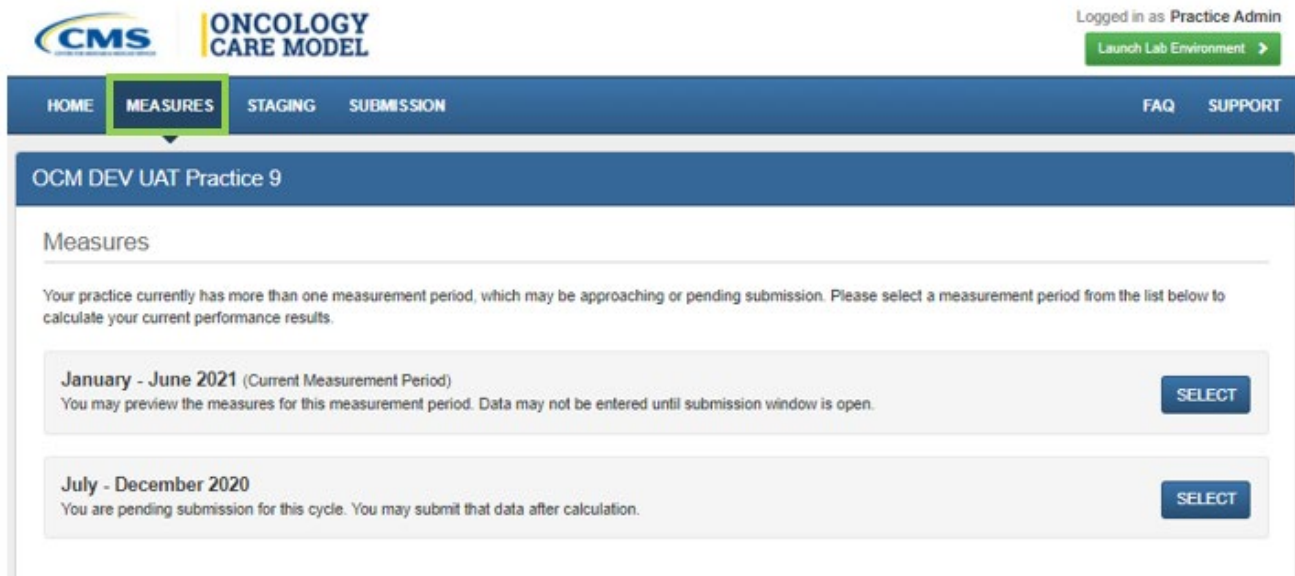
The Measures tab is the primary location where users will enter aggregate measure results. The home screen of the Measures tab allows users to report on aggregate measure results. If there is only one approaching or current measurement period users will be taken to that measurement period (Figure 10). If there is more than one approaching or current measurement period users will be able to select the measurement period to report on aggregate measure results (Figure 11). After saving the aggregate measure results, the performance rate is calculated. More information about the Measures tab is provided in the 'Steps to User the Data Registry' section.

Figure 10: Measures Tab Screen with One Measurement Period

The screenshot displays the 'Measures' tab interface. At the top, the CMS Oncology Care Model logo is visible, along with a 'Logged in as Practice Admin' status and a 'Launch Lab Environment' button. The navigation bar includes 'HOME', 'MEASURES' (highlighted), 'STAGING', 'SUBMISSION', 'FAQ', and 'SUPPORT'. Below the navigation bar, the page title is 'OCM DEV UAT Practice 9'. The main heading is 'Measures Results for January - June 2021'. A 'MEASUREMENT PERIOD' section shows a timeline of months from JUL to DEC. The 'CURRENT PERIOD (Jan - June 2021)' is highlighted in yellow, with 'JAN', 'FEB', and 'MAR' also highlighted. 'PREVIOUS PERIOD (July - Dec 2020)' and 'NEXT PERIOD (July - Dec 2021)' are shown in blue. Below the timeline, there is a section titled 'OCM Quality Measure Calculations and Definitions' which explains the calculation hierarchy for OCM Quality Measure aggregate totals. It defines the Denominator, Denominator Exclusions, Numerator, and Denominator Exceptions. A yellow box contains a note about the submission window: 'The OCM Quality Measures are listed here for your preview only. You may enter the OCM Quality Measure Aggregate totals once the submission window opens. The submission window is between July 1, 2021 and September 30, 2021.' Below this, there is a section for 'OCM FFS Beneficiary Measures (OCM-4a, OCM-4b, OCM-5)' with instructions to provide patient or encounter counts. A dropdown menu shows 'OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified'. At the bottom, there are input fields for 'Measurement Period' (set to 'January - June 2021') and 'Denominator Question' (marked with a red asterisk, asking 'How many patient encounters for OCM FFS Beneficiaries in your practice met all the criteria in one of the two following online?').



Figure 11: Measures Tab Screen with Two Measurement Periods



### 4.1.3 Staging Tab

The Staging tab is the primary location where users will enter staging and clinical data (Figure 12).

During an open performance period, the first and default sub-tab will display for that period, e.g., PP8 Attribution, allowing users to view only the patients that are attributed for that performance period.

The 'All Patients in Registry' sub-tab allows users to view data for all patients in the Data Registry, including those that have never been attributed to a performance period. This sub-tab is the default tab if there are no open performance periods. More information about the patient grid is provided in the 'Steps to Use the Data Registry' section.



Figure 12: Staging Tab Screen

ONCOLOGY

CARE MODEL

Logged in as: Practice Admin

Launch Lab Environment >

HOMEMEASURESTAGINGSUBMISSION

FAQSUPPORT

OCM DEV UAT Practice 9

Staging

Manually Enter Patient Data

Add individual patient data using web-based forms.

ADD NEW PATIENT

Upload Your Own File

Add your practice data online using a spreadsheet, such as a CSV or Excel file.

UPLOAD SPREADSHEET

Attention! There are duplicate patient records reported in the registry for your practice. Click Here to view and address the duplicate patient records.

View Previous Uploads

Perform Bulk Actions

PP8 Attribution

18 of 81 need attention

All Patients in Registry

997 patients

PP8 Attribution

This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients

Search by patient identifier or name

Export Reports

MBVHCN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/16/2021	02/19/2021	
583977HR127	NRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR126	KRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR124	ALK Gene Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR119	Tumor Type	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR118	Revised ISS Stage	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR104	Resection	DataElement3	06/01/1975	02/16/2021	02/16/2021	

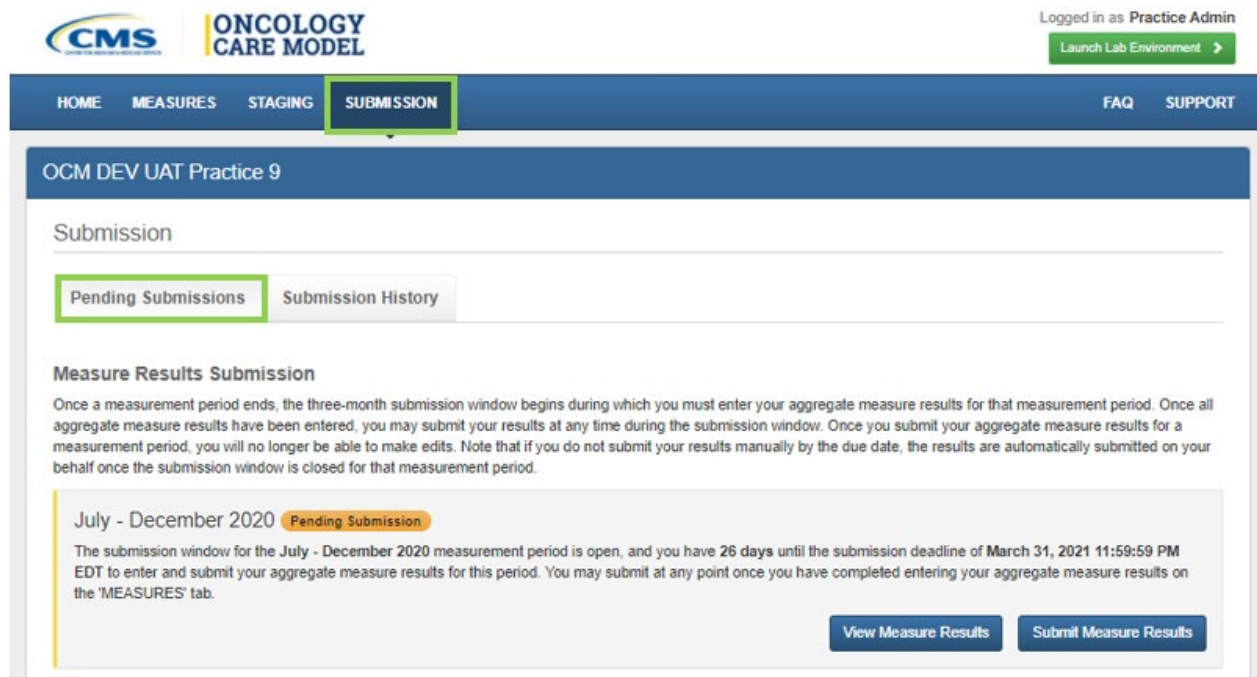


### 4.1.4 Submission Tab

The Submission tab is the primary place where users will view pending submission periods, submit aggregate measure results, submit staging and clinical data, and view submission history.

Under 'Pending Submissions' (Figure 13) users can review and submit aggregate measure results for pending measurement periods, as well as review patient registry statistics and submit staging and clinical data for open performance periods.

Figure 13: Submission Tab Screen – Pending Submissions

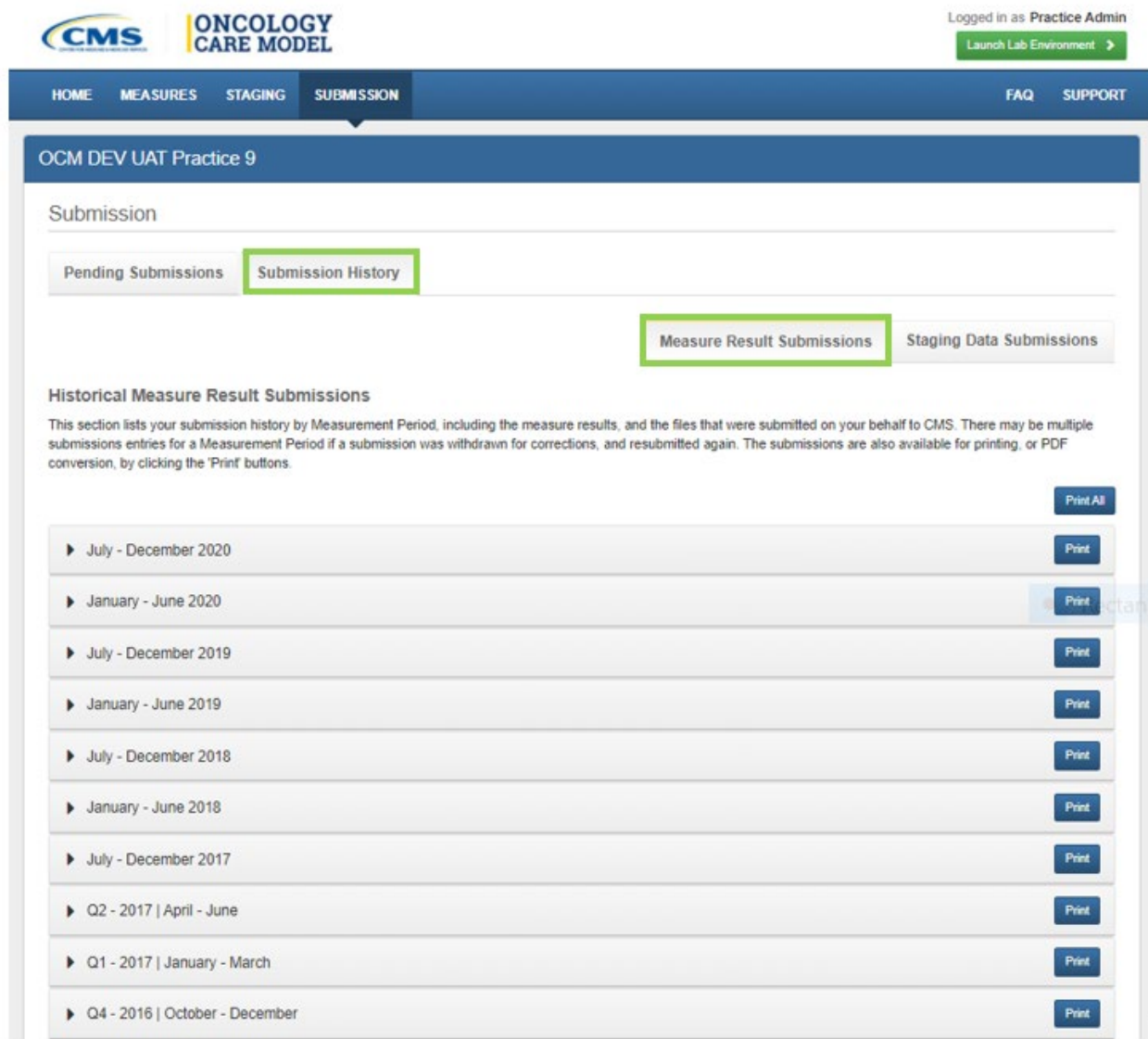




Under 'Submission History' users can view Measure Result Submissions and Staging Data Submissions.

- The Measure Result Submissions sub-tab (Figure 14) provides access to historical measure result submissions by measurement period, including the measures results and files that were submitted to CMS.
  - MeasureResultsFile.csv – contains the measure results reported for the measurement period.

Figure 14: Submission Tab Screen – Submission History Measure Result Submissions



- The Staging Data Submissions sub-tab (Figure 15) provides access to historical staging data submissions by performance period, including patient registry statistics for PP3 and future performance periods, and files that were submitted to CMS.
  - PatientFile.csv - contains the patients included in the data at the time the Performance Period was submitted.
  - PP#StagingDataSubmittedExport\_YYYY\_MM\_DD\_HH\_MM\_SS\_ET.csv - contains the staging and clinical data which was submitted to CMS. This report will include all patients in the Data Registry at the time the



performance period was submitted, not just the patients attributed for that performance period.

- StagingCompletenessFile.csv – contains the list of patients attributed for the Performance Period and indicates if each patient had complete patient and staging and clinical data at the time the PP was submitted.

Figure 15: Submission Tab Screen – Submission History Staging Data Submissions

The screenshot displays the 'Submission' tab in the OCM Data Registry. The navigation bar at the top includes 'HOME', 'MEASURES', 'STAGING', and 'SUBMISSION' (which is highlighted). Below the navigation bar, there is a 'Submission' section with two tabs: 'Pending Submissions' and 'Submission History' (which is selected). To the right of these tabs are two buttons: 'Measure Result Submissions' and 'Staging Data Submissions' (which is highlighted). Below the 'Staging Data Submissions' button, there is a section titled 'Historical Staging Data Submissions'. This section contains a list of performance periods (PP1 to PP8) and a 'Print All' button. Each performance period entry has a 'Print' button next to it.

Performance Period	Action
PP8	Print
PP6	Print
PP5	Print
PP4	Print
PP3	Print
PP2	Print
PP1	Print



### 4.1.5 FAQ Tab

The FAQ tab provides answers to questions that users have about the Data Registry (Figure 16).

Figure 16 FAQ Tab Screen



### 4.1.6 Support Tab

The Support tab provides an additional layer of assistance (Figure 17). This is the location where users can go if their questions have not been answered in the FAQ tab. Users can submit a message to the OCM Support team as well as view links that can point them to additional information about the Data Registry and OCM.



Figure 17: Support Tab Screen

My Apps

Logged in as Practice Admin  
Launch Lab Environment >

HOME MEASURES STAGING SUBMISSION FAQ **SUPPORT**

### Support

The Oncology Care Model Support page is your starting point for help with your questions including accessing patient data, performing manual data entry, data uploads, measure information, and reports.

#### Send a Message

Have a question about the OCM Registry? Please take a moment to enter the required fields below. A member of our team will respond to you as soon as possible. Please provide us with as much detail as possible so that our staff can better assist you.

CORMACFOURTEEN OCMVALID-ONE

Practice Name

ocm\_cormac@mailinator.com

Additional Email

2766180446

Subject

Comments / Questions (Do not enter PHI or any other sensitive information)

SEND MESSAGE

#### Quick Links

- Frequently Asked Questions
- Oncology Care Model Website

#### Website Viewing Requirements

The Oncology Care Model (OCM) Registry was designed to provide maximum accessibility and support most types of machines and browsers. The latest version of any of the following browsers are recommended:

- Mozilla Firefox
- Internet Explorer 11+
- Google Chrome
- Safari

If the OCM Registry is not displaying properly, we recommend updating your browser to its latest version for optimal viewing and improved security. Please contact us via the support form on the left with any questions or concerns about the OCM Registry.

## 4.2 Data Registry Functionality

The Data Registry has several key functionalities that can be grouped into viewing data, reporting data, updating data, and submitting data.

### 4.2.1 Steps to Use the Data Registry – Staging Tab

The Staging tab provides access to saved patient staging and clinical data, as well as information regarding the patient's attribution status by performance period and attributed cancer bundles. The Staging tab is broken down into one or more sub-tabs: a sub-tab for the current open performance period (e.g., PP8 Attribution) and 'All Patients in Registry' sub-tab.

The patient grid on each of the sub-tabs allows users to sort and filter on numerous fields, and includes icons indicating actions that must be taken for patient data. We will review the functionality of the sub-tabs in depth in the following section.



### 4.2.1.1 Current Open Performance Period Attribution Sub-Tab

The current open performance period Attribution sub-tab (e.g., PP8 Attribution) shows all patients that are attributed to the currently open performance period. This is the default sub-tab when the Staging tab is selected. The sub-tab will not display until the attribution data is loaded by CMS for a performance period, and this sub-tab will disappear once the performance period is submitted.

The performance period Attribution sub-tab will show 'X of X need attention' to indicate the number of patients that need attention and will be highlighted in yellow (Figure 18). 'Need attention' includes patients with incomplete patient data and/or incomplete staging data, which include patients flagged as 'NEW'. If at least one diagnosis code/date combination that is reported for the attributed cancer bundle for the performance period is complete, the patient will not be included in the 'need attention' count, even if there is another diagnosis code/date combination in that attributed cancer bundle for the PP that is incomplete.

Figure 18: Current Open Performance Period Attribution Sub-Tab

The screenshot displays the Oncology Care Model Data Registry interface. At the top, there is a navigation bar with tabs: HOME, MEASURES, STAGING (selected), and SUBMISSION. To the right of the navigation bar, it says "Logged in as Practice Admin" and "Launch Lab Environment". Below the navigation bar, there is a header for "OCM DEV UAT Practice 9". The main content area is titled "Staging" and contains two main sections: "Manually Enter Patient Data" with an "ADD NEW PATIENT" button, and "Upload Your Own File" with an "UPLOAD SPREADSHEET" button. Below these sections, there is a yellow alert box stating: "Attention! There are duplicate patient records reported in the registry for your practice. Click Here to view and address the duplicate patient records." To the right of the alert box, there are links for "View Previous Uploads" and "Perform Bulk Actions". Below the alert box, there are two tabs: "PP8 Attribution" (selected) and "All Patients in Registry". The "PP8 Attribution" tab shows "18 of 81 need attention". Below the tabs, there is a section titled "PP8 Attribution" with a description: "This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period." Below the description, there is a search bar with the text "All Incomplete Patients" and a search button. To the right of the search bar, there is a link for "Export Reports". Below the search bar, there is a table with the following columns: MB/HICN (F), First Name, Last Name, Date Of Birth, Last Submitted (F), Last Updated (F), and Actions. The table contains six rows of patient data.

MB/HICN (F)	First Name	Last Name	Date Of Birth	Last Submitted (F)	Last Updated (F)	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/16/2021	02/19/2021	[Settings]
583977HR127	NRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	[Settings]
583977HR126	KRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	[Settings]
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	[Settings]
583977HR124	ALK Gene Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	[Settings]
583977HR119	Tumor Type	DataElement4	07/01/1978	02/16/2021	02/16/2021	[Settings]

### 4.2.1.2 All Patients in Registry Sub-Tab

The 'All Patients in Registry' sub-tab (Figure 19) shows all patients that have been added to the Data Registry and includes patients that have been attributed or not attributed to previous performance periods, as well as patients that are pending attribution or that have



Invalid HICN/Invalid MBI. This is the default sub-tab that displays if there are no current open performance periods.

**Figure 19: All Patients in Registry Sub-Tab**

**All Patients in Registry**  
 997 patients

**All Registry Patients**

Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have Invalid HICN/Invalid MBI.

All Incomplete Patients
Search by patient identifier or name
Q
x
Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
583977HR129	Prognostic...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
8XX4P11XX07				Not Attributed PP8	02/16/2021	02/16/2021	
2315509138	FN_42	LN_42	04/04/1980	Not Attributed PP8	02/16/2021	02/16/2021	
583977HR127	NRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR126	KRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR125	ROS1 Gene Mutat...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR124	ALK Gene Mutati...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR119	Tumor Type	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR118	Revised ISS Sta...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR104	Resection	DataElement3	06/01/1975	Attributed PP8	02/16/2021	02/16/2021	

Showing 1 - 10 of 656 Listings Per Page: 5 10 25 50 1 2 3 4 5 Next Last

#### 4.2.1.3 Patient Grid Icons and Alerts

The icons, which are displayed in the Legend below the patient grid on each of the sub-tabs, alert users to actions that must be taken for patient data (Figure 20).



Figure 20: Patient Grid Legend

PP8 Attribution  
18 of 81 need attention

All Patients in Registry  
997 patients

**All Registry Patients**

Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have Invalid HICN/Invalid MBI.

All Incomplete Patients Search by patient identifier or name

MBI/HICN	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
583977HR129	Prognostic...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/19/2021	
8XX4P11XX07				Not Attributed PP8	02/16/2021	02/18/2021	
231550913B	FN_42	LN_42	04/04/1980	Not Attributed PP8	02/16/2021	02/18/2021	
583977HR127	NRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR126	KRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR125	ROS1 Gene Mutat...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR124	ALK Gene Mutati...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR119	Tumor Type	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR118	Revised ISS Sta...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR104	Resection	DataElement3	06/01/1975	Attributed PP8	02/16/2021	02/16/2021	

Showing 1 - 10 of 656 Listings Per Page: 5 10 25 50 1 2 3 4 5 Next Last

**Legend:**

- Incomplete Patient Data indicates that fields are missing that are required for the patient including MBI or HICN, First Name, Last Name, Gender, and Date of Birth.
- Incomplete Staging Data indicates that all the staging elements have not been provided. Some staging elements may be required depending on the diagnosis.
- Add Cancer Diagnosis indicates that the patient is attributed to a cancer bundle that was not reported. Please edit the patient's staging information to add the attributed cancer bundle's diagnosis and staging information.
- Invalid Patient Identifier indicates that the patient could not be found in the claims data. Please verify the HICN or MBI for the patient by selecting "Edit Patient" in the "Actions" dropdown.
- Duplicate Patient indicates that the patient has been identified on the Duplicate Records Patient List. Please navigate to the Duplicate Records Patient List Page to view and address the duplicate patient records for your practice.
- Newly Added With Attribution indicates that the patient was found to be attributed to your practice, but was not reported on. Please complete the staging data for the attributed patient with the "New" label.

### Legend:

#### Incomplete Patient Data Icon

This indicates the patient record is missing data for required fields, including MBI or HICN, First Name, Last Name, Gender, and Date of Birth.

#### Incomplete Staging Data Icon

This indicates the staging information is not complete for the cancer bundle reported. The required staging and clinical data elements are based on the reported ICD-10 diagnosis code and the cancer bundle it is associated with.

On the **'All Patients in Registry'** tab – This icon will display for the patient if any reported cancer bundle does not have at least one cancer diagnosis code/initial diagnosis date with complete staging and clinical data, regardless of if the cancer bundle is attributed or not. This icon will also display on the Staging Information tab for each cancer diagnosis that does not have complete staging and clinical data reported.

On the **'PP# Attribution'** tab (e.g. PP8 Attribution) – This icon will display if the attributed cancer bundle for the performance period does not have at least one cancer diagnosis/initial diagnosis date reported with complete staging and clinical data. Practices must complete staging and clinical data for at least one reported cancer diagnoses/initial diagnosis date that are within the cancer bundle identified as attributed



for the respective performance period. If a patient has multiple cancer diagnoses reported for the attributed cancer bundle, and at least one cancer diagnosis/initial diagnosis date associated with the attributed cancer bundle has complete data, this icon will not display for the patient and the patient will be counted toward meeting the minimum reporting requirement. If a practice has completed staging and clinical data on a patient for a cancer diagnosis that is not associated with the cancer bundle attributed to the performance period associated with this tab, the patient will not be counted toward meeting the minimum reporting requirement. This icon will also display on the Staging Information tab for each cancer diagnosis that does not have complete staging and clinical data reported.

#### Add Cancer Diagnosis Icon

This indicates that the patient is attributed to a cancer bundle that was not reported previously and needs to be added to have all required staging data elements completed. Please edit the patient's staging information to add the attributed cancer bundle's diagnosis and staging information.

#### Invalid Patient Identifier Icon

This indicates that the patient could not be found in the claims data when attribution data was loaded and needs to be verified. Practices should verify the HICN or MBI for the patient. Patients with the Invalid Patient Identifier icon will only be visible via the 'All Patients in Registry' tab.

If the practice has a patient with the Invalid Patient Identifier icon, the practice needs to identify if the same patient exists in the OCM Data Registry under the correct HICN/MBI (either entered by the practice or added via attribution with the correct HICN/MBI).

If the patient was added to the Data Registry with the correct HICN/MBI through the attribution data load, the patient will have a 'New' icon, and all attribution information will be associated with this record. Practices should enter the staging data under the patient record with the correct HICN/MBI and delete the record with the invalid HICN/MBI. Staging and clinical data may be added to the correct HICN/MBI by manual entry or by upload.

If the patient does not already exist in the Data Registry with the correct HICN/MBI, practices should correct the invalid HICN/MBI reported for this patient.



#### Duplicate Patient Icon

This indicates that the patient has been identified on the Duplicate Records Patient List. Please navigate to the Duplicate Records Patient List Page to view and address the duplicate patient records for your practice.



#### Newly Added With Attribution Icon

This indicates that the patient was found to be attributed to the practice but was not reported on. Please complete the staging information for this patient.

### 4.2.1.4 Patient Grid Filtering and Searching on the Staging Sub-Tabs

At the top of the patient grid on each of the Staging sub-tabs, users are able to filter data through various selections in the drop-down (Figure 21).



**Note:** The filtering of 'All Incomplete Patients' or 'Incomplete Staging Data' on the current open performance period sub-tab, or the 'All Patients in Registry' sub-tab will not display patients with only optional data fields missing.

The available filter options on the current open performance period attribution sub-tab (e.g., PP8 Attribution) include:

- All Patients – selecting this filter will display all patients attributed to the performance period.
- All Incomplete Patients – selecting this filter will display all patients with any incomplete patient demographic information and/or staging and clinical data. This is the default filter on this sub-tab. The number of the patients returned with this filter applied will match the number of patients indicated as needing attention as shown below the tab name.
- Incomplete Patient Information – selecting this filter will display all patients with incomplete patient demographic information.
- Incomplete Staging Data – selecting this filter will display all patients with staging and clinical data that is incomplete for the cancer bundle that is attributed for the performance period, including patients with the “Add Cancer Diagnosis” icon. If one cancer diagnosis code/initial diagnosis date combination in the attributed cancer bundle is complete, the patient will not be included in this filter even if additional reported cancer diagnoses in the attributed cancer bundle are incomplete.
- “New” Patients – selecting this filter will display all patients newly added through the attribution process for the performance period.

Figure 21: Performance Period Attribution Sub-Tab Filters

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

Search by patient identifier or name

Export Reports

	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
1	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	Revised ISS Stage	DataElement4	07/01/1976	02/16/2021	02/16/2021	
1	Resection	DataElement3	08/01/1975	02/16/2021	02/16/2021	
1	Tumor Grade	DataElement3	08/01/1975	02/16/2021	02/16/2021	
1	Tumor Type	DataElement3	08/01/1975	02/16/2021	02/16/2021	

Showing 1 - 10 of 18

Listings Per Page: 5 10 25 50

1 2 Next Last

The available filter options on the 'All Patients in Registry' tab include:

- All Patients – selecting this filter will display all patients in the Data Registry (Figure 22).



- All Incomplete Patients – selecting this filter will return all patients with any incomplete patient demographic information and/or staging and clinical data. This is the default filter on this sub-tab.
- Incomplete Patient Information – selecting this filter will display all patients with incomplete patient demographic information.
- Incomplete Staging Data – selecting this filter will display patients that have any reported cancer bundle with incomplete staging and clinical data for all reported cancer diagnosis code/initial diagnosis dates. Note that if at least one cancer diagnosis code/initial diagnosis date within a reported cancer bundle is complete, the patient will not populate under this filter.
- “New” Patients – selecting this filter will display all patients that were newly added through the attribution process.
- Attributed PPX – selecting this filter will display all patients that were attributed to Performance Period X. A filter will be available for each previous performance period (e.g., Attributed PP1, Attributed PP2, Attributed PP3, Attributed PP4, Attributed PP5, Attributed PP6, and Attributed PP7 filter options will display when PP8 is the current open performance period).
- Not Attributed to PPY – selecting this filter will display all patients that were not attributed to Performance Period Y, which is the current open performance period (e.g., Not Attributed to PP8 will display when PP8 is the current open performance period).
- Invalid HICN/MBI – selecting this filter will return all patients who could not be found in claims data and need verification.
- Pending Attribution – selecting this filter will return all patients that have been added to the Data Registry since the attribution data loaded for the most recent performance period.

Figure 22: All Patients in Registry Tab Filters

PP8 Attribution 18 of 81 need attention

**All Patients in Registry** 997 patients

**All Registry Patients**

Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have invalid HICN/Invalid MBI.

Search by patient identifier or name

Export Reports

	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
1	Prognostic...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/19/2021	
1				Not Attributed PP8	02/16/2021	02/18/2021	
1	FN_42	LN_42	04/04/1980	Not Attributed PP8	02/16/2021	02/18/2021	
1	NRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
1	KRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
1	ROS1 Gene Mutat...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
1	ALK Gene Mutati...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
1	Tumor Type	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
1	Revised ISS Sta...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
1	Resection	DataElement3	06/01/1975	Attributed PP8	02/16/2021	02/16/2021	

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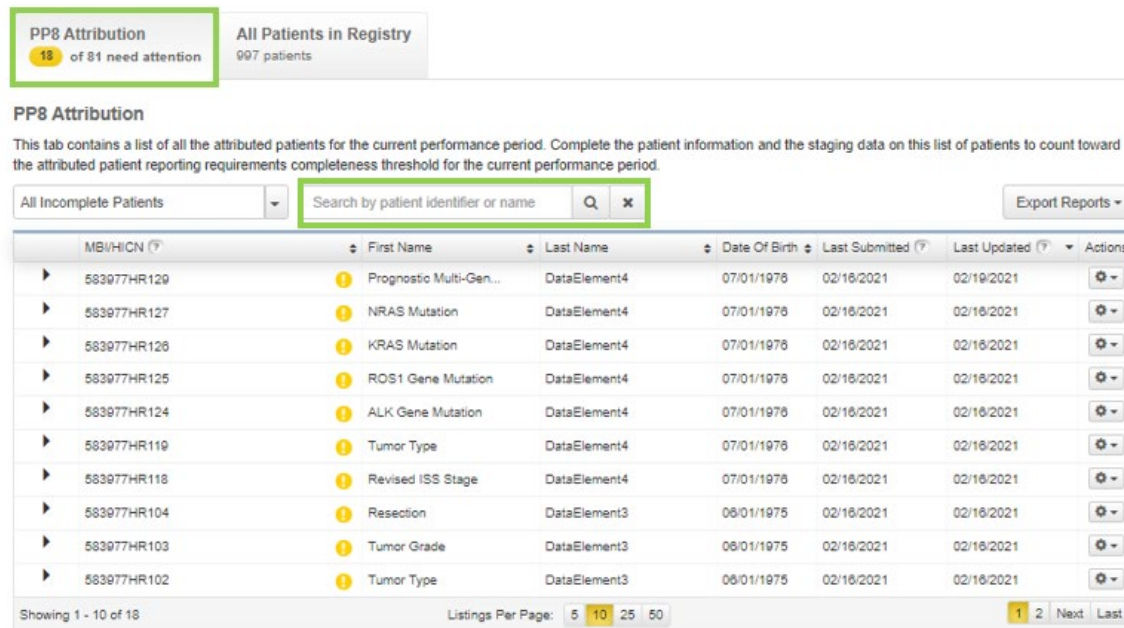
1 2 3 4 5 Next Last



In addition to filtering by the drop-downs, users can also input full or partial patient-identifying criteria into the 'Search' box on each Staging sub-tab and select the magnifying glass icon or press the keyboard's 'Enter' button to search (Figure 23). The search box provides instruction to 'Search by patient identifier or name', and allows practices to search by first name, last name, HICN, MBI, or DOB (only if the complete DOB is entered).

To remove search criteria, select the 'X' icon. 'X' will clear the search criteria but will not reset the filter to its default.

Figure 23: Current Open Performance Period Attribution Sub-Tab Search



**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients

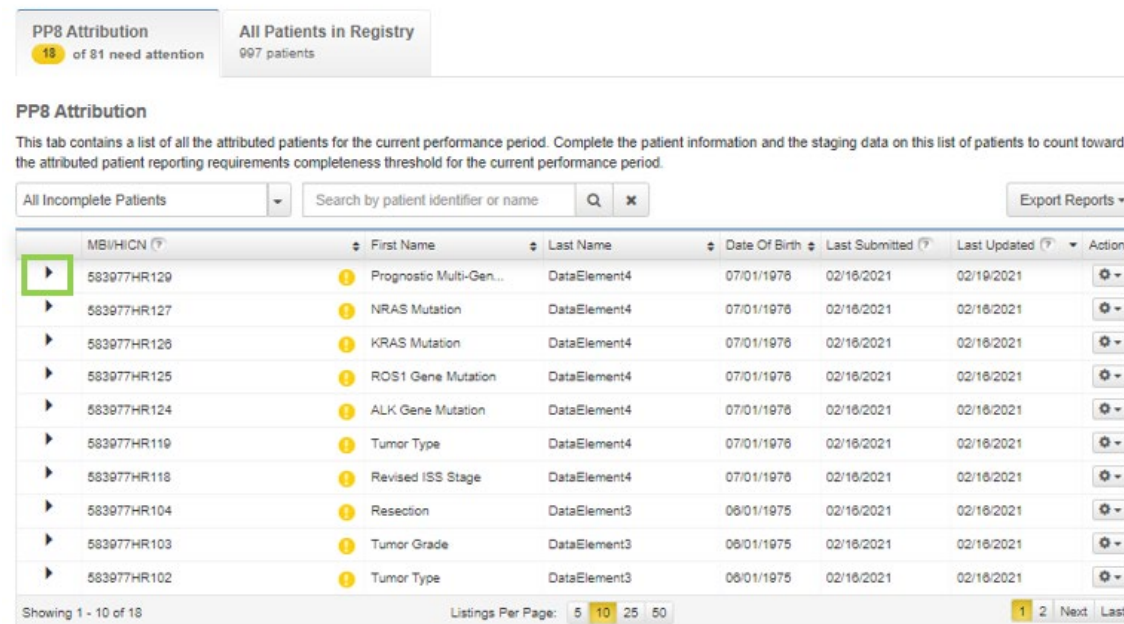
MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	<input type="button" value="Q"/>
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR119	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR118	Revised ISS Stage	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR104	Resection	DataElement3	06/01/1975	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR103	Tumor Grade	DataElement3	06/01/1975	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR102	Tumor Type	DataElement3	06/01/1975	02/16/2021	02/16/2021	<input type="button" value="Q"/>

Showing 1 - 10 of 18 Listings Per Page: 5 10 25 50 1 2 Next Last

#### 4.2.1.5 Patient Grid – Staging Information and Attribution History

To view more information within the patient grid on all of the Staging sub-tabs, select the arrow icon to the left of the MBI/HICN on a row of patient data (Figure 24).

Figure 24: Patient Grid – Staging Information and Attribution History Sub-Grid



**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	<input type="button" value="Q"/>
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR119	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR118	Revised ISS Stage	DataElement4	07/01/1976	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR104	Resection	DataElement3	06/01/1975	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR103	Tumor Grade	DataElement3	06/01/1975	02/16/2021	02/16/2021	<input type="button" value="Q"/>
583977HR102	Tumor Type	DataElement3	06/01/1975	02/16/2021	02/16/2021	<input type="button" value="Q"/>

Showing 1 - 10 of 18 Listings Per Page: 5 10 25 50 1 2 Next Last



This will expand to show a sub-grid containing two tabs: Staging Information and Attribution History.

The Staging Information tab (Figure 25), displays the following fields for each of the diagnosis codes entered for the patient:

- **OCM Cancer Bundle** – indicates the cancer bundle in which the ICD-10 code is included.
- **Initial Diagnosis Date** – indicates the initial diagnosis date entered for the corresponding ICD-10 code. If the patient is attributed to a cancer bundle for which an Initial Diagnosis Date has not been entered, this field will display 'Pending Entry'.
- **ICD-10 Code** – indicates the ICD-10 code entered for the patient. If the patient is attributed to a cancer bundle for which an ICD-10 code has not been entered, this field will display 'Pending Entry'.
- **Staging Status** – indicates 'Complete' if all required staging and clinical data have been entered for the corresponding diagnosis, or 'Incomplete' if all required staging and clinical data have not been entered for the corresponding diagnosis. On the 'All Patients in Registry' sub-tab, this is based on the most recent performance period associated with the attributed bundle/cancer diagnosis.
- **Bundle Attribution Status** (current open performance period (e.g., PP8 Attribution) and Staging Information sub-tab only) – indicates 'Attributed' if the OCM Cancer Bundle is attributed to the performance period being viewed and will be blank if the OCM Cancer Bundle is not attributed for the performance period being viewed.

**Figure 25: Patient Sub-Grid – Staging Information**

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Export Reports

MB/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/16/2021	02/19/2021	

**Staging Information** Attribution History

OCM Cancer Bundle	Initial Diagnosis Date	ICD-10 Code	Staging Status	Bundle Attribution Status
Breast Cancer Group	12/02/2019	C50.129	Incomplete	Attributed

The Attribution History tab (Figure 26) displays the following fields for each performance period:

- **Performance Period** - indicates for which performance period the data applies
- **Attribution Status** - indicates 'Attributed' if the patient was attributed to the corresponding performance period, or 'Not Attributed' if the patient was not attributed to the corresponding performance period.
- **OCM Cancer Bundle** - indicates the cancer bundle for which the patient was attributed for the corresponding performance period or will be blank if the patient was not attributed to that performance period.



**Figure 26: Patient Sub-Grid – Attribution History**

PP8 Attribution 18 of 81 need attention All Patients in Registry 997 patients

**PP8 Attribution**

This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/16/2021	02/19/2021	

Staging Information **Attribution History**

Performance Period	Attribution Status	OCM Cancer Bundle
PP8	Attributed	Breast Cancer Group
PP6	Not Attributed	
PP5	Not Attributed	
PP4	Not Attributed	
PP3	Not Attributed	
PP2	Not Attributed	
PP1	Not Attributed	



#### 4.2.1.6 Staging Data Gap Export Report

This report allows practices to export all reported staging and clinical data currently in the Data Registry for every patient identified as staging incomplete on the sub-tab, regardless of the filter on the Patient List at the time the report is requested. If the patient also has incomplete Patient Information in addition to missing staging and clinical data, those data gaps will be displayed in the Staging Data Gap Export report as well.

To export the Staging Data Gap Export Report, select the 'Export Reports' button, and then 'Export Gap Report' (Figure 27 and Figure 28). The 'Export Reports' button and 'Export Gap Report' options are available on each of the Staging sub-tabs.



Figure 27: Staging Data Gap Export Report- 'Export Reports' Button

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FAQ SUPPORT

OCM DEV UAT Practice 9

Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.

ADD NEW PATIENT

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.

UPLOAD SPREADSHEET

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

View Previous Uploads

Perform Bulk Actions

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**

This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients

Search by patient identifier or name

Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR125	R/S1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	



Figure 28: Export Gap Report

OCM DEV UAT Practice 9

Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.  
[ADD NEW PATIENT](#)

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.  
[UPLOAD SPREADSHEET](#)

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

[View Previous Uploads](#)  
[Perform Bulk Actions](#)

**PP8 Attribution**  
19 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/18/2021	02/19/2021
583977HR127	NRAS Mutation	DataElement4	07/01/1978	02/18/2021	02/18/2021
583977HR126	KRAS Mutation	DataElement4	07/01/1978	02/18/2021	02/18/2021

Export Reports  
Export Gap Report  
Export Patient List

Once a user selects 'Export Gap Report', a blue box will pop up in the bottom right hand corner signifying the export is underway (Figure 29). Once the export is complete, this box will alert the user that the file has successfully downloaded, and the user will be able to open or save the export file.

The Data Registry will include "Staging Incomplete" patients in the Staging Data Gap Export report based on the following criteria:

- All Patients in Registry sub-tab:** The patient will be included in the Staging Data Gap Export Report only if any cancer bundle has all reported cancer diagnoses in that cancer bundle staging incomplete at the time the Staging Data Gap Export Report is generated.

**Note:** Cancer bundles with only optional data gaps for all reported cancer diagnoses in that bundle will not be included in the Staging Data Gap Export Report.

- PP# Attribution sub-tab (e.g., PP8):** The patient will be included in the Staging Data Gap Export Report only if the PP# attributed cancer bundle has all reported cancer diagnoses staging incomplete at the time the Staging Data Gap Export Report is generated.

**Note:** PP# attributed cancer bundles with only optional data gaps for all reported diagnoses in that bundle will not be included in the Staging Data Gap Export Report.



Figure 29: Export Gap Report Download

#### 4.2.1.7 Staging Data Gap Export Report File

Figure 30 is an example of an exported Staging Data Gap Export Report file. Users will see "DATA GAP" when there are missing required data elements, and "OPTIONAL DATA GAP" when there are missing optional data elements for a patient entry (examples highlighted below).

When the report is generated from the 'PP#' Attribution sub-tab, the file name will generate as "PP#StagingDataGapExport.xlsx" and when the report is generated from the 'All Patients in Registry' sub-tab, the file name "AllPatientsStagingDataGapExport.xlsx" will be generated.

Figure 30: Staging Data Gap Export Report File

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	AB	AC	AD
1	Delete_Ind	HICN	MBI	Patient_Fi	Patient_La	Initial_Dia	ICD-10	CaDescriptor	OCM_Can	Clinical_St	Current_C	Current_CA	ICC_Edit	Primary_T	Nodal_Dis	Metastasi	KRAS_Mut	NRAS_Mu	BRAF_Mu
77			1D11A11C	DATA GAF	DATA GAF	12/16/2013	C91.00	Acute lym	Acute Leu										
78			3TE4W44	Stage PP4	M3	01/01/2013	C03.1	Malignant Head and											
79			3TE4W44	Stage PP4	M3	01/01/2013	C03.1	Malignant Head and											
80			8K10MM1	CR251	Twenty-fo	01/01/2013	C18.0	Malignant Small Inte											
81			8K10MM1	CR251	Twenty-fo	01/01/2013	C02.4	Malignant Head and											
82			8K10MM1	CR251	Thirty-tw	01/01/2013	C84.A7	Cutaneous Lymphom											
83			8K10MM1	CR251	Thirty-tw	01/01/2013	C84.A7	Cutaneous Lymphom											
84			8K10MM1	CR251	Thirty-tw	01/01/2013	C84.A7	Cutaneous Lymphom											
85			8K10MM1	CR251	Thirty-thr	01/01/2013	C61	Malignant Prostate C											
86			8K10MM1	CR251	Thirty-thr	01/01/2013	C61	Malignant Prostate C											
87			8K10MM1	CR251	Thirty-thr	01/01/2013	C7A.1	Malignant Endocrine											

The Staging Data Gap Export Report is comprised of a Staging tab that contains each of the fields listed in Table 2.

Table 2: Staging Data Gap Export Report Fields and Data Gaps

Field	Data Gap Message Populated
Delete_Ind	N/A
HICN	N/A



Field	Data Gap Message Populated
MBI	N/A
Patient_First_Name	DATA GAP - Incomplete Patient Data <b>Note:</b> Populates in the demographic fields for demographic data elements that are not completed when there are staging data gaps to be displayed
Patient_Last_Name	DATA GAP - Incomplete Patient Data <b>Note:</b> Populates in the demographic fields for demographic data elements that are not completed when there are staging data gaps to be displayed.
Initial_Diagnosis_Date	DATA GAP <b>Note:</b> Populates for any newly attributed patient that have been added to the registry via the attribution process for MEOS Only bundles
ICD-10_Cancer_Diagnosis_Code	DATA GAP <b>Note:</b> Populates for any newly attributed patient that have been added to the registry via the attribution process for MEOS Only bundles
Descriptor	DATA GAP
OCM_Cancer_Bundle	DATA GAP / Add All Required Data / Add Cancer Diagnosis: <insert bundle name> <b>Note:</b> Populates for any newly attributed patients that have been added to the registry via the attribution process for non-MEOS Only (reconciliation eligible) bundles DATA GAP / Add Cancer Diagnosis: <insert bundle name> <b>Note:</b> Populates for any newly attributed patient that have been added to the registry via the attribution process for MEOS Only bundles
Clinical_Status_Delete_Ind	N/A
Current_Clinical_Status	DATA GAP
Current_Clinical_Status_Date	DATA GAP
AJCC_Edition	DATA GAP
Primary_Tumor	DATA GAP
Nodal_Disease	DATA GAP
Metastasis	DATA GAP
Revised_ISS_Stage_Optional	OPTIONAL DATA GAP
Tumor_Type_Optional	OPTIONAL DATA GAP
Tumor_Grade_Optional	OPTIONAL DATA GAP



Field	Data Gap Message Populated
Resection_Optional	OPTIONAL DATA GAP – CNS LYMPHOMA ONLY <b>Note:</b> Populates when the Tumor Type value is (OPTIONAL DATA GAP) in the Staging Gap Report; and when Tumor Type value is “CNS Lymphoma”
Clinical_Stage_Optional	OPTIONAL DATA GAP <b>Note:</b> Populates when the Tumor Type value is (OPTIONAL DATA GAP) in the Staging Gap Report; and when the Tumor Type value is “None Selected”
EGFR_Activating_Mutation_Optional	OPTIONAL DATA GAP
ALK_Gene_Mutation_Optional	OPTIONAL DATA GAP
ROS1_Gene_Mutation_Optional	OPTIONAL DATA GAP
Estrogen_Receptor	DATA GAP
Progesterone_Receptor	DATA GAP
HER2_Amplification	DATA GAP
KRAS_Mutation_Optional	OPTIONAL DATA GAP
NRAS_Mutation_Optional	OPTIONAL DATA GAP
BRAF_Mutation_Optional	OPTIONAL DATA GAP
Histology	DATA GAP
Prognostic_Multi-Gene_Assay_Performed_Optional	OPTIONAL DATA GAP <b>Note:</b> When the Prognostic Multi-Gene Assay field is “Yes” or is a “OPTIONAL DATA GAP”; the following fields will populate with “OPTIONAL DATA GAP” if results have not been reported: <ul style="list-style-type: none"> <li>• Mamma Print Result</li> <li>• Oncotype Dx Result</li> <li>• Prosigna Result</li> </ul>
MammaPrint_Result_Optional	OPTIONAL DATA GAP <b>Note:</b> Populates when the Prognostic Multi-Gene Assay field is “Yes” or is a “OPTIONAL DATA GAP”; and when the cell does not have results if Prognostic Multi-Gene Assay is “Yes”.
Oncotype_Dx_Result_Optional	OPTIONAL DATA GAP <b>Note:</b> Populates when the Prognostic Multi-Gene Assay field is “Yes” or is a “OPTIONAL DATA GAP”; and when the cell does not have results if Prognostic Multi-Gene Assay is “Yes”.



Field	Data Gap Message Populated
Prosigna_Result_Optional	OPTIONAL DATA GAP  <b>Note:</b> <i>Populates when the Prognostic Multi-Gene Assay field is “Yes” or is a “OPTIONAL DATA GAP”; and when the cell does not have results if Prognostic Multi-Gene Assay is “Yes”.</i>
BRCA1_Result_Optional	OPTIONAL DATA GAP
BRCA2_Result_Optional	OPTIONAL DATA GAP
IDH2_Result_Optional	OPTIONAL DATA GAP
FLT3_Result_Optional	OPTIONAL DATA GAP
dMMR_Result_Optional	OPTIONAL DATA GAP
Episode_Dates	N/A

#### 4.2.1.7.1 Updating and Uploading the Staging Data Gap Export Report File

After downloading the Staging Data Gap Export report, practices may complete data elements identified as a “DATA GAP” or “OPTIONAL DATA GAP” by updating the file with valid values from the OCM Staging and Clinical Data Specifications\_PP8\_v3.0 and uploading the updated file to the OCM Data Registry. To upload the Staging Data Gap Export report file, select ‘Upload Spreadsheet’ on the Staging tab, then use the ‘Select Patient Staging Files’ button (to learn more uploading the Staging Data Gap Export file to the Data Registry go to section [4.2.2.7.1](#)).

The Staging Data Gap Export report may display more than one row for each ICD-10 code/Initial Diagnosis Date. When multiple rows display for an ICD-10 code/Initial Diagnosis Date, the last row will include the staging and clinical data reported and identify any data elements that have data gaps (highlighted in Figure 31), and any row(s) above the last row will only display additional Current Clinical Status values reported. For patients to be completed, populate all data elements identified as a “DATA GAP” in the last row in the report for the ICD-10 code/Initial Diagnosis Date, as staging and clinical data will only be processed from the last row. Data elements identified as “OPTIONAL DATA GAP” are *not* required to be completed for the patient to be complete.

While the staging and clinical data displayed in the report can be updated, removing data from the file and leaving the field empty when the file is uploaded will result in the previously reported data being removed from the Data Registry and the data element will become incomplete.



Figure 31: Staging Data Gap Export Report – Multiple Row Display for ICD-10 Code

	C	D	E	F	G	K	L	M	R	S	T	U	AN	AO
1	MBI	Patient_First_Name	Patient_Last_Name	Initial_Diagnosis_Date	ICD-10_Cancer_Diagnosis_Code	Current_Clinical_Status	Current_Clinical_Status_Date	AJCC_Edition	Tumor_Type	Tumor_Grade	Resection	Clinical_Stage	dMMR_Result	Episode_Dates
23		FN_65	LN_65	02/03/2018	C70.0	No Evidence of Disease/Remission	07/22/2019							
24		FN_65	LN_65	02/03/2018	C70.0	DATA GAP	DATA GAP	7th	Oligodendroglioma	III	Partial Resection	Distant CNS spread	Positive (Expressed)	PP5: 11/25/2018 - 05/24/2019
25		FN_65	LN_65	02/03/2018	C71.1	DATA GAP	DATA GAP	7th	DATA GAP	II	None Selected	Local extension	OPTIONAL DATA GAP	PP5: 11/25/2018 - 05/24/2019
26		FN_65	LN_65	02/03/2018	C70.1	Stable Disease	04/01/2018							
27		FN_65	LN_65	02/03/2018	C70.1	DATA GAP	DATA GAP	8th	CNS lymphoma	II	Partial Resection	None Selected	OPTIONAL DATA GAP	PP5: 11/25/2018 - 05/24/2019
28		FN_65	LN_65	02/03/2018	C70.9	DATA GAP	DATA GAP	8th	Astrocytoma	DATA GAP	DATA GAP	DATA GAP	OPTIONAL DATA GAP	PP5: 11/25/2018 - 05/24/2019
29		FN_65	LN_65	02/03/2018	C71.0	Metastasis	11/25/2018	8th	Germ cell tumors	IV	DATA GAP	None Selected	OPTIONAL DATA GAP	PP5: 11/25/2018 - 05/24/2019

The rows that only display reported Current Clinical Status values will result in a warning when the file is uploaded (highlighted in Figure 32); to avoid this, practices may remove these rows prior to uploading the Staging Data Gap Export report file.

Figure 32: Staging Data Gap Export Report – Current Clinical Status Values Missing

	E	F	G	H	I	K	L	M	N	O	P	AB	AC	AN	AO	AP	AC										
1	Patient	LastInitial	Diagno	ICD-10	CaDescriptor	OCM	Can	Current	Clinical	Status	Current	Clinical	StAJCC	Edit	Primary	T	Nodal	Dis	Metastasi	KRAS	Mut	NRAS	Mu	dMMR	Re	Episode	Dates
8	F		02/01/2018	C30.1	Malignant Head and	Initial	Diagnosis				11/01/2018																
9	F		02/01/2018	C30.1	Malignant Head and	Initial	Diagnosis				11/05/2018																
10	F		02/01/2018	C30.1	Malignant Head and	DATA	GAP				DATA	GAP	8th													Positive (E PP4: 01/02/2018 - 10/22/2018)	
11	H		02/01/2018	C32.9	Malignant Head and	Progressive	Disease				05/05/2019																

Patients with incomplete staging and clinical data that are also missing their demographic information will be included in the Staging Data Gap Export Report and display “DATA GAP” in the demographics fields that need to be reported. To complete these fields, practices must either upload the patient demographics in a Patient Upload file, or manually enter the missing information. Populating these fields in the Staging Data Gap Export report prior to uploading the Staging Data Gap Export report will not complete these fields—they will remain incomplete.

Patients that were attributed for more than one performance period for different cancer bundles with at least one data gap for each cancer bundle will display a row for each performance period (Figure 33). The most recent performance period the cancer bundle was attributed to will display in the last row. Only the last row displayed for each cancer bundle should be populated with staging and clinical data to complete the patient.

When data is entered or uploaded that was missing for a prior performance period so the ICD-10 code/Initial Diagnosis Date is now staging complete, that performance period will no longer display in the Staging Data Gap Export report. If the cancer bundle was incomplete at the time of submission for that performance period, it will continue to be considered incomplete and the patient will not count towards the minimum reporting threshold for the performance period. Optional data gaps can be, but are *not* required to be reported for the patient to be complete.





**Figure 33: Staging Data Gap Export Report – Different Cancer Bundles Attributed to Different Performance Periods**

	D	E	F	G	H	I	K	L	M	N	O	T	U	AA	AN	AO
	Patient_	Patient_		ICD-				Current_						HER2_Am		
1	First_Na	Last_Na	Initial_Diag	10_Canc	er_Diagn	OCM_Canc	Current_C	Clinical_St	Status_D	AJCC_Edi	Primary_	Nodal_Di	Resectio	Clinical_S	dMMR_Res	Episode Dates
	me	me	nosis Date	er	osis_Cod	er Bundle	atus	ate	tion	Tumor	sease	n	stage	n	ult	
676	FN_15	LN_15	06/02/2017	C16.8		Malignant neoplasm of overlapping sites of stomach	Gastro/Eso phageal Cancer Group	DATA GAP	DATA GAP	7th	DATA GAP	DATA GAP		DATA GAP	OPTIONAL DATA GAP	PP3: 07/02/2017 - 01/01/2018
677	FN_15	LN_15	04/15/2018	C70.1		Malignant neoplasm of spinal meninges	CNS Tumor Group	DATA GAP	DATA GAP	7th			DATA GAP	DATA GAP	OPTIONAL DATA GAP	PP5: 11/12/2018 - 05/11/2019

#### 4.2.1.8 Patient List Export

To export data for all of the patients in the patient grid, select the 'Export Reports' button, and then 'Export Patient List' (Figure 34 and Figure 35). The 'Export Reports' button and 'Export Patient List' option are available on each of the Staging sub-tabs. If any filters were applied to the patient grid, the data in the export file will be based on the filter criteria applied.

**Figure 34: Export Reports Button- Patient List Export**

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Staging

**Manually Enter Patient Data**  
 Add individual patient data using web-based forms.
   
[ADD NEW PATIENT](#)

**Upload Your Own File**  
 Add your practice data online using a spreadsheet, such as a CSV or Excel file.
   
[UPLOAD SPREADSHEET](#)

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

[View Previous Uploads](#)  
[Perform Bulk Actions](#)

**PP8 Attribution**  
 15 of 81 need attention

**All Patients in Registry**  
 997 patients

**PP8 Attribution**  
 This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients
 
[Export Reports](#)

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/16/2021	02/19/2021	
583977HR127	NRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	



Figure 35: Export Patient List

OCM DEV UAT Practice 9

Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.

**ADD NEW PATIENT**

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.

**UPLOAD SPREADSHEET**

Attention! There are duplicate patient records reported in the registry for your practice. Click [Here](#) to view and address the duplicate patient records.

View Previous Uploads  
Perform Bulk Actions

**PP8 Attribution**  
15 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated
563977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021
563977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021
563977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021

Export Reports  
Export Gap Report  
Export Patient List

Once a user selects 'Export Patient List', a blue box will pop up in the bottom right hand corner signifying the export is underway (Figure 36). Once the export is complete, this box will alert the user that the file has successfully downloaded, and the user will be able to open or save the export file.

Figure 36: Export Patient List Download

**PP8 Attribution**  
15 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
563977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	
563977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
563977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
563977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
563977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
563977HR119	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	
563977HR118	Revised ISS Stage	DataElement4	07/01/1976	02/16/2021	02/16/2021	
563977HR104	Resection	DataElement3	06/01/1975	02/16/2021	02/16/2021	
563977HR103	Tumor Grade	DataElement3	06/01/1975	02/16/2021	02/16/2021	
563977HR102	Tumor Type	DataElement3	06/01/1975	02/16/2021	02/16/2021	

Showing 1 - 10 of 18 Listings Per Page: 5 10 25 50

**Legend:**

- Incomplete Patient Data indicates that fields are missing that are required for the patient including MBI or HICN, First Name, Last Name, Gender, and Date of Birth.
- Incomplete Staging Data indicates that all the staging elements have not been provided. Some staging elements may be required depending on the diagnosis.
- Add Cancer Diagnosis indicates that the patient is attributed to a cancer bundle that was not reported. Please edit the patient's staging information to add the attributed cancer bundle's diagnosis and staging information.
- Invalid Patient Identifier indicates that the patient could not be found in the claims data. Please verify the HICN or MBI for the patient by selecting 'Edit Patient' in the 'Actions' dropdown.
- Duplicate Patient indicates that the patient has been identified on the Duplicate Records Patient List. Please navigate to the Duplicate Records Patient List Page to view and address the duplicate patient records for your practice.
- Newly Added With Attribution indicates that the patient was found to be attributed to your practice, but was not reported on. Please complete the staging data for the attributed patient.

**Exporting...**  
Exporting attributed patient data for OCM DEV UAT Practice 9 and performance period PP8. File will be automatically downloaded when it is ready.



### 4.2.1.9 Patient List Export File

Figure 37 and Figure 38 are examples of an exported Patient List file. Users will see columns with patient data, filtered by any criteria that were applied at the time of the export.

There are two tabs in each export file: Results, and Filter\_Criteria\_Used. The Results tab contains all of the patient data, and the Filter\_Criteria\_Used tab indicates the filters that were applied to the patient data contained in the export file.

The Results tab of the export file contains a row for each cancer diagnosis and initial diagnosis date combination entered for a patient. Thus, it is possible for a single patient (i.e., same HICN or MBI) to have more than one row in the filtered export file.

Figure 37: Patient List Export File – Results

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
1	MBI	HICN	Patient ID	Patient Fir	Patient La: DOB	Created O	Last Upda	Patient Inf	Bundle At	Last Subm	Cancer Bu	Initial Diag	ICD-10 Co	Staging Str	Reporting	Data Gaps		
2	9UU9YY1V					03/20/2010	04/05/201	Incomple	Attributed		Prostate C	07/16/201	C61	Incomple	N	Patient First Name, Patient Last Na		
3	9UU9YY1VW65					03/20/2010	04/05/201	Incomple	Attributed		Prostate C	07/16/201	C61	Complete	N	Patient First Name, Patient Last Na		
4	9UU9YY1V					03/20/2010	04/05/201	Incomple			Head and	09/18/201	C69.60	Complete	N	Patient First Name, Patient Last Na		
5	3TE4W44H	00000000	Stage PP4	M16	01/23/197	03/26/2010	04/05/201	Complete	Attributed		Head and	12/05/201	C32.2	Incomple	N	Add a Current Clinical Status for th		
6	33333363					03/29/2010	04/05/201	Incomple	Attributed		Small Inte	01/18/201	C18.7	Incomple	N	Patient First Name, Patient Last Na		
7	33333363					03/29/2010	04/05/201	Incomple	Attributed		Small Inte	11/18/201	C18.1	Incomple	N	Patient First Name, Patient Last Na		
8	33333363					03/29/2010	04/05/201	Incomple	Attributed		Small Inte	05/01/201	C18.8	Incomple	N	Patient First Name, Patient Last Na		
9	33333363					03/29/2010	04/05/201	Incomple	Attributed		Small Inte	03/01/201	C18.5	Incomple	N	Patient First Name, Patient Last Na		
10	33333363					03/29/2010	04/05/201	Incomple	Attributed		Small Inte	01/01/201	C18.0	Complete	N	Patient First Name, Patient Last Na		
11	1D11A11C					03/29/2010	04/05/201	Incomple	Attributed		Kidney Cai	12/16/201	C64.1	Complete	N	Patient First Name, Patient Last Na		
12	1D11A11C					03/29/2010	04/05/201	Incomple	Attributed		Head and	12/16/201	C76.0	Complete	N	Patient First Name, Patient Last Na		
13	1D11A11C					03/29/2010	04/05/201	Incomple	Attributed		Head and	12/16/201	C00.0	Complete	N	Patient First Name, Patient Last Na		
14	1D11A11C					03/29/2010	04/05/201	Incomple	Attributed		Breast Car	12/16/201	C50.011	Complete	N	Patient First Name, Patient Last Na		
15	1D11A11C					03/29/2010	04/05/201	Incomple	Attributed		Acute Leu	12/16/201	C91.00	Complete	N	Patient First Name, Patient Last Na		
16	1D11A11C					03/29/2010	04/05/201	Incomple	Attributed		Gastro/Es	12/16/201	C15.3	Complete	N	Patient First Name, Patient Last Na		
17	3TE4W44H	00000000	Stage PP4	M8	01/15/197	03/26/2010	04/05/201	Complete	Attributed		Bladder C	05/06/201	C67.5	Incomple	N	Add a Current Clinical Status for th		
18	3TE4W44H	00000000	Stage PP4	M4	01/11/197	03/26/2010	04/05/201	Complete	Attributed		Head and	01/01/201	C32.9	Incomple	N	Add a Current Clinical Status for th		
19	3TE4W44H	00000000	Stage PP4	M3	01/10/197	03/26/2010	04/05/201	Complete	Attributed		Head and	01/01/201	C03.1	Incomple	N	Add a Current Clinical Status for th		
20	3TE4W44H	00000000	Stage PP4	M1	01/08/197	03/26/2010	04/05/201	Complete	Attributed		Endocrine	01/01/201	C7A.021	Incomple	N	Add a Current Clinical Status for th		
21	3TD4W44H	00000001	Stage PP4	O	04/23/197	03/26/2010	04/05/201	Complete	Attributed		Gastro/Es	11/27/201	C15.9	Incomple	N	Add a Current Clinical Status for th		
22	3TD4W44H	00000001	Stage PP4	N	04/22/197	03/26/2010	04/05/201	Complete	Attributed		Gastro/Es	05/06/201	C15.8	Incomple	N	Add a Current Clinical Status for th		

Figure 38: Patient List Export File – Filter Criteria Used

A	B	C	D	E	F	G	H	I	J	K	L
1	FILTER_CRITERIA	FILTER_USED									
2	Performance Period	PP4									
3	Sort by	Last Updated									
4	Sort Order	Descending									
5	Search Filter	All Incomplete Patients									
6	Search Text										
7											
8											
9											
10											
11											
12											

Each of the fields in the Patient List Export file are described in Table 3.


Table 3: Patient List Export File Field Definitions

Field	Description
MBI	Patient's Medicare Beneficiary Identifier (MBI), if exists in the Data Registry.
HICN	Patient's Health Insurance Claim Number (HICN), if exists in the Data Registry. <b>Note:</b> If a HICN and MBI are uploaded, only the MBI will display.
Patient ID	Patient's Patient ID as entered in the Data Registry, if applicable.



Field	Description
Patient First Name	Patient's first name
Patient Last Name	Patient's last name
DOB	Patient's date of birth (DOB)
Created On Date	Date the patient record was added to the Data Registry
Last Updated	Date of the last update to the patient record, whether the patient record was created, updated manually, updated through a staging file upload, or updated as part of automated processing (e.g., attribution data load).
Patient Information Status	Status of the patient's demographic information (i.e., First Name, Last Name, Gender, Date of Birth). The field will display 'Complete' if the patient demographic information is complete, or 'Incomplete Patient Information' if the patient demographic information is incomplete.
Latest Attribution Status	<p>Indicates the attribution status for the patient for the most recent performance period. The field will display 'Attributed PP#' (e.g., Attributed PP8) if the patient is attributed to the most recent performance period, 'Not Attributed PP#' (e.g., Not Attributed PP8) if the patient is not attributed for the most recent performance period, or 'Pending Attribution' if the patient was added since the attribution data was loaded for the most recent performance period.</p> <p><b>Note:</b> This field is included in exports from the 'All Patients in Registry' sub-tab only.</p> <p><b>Note:</b> Historical attribution statuses are provided in the patient details in the sub-grid that can be expanded under the patient.</p>
Bundle Attribution Status	<p>Indicates if the OCM Cancer Bundle is attributed for the performance period (e.g., Attributed PP8).</p> <p><b>Note:</b> In the export from the 'All Patients in Registry' tab, this is the attribution status for the most recent performance period.</p> <p><b>Note:</b> This field will be blank for any diagnosis that is not in the cancer bundle attributed to the performance period.</p>
Cancer Bundle	<p>Name of the cancer bundle applicable to the ICD-10 code.</p> <p><b>Note:</b> If the patient is attributed to a cancer bundle for which an ICD-10 code has not yet been entered in the Data Registry, the name of the attributed cancer bundle will display in this field and the ICD-10 code field will be blank.</p>
Last Submitted	<p>Date of the last patient record submittal to CMS, whether submitted by the practice prior to a submission deadline or as part of an auto-submission at the submission deadline.</p> <p><b>Note:</b> This field will be blank if the patient record has not been submitted to CMS.</p>
Initial Diagnosis Date	<p>Initial diagnosis date for the ICD-10 code.</p> <p><b>Note:</b> If the patient is attributed to a cancer bundle for which an ICD-10 code has not yet been entered in the Data Registry, this field will be blank.</p>



Field	Description
ICD-10 Code	ICD-10 code for the cancer diagnosis. <b>Note:</b> <i>If the patient is attributed to a cancer bundle for which an ICD-10 code has not yet been entered in the Data Registry, this field will be blank.</i>
Staging Status	Indicates if all required staging and clinical data elements have been provided for the cancer diagnosis. The field will display 'Complete' if all data has been provided, or 'Incomplete Staging' if all staging and clinical data has not been provided.
Reporting Completeness	Displays a 'Y' for Yes if all required data elements are complete and the only data gaps are optional data elements. The field will display a 'N' for No if any required data elements are missing for PP8 and forward. <b>Note:</b> <i>The report will continue to display "Y" even if there are only optional data gaps.</i>
Data Gaps	List of any patient demographic information or staging and clinical data that was not provided for the patient and/or diagnosis that results in the patient information or staging and clinical data being considered incomplete. If more than one field is missing, the fields will be listed separated by a comma. <b>Note:</b> <i>'No staging added' will display when no ICD-10 code has been added for the patient.</i> <b>Note:</b> <i>'Add Cancer Diagnosis: &lt;Cancer bundle name&gt;' will display if a cancer diagnosis code within the attributed cancer bundle has not been added to the Data Registry.</i> <b>Note:</b> <i>'Add Cancer Diagnosis' (without a cancer bundle name) will display if a patient has no staging data reported for any cancer diagnosis.</i> <b>Note:</b> <i>For cancer diagnoses codes/dates in attributed cancer bundles, 'Add a Current Clinical Status for the Episode Dates: xx/xx/xxxx – xx/xx/xxxx' will display if there is no current clinical status value and associated date that falls within the performance period episode dates. For cancer diagnoses codes/dates that are not attributed, "Current Clinical Status" will display if there is no current clinical status value and associated date.</i> <b>Note:</b> <i>Optional data gaps do not display in this report. </i>

#### 4.2.1.10 Patient List Export – Identifying Incomplete Attributed Patients

Practices may optionally choose to use the Patient List Export that is available in the OCM Data Registry to identify attributed patients that have incomplete patient information and/or incomplete staging and clinical data, and therefore require additional reporting to be considered "complete." We will provide instructions on using the Patient List Export to identify incomplete attributed patients from the sub-tabs in the following sections.

##### 4.2.1.10.1 PP# Attribution Tab

During the submission window for each performance period, the 'PP# Attribution' tab displays for the most recently attributed performance period available in the OCM Data Registry and may be used to identify the patients that remain "incomplete" for the most recently attributed performance period available in the OCM Data Registry.

**Note:** *Staging completeness evaluation on the 'PP# Attribution' tab is based on the cancer bundle attributed for the performance period being reported on this tab. Patients attributed for the performance period with at least one cancer diagnosis in the attributed cancer bundle with 1) complete patient data and 2)*



*complete staging and clinical data for all required data fields (including a Current Clinical Status Date during the PP# episode dates) will be considered “complete” on this tab. If a patient has at least one diagnosis code/initial diagnosis date combination in the attributed cancer bundle that is “complete”, but additional diagnosis code/initial diagnosis date combinations in the attributed cancer bundle are “incomplete”, or if other reported cancer bundles that are not attributed for the most recent performance period have diagnosis code/initial diagnosis date combinations that are “incomplete”, the patient will still be considered “complete” for PP# reporting.*

The ‘Export Patient List’ file will display all reported diagnosis code/initial diagnosis date combinations reported for each patient. If at least one diagnosis code/initial diagnosis date combination in the attributed cancer bundle is “complete”, Column P (Reporting Completeness) will display ‘Y’ in every row for that patient to reflect the patient is considered “complete” for PP# reporting. While the patient is “complete”, any diagnosis code/initial diagnosis date combination(s) in the attributed cancer bundle that is considered “incomplete” will display ‘Incomplete’ in Column O (Staging Status). The rows displaying “Attributed” in Column J (Bundle Attribution) are the cancer bundles attributed for the most recent performance period.

Patients that are “complete” for PP# reporting:

1. **Will not display** in the default search results for ‘All Incomplete Patients’
2. **Will not be included** in the ‘Export Patient List’ file if the ‘All Incomplete Patients’ filter is selected (this is the default filter for this tab)
3. **Will be included** in the ‘Export Patient List’ file if the ‘All Patients’ filter is selected
4. **Will not be included** in the count of patients that “need attention” on the ‘PP# Attribution’ tab
5. **Will be included** in the ‘Percent of Attributed Patients with Complete Data’ on the ‘Patient Registry Statistics for PP#’ available on the Submission tab.

#### 4.2.1.10.2 All Patients in Registry Tab

After each submission deadline, when the ‘PP# Attribution’ tab has closed for the most recently attributed performance period available in the OCM Data Registry, the ‘All Patients in Registry’ tab may be used to identify the patients that remain “incomplete” for the most recently attributed performance period available in the OCM Data Registry. While the ‘PP# Attribution’ tab evaluates staging completeness based only on the cancer bundle attributed for the most recently attributed performance period available in the OCM Data Registry, the ‘All Patients in Registry’ tab evaluates staging completeness based on all reported cancer bundles. Patients with at least one diagnosis code/initial diagnosis date combination for each reported cancer bundle with complete patient and staging and clinical data for all required data fields will be considered “complete” on this tab. If additional diagnosis code/initial diagnosis date combinations in any reported cancer bundle are “incomplete”, the patient will still be considered “complete” on this tab.

**Note:** *These instructions apply to the default filter only. Practices wishing to do the same manipulation for previous performance periods using the ‘Attributed PPX’ filter on the ‘All Patients in Registry’ tab should contact [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov) if they have questions or require assistance.*

Follow these steps to use the ‘Export Patient List’ to identify the patients that are incomplete for the most recently attributed PP available in the OCM Data Registry:



Step 1: On the Staging tab, select the 'All Patients in Registry' tab. The default filter is 'All Incomplete Patients' – do not change the filter. This will display the patients with at least one reported cancer bundle that is "incomplete" for the most recently attributed performance period available in the OCM Data Registry.

Step 2: From the "Export Reports" button, select the "Export Patient List" option, and once the export is complete, open or save the file.

Step 3: Once the file is open, sort Column K (Bundle Attribution Status) by selecting "Sort A to Z". Delete all rows that do NOT display "Attributed PP#" (e.g. "Attributed PP8" if PP8 was the most recently attributed performance period available in the OCM Data Registry) in Column K (Bundle Attribution Status).

**Note:** While the attributed cancer bundle is considered "complete", if the patient has another reported cancer bundle that has ALL reported cancer diagnosis code/initial diagnosis date combination(s) "incomplete", Column Q (Reporting Completeness) will display "N" for every row for that patient to reflect the patient is considered "incomplete."

Practices may have entered some patients in the Data Registry with more than one cancer diagnosis in the same performance period attributed cancer bundle, or with the same cancer diagnosis more than once (using different initial diagnosis dates) for the performance period attributed cancer bundle. For these patients, following the above steps will result in the patient displaying in two or more rows. Follow these additional steps to identify the number of patients that have incomplete data for the most recently attributed performance period available in the OCM Data Registry:

Step 4: Any patients listed in more than one row after following the instructions above will need to have duplicate rows removed, or the total number of incomplete patients in the export file will be inflated. Steps to remove the duplicate rows for each patient:

- Sort Column A (MBI) by selecting "Sort A to Z".
- Select Column A (MBI).
  - On the "Home" tab, use the Styles tool "Conditional Formatting".
  - Select "Highlight Cells Rules"; select "Duplicate Values".
  - Select OK.

Step 5: For the rows with MBIs that are highlighted pink, the MBIs that are duplicated will display in consecutive rows more than once; delete or hide any duplicate rows, so each patient is only listed in one row. If at least one row for the patient displays "Complete" in both Column I (Patient Information Status) and Column P (Staging Status), retain one "Complete" row and delete the other duplicate rows for the patient.

Step 6: Repeat steps 4 and 5 with Column B (HICN).

Step 7: Delete patients that display "Complete" in both Column I (Patient Information Status) and Column P (Staging Status).

The number of rows remaining will reflect the number of patients with incomplete data for the most recently attributed performance period available in the OCM Data Registry. Column R (Data Gaps) identifies the information that is missing for each patient. The patients that have "Add Cancer Diagnosis...." or "No Staging Added" require a cancer diagnosis for the attributed cancer bundle reported with all associated staging and clinical data.



## 4.2.2 Steps to Use the Data Registry – Reporting Staging and Clinical Data

The Data Registry provides two methods to report staging and clinical data – manual data reporting and file upload data reporting.

### 4.2.2.1 Updating the HICN or MBI via Manual Entry

A 'HICN' or 'MBI' is required for each patient being reported. If a HICN was reported for a patient without an MBI, the HICN will be displayed for the patient in the Data Registry. If an MBI is reported for a patient without a HICN, the MBI will display for the patient in the Data Registry. If both a HICN and MBI are uploaded for a patient, only the MBI will display for the patient in the Data Registry.

#### 4.2.2.1.1 *Updating records identified as “Invalid HICN” or “Invalid MBI”*

When a practice has patients identified during the attribution data load as “Invalid HICN” or “Invalid MBI” the patient record will need to be either updated or deleted. If the patient has also been reported by the practice or added with the attribution data load with the correct HICN/MBI, delete the “Invalid HICN” or “Invalid MBI” record with the incorrect HICN/MBI and continue reporting under the correct HICN/MBI. Practices will not be able to delete the record with the correct HICN/MBI that was added with the attribution data load, to maintain the attribution status for the patient and prevent the staging statistics on the Submission tab from being impacted. Staging and clinical data may be added to the correct HICN/MBI by manual entry or by upload. If the patient does not already exist in the Data Registry with the correct HICN/MBI, verify and correct the HICN/MBI in this record.

#### 4.2.2.1.2 *Updating records from HICN to MBI*

When a practice obtains the MBI for a patient who has previously been entered in the Data Registry with a HICN, the practice may modify the patient record to remove the HICN and add the MBI by manually editing the patient data.

### 4.2.2.2 Updating Data Registry Patients from HICN to MBI via Upload

A Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) is required for each patient being reported. If a HICN is reported for a patient without an MBI, the HICN will be displayed for the patient in the Data Registry until the HICN is updated to the valid MBI for the patient. Beginning with PP4 staging and clinical data reporting, in addition to manually updating a patient from HICN to MBI, practices will have an upload option available as well. This section provides instruction to practices preparing to use the upload option to transition patients from HICN to MBI.

#### 4.2.2.2.1 *MBI Transition Upload Template Definition File*

The 'MBI Transition Upload Template Definition' file includes the file definitions for the 'MBI Transition Upload Template'.

#### 4.2.2.2.2 *MBI Transition Upload Template*

The Data Registry has been updated to allow practices to use the 'MBI Transition Upload Template' to update patients displaying with a HICN in the Data Registry to an MBI. When a practice obtains the MBI for a patient who has previously been entered in the Data Registry with a HICN, the practice may modify the patient record to remove the HICN and add the MBI by populating the valid patient identifiers in the 'MBI Transition Upload Template' and



uploading that file to the Data Registry. The HICN will no longer display in the Data Registry after the patient is transitioned to the MBI.

**Note:** *Practices may copy HICNs and MBIs into the 'MBI Transition Upload Template' but should use the 'Paste Special' function to ensure the HICN/MBI values copy correctly. After copying the HICN/MBI values, paste the copied data into the HICN and MBI columns in the 'MBI Transition Upload Template' using Paste Special:*

Right-click \ Select **Paste Special** \ Select the **Values** radio button \ Select **OK**.

(For non-mouse users, the right-click keyboard shortcut is to hold down SHIFT and then press F10.)

#### 4.2.2.3 Self-Service Duplicate Patient Management

The Data Registry has been updated to alert users if your practice has at least one attributed patient that was reported to the OCM Data Registry using two different patient identifiers, thereby creating two different patient records. One way a duplicate patient record may have been created is if a practice reports a patient with a HICN in the Data Registry, and then staging data is uploaded using the patient's MBI without first updating the HICN in the original patient record to the patient's MBI manually or by using the MBI Transition Upload Template. As a result, both records for this patient will be displayed in the Data Registry. Your practice will have the ability to view and address the duplicate patient records and the staging and clinical data reported for each duplicate record. After reviewing the records your practice may choose to identify the patient record that should be kept and which of the duplicate patient records should be deleted from the Data Registry.

When duplicate patient records exist for your practice a banner message will display on the Staging page and a 'Duplicate Patient' icon will display in the Staging patient grid subtabs for each duplicate patient record (Figure 39). The icon will display next to the patient identifier in the patient grid. The 'Duplicate Patient' icon will no longer display in the patient grid after the duplicate records for the patient are resolved, or the patient record is manually deleted. Duplicate record sets are resolved by selecting and confirming the record to be kept, as explained below. The Data Registry will remove a duplicate record set from the Duplicate Records Patient List Page if only one record remains after all other duplicate records in the set were manually deleted by the user.

**Note:** *Duplicate records that have never been attributed can be deleted on the patient grid, all other duplicate records will need to be resolved on the Duplicate Records Patient List page.*

**Note:** *Duplicate record sets that were left unresolved at the time of the Registry update to support PP8 reporting will be updated to reflect the updated reporting requirements on the self-service duplicate management page.. Duplicate patient records with only optional data gap(s) will not display the "Incomplete Staging Data" icon.*



Figure 39: Self-Service Duplicate Patient Management – Duplicate Patient Display Banner

The screenshot shows the 'Staging' section of the Oncology Care Model Data Registry. At the top, there are navigation tabs: HOME, MEASURES, STAGING (selected), and SUBMISSION. On the right, it says 'Logged in as Practice Admin' with a 'Launch Lab Environment' button. Below the navigation bar, the page title is 'OCM DEV UAT Practice 9'. The 'Staging' section has two main options: 'Manually Enter Patient Data' with an 'ADD NEW PATIENT' button, and 'Upload Your Own File' with an 'UPLOAD SPREADSHEET' button. A green banner with a yellow border contains the message: 'Attention! There are duplicate patient records reported in the registry for your practice. Click Here to view and address the duplicate patient records.' Below this banner, there are two buttons: 'View Previous Uploads' and 'Perform Bulk Actions'. At the bottom left, there are two summary boxes: 'PP8 Attribution' showing '18 of 81 need attention' and 'All Patients in Registry' showing '997 patients'. The 'All Registry Patients' section lists patients with columns for MBI/HICN, First Name, Last Name, Date Of Birth, Latest Attribution Status, Last Submitted, Last Updated, and Actions. The table shows five patients, with the first two having status icons (yellow and red) indicating issues.

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.

**Attention!** There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

View Previous Uploads  
Perform Bulk Actions

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**All Registry Patients**  
Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have Invalid HICN/Invalid MBI.

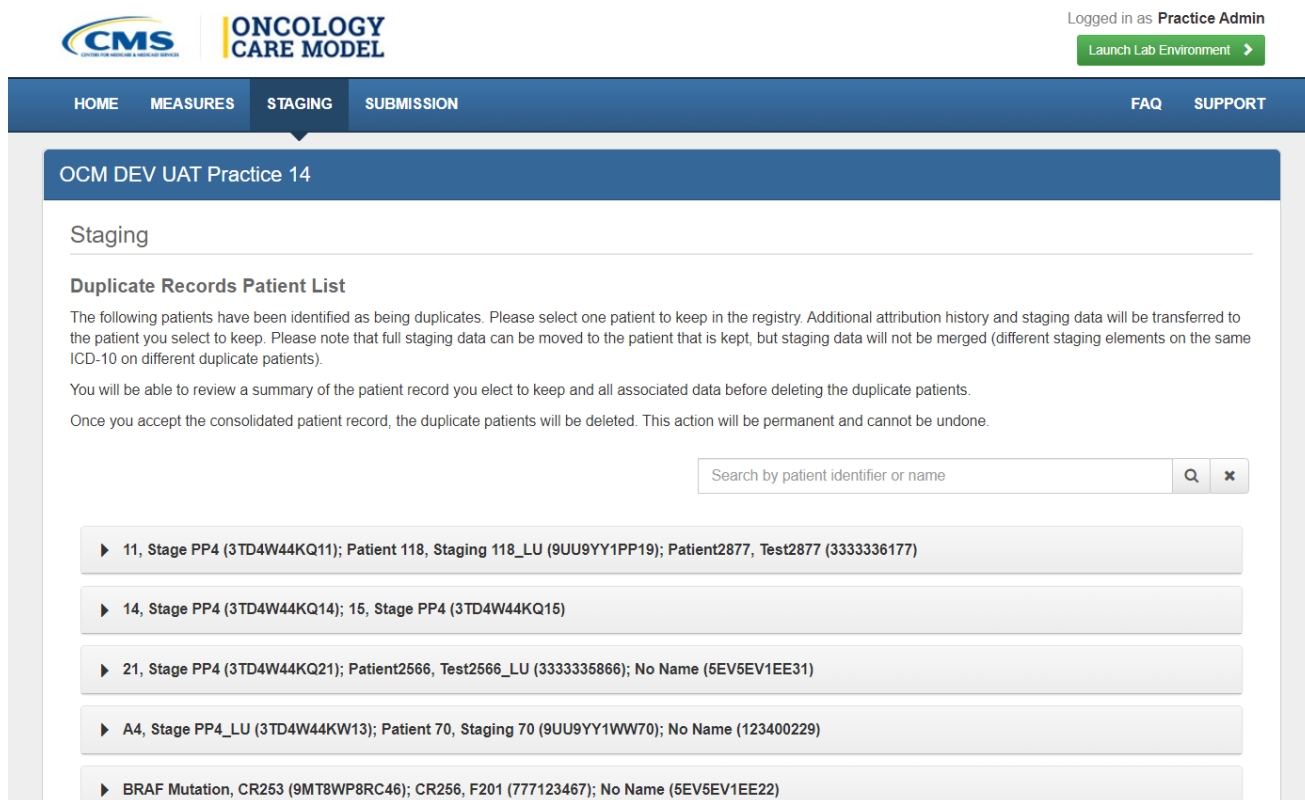
All Incomplete Patients Search by patient identifier or name Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
583977HR129	Prognostic...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/19/2021	
8XX4P11XX07				Not Attributed PP8	02/16/2021	02/16/2021	
231559913B	FN_42	LN_42	04/04/1980	Not Attributed PP8	02/16/2021	02/16/2021	
583977HR127	NRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	
583977HR126	KRAS Mu...	DataElement4	07/01/1976	Attributed PP8	02/16/2021	02/16/2021	

**Note:** The duplicate patient banner will not display in the Lab Environment.

Users can select the 'Click Here' hyperlink in the Duplicate Patient Banner to view and address the duplicate patient records. The hyperlink will navigate users to the Duplicate Records Patient List page (Figure 40) when selected.



**Figure 40: Self-Service Duplicate Patient Management – Duplicate Records Patient List Page**


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Staging

**Duplicate Records Patient List**

The following patients have been identified as being duplicates. Please select one patient to keep in the registry. Additional attribution history and staging data will be transferred to the patient you select to keep. Please note that full staging data can be moved to the patient that is kept, but staging data will not be merged (different staging elements on the same ICD-10 on different duplicate patients).

You will be able to review a summary of the patient record you elect to keep and all associated data before deleting the duplicate patients.

Once you accept the consolidated patient record, the duplicate patients will be deleted. This action will be permanent and cannot be undone.

Search by patient identifier or name

- ▶ 11, Stage PP4 (3TD4W44KQ11); Patient 118, Staging 118\_LU (9UU9YY1PP19); Patient2877, Test2877 (3333336177)
- ▶ 14, Stage PP4 (3TD4W44KQ14); 15, Stage PP4 (3TD4W44KQ15)
- ▶ 21, Stage PP4 (3TD4W44KQ21); Patient2566, Test2566\_LU (3333335866); No Name (5EV5EV1EE31)
- ▶ A4, Stage PP4\_LU (3TD4W44KW13); Patient 70, Staging 70 (9UU9YY1WW70); No Name (123400229)
- ▶ BRAF Mutation, CR253 (9MT8WP8RC46); CR256, F201 (777123467); No Name (5EV5EV1EE22)

The Duplicate Records Patient List page provides instructional text for users at the top of the page. A search bar is also present to allow users to search for a set of duplicate records by First Name, Last Name, HICN, or MBI (Figure 41).

**Note:** “No Name” is not searchable for duplicate patient records that do not have a reported patient First Name and Last Name.

Visible at the bottom of the page is an icon legend (Figure 41) similar to the legend that is present on the Staging page. Descriptions of the ‘Incomplete Patient Data’, ‘Incomplete Staging Data’ and ‘Add Cancer Diagnosis’ icons can be found in [Section 4.2.1.3](#). This page also includes the ‘Incomplete Current Clinical Status Icon’:



**Incomplete Current Clinical Status** indicates that a current clinical status was not provided within the episode dates for an attributed cancer bundle.

There is also a ‘Return to Patient Registry’ button below the legend (Figure 41), which will navigate users back to the Staging tab.



**Figure 41: Self-Service Duplicate Patient Management – Duplicate Records Patient List Page Continued**

**Duplicate Records Patient List**

The following patients have been identified as being duplicates. Please select one patient to keep in the registry. Additional attribution history and staging data will be transferred to the patient you select to keep. Please note that full staging data can be moved to the patient that is kept, but staging data will not be merged (different staging elements on the same ICD-10 on different duplicate patients).

You will be able to review a summary of the patient record you elect to keep and all associated data before deleting the duplicate patients.

Once you accept the consolidated patient record, the duplicate patients will be deleted. This action will be permanent and cannot be undone.

Q x

▶ 11, Stage PP4 (3TD4W44KQ11); Patient 118, Staging 118\_LU (9UU9YY1PP19); Patient2877, Test2877 (3333336177)

▶ 14, Stage PP4 (3TD4W44KQ14); 15, Stage PP4 (3TD4W44KQ15)

▶ 21, Stage PP4 (3TD4W44KQ21); Patient2566, Test2566\_LU (3333335866); No Name (5EV5EV1EE31)

▶ A4, Stage PP4\_LU (3TD4W44KW13); Patient 70, Staging 70 (9UU9YY1WW70); No Name (123400229)

▶ BRAF Mutation, CR253 (9MT8WP8RC46); CR256, F201 (777123467); No Name (5EV5EV1EE22)

▶ BRCA1 Result, CR253 (2CH0EJ9NW05); No Name (123400228)

▶ Clinical Stage, CR253\_LU (6ME8RT1MN83); CR256, D200 (777123457); CR256, D201 (777123458)

▶ CR256, D203\_LU (777123460); CR256, D202 (777123459); LN\_167, FN\_167 (2PM5KC7AF42)

▶ CR256, E204 (777123465); Patient 145, Staging 145 (9UU9YY1PP46)

▶ CR256, E203 (777123464); Patient 155, Staging 155 (9UU9YY1PP56)

Showing 1 - 10 of 24      Listings Per Page: 5 10 25 50      1 2 3 Next Last

**Legend:**

- ❗ Incomplete Patient Data indicates that fields are missing that are required for the patient including MBI or HICN, First Name, Last Name, Gender, and Date of Birth.
- ⚠ Incomplete Staging Data indicates that all the staging elements have not been provided. Some staging elements may be required depending on the diagnosis.
- ➕ Add Cancer Diagnosis indicates that the patient is attributed to a cancer bundle that was not reported.
- ⚠ Incomplete Current Clinical Status indicates that a current clinical status was not provided within the episode dates for an attributed cancer bundle.

[RETURN TO PATIENT REGISTRY](#)

The patient's Last Name, First Name, and HICN or MBI for each patient record in the duplicate record set will display on the expansion bar. The page will display duplicate patient record sets in alphabetical order by last name. The patient name will be listed as "No Name" if no demographic data was reported for a patient record within the duplicate record set. If the first and last name were not reported for all patient records in a duplicate record set, then the patient record will display at the top of the page before the alphabetical order by last name begins.

**Note:** If a patient record was added by uploading a staging file without first uploading a Patient Upload File or manually entering patient demographics, the patient record will display as "No Name".

Users can select the arrow next to a patient in the Duplicate Records Patient List to select a duplicate record set for viewing. When a duplicate record set is selected from the list, an expansion box will display for each set (Figure 42).



Figure 42: Self-Service Duplicate Patient Management – Expansion Box

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Staging

**Duplicate Records Patient List**

The following patients have been identified as being duplicates. Please select one patient to keep in the registry. Additional attribution history and staging data will be transferred to the patient you select to keep. Please note that full staging data can be moved to the patient that is kept, but staging data will not be merged (different staging elements on the same ICD-10 on different duplicate patients).

You will be able to review a summary of the patient record you elect to keep and all associated data before deleting the duplicate patients.

Once you accept the consolidated patient record, the duplicate patients will be deleted. This action will be permanent and cannot be undone.

Search by patient identifier or name

11, Stage PP4 (3TD4W44KQ11); Patient 118, Staging 118\_LU (9UU9YY1PP19); Patient2877, Test2877 (3333336177)

<p>MBI: 3TD4W44KQ11 First Name: Stage PP4 Last Name: 11 Gender: Female DOB: 02-24-1976 Patient ID: 0000000057 Attributed PP4: Bladder Cancer Group Episode Dates: PP4: 01/02/2018 - 10/22/2018</p> <p>▶ Bladder Cancer Group (01-27-2016)</p> <p>KEEP PATIENT</p>	<p>MBI: 9UU9YY1PP19 First Name: Staging 118_LU Last Name: Patient 118 Gender: Female DOB: 01-26-1976 Patient ID: 112 Attributed PP4: Bladder Cancer Group Episode Dates: PP4: 03/05/2018 - 11/08/2018</p> <p>▶ Lung Cancer Group (06-05-2018)</p> <p>▶ Small Intestine/Colorectal Cancer Group (01-15-2018)</p> <p>KEEP PATIENT</p>	<p>HICN: 3333336177 First Name: Test2877 Last Name: Patient2877 Gender: Female DOB: 03-03-1943 Patient ID: 3457 Not Attributed</p> <p>▶ Breast Cancer Group (03-03-2017)</p> <p>KEEP PATIENT</p>
---	---	--

▶ 14, Stage PP4 (3TD4W44KQ14); 15, Stage PP4 (3TD4W44KQ15)

▶ 21, Stage PP4 (3TD4W44KQ21); Patient2566, Test2566\_LU (3333335866); No Name (5EV5EV1EE31)

When the expansion box is displayed users should select the arrow next to a cancer bundle expansion box to see all of the staging and clinical data for that diagnosis code/diagnosis date (Figure 43).

Figure 43: Self-Service Duplicate Patient Management – Cancer Bundle Expanded

▼ 14, Stage PP4 (3TD4W44KQ14); 15, Stage PP4 (3TD4W44KQ15)

<p>MBI: 3TD4W44KQ14 First Name: Stage PP4 Last Name: 14 Gender: Male DOB: 02-27-1976 Patient ID: 0000000060 Attributed PP4: Gastro/Esophageal Cancer Group Episode Dates: PP4: 01/02/2018 - 10/22/2018</p> <p>▶ Gastro/Esophageal Cancer Group (05-08-2017)</p> <p>KEEP PATIENT</p>	<p>MBI: 3TD4W44KQ15 First Name: Stage PP4 Last Name: 15 Gender: Female DOB: 02-28-1976 Patient ID: 0000000061 Attributed PP4: Gastro/Esophageal Cancer Group Episode Dates: PP4: 01/02/2018 - 10/22/2018</p> <p>▶ Gastro/Esophageal Cancer Group (11-27-2017)</p> <p>KEEP PATIENT</p>
---	---



Each duplicate record for a patient will be displayed within the expansion box (Figure 44). The expansion box will include the patient demographic information, attribution status, and the staging and clinical data reported for each duplicate record. If the patient was attributed for any performance period, the attributed performance periods, the cancer bundle name(s) and episode dates will also display (episode dates will not display for PP1 or PP2). If an attributed cancer bundle is missing a Current Clinical Status during the episode dates, the 'Incomplete Current Clinical Status' icon will display next to the episode dates. If no information is provided for patient demographic or staging and clinical data, then the fields will be left blank.

**Note:** Patient demographic and staging and clinical data for any of the identified duplicate patient records in the duplicate record sets may be edited by the practice on the Staging page while they are listed as duplicate records on the Duplicate Records Patient List page. While this will not resolve the duplicate patient records, changes made will be reflected for any duplicate patient records that were updated.

**Figure 44: Self-Service Duplicate Patient Management – Expansion Box Details**

▼ 14, Stage PP4 (3TD4W44KQ14); 15, Stage PP4 (3TD4W44KQ15)

Record 14: Stage PP4 (3TD4W44KQ14)	Record 15: Stage PP4 (3TD4W44KQ15)
<b>MBI:</b> 3TD4W44KQ14 <b>First Name:</b> Stage PP4 <b>Last Name:</b> 14 <b>Gender:</b> Male <b>DOB:</b> 02-27-1976 <b>Patient ID:</b> 0000000060 <b>Attributed PP4:</b> Gastro/Esoophageal Cancer Group <b>Episode Dates:</b> PP4: 01/02/2018 - 10/22/2018 ⚠️	<b>MBI:</b> 3TD4W44KQ15 <b>First Name:</b> Stage PP4 <b>Last Name:</b> 15 <b>Gender:</b> Female <b>DOB:</b> 02-28-1976 <b>Patient ID:</b> 0000000061 <b>Attributed PP4:</b> Gastro/Esoophageal Cancer Group <b>Episode Dates:</b> PP4: 01/02/2018 - 10/22/2018 ⚠️
<b>Gastro/Esoophageal Cancer Group (05-06-2017)</b> <b>Initial Diagnosis Date:</b> 05-06-2017 <b>ICD-10 Code:</b> C15.3 <b>AJCC Edition:</b> 7th <b>Primary Tumor:</b> <b>Nodal Disease:</b> <b>Metastasis:</b> <b>HER2 Amplification:</b> <b>Histology:</b> Other <b>dMMR Result:</b> <b>Clinical Statuses:</b> No clinical statuses associated with this cancer diagnosis.	<b>Gastro/Esoophageal Cancer Group (11-27-2017)</b> <b>Initial Diagnosis Date:</b> 11-27-2017 <b>ICD-10 Code:</b> C15.4 <b>AJCC Edition:</b> 7th <b>Primary Tumor:</b> <b>Nodal Disease:</b> <b>Metastasis:</b> <b>HER2 Amplification:</b> <b>Histology:</b> Other <b>dMMR Result:</b> <b>Clinical Statuses:</b> No clinical statuses associated with this cancer diagnosis.
<b>KEEP PATIENT</b>	<b>KEEP PATIENT</b>

When a patient record has more than one diagnosis reported then an expansion box will display for each diagnosis within the duplicate patient record (Figure 45). The diagnoses will be sorted by diagnosis date with the most recent at the top within the expansion box.



**Figure 45: Self-Service Duplicate Patient Management – Expansion Box with Multiple Diagnoses**

▼ 11, Stage PP4 (3TD4W44KQ11); Patient 118, Staging 118\_LU (9UU9YY1PP19); Patient2877, Test2877 (3333336177)

<p>MBI: 3TD4W44KQ11 First Name: Stage PP4 Last Name: 11 Gender: Female      DOB: 02-24-1976 Patient ID: 0000000057 Attributed PP4: Bladder Cancer Group Episode Dates: PP4: 01/02/2018 - 10/22/2018</p> <p>▶ Bladder Cancer Group (01-27-2018)</p> <p>KEEP PATIENT</p>	<p>MBI: 9UU9YY1PP19 First Name: Staging 118_LU Last Name: Patient 118 Gender: Female      DOB: 01-26-1976 Patient ID: 112 Attributed PP4: Bladder Cancer Group Episode Dates: PP4: 03/05/2018 - 11/08/2018</p> <p>▶ Lung Cancer Group (08-05-2018)</p> <p>▶ Small Intestine/Colorectal Cancer Group (01-18-2018)</p> <p>KEEP PATIENT</p>	<p>HICN: 3333336177 First Name: Test2877 Last Name: Patient2877 Gender: Female      DOB: 03-03-1943 Patient ID: 3457 Not Attributed</p> <p>▶ Breast Cancer Group (03-03-2017)</p> <p>KEEP PATIENT</p>
--	--	---

When more than one diagnosis box is displayed users may select the arrows next to each diagnosis to expand more than one diagnosis box at the same time (Figure 46).



**Figure 46: Self-Service Duplicate Patient Management – Multiple Diagnoses Expanded**

11, Stage PP4 (3TD4W44KQ11); Patient 118, Staging 118\_LU (9UU9YY1PP19); Patient2877, Test2877 (3333336177)

MBI: 3TD4W44KQ11  
First Name: Stage PP4  
Last Name: 11  
Gender: Female DOB: 02-24-1976  
Patient ID: 0000000057  
Attributed PP4: Bladder Cancer Group  
Episode Dates: PP4: 01/02/2018 - 10/22/2018

Bladder Cancer Group (01-27-2018)

KEEP PATIENT

MBI: 9UU9YY1PP19  
First Name: Staging 118\_LU  
Last Name: Patient 118  
Gender: Female DOB: 01-26-1976  
Patient ID: 112  
Attributed PP4: Bladder Cancer Group  
Episode Dates: PP4: 03/05/2018 - 11/08/2018

Lung Cancer Group (08-05-2018)

Initial Diagnosis Date	08-05-2018
ICD-10 Code	C34.12
AJCC Edition	7th
Primary Tumor	
Nodal Disease	
Metastasis	
EGFR Activating Mutation	
ALK Gene Mutation	
ROS1 Gene Mutation	
Histology	
dMMR Result	
Clinical Statuses	
Initial Diagnosis (08-20-2018)	

Small Intestine/Colorectal Cancer Group (01-16-2018)

Initial Diagnosis Date	01-16-2018
ICD-10 Code	C17.0
AJCC Edition	7th
Primary Tumor	T1a
Nodal Disease	N1
Metastasis	M0
dMMR Result	Negative (Absent)
Clinical Statuses	
Initial Diagnosis (01-16-2018)	

KEEP PATIENT

HICN: 3333336177  
First Name: Test2877  
Last Name: Patient2877  
Gender: Female DOB: 03-03-1943  
Patient ID: 3457  
Not Attributed

Breast Cancer Group (03-03-2017)

KEEP PATIENT

In some cases, patients may not be attributed or have a diagnosis reported (Figure 47). The Incomplete Staging icon will not display in this case, as it displays based on the most recent performance period.



Figure 47: Self-Service Duplicate Patient Management – Not Attributed and No Diagnosis Reported

► BRCA1 Result, CR253 (2CH0EJ9NW05); No Name (123400228)

► Clinical Stage, CR253\_LU (6ME8RT1MN83); CR256, D200 (777123457); CR256, D201 (777123458)

▼ CR256, D202 (777123459); CR256, D203\_LU (777123460); LN\_167, FN\_167 (2PMSKC7AF42)

Patient 1	Patient 2	Patient 3 (Highlighted)
HICN: 777123459 First Name: D202 Last Name: CR256 Gender: Female DOB: 06-10-1981 Patient ID: 00103 Attributed PP4: Breast Cancer Group Attributed PP3: Breast Cancer Group Episode Dates: PP4: 03/05/2018 - 11/08/2018 ⚠ PP3: 09/14/2017 - 03/05/2018	HICN: 777123460 First Name: D203_LU Last Name: CR256 Gender: Female DOB: 04-05-1980 Patient ID: 00104 Attributed PP4: Breast Cancer Group Episode Dates: PP4: 03/05/2018 - 11/08/2018 ⚠	MBI: 2PMSKC7AF42 First Name: FN_167 Last Name: LN_167 Gender: Female DOB: 03-15-1982 Patient ID: Not Attributed
► Breast Cancer Group (08-01-2017) ⚠		
KEEP PATIENT	KEEP PATIENT	KEEP PATIENT

If a patient is attributed for any performance period and the attributed cancer bundle does not have a diagnosis reported, the Add Cancer Diagnosis icon will display as well as the Incomplete Current Clinical Status icon (Figure 48).

Figure 48: Self-Service Duplicate Patient Management – Attributed and No Diagnosis Reported

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Logged in as Practice Admin  
Launch Lab Environment

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Staging

**Duplicate Records Patient List**

The following patients have been identified as being duplicates. Please select one patient to keep in the registry. Additional attribution history and staging data will be transferred to the patient you select to keep. Please note that full staging data can be moved to the patient that is kept, but staging data will not be merged (different staging elements on the same ICD-10 on different duplicate patients).

You will be able to review a summary of the patient record you elect to keep and all associated data before deleting the duplicate patients.

Once you accept the consolidated patient record, the duplicate patients will be deleted. This action will be permanent and cannot be undone.

Search by patient identifier or name 🔍 ✕

▼ 11, Stage PP4 (3TD4W44KQ11); Patient 118, Staging 118\_LU (9UU9YY1PP19); Patient2877, Test2877 (3333336177)

Patient 1	Patient 2 (Highlighted)	Patient 3
MBI: 3TD4W44KQ11 First Name: Stage PP4 Last Name: 11 Gender: Female DOB: 02-24-1976 Patient ID: 0000000057 Attributed PP4: Bladder Cancer Group Episode Dates: PP4: 01/02/2018 - 10/22/2018	MBI: 9UU9YY1PP19 First Name: Staging 118_LU Last Name: Patient 118 Gender: Female DOB: 01-26-1976 Patient ID: 112 Attributed PP4: Bladder Cancer Group Episode Dates: PP4: 03/05/2018 - 11/08/2018 ⚠	HICN: 3333336177 First Name: Test2877 Last Name: Patient2877 Gender: Female DOB: 03-03-1943 Patient ID: 3457 Not Attributed
► Bladder Cancer Group (01-27-2016)	► Lung Cancer Group (06-05-2018) ⚠ ► Small Intestine/Colorectal Cancer Group (01-18-2018)	► Breast Cancer Group (03-03-2017) ⚠
KEEP PATIENT	KEEP PATIENT	KEEP PATIENT



At the bottom of each duplicate record within the Duplicate Record Expansion Box is a 'Keep Patient' button (Figure 49), so the user can select which patient record within the duplicate record set to keep.

**Note:** A user may only select one patient record to be kept per duplicate patient record.

Figure 49: Self-Service Duplicate Patient Management – Keep Patient Button

The screenshot displays a web interface for managing duplicate patient records. At the top, a header bar lists the duplicate records: "Doe, Jane (t07031967); Doe Jane (S07031967); Doe, Jane (1Y02X19WA16)". Below this, three panels show details for each record. Each panel includes a dropdown menu to select a cancer group, followed by a table of clinical data, and a "KEEP PATIENT" button at the bottom.

Record ID	First Name	Last Name	Gender	DOB	Patient ID	Attributed PP	Episode Dates	Cancer Group	Initial Diagnosis Date	ICD-10 Code	AJCC Edition	Primary Tumor	Nodal Disease	Metastasis	dMMR Result	Clinical Statuses
t07031967	Jane	Doe	Female	01-01-1950	123456789	Female GU Cancer other than Ovary Group	PP3: 7/1/2017 - 12/31/2017	Female GU Cancer other than Ovary Group (08-15-2017)	08-15-2017	C55	7th	T0	N0	M0	Not Tested	Responding (01-11-2018)
S07031967	Jane	Doe	Female	01-01-1950	123456789	Head and Neck Cancer Group	PP4: 1/1/2018 - 6/30/2018	Head and Neck Cancer Group (01-01-2018)	01-01-2018	C76.0	8th	T0	N0	M0	Negative (Absent)	Responding (05-24-2018)
1Y02X19WA16	Jane	Doe	Female	01-01-1950	123456789	Head and Neck Cancer Group	Not Attributed	Head and Neck Cancer Group (01-01-2018)	01-01-2018	C76.0	8th	T0	N0	M0	Negative (Absent)	Responding (05-24-2018)

**Note:** If an ICD-10 Diagnosis Code/Initial Diagnosis Date (ICD-10/IDD) is reported on more than one patient record within the duplicate record set, the staging and clinical data associated with the ICD-10/IDD for the patient record that is selected with the 'Keep Patient' button will be kept. If the ICD-10/IDD are reported on patient records within the duplicate record set that are not selected with the 'Keep Patient' button, the staging and clinical data associated with the ICD-10/IDD for the patient record that was most recently updated based on the 'Last Updated Date' on the Patient Registry Grid will be kept.

Once a user selects the 'Keep Patient' button for one of the patient records in the expansion box a Preview Modal Window (Figure 50) will display. This consolidated view displays the patient information and staging and clinical data that will be kept for the patient when the duplicate records are resolved.



**Figure 50: Self-Service Duplicate Patient Management – Keep Patient Preview Modal Window**

**Doe, Jane (1Y02X19WA16)**

HICN: MBI: 1Y02X19WA16 Attributed PP4: Head and Neck Cancer Group Episode Dates: PP4: 1/1/2018 - 6/30/2018  
 First Name: Jane Attributed PP3: Female GU Cancer other than Ovary Group Episode Dates: PP3: 7/1/2017 - 12/31/2017  
 Last Name: Doe  
 Gender: Female DOB: 01-01-1950  
 Patient ID: 123456789

**Female GU Cancer other than Ovary Group (01-01-2018)**

Initial Diagnosis Date: 08-15-2017  
 ICD-10 Code: C55  
 AJCC Edition: 7th  
 Primary Tumor  
 Nodal Disease  
 Metastasis  
 dMMR Result  
 Clinical Statuses  
 Responding (01-05-2018)

**Head and Neck Cancer Group (01-01-2018)**

Initial Diagnosis Date: 01-01-2018  
 ICD-10 Code: C76.0  
 AJCC Edition: 8th  
 Primary Tumor  
 Nodal Disease  
 Metastasis  
 dMMR Result  
 Clinical Statuses  
 Deceased (01-05-2018)

**CANCEL ACCEPT**

The Preview Modal Window provides users with two buttons (Figure 50). The 'Accept' button allows the user to accept the changes upon review of the consolidated data displayed. The 'Cancel' button allows the user to cancel any changes made and navigate back to the Duplicate Record Expansion Box

If the 'Accept' button is selected, a confirmation window will display (Figure 51). The confirmation window informs users that selecting 'Yes' will permanently delete the duplicate record(s) that were not selected to be kept. This action should only be completed if the user is ready for the duplicate records to be permanently deleted. If the user does not confirm the action by selecting 'Yes', the user will be returned to the Duplicate Record Expansion Box.

**Figure 51: Self-Service Duplicate Patient Management Requirements – Confirmation Modal**

**Confirm**

Are you sure you would like to keep this patient and delete the other duplicate patient(s). This action is permanent and cannot be undone.

**Yes No**

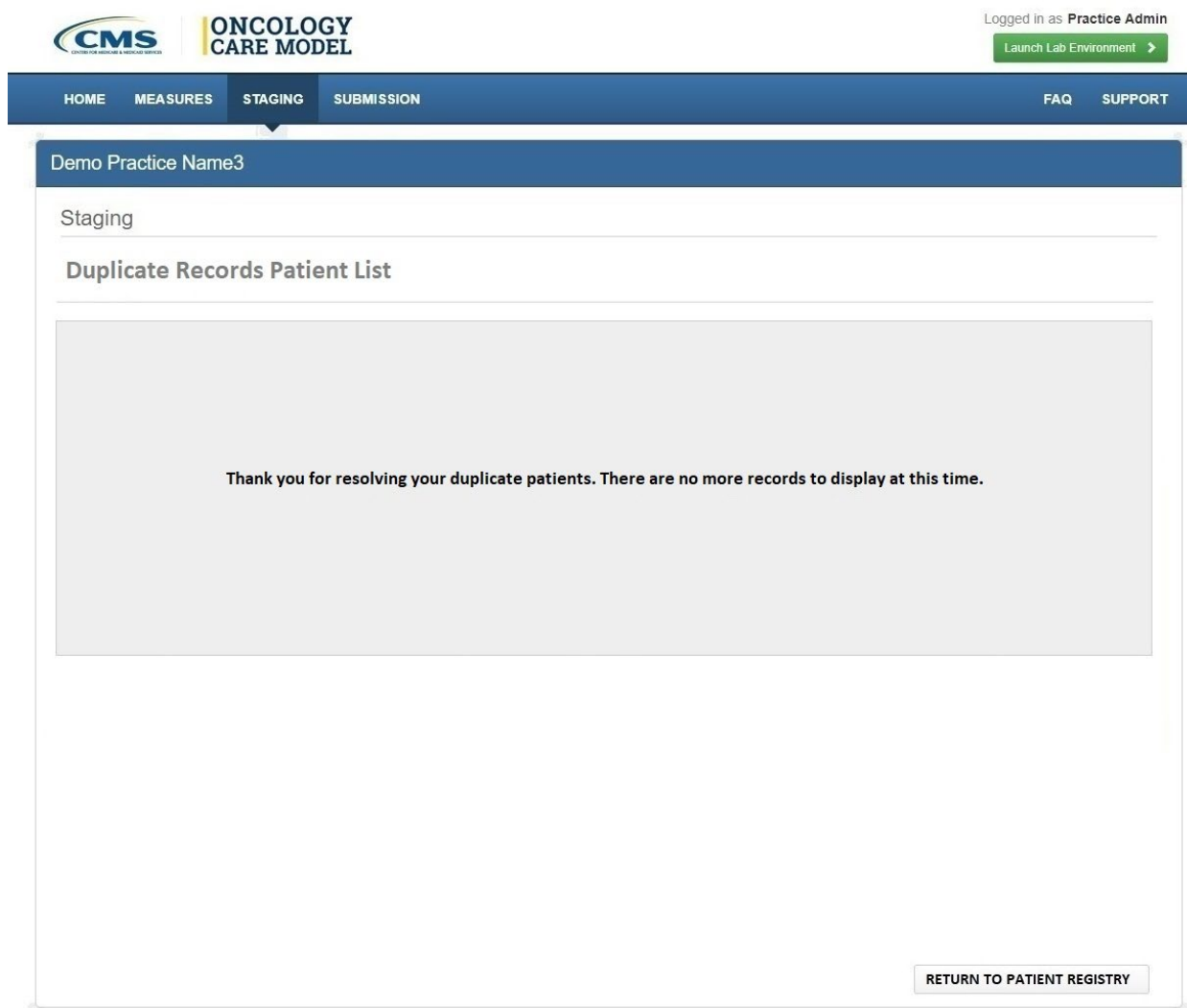
If the user selects 'Yes', the Data Registry will delete the duplicate patient records that were not selected to be kept. The user will be returned back to the Duplicate Records Patient List page and the patient will now display the attribution, staging and clinical data from the consolidated view.

Duplicate patient records that are deleted as part of resolving duplicates will no longer display in the 'All Patients in Registry' Sub-tab or the 'PP# Attribution' Sub-tab. The Duplicate Records Patient List page will only display the remaining unresolved duplicate record sets and will not display any duplicate record sets that have been resolved. Any



remaining unresolved duplicate sets will be updated to reflect the updated reporting requirements, and continue to display on the self-service duplicate management page. Once all duplicate records are resolved, the Duplicate Records Patient List Page will display a message confirming there are no more duplicate records and a 'Return to Patient Registry' button (Figure 52). The user will return to the Staging page after selecting the 'Return to Patient Registry' button.

Figure 52: Self-Service Duplicate Patient Management – All Duplicate Records Resolved



After all duplicate records are resolved on the Duplicate Records Patient List page, the Duplicate Patient Banner on the Staging page will no longer display.

The "Last Updated" date on the Patient Registry Grid will be changed to the date when the duplicate records were resolved only if the record being kept was updated by adding attribution records or ICD-10/IDD (with associated staging and clinical data including CCS/CCSD) from the duplicate patient record(s) being deleted.

#### 4.2.2.4 Preparing to Transition Patients to MBI

Practices may use the 'Export Patient List' functionality that is available when selecting the 'Export Reports' button on the Staging tab in the Data Registry to obtain a 'Patient Data Export' file. This file can be used to confirm the patients that are currently reported in the Data Registry with a HICN. These patients can be transitioned to MBI when the practice obtains the MBI for the patient. The HICN in the Data Registry for the patient (and shown in



the 'Patient Data Export' file) must be the HICN populated in the 'HICN' column of the 'MBI Transition Upload Template' for the transition to be successful. Practices will add the MBI for the patient in the 'MBI' column.

Once the template has been uploaded to the Data Registry and processed without errors, the patient will be displayed with the MBI instead of the HICN. It is important to note that once the template has been uploaded, practices **must** view/download the error log before closing the confirmation window. After the confirmation window is closed the error log will no longer be accessible. Any staging data uploaded to the Data Registry after the patient is transitioned to the MBI will need to include the MBI used to transition the patient.

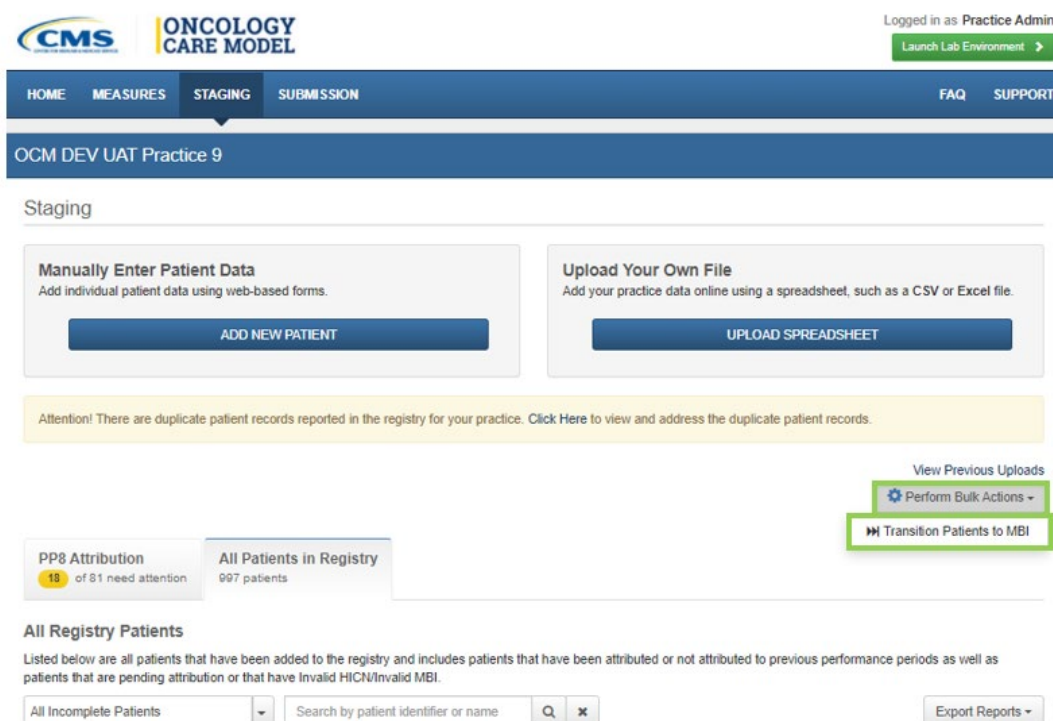
**Note:** In the 'Patient Upload File' and the 'Patient Data Export', the MBI column is included to the left of the HICN column. If your practice plans to copy HICNs from the 'Patient Upload File' or the 'Patient Data Export' into the 'MBI Transition Upload Template', please be aware that the HICN and MBI columns in this file are not listed in the same order as they are in the 'Patient Upload File' or the 'Patient Data Export'.

#### 4.2.2.4.1 MBI Transition Upload Process

**Note:** Please refer to the OCM File Submission Guide as a supplement for this section.

Step 1: To update an existing patient from a HICN to the valid MBI for the patient via the upload of a file, select 'Perform Bulk Actions' and then 'Transition Patients to MBI' (Figure 53).

Figure 53: Staging Tab - Transition Patients to MBI



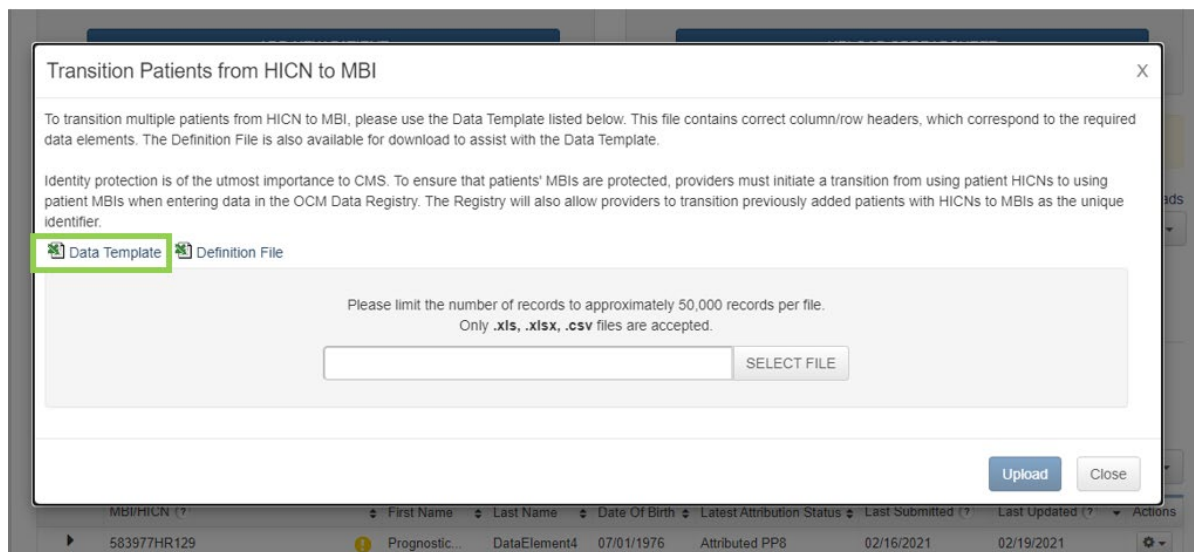
Step 2: Download the 'MBI Transition Upload Template' (Data Template, see Figure 54). Copy HICNs and MBIs into the 'MBI Transition Upload Template' by using the 'Paste Special' function to ensure the HICN/MBI values copy correctly. After copying the HICN/MBI values, paste the copied data into the HICN and MBI columns in the 'MBI Transition Upload Template' using Paste Special:



Right-click \ Select **Paste Special** \ Select the **Values** radio button \ Select **OK**.

(For non-mouse users, the right-click keyboard shortcut is to hold down SHIFT and then press F10.)

**Figure 54: Download MBI Upload Transition Document**

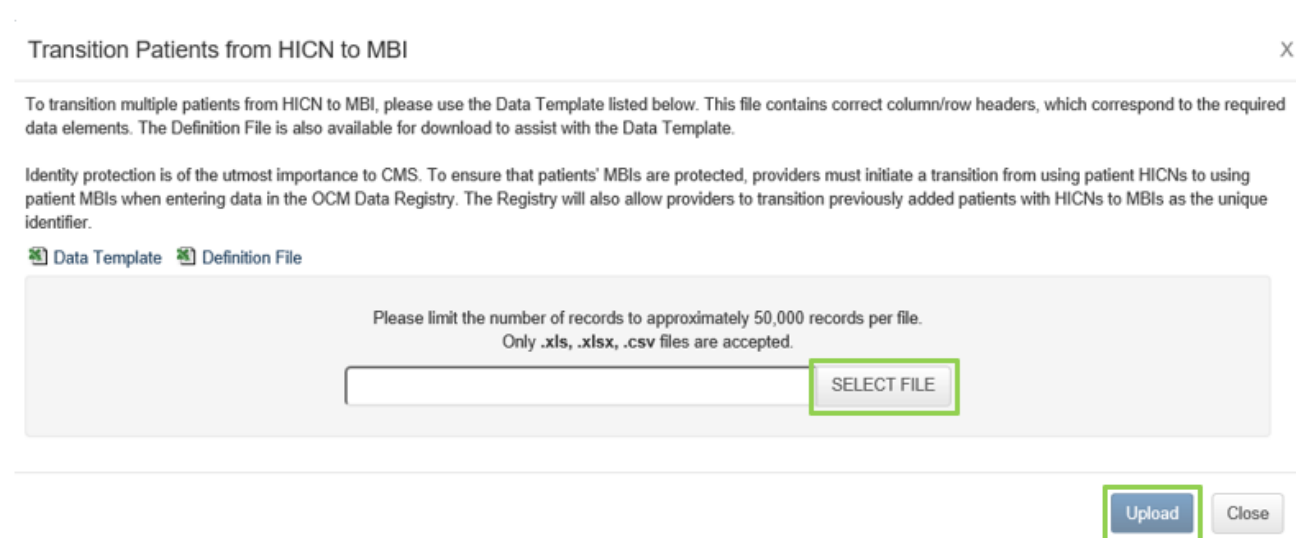


Step 3: To select MBI transition template files to upload, select the 'SELECT FILE' option. Only .xls, xlsx, and .csv files are accepted. The names of each of the selected files will display on the screen, each with an option to remove the file, if desired.

The maximum upload size acceptable for the MBI Transition Upload Template file is 50,000 rows per file. If a practice has more than 50,000 rows of data to upload, split the file into two or more separate files. These two or more files may be uploaded together at the same time. File headers must match as they are provided in the data templates.

Select '**Upload**' to complete the file upload (Figure 55).

**Figure 55: Select File - MBI Transition Upload Template**

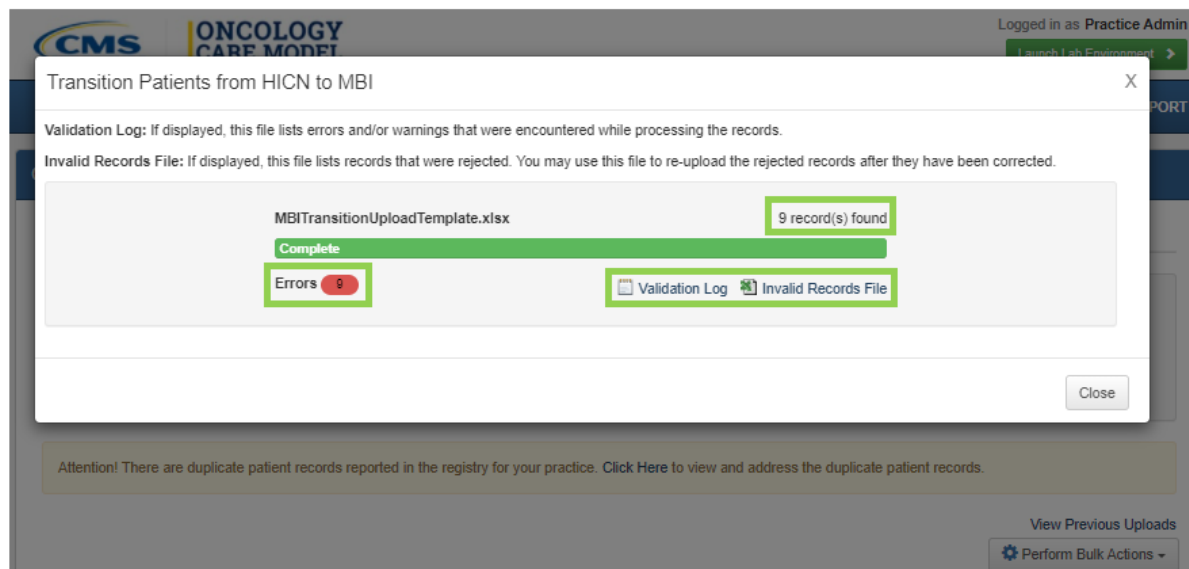


Step 4: Once the file has uploaded, check to see if there are any errors. The number of errors will be displayed in the confirmation window with the uploaded file name, along with the Validation log (list of errors) and Invalid Records File (list of patients with errors) both



available for download (Figure 56). Practices **must** view/download the validation log before closing the confirmation window. If the confirmation window is closed without viewing/downloading, the validation log will no longer be accessible.

Figure 56: Upload Completed - MBI Transition Upload Template

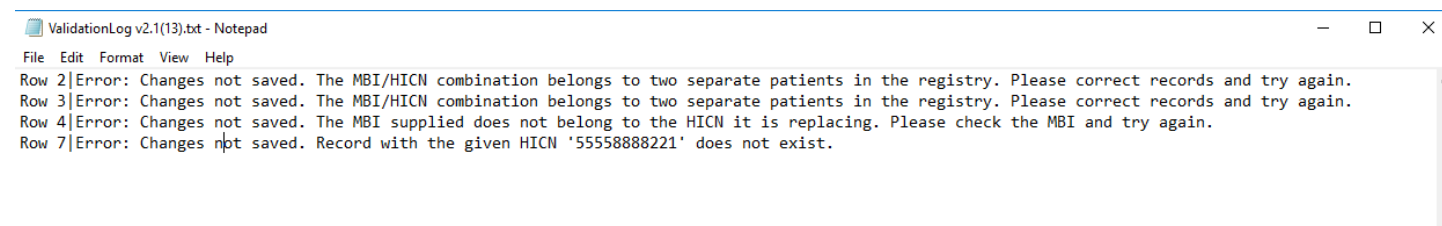


Select the 'Validation Log' link or the 'Invalid Records File' to view errors and correct the errors in the Data Registry. The 'Invalid Records File' (Figure 57) will display the HICN/MBI that triggered an error, and the 'Validation Log' will provide the error description (Figure 58).

Figure 57: MBI Transition Update - Invalid Records File

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	RowNumber	HICN	MBI											
2		2 K14592109	9FF1YY2DD07											
3		3 K14592110	9FF1YY2DD06											
4		4 K14592112	9FF1YY2DD08											
5		5 K14592111	9FF1YY2DD09											
6		6 231559956B	8MN2TT1CC04											
7		7 55558888221	5DE5EV1EE35											
8		8 K14592113	9FF1YY2DD11											
9		9 K14592114	9FF1YY2DD12											
10		10 K14592115	9FF1YY2DD13											
11														
12														

Figure 58: MBI Transition Update - Validation Log



Once the files have been viewed/downloaded, select 'Close' to navigate back to the Staging patient grid sub-tabs.

Step 5: For a list of MBI Transition Upload Template error messages, please visit the OCM File Submission Guide, available on OCM Connect. To correct the errors listed in the



Validation Log, review the HICN and MBI included in the MBI Transition Upload Template for the patient and update the file as needed. Once rectified, re-upload the corrected template.

#### 4.2.2.5 Updating Staging and Clinical Data to Current Clinical Reporting Requirements

The OCM Data Registry is updated for each performance period to support reporting the staging and clinical data as required by the OCM Staging and Clinical Data Specifications for that performance period. Existing patients in the Data Registry, who were entered prior to the Data Registry being updated to the clinical reporting requirements for the current performance period, may be updated to the current clinical reporting requirements in one of two ways.

##### 4.2.2.5.1 Automatic Update to Current Clinical Reporting Requirements

Existing patients in the Data Registry, who are attributed to the current performance period, will have their staging and clinical data automatically updated to the clinical reporting requirements for the current performance period at the time of the attribution data load into the Data Registry (if the practice hasn't manually updated the patient to the clinical reporting requirements for the current performance period prior to the attribution data load-see Section [4.2.2.6.2](#)). This means that patients who previously had complete staging information in the Data Registry could become staging incomplete at the time of the attribution data load when the staging and clinical data for the patient have been updated to the clinical reporting requirements for the current performance period.

Practices will need to review all patients with incomplete staging data that are attributed to the current performance period to determine the staging and clinical data gaps that exist for the patient. The missing required staging and clinical data will need to be added for these patients for all diagnoses and associated initial diagnoses dates in the attributed cancer bundle to make the patient staging complete, and therefore include the patient in the count meeting the minimum reporting threshold for the performance period.

In addition, existing patients in the Data Registry, who are not attributed to the current performance period but who have incomplete staging data, will have their staging and clinical data automatically updated to the clinical reporting requirements for the current performance period at the time of the attribution data load into the Data Registry.

**Note:** *The only patients who are not automatically updated to the clinical reporting requirements for the current performance period at the time of the attribution data load are those patients with complete staging information who are not attributed to the current performance period.*

##### 4.2.2.5.2 Manual and File Upload Update to Current Clinical Reporting Requirements

Once the Data Registry is updated to support reporting the staging and clinical data as required by the OCM Staging and Clinical Data Specifications for a performance period, practices will be able to manually update a patient to the current clinical reporting requirements for that performance period.

If a practice anticipates that a patient will be attributed to the upcoming performance period, and, prior to the attribution data load for that performance period would like to update the patient's staging and clinical data to meet the current clinical reporting requirements for that performance period, the practice may manually update the patient to the current performance period's clinical reporting requirements either through staging file upload, or through manually updating the patient in the Data Registry.



To update a patient to the clinical reporting requirements for the current performance period via file upload, the practice may upload the staging and clinical data for the patient using the Staging Abstraction Tool or Staging Upload Template file applicable to the current performance period. Uploading the Patient Template with updates to an existing patient will not update the patient to the current clinical reporting requirements for the performance period.

To update a patient to the clinical reporting requirements for the current performance period manually in the Data Registry:

Step 1: Access the Staging Information screen (Figure 59) for the patient in the Data Registry.

**Figure 59: Update to Current Clinical Reporting Requirements**

### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 1112223333  
Patient Name: UAT\_FN\_2 UAT\_LN\_2 (Female)  
Date of Birth: 07/19/1941

▼ Pancreatic Cancer Group (02-15-2017) Update to Current Clinical Reporting Requirements

ICD-10 Code \* C25.0 Malignant neoplasm of head of pancreas

Initial Diagnosis Date \* 02-15-2017

Step 2: The Staging Information screen is read-only for patients who have not been updated to current clinical reporting requirements. All previously entered staging and clinical data for each diagnosis entered for the patient is displayed on the page.

Select the OCM Cancer Bundle/ICD-10 code/initial diagnosis date section that requires updating and select 'Update to Current Clinical Reporting Requirements' (Figure 60).

**Figure 60: Update to Current Clinical Reporting Requirements Button**

### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 1112223333  
Patient Name: UAT\_FN\_2 UAT\_LN\_2 (Female)  
Date of Birth: 07/19/1941

▼ Pancreatic Cancer Group (02-15-2017) Update to Current Clinical Reporting Requirements

ICD-10 Code \* C25.0 Malignant neoplasm of head of pancreas

Initial Diagnosis Date \* 02-15-2017

Step 3: Review the information in the Update to Current Clinical Reporting Requirements Preview pop-up box (Figure 61). This box identifies, for each field, the 'Old Field Value'



entered for the patient, as well as the 'New Field Value' that will display for the patient upon completion of the update. Most of the data values will be carried over to the new reporting requirements; however, some data values will not be carried over, such as when a field or field value has been retired. Current Clinical Status values reported prior to PP3 will not be updated to the current clinical reporting requirements. Fields that are new for the current clinical reporting requirements will display 'Not Applicable' as the old field value.

Figure 61: Update to Current Clinical Reporting Requirements Preview

Field Name	Old Field Value	New Field Value
Initial Diagnosis Date	02-15-2017	02-15-2017
ICD-10 Code	C25.0	C25.0
AJCC Edition	7th	7th
Primary Tumor	T1	T1
Nodal Disease	NX	NX
Metastasis	M0	M0
dMMR Result	Not applicable	Value not entered

*Previously reported Clinical Statuses will not be updated to current clinical reporting requirements.*

Do Not Update Update

Step 4: Select 'Do Not Update' to cancel the update to the current clinical reporting requirements and return to the Staging Information page or select 'Update' to proceed with updating the OCM Cancer Bundle/ICD-10 code/initial diagnosis date to the current clinical reporting requirements (Figure ).



Figure 62: Update to Current Clinical Reporting Requirements Preview – Update

Field Name	Old Field Value	New Field Value
Initial Diagnosis Date	02-15-2017	02-15-2017
ICD-10 Code	C25.0	C25.0
AJCC Edition	7th	7th
Primary Tumor	T1	T1
Nodal Disease	NX	NX
Metastasis	M0	M0
dMMR Result	Not applicable	Value not entered

*Previously reported Clinical Statuses will not be updated to current clinical reporting requirements.*

Do Not Update **Update**

Step 5: If the practice chooses to update the OCM Cancer Bundle/ICD-10 code/initial diagnosis date to the current clinical reporting requirements, the Staging Information screen will reload and display the updated reporting requirements for the current performance period. The screen will now be editable.

Practices must select the 'Save' button at the bottom of the screen, even after selecting the Update button, or none of the changes will be saved (Figure 63).

Figure 63: Update to Current Clinical Reporting Requirements – Save

**Molecular Mutations**

dMMR Result

Select

ADD ADDITIONAL CANCER DIAGNOSIS

CANCEL **SAVE**

#### 4.2.2.6 Manual Data Reporting

Step 1: To manually add a patient in the Data Registry for the practice selected, select 'Add New Patient' on the Staging tab. Also, note the Staging sub-tabs and Legend in the bottom half of the screen (Figure 64).



To add or modify staging data, the patient data must be complete. To meet OCM requirements for reporting staging and clinical data, each patient must have complete staging data for the attributed cancer bundle for the performance period.

A newly added patient will have an Attribution Status of 'Pending Attribution', and will only be accessible from the 'All Patients in Registry' tab.

Figure 64: Manually Enter Patient Data

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Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.

**ADD NEW PATIENT**

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.

**UPLOAD SPREADSHEET**

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

[View Previous Uploads](#)

[Perform Bulk Actions](#)

**PP8 Attribution**  
13 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Q X Export Reports

MB/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	[Settings]
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Settings]
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Settings]
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Settings]
583977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Settings]



Step 2: Selecting 'Add New Patient' will take the user to a blank 'Add a Patient' screen (Figure 65).

**Note:** An asterisk (\*) next to a field means that the field is mandatory.

Figure 65: Add a Patient

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OCM DEV UAT Practice 14

Staging Information Summary

No staging information added yet.

Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

A patient identifier is required \*

☒ Medical Beneficiary Identifier (MBI) ?

☐ Health Insurance Claim Number (HICN) ?

Patient ID

First Name\*

Last Name\*

Gender\*

☐ Male

☐ Female

☐ Unknown

Date Of Birth\*

BACK

SAVE & COMPLETE LATER

CONTINUE



Step 3: Enter the patient's MBI or HICN (Figure 66). The patient identifier is a mandatory field.

Figure 66: Add a Patient – MBI or HICN

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Staging Information Summary

No staging information added yet.

Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

A patient identifier is required \*

☒ Medical Beneficiary Identifier (MBI) ?

☐ Health Insurance Claim Number (HICN) ?

Patient ID

First Name\*

Last Name\*

Gender\*

☐ Male
 ☐ Female
 ☐ Unknown

Date Of Birth\*

MM-DD-YYYY

BACK

SAVE & COMPLETE LATER

CONTINUE



Step 4: Enter the patient's Patient ID, as assigned by the practice (Figure 67).

**Note:** This is an optional field.

Figure 67: Add a Patient – Patient ID

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Staging Information Summary

No staging information added yet.

Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ?
  ?

☒ Health Insurance Claim Number (HICN)\* ?

Patient ID

14225

First Name\*

Last Name\*

Gender\*

☐ Male
 ☐ Female
 ☐ Unknown

Date Of Birth\*

MM-DD-YYYY

BACK

SAVE & COMPLETE LATER

CONTINUE



Step 5: Enter the patient's First Name, which is a mandatory field (Figure 68).

Figure 68: Add a Patient – First Name

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OCM DEV UAT Practice 14

Staging Information Summary

No staging information added yet.

### Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ?

☒ Health Insurance Claim Number (HICN)\* ?

?

Patient ID

First Name\*

Last Name\*

Gender\*

☐ Male
 ☐ Female
 ☐ Unknown

Date Of Birth\*

BACK

SAVE & COMPLETE LATER

CONTINUE



Step 6: Enter the patient's Last Name, which is a mandatory field (Figure 69).

Figure 69: Add a Patient – Last Name

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OCM DEV UAT Practice 14

Staging Information Summary

No staging information added yet.

Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ?

☒ Health Insurance Claim Number (HICN)\* ?

32996741

Patient ID

14225

First Name\*

Test

Last Name\*

One

Gender\*

☐ Male☐ Female☐ Unknown

Date Of Birth\*

MM-DD-YYYY

BACK

SAVE & COMPLETE LATER

CONTINUE



Step 7: Enter the patient's Gender, which is a mandatory field (Figure 70).

Figure 70: Add a Patient – Gender

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OCM DEV UAT Practice 14

Staging Information Summary

No staging information added yet.

### Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ?

☒ Health Insurance Claim Number (HICN)\* ?

?

Patient ID

First Name\*

Last Name\*

Gender\*

☐ Male
 ☒ Female
 ☐ Unknown

Date Of Birth\*

BACK

SAVE & COMPLETE LATER

CONTINUE



Step 8: Enter the patient's Date of Birth, which is a mandatory field (Figure 71). The pop-up calendar can be used to enter the Date of Birth. Date of Birth must be in MM-DD-YYYY format.

Figure 71: Add a Patient – Date of Birth

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OCM DEV UAT Practice 14

Staging Information Summary

No staging information added yet.

### Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ? ☒ Health Insurance Claim Number (HICN)\* ?

?

Patient ID

First Name\*

Last Name\*

Gender\* ☐ Male ☒ Female ☐ Unknown

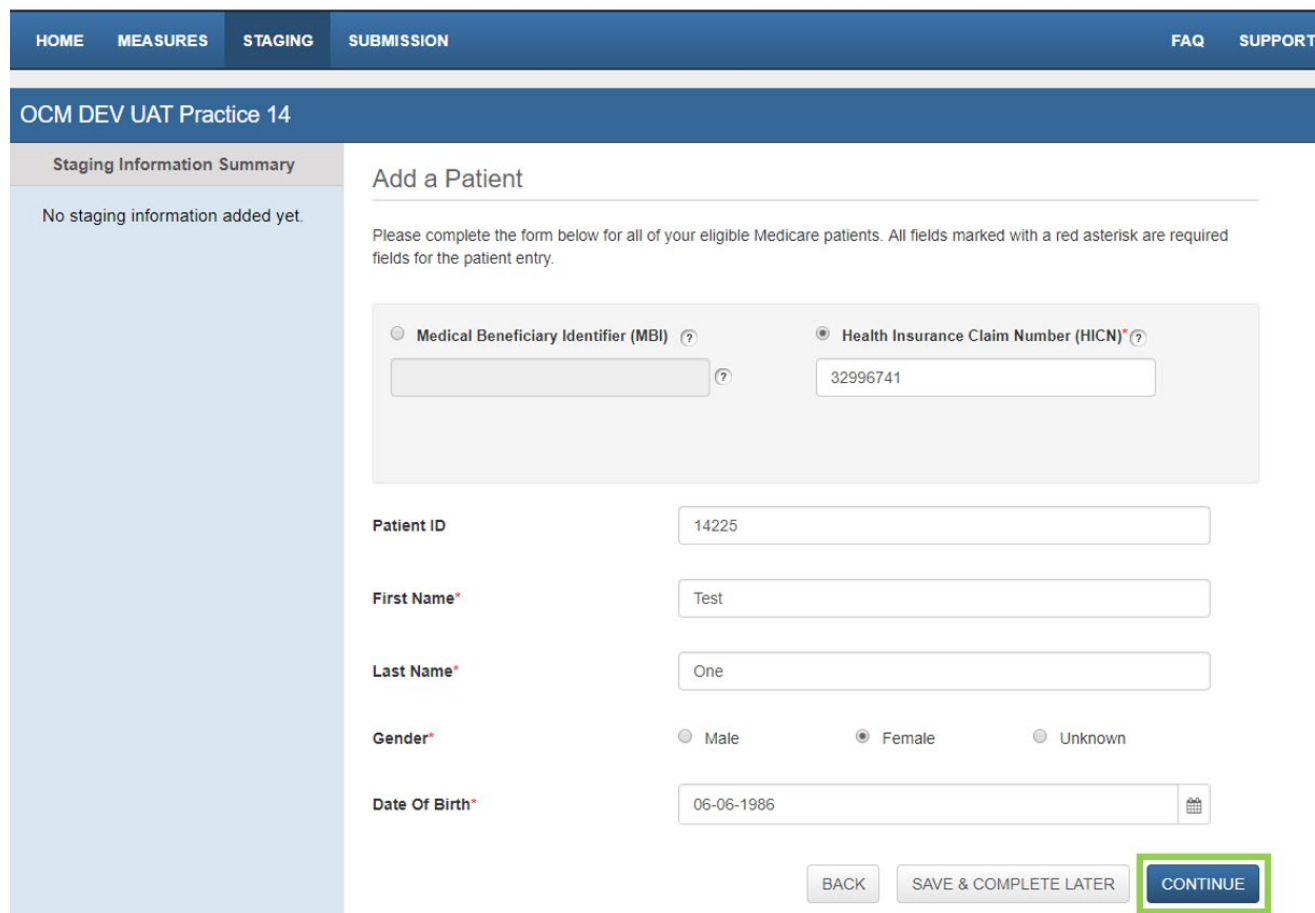
Date Of Birth\*

BACK SAVE & COMPLETE LATER CONTINUE



Step 9: Once all mandatory fields are filled out, select 'Continue' to save data and continue to the Staging Information screen for the patient (Figure 72). Selecting 'Back' will refresh the screen and navigate to the home screen of the Staging tab. Any data entered on the Add a Patient screen will not be saved. Selecting 'Save & Complete Later' will save the data and navigate to the home screen of the Staging tab.

Figure 72: Add a Patient – Continue



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OCM DEV UAT Practice 14

Staging Information Summary

No staging information added yet.

### Add a Patient

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ? ☒ Health Insurance Claim Number (HICN)\* ?


?

Patient ID

First Name\*

Last Name\*

Gender\* ☐ Male ☒ Female ☐ Unknown

Date Of Birth\*  

BACK SAVE & COMPLETE LATER **CONTINUE**



Step 10: Selecting 'Continue' on the Add a Patient page will take the user to a blank Staging Information screen for the patient (Figure 73). The patient data entered in the previous screen, consisting of the patient identifier, patient name, gender, and date of birth, will appear on this screen as well to view at all times.

Figure 73: Staging Information

The screenshot displays the 'Staging Information' screen. At the top is a navigation bar with links: HOME, MEASURES, STAGING (active), SUBMISSION, FAQ, and SUPPORT. Below this is a header 'OCM DEV UAT Practice 3'. The main title 'Staging Information' is followed by a detailed instruction: 'Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.'

Patient information is displayed in a box: MBI/HICN: 9078563412, Patient Name: Test One (Female), and Date of Birth: 02/16/1950. Below this is a form for adding cancer diagnosis information. It includes a dropdown for 'Initial Diagnosis Date' (placeholder: MM-DD-YYYY) and a text input for 'ICD-10 Code' (placeholder: Start typing to select ICD-10 Code). At the bottom left is a button 'ADD ADDITIONAL CANCER DIAGNOSIS'. At the bottom right are buttons 'BACK' and 'SAVE'.



Step 11: Enter the patient's Initial Diagnosis Date, which is a mandatory field (Figure 74). Initial Diagnosis Date must be in MM-DD-YYYY format and a built-in calendar can be used to select the appropriate date. The Initial Diagnosis Date should be answered as precisely as possible with an accurate month, day and year. However, there may be instances (such as an initial diagnosis that occurred 20 years ago) where an exact date is not known. In these cases, if the initial diagnosis is known to be, for example, in March 1995, then 03/01/1995 should be reported. If the initial diagnosis is only known to have occurred in 1995, then 01/01/1995 should be reported.

**Note:** All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code.

Figure 74: Staging Information – Initial Diagnosis Date

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### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 9078563412  
Patient Name: Test One (Female) Date of Birth: 02/16/1950

Initial Diagnosis Date \* 03-04-2018

ICD-10 Code \* Start typing to select ICD-10 Code

ADD ADDITIONAL CANCER DIAGNOSIS

BACK SAVE



Step 12: Enter the patient's ICD-10 Code or diagnosis description, which is a mandatory field (Figure 75). As the ICD-10 code or description is being typed, the system will display up to 100 matches from which to choose based on what is typed.

Figure 75: Staging Information – ICD-10 Code

### OCM DEV UAT Practice 3

#### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 9078563412

Patient Name: Test One (Female)

Date of Birth: 02/16/1950

The screenshot displays the 'Staging Information' form. At the top, patient information is shown: MBI/HICN: 9078563412, Patient Name: Test One (Female), and Date of Birth: 02/16/1950. Below this, the 'Initial Diagnosis Date\*' is set to 03-04-2018. The 'ICD-10 Code\*' field is highlighted with a green box and has a dropdown menu open, showing a list of cancer codes and descriptions. The dropdown list includes: C00.0 Malignant neoplasm of external upper lip, C00.1 Malignant neoplasm of external lower lip, C00.2 Malignant neoplasm of external lip, unspecified, C00.3 Malignant neoplasm of upper lip, inner aspect, C00.4 Malignant neoplasm of lower lip, inner aspect, C00.5 Malignant neoplasm of lip, unspecified, inner aspect, C00.6 Malignant neoplasm of commissure of lip, unspecified, and C00.8 Malignant neoplasm of overlapping sites of lip. To the left of the dropdown, there is a button labeled 'ADD ADDITIONAL CANCER DIAGNOSIS'. To the right of the dropdown, there are 'BACK' and 'SAVE' buttons.



Step 13: Once the Initial Diagnosis Date and ICD-10 Code are entered, the AJCC Edition field will appear. Select the applicable AJCC Edition (Figure 76).

**Note:** For MEOS-only ICD-10 codes, the Initial Diagnosis Date and ICD-10 code are the only fields that will display for the diagnosis.

If an Initial Diagnosis Date prior to 01/01/2018 is reported, the AJCC Edition field will pre-populate with a value of '7th' and will not be editable. If an Initial Diagnosis Date of 01/01/2018 or later is reported, the AJCC Edition field will allow the user to select a value of '7th' or '8th'.

After the AJCC Edition is selected, the Data Registry will display all applicable staging fields (both required and optional) based on the diagnosis provided. Data elements displayed will not indicate which are required and which are optional. Refer to the OCM Staging and Clinical Data Specifications PP8 v3.0 document for the required and optional staging data elements for each OCM Cancer Bundle and diagnosis code.

Figure 76: Staging Information – AJCC Edition

#### OCM DEV UAT Practice 3

##### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 9078563412

Patient Name: Test One (Female)

Date of Birth: 02/16/1950

Initial Diagnosis Date \*

03-04-2018

ICD-10 Code \*

C50.011 Malignant neoplasm of nipple and areola, right female breast

AJCC Edition \*

Select

7th

8th

ADD ADDITIONAL CANCER DIAGNOSIS

BACK

SAVE



Step 14: Enter the patient's Current Clinical Status and Current Clinical Status Date (Figure 77). Select the question mark icon next to the Current Clinical Status field to view the definition of each status option. After selecting the Current Clinical Status and Date, select 'Add' to add the status to the Clinical Status History.

**Figure 77: Staging Information – Current Clinical Status Add**

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Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.


**MBI/HICN:** 9078563412

**Patient Name:** Test One (Female)


**Date of Birth:** 02/16/1950

▼ Breast Cancer Group (03-04-2018)


**Initial Diagnosis Date \***





**ICD-10 Code \***





**AJCC Edition \***



**Current Clinical Status**

**Clinical Status History**

Clinical Status	Clinical Status Date	Actions
No clinical statuses have been added yet.		



Practices are encouraged to update the Current Clinical Status whenever there is a change in the patient's clinical status. If there is a change in clinical status at any point, users can add a new Current Clinical Status with the appropriate date. The Clinical Status History section shows a patient's previous and current clinical statuses reported by the practice (Figure 78). Practices may edit or delete current clinical status values or dates that have been reported.

Figure 78: Staging Information – Clinical Status History

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### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 9078563412

Patient Name: Test One (Female)

Date of Birth: 02/16/1950

▼ Breast Cancer Group (03-04-2018)

Initial Diagnosis Date \*

03-04-2018

ICD-10 Code \*

C50.011 Malignant neoplasm of nipple and areola, right female breast

AJCC Edition \*

8th

Current Clinical Status

Select

MM-DD-YYYY

Add

Clinical Status History

Clinical Status	Clinical Status Date	Actions
Responding	05-31-2018	Edit Delete



To edit a current clinical status that has been reported, select 'Edit' and the status and date may be modified. Select 'Save' to save the updates, or 'Cancel' to make no updates (Figure 79).

Figure 79: Staging Information – Current Clinical Status Edit

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OCM DEV UAT Practice 3

### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 9078563412  
Patient Name: Test One (Female) Date of Birth: 02/16/1950

▼ Breast Cancer Group (03-04-2018)

Initial Diagnosis Date \* 03-04-2018

ICD-10 Code \* C50.011 Malignant neoplasm of nipple and areola, right female breast

AJCC Edition \* 8th

Current Clinical Status Select MM-DD-YYYY Add

Clinical Status History		
Clinical Status	Clinical Status Date	Actions
Responding	05-31-2018	Save Cancel

To delete a current clinical status that has been reported, select 'Delete'. A pop-up will appear. Select 'Yes' to delete the status, or 'No' to cancel the delete (Figure 80).

Figure 80: Staging Information – Current Clinical Status Delete Confirmation Window

Confirm X

Are you sure you would like to delete this current clinical status information?

Yes No

If a patient has complete staging and clinical data reported for a performance period, and initiates a subsequent episode in another performance period, practices are required to update the Current Clinical Status. At a minimum, Current Clinical Status must be reviewed and reported with an associated date that falls within the dates of each episode for a patient, for each performance period the patient is attributed. A Current Clinical Status and the



associated date that falls within the dates of the episode must be reported for each performance period the patient is attributed to your practice even if the patient's Current Clinical Status did not change from the prior performance period.

To view the episode dates for which a diagnosis has been attributed for a performance period, select the "Click Here" button above the Clinical Status History (Figure 81). Episode dates will not display for PP1 or PP2. Diagnoses that are never attributed will not display the episode dates box.

Figure 81: Staging Information with Episode Dates Box

**OCM DEV UAT Practice 9**

### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

**MBI/HICN:** 5EV5EV1EE25  
**Patient Name:** S205 Submission\_205 (Female)  
**Date of Birth:** 03/09/1947

**Female GU Cancer other than Ovary Group (04-02-2018)**

**Initial Diagnosis Date \*** 04-02-2018

**ICD-10 Code \*** C54.2 Malignant neoplasm of myometrium

**AJCC Edition \*** 8th

**Current Clinical Status** Select ? MM-DD-YYYY Add

**Click Here** to show the list of attributed episodes for this Cancer Bundle.

#### Clinical Status History

Clinical Status	Clinical Status Date	Actions
Local or Regional Recurrence/Relapse	06-13-2018	Edit Delete

The episode start and end dates are displayed (Figure 82). If a warning icon (yellow triangle containing an exclamation point) displays next to the episode dates, this indicates a Clinical Status must be entered within the episode date range for the performance period. The staging and clinical data will be considered incomplete for the corresponding performance period as long as this is missing.



**Figure 82: Staging Information with Episode Dates Box Expanded**

**HOME MEASURES STAGING SUBMISSION FAQ SUPPORT**

**OCM DEV UAT Practice 9**

### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

**MBI/HICN:** 5EV5EV1EE25  
**Patient Name:** S205 Submission\_205 (Female)  
**Date of Birth:** 03/09/1947

**Female GU Cancer other than Ovary Group (04-02-2018)**

**Initial Diagnosis Date \*** 04-02-2018

**ICD-10 Code \*** C54.2 Malignant neoplasm of myometrium

**AJCC Edition \*** 8th

**Current Clinical Status** Select

[Click Here](#) to show the list of attributed episodes for this Cancer Bundle.

PP3: 09/14/2017 - 03/05/2018 ⚠

**Step 15:** Complete the remaining staging fields that are displayed on the screen (Figure 83).

The practice must supply all required staging information for a particular cancer bundle by the submission deadline for the performance period to meet the requirement of complete reporting of staging and clinical data for the model. Required staging information for each cancer bundle can be found in the OCM Staging and Clinical Data Specifications\_PP8\_v3.0 document.

**Note:** There are several required and optional fields in the patient demographic form and patient staging form based on the OCM Cancer Bundle (Steps 2 – 16). Refer to the OCM Staging and Clinical Data Specifications PP8 v3.0 document for the required and optional staging data elements for each OCM Cancer Bundle and diagnosis code.



Figure 83: Staging Information – Additional Information

Breast Cancer Group (03-04-2018)

Initial Diagnosis Date \*

03-04-2018

ICD-10 Code \*

C50.011 Malignant neoplasm of nipple and areola, right female breast

AJCC Edition \*

8th

Current Clinical Status

Select

MM-DD-YYYY

Add

Clinical Status History

Clinical Status	Clinical Status Date	Actions
Responding	05-31-2018	<div>Edit</div> <div>Delete</div>

Showing 1 - 1 of 1

Primary Tumor

Select

Nodal Disease

Select

Metastasis

Select

Histology

Select

Molecular Mutations

Estrogen Receptor

Select

Progesterone Receptor

Select

HER2 Amplification

Select

BRCA1 Result

Select

BRCA2 Result

Select

dMMR Result

Select

Prognostic Multi-Gene Assay Performed?

Select

ADD ADDITIONAL CANCER DIAGNOSIS

BACK

SAVE



Step 16: If any additional cancer diagnosis needs to be added for a patient, select 'Add Additional Cancer Diagnosis' (Figure 84). If no additional cancer diagnoses need to be added for a patient, select 'Save'.

Figure 84: Add Additional Cancer Diagnosis and Save

Primary Tumor: pTX

Nodal Disease: N0

Metastasis: cM0(i+)

Histology: Inflammatory

Molecular Mutations:

- Estrogen Receptor: Negative
- Progesterone Receptor: Positive
- HER2 Amplification: Negative
- BRCA1 Result: Positive
- BRCA2 Result: Positive
- dMMR Result: Negative (Absent)

Prognostic Multi-Gene Assay Performed?: No

Buttons: ADD ADDITIONAL CANCER DIAGNOSIS, BACK, SAVE

**Note:** There are several required and optional fields in the patient demographic form and patient staging form based on the OCM Cancer Bundle (Steps 2 – 16). Refer to the OCM Staging and Clinical Data Specifications PP8 v3.0 document for the required and optional staging data elements for each OCM Cancer Bundle and diagnosis code.

#### 4.2.2.6.1 Editing or Deleting a Previously Reported Patient Manually

In the Staging tab, practices may manually edit or delete previously reported patients in the Data Registry.

Practices may delete patients who have never been attributed to any performance period. However, practices are not able to delete patients that have ever been attributed to any performance period. As an example, if a patient was attributed to your practice for PP8, you will not be able to delete them in the Data Registry since they have been attributed to one of the performance periods.

To edit or delete previously reported patients in the Data Registry, you may complete the following steps.



Step 1: In the Staging tab, go to the 'Actions' column and select the gear drop down of the patient for which you would like to edit or delete patient data (Figure 85).

Figure 85: Edit or Delete Patient Action

The screenshot shows the 'Staging' tab in the OCM DEV UAT Practice 9 interface. The top navigation bar includes 'HOME', 'MEASURES', 'STAGING' (selected), and 'SUBMISSION'. The right side shows 'Logged in as Practice Admin' and a 'Launch Lab Environment' button. Below the navigation bar, the 'Staging' section contains two main options: 'Manually Enter Patient Data' with an 'ADD NEW PATIENT' button, and 'Upload Your Own File' with an 'UPLOAD SPREADSHEET' button. A yellow alert box states: 'Attention! There are duplicate patient records reported in the registry for your practice. Click Here to view and address the duplicate patient records.' Below this, there are buttons for 'View Previous Uploads' and 'Perform Bulk Actions'. The 'PP8 Attribution' section shows '18 of 81 need attention' and 'All Patients in Registry' with '997 patients'. The 'PP8 Attribution' table lists patients with columns for MBI/HICN, First Name, Last Name, Date Of Birth, Last Submitted, Last Updated, and Actions. The 'Actions' column for each row contains a gear icon, which is highlighted by a green box in the original image.

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/18/2021	02/18/2021	[Gear Icon]
583977HR127	NRAS Mutation	DataElement4	07/01/1978	02/18/2021	02/18/2021	[Gear Icon]
583977HR126	KRAS Mutation	DataElement4	07/01/1978	02/18/2021	02/18/2021	[Gear Icon]
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1978	02/18/2021	02/18/2021	[Gear Icon]
583977HR124	ALK Gene Mutation	DataElement4	07/01/1978	02/18/2021	02/18/2021	[Gear Icon]



Step 2: Select 'Edit Patient' or 'Delete Patient', depending on what action you want to take for the respective patient (Figure 86).

**Note:** Only 'Edit Patient' and 'Edit Staging Data' options will show for attributed patients (Figure 87).

Figure 86: Edit Patient or Delete Patient

PP8 Attribution  
18 of 81 need attention

All Patients in Registry  
997 patients

**All Registry Patients**  
Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have Invalid HICN/Invalid MBI.

All Incomplete Patients Search by patient identifier or name Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
5EV5EV1EE25	S205	Submission...	03/09/1947	Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
9UU9Y1WW63	Staging 83	Patient 83	12/02/1975	Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
9UU9Y1WW10	Staging 10	Patient 10	10/10/1975	Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
K824882484	Staging 59	Patient 59	05/25/1982	Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
K824882483	Staging 58	Patient 58	05/24/1982	Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
A171475585				Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
A171475574				Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
231559908	FN_44	LN_44	04/05/1980	Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
777123479				Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]
4DH5KCTAF81				Not Attributed PP8	02/16/2021	02/11/2021	[Edit Patient] [Edit Staging Data] [Delete Patient]

Showing 31 - 40 of 656 Listings Per Page: 5 10 25 50 First Previous 2 3 4 5 6 Next Last

Figure 87: Edit Patient or Edit Staging Data for an Attributed Patient

PP8 Attribution  
18 of 81 need attention

All Patients in Registry  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	[Edit Patient] [Edit Staging Data]
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR119	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR118	Revised ISS Stage	DataElement4	07/01/1976	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR104	Resection	DataElement3	06/01/1975	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR103	Tumor Grade	DataElement3	06/01/1975	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]
583977HR102	Tumor Type	DataElement3	06/01/1975	02/16/2021	02/16/2021	[Edit Patient] [Edit Staging Data]

Showing 1 - 10 of 18 Listings Per Page: 5 10 25 50 1 2 Next Last



Step 3: If you chose to 'Edit Patient', make changes on the Edit Patient page and save (Figure 88).

Figure 88: Edit Patient Page

OCM DEV UAT Practice 1

Staging Information Summary

Small Intestine/Colorectal Cancer Group (04-05-2017)

Edit Staging Data

**Edit Patient**

Please complete the form below for all of your eligible Medicare patients. All fields marked with a red asterisk are required fields for the patient entry.

☐ Medical Beneficiary Identifier (MBI) ?
 ☒ Health Insurance Claim Number (HICN)\* ?

?

Patient ID

First Name\*

Last Name\*

Gender\*
 ☒ Male
 ☐ Female
 ☐ Unknown

Date Of Birth\*

BACK SAVE

If you chose 'Delete Patient', you will be asked to confirm that you want to delete this patient and all the data associated with this patient from the Data Registry by selecting 'Yes'. This change cannot be reversed (Figure 89).

Figure 89: Confirm Patient Deletion

Confirm

Are you sure you would like to delete this patient (**Test Patient1**) and all of the data associated with this patient?

Yes No

#### 4.2.2.6.2 Editing or Deleting Previously Reported Staging and Clinical Data Manually

In the Staging tab, practices may manually edit or delete previously reported staging and clinical data in the Data Registry.

Practices may only delete ICD-10 diagnosis codes on the Staging Information Page for attributed patients if there is more than one ICD-10 diagnosis code reported for that patient. The Add Cancer Diagnosis icon will be displayed on the Staging Information Page, Patient Grid, and on the left navigation screen of the Patient Edit Page if there was only one ICD-10



diagnosis code associated with an attributed cancer bundle and the practice deleted it. Practices will need to edit or upload the patient's staging information to add the attributed cancer bundle's diagnosis and required staging and clinical data.

To add, edit or delete staging and clinical data, you may complete the following steps.

Step 1: In the Staging tab, go to the 'Actions' column and select the gear drop down of the patient for whom you would like to edit or delete staging and clinical data (Figure 90).

Figure 90: Edit or Delete Staging and Clinical Data Action

**OCM DEV UAT Practice 9**

Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.  
**ADD NEW PATIENT**

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.  
**UPLOAD SPREADSHEET**

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

View Previous Uploads  
**Perform Bulk Actions**

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Q X Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/19/2021	
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR119	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR118	Revised ISS Stage	DataElement4	07/01/1976	02/16/2021	02/16/2021	



## Step 2: Select 'Edit Staging Data' (Figure 91).

Figure 91: Edit Staging Data

PP8 Attribution  
18 of 81 need attention

All Patients in Registry  
997 patients

### All Registry Patients

Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have Invalid HICN/Invalid MBI.

All Incomplete Patients Search by patient identifier or name Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
5EV5EV1EE25	S205	Submission...	03/09/1947	Not Attributed PP8	02/16/2021	02/11/2021	
9UU9YY1WW83	Staging 83	Patient 83	12/02/1975	Not Attributed PP8	02/16/2021	02/11/2021	
9UU9YY1WW10	Staging 10	Patient 10	10/10/1975	Not Attributed PP8	02/16/2021	02/11/2021	
K824882484	Staging 59	Patient 59	08/25/1982	Not Attributed PP8	02/16/2021	02/11/2021	
K824882483	Staging 58	Patient 58	08/24/1982	Not Attributed PP8	02/16/2021	02/11/2021	
A171475585				Not Attributed PP8	02/16/2021	02/11/2021	

Staging Information Attribution History

OCM Cancer Bundle	Initial Diagnosis Date	ICD-10 Code	Staging Status
Secondary Malignant Neoplasm of Respiratory and Digestive Organs Group	10/26/2011	C78.7	Complete

A171475574			Not Attributed PP8	02/16/2021	02/11/2021	
2315599908	FN_44	LN_44	Not Attributed PP8	02/16/2021	02/11/2021	
777123479			Not Attributed PP8	02/16/2021	02/11/2021	
4DH5KCTAF81			Not Attributed PP8	02/16/2021	02/11/2021	

Showing 31 - 40 of 656 Listings Per Page: 5 10 25 50 First Previous 2 3 4 5 6 Next Last

[Edit Patient](#)  
[Edit Staging Data](#)  
[Delete Patient](#)



Step 3: Here you can edit or delete ICD-10 cancer diagnosis codes, and the optional or required staging and clinical data reported. Make changes on the Staging Information Page and save (Figure 92).

Figure 92: Edit or Delete Staging Information Page

HOME
MEASURES
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SUPPORT

OCM DEV UAT Practice 3

### Staging Information

Please provide all additional Staging information available for the patient. All fields marked with a red asterisk are required to save the record; refer to the OCM Staging and Clinical Data Specifications which list the fields required for each ICD-10 cancer diagnosis code. If the patient has multiple cancers, please select "Add Additional Cancer Diagnosis" to add additional cancer diagnosis information.

MBI/HICN: 2555123A348

Patient Name: FN\_148 LN\_148 (Female)

Date of Birth: 05/06/1944

Chronic Leukemia Group (08-07-2017)
Delete

Initial Diagnosis Date \*
08-07-2017

ICD-10 Code \*
C91.11 Chronic lymphocytic leukemia of B-cell type in remission

Current Clinical Status
Select
MM-DD-YYYY
Add

Click Here to show the list of attributed episodes for this Cancer Bundle.

#### Clinical Status History

Clinical Status	Clinical Status Date	Actions
Responding	12-18-2017	Edit Delete

Breast Cancer Group (04-10-2017)
Update to Current Clinical Reporting Requirements
Delete

ADD ADDITIONAL CANCER DIAGNOSIS

CANCEL
SAVE



## 4.2.2.7 File Upload Data Reporting

**Note:** Files for upload contain both required and optional data elements. Optional data elements include ‘\_Optional’ in the file column headers, and reporting of the optional data elements is not required for the patient record to be considered complete. Please refer to section [4.2.2.7.1](#) or the OCM File Submission Guide as a supplement for this section.

Step 1: To add patient and/or staging and clinical data for the practice via the upload of a file, select ‘Upload Spreadsheet’ (Figure 93).

Figure 93: Staging Tab – Upload Patients and Patient Staging and Clinical Data

OCM DEV UAT Practice 9

Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

View Previous Uploads  
Perform Bulk Actions

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients

**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Export Reports

MBI/HICN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR127	NRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR126	KRAS Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR124	ALK Gene Mutation	DataElement4	07/01/1976	02/16/2021	02/16/2021	
583977HR119	Tumor Type	DataElement4	07/01/1976	02/16/2021	02/16/2021	



Step 2: The Resources section (Figure 94) of the Upload Patients and Patient Data screen contains four downloadable files:

- Patient Template – this Patient Upload File allows users to add, edit and delete patient demographic data in the Data Registry.
- Definition File – this file includes the file definitions for the Patient Template and Staging Upload Template/Staging Abstraction Tool, as well as provides sample patient and staging files.
- Staging Abstraction Tool – this tool allows users to add, edit and delete staging and clinical data for patients in the Data Registry. This file is different from the Staging Template, in that it provides field-level validation as well as field enabling/disabling based on the ICD-10 code entered. An Instructions tab is included to assist users.
- Staging Template – this Staging Upload File allows users to add, edit and delete staging and clinical data for patients in the Data Registry.

All downloadable files noted above, as well as the OCM File Submission Guide are also available via OCM Connect.

Figure 94: Upload Patients and Patient Staging Data – Resources

The screenshot displays the 'Upload Patients and Patient Data' interface. At the top, a navigation bar includes 'HOME', 'MEASURES', 'STAGING' (the active tab), and 'SUBMISSION'. To the right of the navigation bar are links for 'FAQ' and 'SUPPORT'. Below the navigation bar, a blue header reads 'OCM DEV UAT Practice 14'. The main heading is 'Upload Patients and Patient Data'. A paragraph explains that users should download Data Templates to ensure correct column/row headers. To the right, a 'Resources' box lists four downloadable files: 'Patient Template', 'Definition File', 'Staging Abstraction Tool', and 'Staging Template'. Below this, two sections are provided: 'Upload Patient Files' with a 'SELECT PATIENT FILES' button, and 'Upload Staging Files' with a 'SELECT PATIENT STAGING FILES' button. Both sections include instructions on file formats (.xls, .xlsx, .csv) and record limits.

The Staging tab contains one file you can upload to enter staging and clinical data into the Data Registry, the Staging Data Gap Export Report. This upload file allows users to update the report by populating valid values for any of the data gaps and uploading the updated file to the OCM Data Registry. This report is located on both the current open performance period Attribution sub-tab (e.g., PP8 Attribution), and the All Patients in Registry sub-tab. See section [4.2.1.6](#) for more details.

Download the desired data tool/template(s) and enter the necessary data in the tool/template(s).

**Note:** Editing the column headers in a tool/template will cause errors during upload. Editing tab names from "Staging" in the Staging Abstraction Tool, Staging Template, or Staging Data Gap Export



*Report will cause the processing of the files to fail. The file name given to the file when it is saved does not matter.*

Step 3: To select patient files to upload, select the 'Select Patient Files' option (Figure 95). To select staging and clinical data files, select the 'Select Patient Staging Files' option. Multiple patient and/or staging and clinical data files can be selected and then uploaded at the same time. Only .xls, .xlsx, and .csv files are accepted. The names of each of the selected files will display on the screen, each with an option to remove the file, if desired.

The maximum upload size acceptable for the Patient Upload File is 50,000 rows per file. If a practice has more than 50,000 rows of data to upload, split the file into two or more separate files, making sure that an individual patient's data is not split between the files. These two or more files may be uploaded together at the same time. File headers must match as they are provided in the data templates, but columns may be provided in any order.

The maximum upload size acceptable for the Staging Abstraction Tool and the Staging Template upload files is no more than 3,000 rows. If the user wishes to include more than 3,000 rows of data, multiple files may be uploaded to the OCM Data Registry.

**Figure 95: Upload Patients and Patient Staging Data – Select Files**

HOME MEASURES **STAGING** SUBMISSION FAQ SUPPORT

OCM DEV UAT Practice 14

## Upload Patients and Patient Data

To begin the upload process, please download the Data Templates. These files contain the correct column/row headers which correspond to the required data elements. Place the appropriate data into the template, and ensure that the columns match properly. Editing the template column header will cause errors during the upload process. The Definition File is available for download if you need assistance with the data templates.

For all patient data uploads, please upload the entire patient history. All previously uploaded patient data history will be erased and replaced with the currently uploaded data for any patients that are included in the uploaded staging files. At the end of each submission period, the data for that measurement period will be archived.

**Resources**

- Patient Template
- Definition File
- Staging Abstraction Tool
- Staging Template

**Upload Patient Files**

Select patient files to upload. You may upload the patient file and the staging data file at the same time. Please limit uploaded files to approx. 50,000 records per file. Only .xls, .xlsx, .csv files are accepted.

**SELECT PATIENT FILES**

**Upload Staging Files**

Select staging data files to upload. Please upload the entire patient history in the same staging file. You may upload the patient file and the staging data file at the same time. Please limit uploaded files to approx. 3,000 records per file. Only .xls, .xlsx, .csv files are accepted.

**SELECT PATIENT STAGING FILES**

OCMR\_Patient\_Upload\_File\_...

**Remove**

OCMDataRegistryStagingAbs...

**Remove**

Step 4: Once the files have been selected, select 'Upload Files' to upload the patient and staging and clinical data files (Figure 96). Users may upload one or many files of each type of file at one time. In addition, users may upload only a patient file or only a staging and clinical data file, if desired.

A Confirmation box is displayed when 'Upload Files' is selected. This box reminds users of the following:

- Patient files: all previously reported patient data will be maintained unless the patient file includes an 'Update Indicator' of 'Y'



- **Staging files:** all previously reported staging data for a patient's cancer diagnosis code/diagnosis date combination will be purged and overwritten with the staging data for that cancer diagnosis code/diagnosis date included in the staging files being uploaded. Please make sure to include all staging data for each cancer diagnosis code/diagnosis date combination in the staging files to complete the patient record in one submittal. Current Clinical Status and Current Clinical Status Date will not be overwritten.

Select 'OK' to proceed with the upload.

**Note:** It is recommended users upload the Patient Upload File before or at the same time as the Staging Abstraction Tool/Staging Template/Staging Data Gap Export Report. If practices upload the Patient Upload File after the Staging Abstraction Tool/Staging Template/Staging Data Gap Export Report, they will need the update indicator (UPDATE\_IND) to indicate "Y" for each patient that had staging data uploaded first. If the patient has been added to the Data Registry previously by the practice, or when the attribution data was loaded, the Patient Upload File does not need to be uploaded again, unless the patient information needs to be updated. Uploading the patient again will result in a warning message.

**Figure 96: Upload Patients and Patient Staging Data – Upload Files**

HOME MEASURES **STAGING** SUBMISSION FAQ SUPPORT

OCM DEV UAT Practice 14

### Upload Patients and Patient Data

To begin the upload process, please download the Data Templates. These files contain the correct column/row headers which correspond to the required data elements. Place the appropriate data into the template, and ensure that the columns match properly. Editing the template column header will cause errors during the upload process. The Definition File is available for download if you need assistance with the data templates.

**Resources**

- Patient Template
- Definition File
- Staging Abstraction Tool
- Staging Template

For all patient data (staging or CSV files) uploads, please upload the entire patient history. All previously uploaded patient data history will be erased and replaced with the currently uploaded data for any patients that are included in the uploaded staging files. At the end of each submission period, the data for that measurement period will be archived.

#### Upload Patient Files

Select patient files to upload. You may upload the patient file and the CSV data file at the same time. Please limit uploaded files to approx. 50,000 records per file. Only .xls, .xlsx, .csv files are accepted.

**SELECT PATIENT FILES**

#### Upload Staging Files

Select staging data files to upload. Please upload the entire patient history in the same staging file. You may upload the patient file and the staging data file at the same time. Please limit uploaded files to approx. 3,000 records per file. Only .xls, .xlsx, .csv files are accepted.

**SELECT PATIENT STAGING FILES**

OCMR\_Patient\_Upload\_File\_...

**Remove**

OCMDataRegistryStagingAbs...

**Remove**

RETURN TO PATIENT REGISTRY **UPLOAD FILES**



Step 5: Once files have uploaded, check to see if there are any errors. If an error log is created, a link to the error log will be displayed in the box with the uploaded file name (Figure 97).

**Figure 97: Upload Patients and Patient Staging Data – Upload Files Errors**

The screenshot displays the 'STAGING' section of the OCM Data Registry interface. At the top, a navigation bar includes links for HOME, MEASURES, STAGING (active), SUBMISSION, FAQ, and SUPPORT. Below this is a header for 'OCM DEV UAT Practice 9'. The main heading is 'Upload Patients and Patient Data'. Instructions for uploading data templates are provided, along with a 'Resources' box containing links for Patient Template, Definition File, Staging Abstraction Tool, and Staging Template. Two upload sections are visible: 'Upload Patient Files' and 'Upload Staging Files'. Each section has a 'SELECT' button. Below these are two file upload boxes. The first box, 'M72\_Patient.xlsx', shows a red 'Error' bar and a link to the 'Error Log'. The second box, 'M72\_Staging.xlsx', also shows a red 'Error' bar, a '0 / 37' status, and a link to the 'Error Log'. At the bottom right, there are buttons for 'RETURN TO PATIENT REGISTRY' and 'UPLOAD FILES'.

Select the 'Error Log' link to view errors and correct the errors in the source file. For a list of Patient Upload File and Staging Template/Staging Abstraction Tool/Staging Data Gap Export Report error messages, please visit the OCM File Submission Guide, available on OCM Connect.



Once rectified, upload files again and then select 'Return to Patient Registry' to navigate back to the Staging patient grid sub-tabs (Figure 98).

Figure 98: Return to Patient Registry Button

**HOME MEASURES STAGING SUBMISSION FAQ SUPPORT**

**OCM DEV UAT Practice 14**

## Upload Patients and Patient Data

To begin the upload process, please download the Data Templates. These files contain the correct column/row headers which correspond to the required data elements. Place the appropriate data into the template, and ensure that the columns match properly. Editing the template column header will cause errors during the upload process. The Definition File is available for download if you need assistance with the data templates.

**Resources**

- Patient Template
- Definition File
- Staging Abstraction Tool
- Staging Template

For all patient data (staging or CSV files) uploads, please upload the entire patient history. All previously uploaded patient data history will be erased and replaced with the currently uploaded data for any patients that are included in the uploaded staging files. At the end of each submission period, the data for that measurement period will be archived.

### Upload Patient Files

Select patient files to upload. You may upload the patient file and the CSV data file at the same time. Please limit uploaded files to approx. 50,000 records per file. Only .xls, .xlsx, .csv files are accepted.

**SELECT PATIENT FILES**

### Upload Staging Files

Select staging data files to upload. Please upload the entire patient history in the same staging file. You may upload the patient file and the staging data file at the same time. Please limit uploaded files to approx. 3,000 records per file. Only .xls, .xlsx, .csv files are accepted.

**SELECT PATIENT STAGING FILES**

OCMR\_Patient\_Upload\_File\_...

**Complete**

0 / 150

OCMDataRegistryStagingAbs...

**Complete**

149 / 149

**RETURN TO PATIENT REGISTRY**

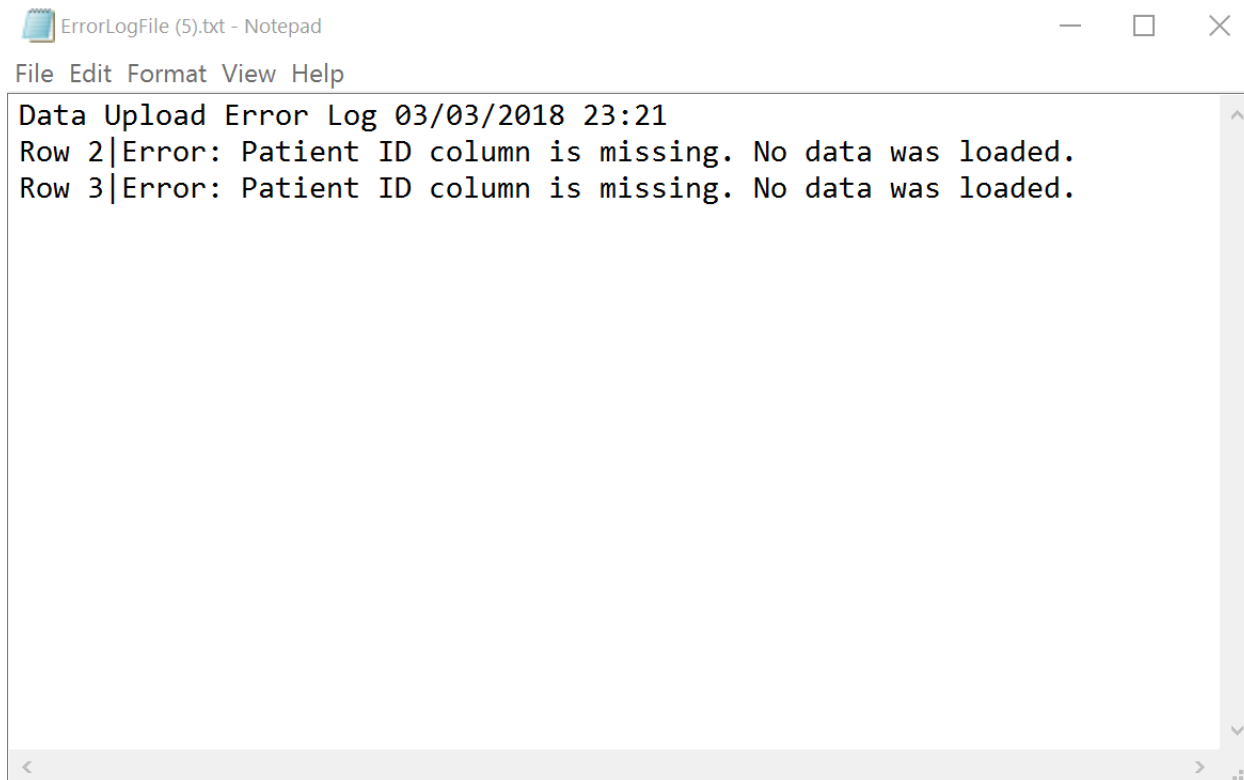
**UPLOAD FILES**



**Note:** The Error log is a text file and the beginning of the log has the date and time of upload (Figure 99). The lines below show the row of the uploaded file to which the error or warning applies, whether it was an error or warning, and the description of the particular error or warning.

**Note:** Errors must be fixed for successful upload to occur. Successful upload can occur with warnings present, but it is best that warnings are reviewed.

**Figure 99: Sample Error Log File**





Original upload files and Error logs can always be downloaded by selecting 'View Previous Uploads' (Figure 100 and Figure 101) on the Staging tab below the 'Upload Your Own File' box. After errors are fixed, the entire file can be uploaded again.

Figure 100: View Previous Uploads

OCM DEV UAT Practice 9

Staging

**Manually Enter Patient Data**  
Add individual patient data using web-based forms.

**ADD NEW PATIENT**

**Upload Your Own File**  
Add your practice data online using a spreadsheet, such as a CSV or Excel file.

**UPLOAD SPREADSHEET**

Attention! There are duplicate patient records reported in the registry for your practice. Click Here to view and address the duplicate patient records.

**View Previous Uploads**

**Perform Bulk Actions**

**PP8 Attribution**  
18 of 81 need attention

**All Patients in Registry**  
997 patients





















**PP8 Attribution**  
This tab contains a list of all the attributed patients for the current performance period. Complete the patient information and the staging data on this list of patients to count toward the attributed patient reporting requirements completeness threshold for the current performance period.

All Incomplete Patients Search by patient identifier or name Export Reports

MB/H/CN	First Name	Last Name	Date Of Birth	Last Submitted	Last Updated	Actions
583977HR129	Prognostic Multi-Gen...	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR127	NRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR126	KRAS Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR125	ROS1 Gene Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	
583977HR124	ALK Gene Mutation	DataElement4	07/01/1978	02/16/2021	02/16/2021	



Figure 101: Previous Uploads Screen

Upload History					
Previous Uploads					
File	Type	Status	Processed	Errors	Download
 OCMR_Patient_Upload_File_Test 1.xlsx Uploaded on Sep 14th 2018, 11:22:54 am	Patient	Complete	36 of 37	1	 Error Log
 OCMR_Patient_Upload_File_Test 1.xlsx Uploaded on Sep 14th 2018, 11:20:47 am	Patient	Complete	35 of 37	2	 Error Log
 OCMR_Patient_Upload_File_Test 1.xlsx Uploaded on Sep 14th 2018, 11:19:24 am	Patient	Complete	35 of 37	2	 Error Log
 OCMR_Patient_Upload_File_Test 1.xlsx Uploaded on Sep 14th 2018, 11:18:29 am	Patient	Complete	0 of 37	37	 Error Log
 OCMR_Patient_Upload_File_Test 1.xlsx Uploaded on Sep 14th 2018, 11:15:38 am	Patient	Complete	0 of 37	37	 Error Log
 OCMR_Patient_Upload_File_Test 1.xlsx Uploaded on Sep 14th 2018, 11:12:59 am	Patient	Complete	0 of 37	37	 Error Log
 OCMR_Patient_Upload_File_Test.xlsx Uploaded on Sep 14th 2018, 11:10:40 am	Patient	Failed	0 of 0	0	 Error Log
 Error Test-OCMDataRegistryStagingAbstractionTool_A... Uploaded on May 23rd 2018, 3:45:16 pm	Staging Data	Failed	0 of 0	0	 Error Log
 Error Test-OCMDataRegistryStagingAbstractionTool_A... Uploaded on May 23rd 2018, 3:41:29 pm	Staging Data	Complete	149 of 149	29	 Error Log
 OCMDataRegistryStagingAbstractionTool_Attribution_... Uploaded on May 21st 2018, 2:50:09 pm	Staging Data	Complete	149 of 149	28	 Error Log
Showing 1 - 10 of 13					
First Previous 1 2 Next Last					

#### 4.2.2.7.1 Uploading the Staging Data Gap Export Report

The Staging tab contains another downloadable file, the Staging Data Gap Export report. This upload file will allow users to update the report to populate valid values for any of the data gaps and upload the updated file to the OCM Data Registry. When exported, the Staging Data Gap Export report will display “DATA GAP” for missing data elements that are required, and “OPTIONAL DATA GAP” for missing data elements that are optional. This report is located on both the current open performance period Attribution sub-tab (e.g., PP8 Attribution), and the All Patients in Registry sub-tab. See section [4.2.1.6](#) for more details.

After downloading the report and updating the file with valid values from the OCM Staging and Clinical Data Specifications\_PP8\_v3.0, users must save and then upload the file by following the same process that is used to upload other staging data files (Staging Abstraction Tool and Staging Template). Follow [Step 4](#) and [Step 5](#) above.

This file is only available on the Staging tab, accessible when selecting the ‘Export Reports’ button, and then the ‘Export Gap Report’ option.

#### 4.2.2.7.2 Editing or Deleting a Previously Reported Patient by File Upload

As an alternative to manual editing or deleting, practices may edit or delete previously reported patients in the Data Registry via file upload in the Staging tab.



As a reminder, practices may delete patients who have never been attributed to any performance period. However, practices are not able to delete patients that have ever been attributed to any performance period. As an example, if a patient was attributed to your practice for PP5, you will not be able to delete them in the Data Registry since they have been attributed to one of the performance periods.

To edit patient data via file upload, users must use the UPDATE\_IND field in the Patient Upload File. When the UPDATE\_IND field is set to 'Y' for a row of data in a file upload, the patient in that row will update and replace the existing data in the Data Registry. Please note, practices are not able to update a HICN, MBI, or update from a HICN to MBI, using the Patient Upload File. A practice may update a HICN or MBI, by manually editing the patient data. In addition, if a practice elects to transition a patient from HICN to MBI, this must be done manually or using the MBI Transition Upload Template by uploading this file through the 'Perform Bulk Actions' function. See section [4.2.2.4.1](#) above for more information.

If you want to delete a patient via file upload and they have not ever been attributed to any performance period, you may do so by using the DELETE\_IND field in the Patient Upload File. When the DELETE\_IND field is set to 'Y' for a row of data in the Patient Upload File, the patient in that row will be deleted from the Data Registry.

If a user tries to delete an attributed patient using the Patient File, an error message will occur. The error message will read "Changes not saved. Patient has not been deleted. This patient has been attributed to at least one Performance Period and cannot be deleted."

#### *4.2.2.7.3 Editing or Deleting Previously Reported Staging and Clinical Data by File Upload*

As an alternative to manual editing or deleting, practices may edit or delete previously reported staging and clinical data in the Data Registry via file upload in the Staging tab.

As a reminder, practices may only delete ICD-10 diagnosis codes on the Staging Information Page for attributed patients if there is more than one ICD-10 Diagnosis Code reported for that patient. The Add Cancer Diagnosis icon will be displayed on the Staging Information Page, Patient Grid, and on the left navigation screen of the Patient Edit Page if there was only one ICD-10 diagnosis code associated with an attributed cancer bundle and the practice deleted it. Practices will need to edit the patient's staging information to add the attributed cancer bundle's diagnosis and required staging and clinical data.

If you would like to delete all previously reported staging and clinical data for a patient and diagnosis via file upload, you may do so by using the DELETE\_IND in the Staging Abstraction Tool, Staging Upload Template, and Staging Data Gap Export Report. When the DELETE\_IND field is set to 'Y' for a row of data in a file upload, all the patient's staging and clinical data for that cancer diagnosis code/date will be deleted from the Data Registry.

Do not use the 'Delete\_Ind' to delete patients that have been reported but were not attributed to your practice. You do not need to take any action on these patients, as they may be attributed to your practice in a future performance period.

**Note:** *If you want to delete the Current Clinical Status, use the Current\_Clinical\_Status\_Delete\_Ind to delete a previously reported Current Clinical Status, not the DELETE\_IND.*

For more details on editing and deleting previously reported staging and clinical data via file upload, please visit the OCM File Submission Guide located on OCM Connect.



## 4.2.3 Steps to Use the Data Registry – Reporting Measure Data

Under the Measures Tab, the Data Registry provides a mechanism for users to enter aggregate measure results for OCM FFS Beneficiary measures OCM-4a, OCM-4b, and OCM-5.

### 4.2.3.1 Performance Rates

Users are required to manually enter denominator, numerator, and denominator exclusions and denominator exceptions (if applicable) values for each measure.

Aggregate measure results are required to be reported for the practice for all quality measures.

OCM Quality Measure aggregate totals are calculated using a measure hierarchy. While not all populations will be used in each measure, the calculation hierarchy to be followed is:

- **Denominator**: All criteria must be met to include the patient/patient encounter in the denominator. The denominator count reported should have denominator exclusions and denominator exceptions removed after evaluating all population criteria.
- **Denominator Exclusions**: To be evaluated for the denominator exclusions, the patient/patient encounter must first meet the denominator criteria.
- **Numerator**: To be evaluated for the numerator, the patient/patient encounter must meet the denominator criteria and NOT meet the denominator exclusions criteria.
- **Denominator Exceptions**: To be evaluated for the denominator exceptions, the patient/patient encounter must first meet the denominator criteria, NOT meet the denominator exclusions criteria and NOT meet the numerator criteria.



Step 1: To enter aggregate OCM FFS Beneficiary measures, go to the 'Measures' tab (Figure 102). If there is currently only one measurement period pending submission for the practice, the user will be navigated to the OCM FFS Beneficiary measures screen for the current measurement period (Figure 103). The measurement period may be available to view but will not be available to report on until the measurement period has completed. Again, users are required to manually enter all applicable values for each measure. Information for the entire practice must be entered.

**Note:** As an exception, if there is more than one measurement period pending submission for the practice, both measurement periods will be displayed on the screen, allowing users to select each one to view the measures entry screen.

Figure 102: Reporting Measure Data – OCM FFS Beneficiary Measures (1)

#### OCM FFS Beneficiary Measures (OCM-4a, OCM-4b, OCM-5)

Please provide the appropriate patient or encounter counts based on the criteria associated with each measure population below. All fields marked with a red asterisk are required fields.

OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified

Measurement Period:

July - December 2020

Denominator Question: \*

How many patient encounters for OCM FFS Beneficiaries in your practice met all the criteria in one of the two following options?

- Patients with an active diagnosis of cancer during the qualifying radiation treatment management encounter and
- Qualifying radiation treatment management encounter for radiation therapy during the measurement period

OR

- Patients with an active diagnosis of cancer during the qualifying provider encounter and
- Qualifying provider encounter (without telehealth modifiers GQ, GT, 95 or POS 02) during the measurement period and
- Chemotherapy administration within 30 days before the end of the qualifying provider encounter AND within 30 days after the end of the qualifying provider encounter

100

Numerator Question: \*

How many patient encounters for OCM FFS Beneficiaries in your practice met the following criteria?

- Pain intensity quantified during qualifying encounter

95

OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain

Measurement Period:

July - December 2020

Denominator Question: \*

How many patient encounters for OCM FFS Beneficiaries in your practice met the following criteria?

- Qualifies for the OCM-4a denominator and numerator and
- Pain present during the qualifying encounter

80

Numerator Question: \*

How many patient encounters for OCM FFS Beneficiaries in your practice met the following criteria?

- Documented plan of care to address pain during the qualifying encounter

70



**Figure 103: Reporting Measure Data – OCM FFS Beneficiary Measures (2)**

▼ OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measurement Period:	July - December 2020	
Denominator Question: *	How many OCM FFS Beneficiaries in your practice meet all the following criteria, and do not meet any of the Denominator Exclusions or Denominator Exceptions criteria? <ul style="list-style-type: none"> <li>Qualifying provider encounter during the measurement period and</li> <li>Aged 18 years or older on the date of the qualifying provider encounter</li> </ul>	100
Denominator Exclusions Question: *	How many OCM FFS Beneficiaries in your practice met at least one of the following criteria? <ul style="list-style-type: none"> <li>The patient had an active depression diagnosis during the qualifying provider encounter or</li> <li>The patient had an active bipolar disorder diagnosis during the qualifying provider encounter</li> </ul>	10
Numerator Question: *	How many OCM FFS Beneficiaries in your practice met all the criteria for one of the following options? <ul style="list-style-type: none"> <li>Screening for depression during the measurement period and</li> <li>Screening for depression 14 days or less before or on the day of the qualifying provider encounter and</li> <li>Screening for depression has a result</li> <li>Most recent screening for depression reviewed and addressed during the qualifying provider encounter AND result was negative</li> </ul> OR <ul style="list-style-type: none"> <li>Screening for depression during the measurement period and</li> <li>Screening for depression 14 days or less before or on the day of the qualifying provider encounter and</li> <li>Screening for depression has a result</li> <li>Most recent screening for depression reviewed and addressed during the qualifying provider encounter AND result was positive and</li> <li>Follow-up plan documented on the same day as the qualifying provider encounter</li> </ul>	85
Denominator Exceptions Question for OCM FFS Beneficiaries who did not meet the Numerator criteria: *	How many OCM FFS Beneficiaries in your practice met at least one of the following criteria? <ul style="list-style-type: none"> <li>The patient had a patient reason for not performing depression screening during the qualifying provider encounter or</li> <li>The patient had a medical or other reason for not performing depression screening during the qualifying provider encounter</li> </ul>	5

Step 2: Once all aggregate measure result values are entered and ready to be saved, select 'Save' (Figure 104).



Figure 104: Reporting Measure Data – Save or Go Back

▼ OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Measurement Period: July - December 2020

Denominator Question: \* How many OCM FFS Beneficiaries in your practice meet all the following criteria, and do not meet any of the Denominator Exclusions or Denominator Exceptions criteria?

- Qualifying provider encounter during the measurement period and
- Aged 18 years or older on the date of the qualifying provider encounter

Denominator Exclusions Question: \* How many OCM FFS Beneficiaries in your practice met at least one of the following criteria?

- The patient had an active depression diagnosis during the qualifying provider encounter or
- The patient had an active bipolar disorder diagnosis during the qualifying provider encounter

Numerator Question: \* How many OCM FFS Beneficiaries in your practice met all the criteria for one of the following options?

- Screening for depression during the measurement period and
- Screening for depression 14 days or less before or on the day of the qualifying provider encounter and
- Screening for depression has a result
- Most recent screening for depression reviewed and addressed during the qualifying provider encounter AND result was negative

OR

- Screening for depression during the measurement period and
- Screening for depression 14 days or less before or on the day of the qualifying provider encounter and
- Screening for depression has a result
- Most recent screening for depression reviewed and addressed during the qualifying provider encounter AND result was positive and
- Follow-up plan documented on the same day as the qualifying provider encounter

Denominator Exceptions Question for OCM FFS Beneficiaries who did not meet the Numerator criteria: \* How many OCM FFS Beneficiaries in your practice met at least one of the following criteria?

- The patient had a patient reason for not performing depression screening during the qualifying provider encounter or
- The patient had a medical or other reason for not performing depression screening during the qualifying provider encounter



Step 3: If 'Save' was chosen, a screen is displayed for users to view the aggregate measure results that were entered, as well as the calculated performance rates for all measures.

Practices should carefully review their results and ensure they reflect the expected measure results based on the aggregate results entered during the measurement period. The performance rates can be used as a tool throughout the measurement period to monitor measure results as data is entered and/or uploaded. To make changes, or to wait to submit, select 'Go Back' (Figure 105). Users may edit aggregate measure results until submission is complete.

To proceed with submission, go to the 'Submission' tab.



Figure 105: Reporting Measure Data – Review and Go Back

Logged in as **Practice Admin**  
[Launch Lab Environment](#)

[HOME](#)
[MEASURES](#)
[STAGING](#)
[SUBMISSION](#)
[FAQ](#)
[SUPPORT](#)

OCM DEV UAT Practice 9

Listed below for your review are the measure results collected so far that will be submitted to CMS on your behalf. If you are ready to finalize your report for CMS Submission, go to the 'SUBMISSION' tab and select the 'Submit Measure Results' button for this measurement period. If you would like to make any edits to the data before submitting, you may visit the 'MEASURES' tab.

### Performance Summary Report (July - December 2020)

Measure	Denominator	Denominator Exclusions	Numerator	Denominator Exceptions	Performance Rate
OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified <a href="#">OCM FFS Beneficiary Measure</a> <a href="#">Payment Measure</a>	100	N/A	95	N/A	95%
OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain <a href="#">OCM FFS Beneficiary Measure</a> <a href="#">Payment Measure</a>	80	N/A	70	N/A	87.5%
OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan <a href="#">OCM FFS Beneficiary Measure</a> <a href="#">Payment Measure</a>	100	10	85	5	85%

GO BACK

Section [4.2.4](#) will explain how to submit aggregate measure results while on the Submission tab.



## 4.2.4 Steps to Use the Data Registry – Submission Tab

### 4.2.4.1 Aggregate Measure Results Submission

If a practice does not submit their aggregate measure results at the time they are entered into the Data Registry, the aggregate measure results may be submitted through the Submission tab.

Step 1: Access the 'Submission' tab and select the 'Pending Submissions' sub-tab. All measurement periods that are pending submission will be displayed in the Measure Results Submission section (Figure 106).

Figure 106: Submission – Measure Results Pending Submissions

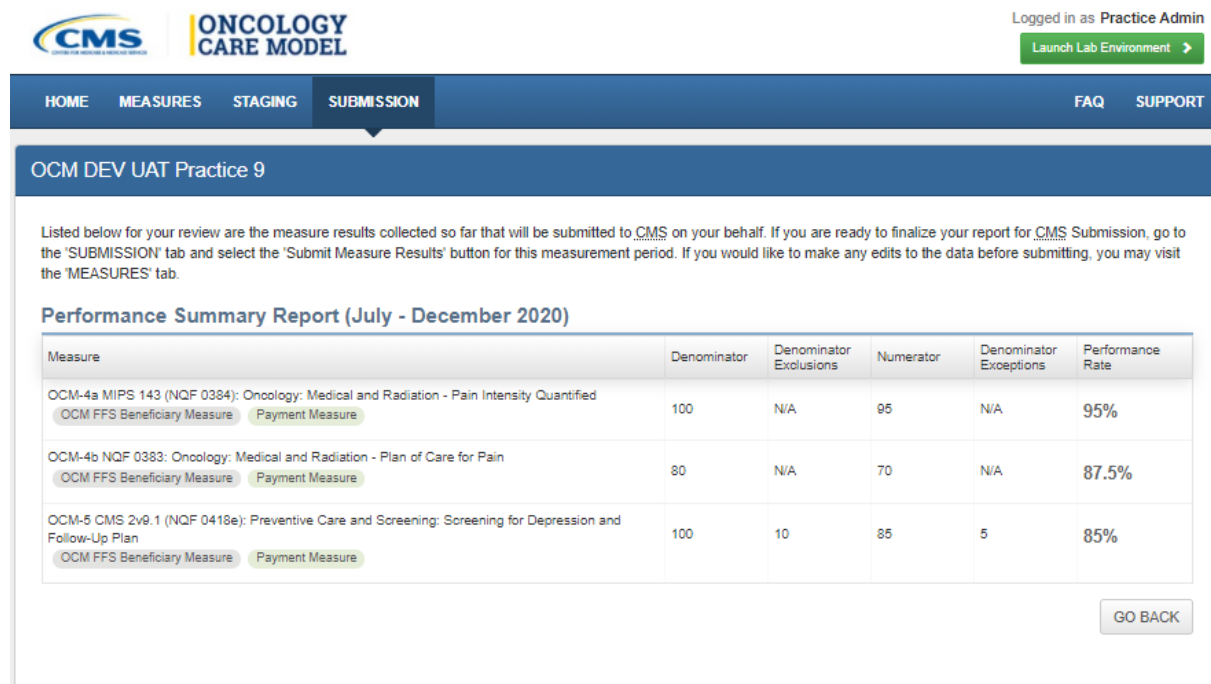
The screenshot displays the OCM Data Registry interface. At the top, there are logos for CMS and the Oncology Care Model, along with a user login status 'Logged in as Practice Admin' and a 'Launch Lab Environment' button. A navigation bar includes links for HOME, MEASURES, STAGING, SUBMISSION (which is highlighted), FAQ, and SUPPORT. Below the navigation bar, the page title is 'OCM DEV UAT Practice 9'. The main content area is titled 'Submission' and contains two tabs: 'Pending Submissions' (selected) and 'Submission History'. Under the 'Pending Submissions' tab, there is a section titled 'Measure Results Submission'. This section contains a message about the submission window for the 'July - December 2020' measurement period, which is marked as 'Pending Submission'. The message states that the submission window is open and provides a deadline of March 31, 2021, 11:59:59 PM EDT. Below the message are two buttons: 'View Measure Results' and 'Submit Measure Results'. Further down, there is a section titled 'Staging Data Submission'. This section contains a message about the submission window for the 'PP8' performance period, which is marked as 'Pending Submission'. The message states that the submission window is open and provides a deadline of March 18, 2021, 11:59:59 PM EDT. Below the message are two buttons: 'View Current Status' and 'Submit Staging Data'. At the bottom, there is a section for 'PP5' which is marked as 'Submitted'. The message states that staging and clinical data has been submitted for PP5.



Step 2: Select 'View Measure Results' to review a report of the aggregate measure results and performance rates that will be submitted to CMS on the practice's behalf (Figure 107).

**Note:** Performance Rate calculations are rounded to two decimal places.

Figure 107: Submission – Review Performance Summary Report



Logged in as Practice Admin  
Launch Lab Environment >

HOME MEASURES STAGING SUBMISSION FAQ SUPPORT

OCM DEV UAT Practice 9

Listed below for your review are the measure results collected so far that will be submitted to CMS on your behalf. If you are ready to finalize your report for CMS Submission, go to the 'SUBMISSION' tab and select the 'Submit Measure Results' button for this measurement period. If you would like to make any edits to the data before submitting, you may visit the 'MEASURES' tab.

**Performance Summary Report (July - December 2020)**

Measure	Denominator	Denominator Exclusions	Numerator	Denominator Exceptions	Performance Rate
OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified OCM FFS Beneficiary Measure Payment Measure	100	N/A	95	N/A	95%
OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain OCM FFS Beneficiary Measure Payment Measure	80	N/A	70	N/A	87.5%
OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan OCM FFS Beneficiary Measure Payment Measure	100	10	85	5	85%

GO BACK



Step 3: Once the report has been reviewed, select 'Go Back' (Figure 108). If changes need to be made to the aggregate measure results, make any changes through the Measures tab.

Figure 108: Submission – Review Performance Summary Report Go Back

Logged in as Practice Admin  
Launch Lab Environment >

HOME MEASURES STAGING **SUBMISSION** FAQ SUPPORT

OCM DEV UAT Practice 9

Listed below for your review are the measure results collected so far that will be submitted to CMS on your behalf. If you are ready to finalize your report for CMS Submission, go to the 'SUBMISSION' tab and select the 'Submit Measure Results' button for this measurement period. If you would like to make any edits to the data before submitting, you may visit the 'MEASURES' tab.

**Performance Summary Report (July - December 2020)**

Measure	Denominator	Denominator Exclusions	Numerator	Denominator Exceptions	Performance Rate
OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified OCM FFS Beneficiary Measure Payment Measure	100	N/A	95	N/A	95%
OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain OCM FFS Beneficiary Measure Payment Measure	80	N/A	70	N/A	87.5%
OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan OCM FFS Beneficiary Measure Payment Measure	100	10	85	5	85%

GO BACK



Step 4: Once the aggregate measure results are ready to be submitted, select 'Submit Measure Results' (Figure 109). The 'Submit Measure Results' button will only display when the submission window is open.

Figure 109: Submission – Review Performance Summary Report Submit Report

The screenshot shows the OCM Data Registry interface. At the top, there are logos for CMS and the Oncology Care Model. A navigation bar includes links for HOME, MEASURES, STAGING, SUBMISSION (which is highlighted), FAQ, and SUPPORT. Below the navigation bar, a header indicates the user is logged in as 'Practice Admin' and provides a 'Launch Lab Environment' button. The main content area is titled 'OCM DEV UAT Practice 9'. It contains a message about reviewing measure results for submission to CMS. Below this is a table titled 'Performance Summary Report (July - December 2020)'.

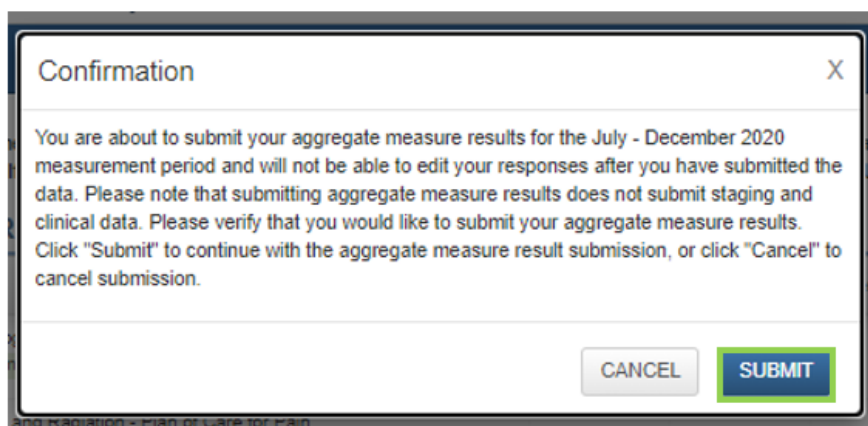
Measure	Denominator	Denominator Exclusions	Numerator	Denominator Exceptions	Performance Rate
OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified OCM FFS Beneficiary Measure Payment Measure	100	N/A	95	N/A	95%
OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain OCM FFS Beneficiary Measure Payment Measure	80	N/A	70	N/A	87.5%
OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan OCM FFS Beneficiary Measure Payment Measure	100	10	85	5	85%

At the bottom right of the table, there are two buttons: 'GO BACK' and 'SUBMIT REPORT'.

Step 5: To complete the submission of the practice's aggregate measure results, select the 'Submit Report' button at the bottom of the 'Performance Summary Report' screen.

Step 6: Once 'Submit Report' is selected, a confirm submittal box will pop-up, advising that practices will not be able to edit their responses once they've submitted. Users should not submit unless ready. If ready to submit, select 'Submit.' (See Figure 110.)

Figure 110: Submission – Measure Submit Button Confirmation Window

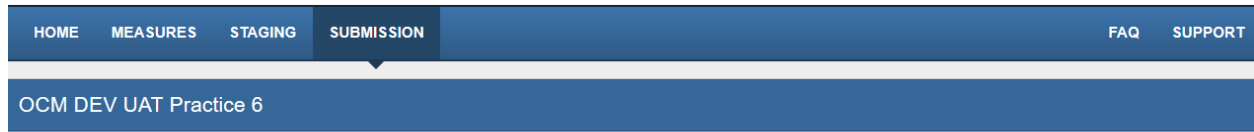


Step 7: Once 'Submit' is selected, the practice's aggregate measure result submission will be processed (Figure 111). While data is being processed, the user can navigate across other tabs.



**Note:** Processing should take approximately 5 minutes. If processing times appear to be much longer (15 minutes or more), please enter a support request.

Figure 111: Submission – Submitting Measure Results



Submitting Measure Results...

Step 8: After submitting, users will see a confirmation screen (Figure 112). At this point, reporting for the measurement period is archived and practices may no longer submit data for this measurement period. This report may be printed.

**Note:** If a practice does not submit by the submission deadline, their aggregate measure results will be automatically submitted and sent to CMS for them.

Figure 112: Submission – Measure Success Message



**Congratulations! You have successfully submitted your report to CMS.**



The submitted report is provided below. This report is also now available under the 'Submission History' tab for future reference. You can print a copy by clicking the 'PRINT' button.

#### Performance Summary Report (July - December 2020)



Measure	Denominator	Denominator Exclusions	Numerator	Denominator Exceptions	Performance Rate
OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified OCM FFS Beneficiary Measure Payment Measure	100	N/A	95	N/A	95%
OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain OCM FFS Beneficiary Measure Payment Measure	80	N/A	70	N/A	87.5%
OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan OCM FFS Beneficiary Measure Payment Measure	100	10	85	5	85%

GO BACK

Step 9: Once the aggregate measure results have been submitted, the measurement period will display on the Pending Submissions sub-tab for ten days and will show a status of 'Submitted' (Figure 113).



Figure 113: Submission – Measures Submitted

Logged in as Practice Admin  
[Launch Lab Environment](#)

[HOME](#)
[MEASURES](#)
[STAGING](#)
[SUBMISSION](#)
[FAQ](#)
[SUPPORT](#)

OCM DEV UAT Practice 9

Submission

[Pending Submissions](#)
[Submission History](#)

### Measure Results Submission

Once a measurement period ends, the three-month submission window begins during which you must enter your aggregate measure results for that measurement period. Once all aggregate measure results have been entered, you may submit your results at any time during the submission window. Once you submit your aggregate measure results for a measurement period, you will no longer be able to make edits. Note that if you do not submit your results manually by the due date, the results are automatically submitted on your behalf once the submission window is closed for that measurement period.

July - December 2020
 Submitted

Your aggregate measure results have been submitted for the July - December 2020 measurement period. The submitted results are available for your reference on the 'Submission History' tab.



Step 10: Also, once aggregate measure results are submitted, the practice administrator can select the 'Submission History' sub-tab of the 'Submission' Tab to review the measure results that were submitted for each measurement period (Figure 114).

Figure 114: Measures Submission History Screen

HOME MEASURES STAGING SUBMISSION FAQ SUPPORT

OCM DEV UAT Practice 9

Submission

Pending Submissions Submission History

Measure Result Submissions Staging Data Submissions

**Historical Measure Result Submissions**

This section lists your submission history by Measurement Period, including the measure results, and the files that were submitted on your behalf to CMS. There may be multiple submissions entries for a Measurement Period if a submission was withdrawn for corrections, and resubmitted again. The submissions are also available for printing, or PDF conversion, by clicking the 'Print' buttons.

	Print All
▶ July - December 2020	Print
▶ January - June 2020	Print
▶ July - December 2019	Print
▶ January - June 2019	Print
▶ July - December 2018	Print
▶ January - June 2018	Print
▶ July - December 2017	Print
▶ Q2 - 2017   April - June	Print
▶ Q1 - 2017   January - March	Print
▶ Q4 - 2016   October - December	Print



To view more information for each submitted measurement period, select the 'Arrow' icon next to the measurement period (Figure 113). When a measurement period is selected, the Performance Summary Report for the period is displayed (Figure 115). The .csv file of the measure results that were submitted to CMS on the practice's behalf is also available for practices to download.

**Note:** As an exception, there may be multiple submissions for entries for a Measurement Period if a submission was withdrawn for corrections and resubmitted again, which would be shown under this expansion.

**Figure 115: Measures Submission History Screen – Expanded**

Submission

Pending Submissions

Submission History

Measure Result Submissions

Staging Data Submissions

**Historical Measure Result Submissions**

This section lists your submission history by Measurement Period, including the measure results, and the files that were submitted on your behalf to CMS. There may be multiple submissions entries for a Measurement Period if a submission was withdrawn for corrections, and resubmitted again. The submissions are also available for printing, or PDF conversion, by clicking the 'Print' buttons.

July - December 2020

Print All

▼ Data submitted on 03/08/2021, 9:21:18 AM EST

Submitted File(s): MeasureResultsFile.csv

**Performance Summary Report**

Measure	Denominator	Denominator Exclusions	Numerator	Denominator Exceptions	Performance Rate
OCM-4a MIPS 143 (NQF 0384): Oncology: Medical and Radiation - Pain Intensity Quantified OCM FFS Beneficiary Measure <span>Payment Measure</span>	100	N/A	95	N/A	95%
OCM-4b NQF 0383: Oncology: Medical and Radiation - Plan of Care for Pain OCM FFS Beneficiary Measure <span>Payment Measure</span>	80	N/A	70	N/A	87.5%
OCM-5 CMS 2v9.1 (NQF 0418e): Preventive Care and Screening: Screening for Depression and Follow-Up Plan OCM FFS Beneficiary Measure <span>Payment Measure</span>	100	10	85	5	85%



### 4.2.4.2 Staging Data Submission

Staging data is submitted through the Submission tab.

Step 1: Access the 'Submission' tab and select the 'Pending Submissions' sub-tab (Figure 116). All performance periods that are pending submission will be displayed in the Staging Data Submission section.

Figure 116: Submission – Staging Pending Submissions

The screenshot shows the OCM Data Registry interface. At the top, there are logos for CMS and the Oncology Care Model, and a user login status: "Logged in as Practice Admin" with a "Launch Lab Environment" button. The navigation bar includes links for HOME, MEASURES, STAGING, SUBMISSION (selected), FAQ, and SUPPORT. Below the navigation bar, the page title is "OCM DEV UAT Practice 9".

The main content area is titled "Submission" and has two tabs: "Pending Submissions" (selected) and "Submission History".

**Measure Results Submission**

Once a measurement period ends, the three-month submission window begins during which you must enter your aggregate measure results for that measurement period. Once all aggregate measure results have been entered, you may submit your results at any time during the submission window. Once you submit your aggregate measure results for a measurement period, you will no longer be able to make edits. Note that if you do not submit your results manually by the due date, the results are automatically submitted on your behalf once the submission window is closed for that measurement period.

**July - December 2020** Pending Submission

The submission window for the July - December 2020 measurement period is open, and you have 23 days until the submission deadline of March 31, 2021 11:59:59 PM EDT to enter and submit your aggregate measure results for this period. You may submit at any point once you have completed entering your aggregate measure results on the 'MEASURES' tab.

[View Measure Results](#) [Submit Measure Results](#)

**Staging Data Submission**

You may enter staging and clinical data for a performance period at any time after you've been notified the Data Registry has been updated to accept data for the performance period. Once every performance period, your staging and clinical data is locked from editing for up to two weeks while attribution data are loaded into the Data Registry; during this time, a notification will display on the 'STAGING' tab. You will be notified when the attribution data load is complete and the data are unlocked for editing, at which time you will have 30 calendar days to enter and submit staging and clinical data on your attributed patients.

**PP8** Pending Submission

The PP8 attribution determinations have been received, and attributed patients can be identified on the 'STAGING' tab. You are required to provide complete staging and clinical data on at least 75% of your attributed patients for this performance period. You have 10 days until the submission deadline of March 18, 2021 11:59:59 PM EDT to complete entry of all required staging and clinical data for PP8 attributed patients.

[View Current Status](#) [Submit Staging Data](#)

**PP5** Submitted

Your staging and clinical data has been submitted for PP5. You may enter or update patients you believe will be attributed to your practice in the upcoming performance periods.



Step 2: Select 'View Current Status' to review a summary of Patient Registry Statistics for staging completeness (Figure 117).

Figure 117: Submission – Staging Pending Submissions View Current Status

The screenshot shows the OCM Data Registry interface. At the top, there are logos for CMS and the Oncology Care Model, along with a user login status 'Logged in as Practice Admin' and a 'Launch Lab Environment' button. A navigation bar includes links for HOME, MEASURES, STAGING, SUBMISSION (which is highlighted), FAQ, and SUPPORT. Below the navigation bar, a banner reads 'OCM DEV UAT Practice 9'. The main content area is titled 'Submission' and has two tabs: 'Pending Submissions' (selected) and 'Submission History'. Under 'Pending Submissions', there is a section for 'Measure Results Submission' with a paragraph explaining the submission window and a box for 'July - December 2020' marked as 'Pending Submission'. This box contains text about the submission window and two buttons: 'View Measure Results' and 'Submit Measure Results'. Below this is a section for 'Staging Data Submission' with a paragraph explaining the process and a box for 'PP8' marked as 'Pending Submission'. This box contains text about attribution determinations and two buttons: 'View Current Status' (highlighted with a green border) and 'Submit Staging Data'. At the bottom, there is a box for 'PP5' marked as 'Submitted' with a paragraph about submitting staging and clinical data.

Step 3: Review the Patient Registry Statistics. This page lists the statistics of the staging and clinical data collected so far in the Data Registry for PP3 and future performance periods.

The numbers displayed for patients with incomplete staging information evaluates if every diagnosis code and date combination within the performance period's attributed cancer bundle was complete. This number is then used to calculate the percent of attributed patients with complete data.



If you would like to make any edits to the reported data before submitting, you may visit the 'Staging' tab. Once the report has been reviewed select 'Go Back' (Figure 118).

Figure 118: Submission – Patient Registry Statistics

The screenshot shows the 'Submission' tab selected in the navigation menu. The page title is 'OCM DEV UAT Practice 12'. A message informs the user that the following statistics are for review and will be submitted to CMS. A table titled 'Patient Registry Statistics for PP8' displays the following data:

Patient Registry Statistics for PP8	
Number of Attributed Patients	81
Number of Attributed Patients with Incomplete Patient Information	0
Number of Attributed Patients with Incomplete Staging Information	17
Percent of Attributed Patients with Complete Data	79.0%

A 'GO BACK' button is located at the bottom right of the statistics section.

Logged in as Practice Admin  
Launch Lab Environment >

HOME MEASURES STAGING SUBMISSION FAQ SUPPORT

OCM DEV UAT Practice 12

Listed below for your review is the statistics of the staging and clinical data collected so far in the Patient Registry, that will be submitted to CMS on your behalf. If you are ready to finalize your report for CMS Submission, go back to the Submission tab and select the 'Submit Staging Data' button for this performance period. If you would like to make any edits to the reported data before submitting, you may visit the 'STAGING' tab.

GO BACK



Step 4: If you are ready to finalize your report for CMS Submission, select the 'Submit Staging Data' button for the performance period on the Pending Submissions sub-tab (Figure 119). The 'Submit Staging Data' button will only display when the submission period is open.

Figure 119: Submission – Staging Pending Submission

**CMS ONCOLOGY CARE MODEL**

Logged in as Practice Admin  
Launch Lab Environment >

HOME MEASURES STAGING **SUBMISSION** FAQ SUPPORT

OCM DEV UAT Practice 9

### Submission

Pending Submissions Submission History

#### Measure Results Submission

Once a measurement period ends, the three-month submission window begins during which you must enter your aggregate measure results for that measurement period. Once all aggregate measure results have been entered, you may submit your results at any time during the submission window. Once you submit your aggregate measure results for a measurement period, you will no longer be able to make edits. Note that if you do not submit your results manually by the due date, the results are automatically submitted on your behalf once the submission window is closed for that measurement period.

**July - December 2020** Pending Submission

The submission window for the July - December 2020 measurement period is open, and you have **23 days** until the submission deadline of **March 31, 2021 11:59:59 PM EDT** to enter and submit your aggregate measure results for this period. You may submit at any point once you have completed entering your aggregate measure results on the 'MEASURES' tab.

View Measure Results Submit Measure Results

#### Staging Data Submission

You may enter staging and clinical data for a performance period at any time after you've been notified the Data Registry has been updated to accept data for the performance period. Once every performance period, your staging and clinical data is locked from editing for up to two weeks while attribution data are loaded into the Data Registry; during this time, a notification will display on the 'STAGING' tab. You will be notified when the attribution data load is complete and the data are unlocked for editing, at which time you will have 30 calendar days to enter and submit staging and clinical data on your attributed patients.

**PP8** Pending Submission

The PP8 attribution determinations have been received, and attributed patients can be identified on the 'STAGING' tab. You are required to provide complete staging and clinical data on at least 75% of your attributed patients for this performance period. You have **10 days** until the submission deadline of **March 18, 2021 11:59:59 PM EDT** to complete entry of all required staging and clinical data for PP8 attributed patients.

View Current Status Submit Staging Data



Step 5: Once the staging and clinical data are ready to be submitted, select the 'Submit Report' button for the performance period (Figure 120).

Figure 120: Submission -- Patient Registry Statistics

OCM DEV UAT Practice 9

Listed below for your review is the statistics of the staging and clinical data collected so far in the Patient Registry, that will be submitted to CMS on your behalf. If you are ready to finalize your report for CMS Submission, click the 'SUBMIT REPORT' button below. If you would like to make any edits to the reported data before submitting, you may visit the 'STAGING' tab.

Patient Registry Statistics for PP8	
Number of Attributed Patients	81
Number of Attributed Patients with Incomplete Patient Information	0
Number of Attributed Patients with Incomplete Staging Information	18
Percent of Attributed Patients with Complete Data	77.8%

GO BACK SUBMIT REPORT

Step 6: Once 'Submit Report' is selected, a confirm submittal box will pop-up, advising that practices will not be able to edit their responses once they've submitted (Figure 121). Users should not submit unless ready. If ready to submit, select 'Submit.'

Figure 121: Submission – Staging and Clinical Data Submit Button Confirmation Window

Confirmation X

You are about to submit your staging and clinical data for the performance period. The submission will process overnight, and any updates made to staging and clinical data after you click "Submit" will not be included for your PP8 submission. Please verify that you would like to submit your data. Click "Submit" to continue, or click "Cancel" to cancel.

CANCEL SUBMIT



Step 7: Once 'Submit' is selected, the practice's staging and clinical data submission will be submitted for overnight processing. The Submitted Status will display "Submitted-Processing" (Figure 122) and a banner will display on the Staging page (Figure 123). While data is being processed, the user can navigate across other tabs.

**Note:** Processing should take place overnight. If processing times appear to be much longer (2 nights or more), please enter a support request.

Figure 122: Submission – Submitted-Processing

The screenshot shows the OCM Data Registry interface. At the top, there are logos for CMS and ONCOLOGY CARE MODEL. The user is logged in as 'Practice Admin' and has a 'Launch Lab Environment' button. The navigation bar includes 'HOME', 'MEASURES', 'STAGING', 'SUBMISSION', 'FAQ', and 'SUPPORT'. The 'SUBMISSION' tab is active, showing 'OCM DEV UAT Practice 14'.

Under the 'Submission' heading, there are two tabs: 'Pending Submissions' and 'Submission History'. The 'Pending Submissions' tab is selected, showing a section for 'Measure Results Submission'.



The 'Measure Results Submission' section includes a message about the submission window for the July - December 2020 measurement period. It states that the submission window is open and the user has 21 days until the submission deadline of March 31, 2021 11:59:59 PM EDT. There are two buttons: 'View Measure Results' and 'Submit Measure Results'.

Below this, there is a section for 'Staging Data Submission'. It explains that staging and clinical data can be entered for a performance period at any time after notification. It also mentions that the data is locked from editing for up to two weeks while attribution data are loaded into the Data Registry.

At the bottom, there is a section for 'PP8' with a status of 'Submitted-Processing'. It states that the PP8 staging and clinical data has been submitted for overnight processing to CMS and that any updates to patients or staging and clinical data after submitting will not be reflected in the PP8 submission.



Figure 123: Submission – Submitted Processing Banner

Logged in as **Practice Admin**  
[Launch Lab Environment](#)

[HOME](#)
[MEASURES](#)
[STAGING](#)
[SUBMISSION](#)
[FAQ](#)
[SUPPORT](#)

OCM DEV UAT Practice 14

Staging

**IMPORTANT NOTE:** Your PP8 staging and clinical data has been submitted for overnight processing to CMS. Any updates to patients or staging and clinical data after submitting will not be reflected in your PP8 submission.

**Manually Enter Patient Data**  
 Add individual patient data using web-based forms.
   
  
[ADD NEW PATIENT](#)

**Upload Your Own File**  
 Add your practice data online using a spreadsheet, such as a CSV or Excel file.
   
  
[UPLOAD SPREADSHEET](#)

Attention! There are duplicate patient records reported in the registry for your practice. [Click Here](#) to view and address the duplicate patient records.

[View Previous Uploads](#)  
[Perform Bulk Actions](#)

**All Patients in Registry**  
 841 patients

**All Registry Patients**  

Listed below are all patients that have been added to the registry and includes patients that have been attributed or not attributed to previous performance periods as well as patients that are pending attribution or that have Invalid HICN/Invalid MBI.

All Incomplete Patients

Search by patient identifier or name

[Export Reports](#)

MBI/HICN	First Name	Last Name	Date Of Birth	Latest Attribution Status	Last Submitted	Last Updated	Actions
3TD4W44KQ58	Stage PP4	H	04/17/1978	Not Attributed PP8	03/31/2020	02/11/2021	
3TD4W44KQ56	Stage PP4	F	04/15/1978	Not Attributed PP8	03/31/2020	02/11/2021	
3TD4W44KQ54	Stage PP4	D	04/13/1978	Not Attributed PP8	03/31/2020	02/11/2021	
9UU9YY1WW65				Not Attributed PP8	03/31/2020	02/11/2021	



Step 8: Once the overnight submission process is complete, the Staging page banner will no longer display, and the staging status on the Pending Submissions sub-tab will display “Submitted” (Figure 124). At this point, reporting for the performance period is archived and practices may no longer submit data for this performance period. This report may be printed.

**Note:** *If a practice does not submit by the submission deadline, their staging and clinical data will be automatically submitted and sent to CMS for them.*

**Figure 124: Submission – Staging Submitted**

OCM DEV UAT Practice 14

Submission

Pending Submissions

Submission History

Measure Results Submission

Once a measurement period ends, the three-month submission window begins during which you must enter your aggregate measure results for that measurement period. Once all aggregate measure results have been entered, you may submit your results at any time during the submission window. Once you submit your aggregate measure results for a measurement period, you will no longer be able to make edits. Note that if you do not submit your results manually by the due date, the results are automatically submitted on your behalf once the submission window is closed for that measurement period.

July - December 2020

Pending Submission

The submission window for the July - December 2020 measurement period is open, and you have **16 days** until the submission deadline of **March 31, 2021 11:59:59 PM EDT** to enter and submit your aggregate measure results for this period. You may submit at any point once you have completed entering your aggregate measure results on the 'MEASURES' tab.

View Measure Results

Submit Measure Results

Staging Data Submission

You may enter staging and clinical data for a performance period at any time after you've been notified the Data Registry has been updated to accept data for the performance period. Once every performance period, your staging and clinical data is locked from editing for up to two weeks while attribution data are loaded into the Data Registry; during this time, a notification will display on the 'STAGING' tab. You will be notified when the attribution data load is complete and the data are unlocked for editing, at which time you will have 30 calendar days to enter and submit staging and clinical data on your attributed patients.

PP8

Submitted

Your staging and clinical data has been submitted for PP8. You may enter or update patients you believe will be attributed to your practice in the upcoming performance periods.



Step 9: Also, after staging and clinical data are submitted, users can select the 'Submission History' sub-tab of the 'Submission' tab (Figure 125), and then the 'Staging Data Submissions' sub-tab to review the staging and clinical data that were submitted for each performance period.

Figure 125: Staging and Clinical Data Submission History Screen

OCM DEV UAT Practice 14

Submission

Pending Submissions Submission History

Measure Result Submissions Staging Data Submissions

**Historical Staging Data Submissions**

This section lists your submission history by Performance Period, including the staging completeness statistics, and the files that were submitted on your behalf to CMS. There may be multiple submissions entries for a Performance Period if a submission was withdrawn for corrections, and resubmitted again. The submissions are also available for printing, or PDF conversion, by clicking the 'Print' buttons.

Print All

▶ PP8	Print
▶ PP6	Print
▶ PP5	Print
▶ PP4	Print
▶ PP3	Print
▶ PP2	Print
▶ PP1	Print

Step 10: To view more information for each submitted performance period, select the 'Arrow' icon next to the performance period (Figure 125). When a performance period is selected, the Patient Registry Statistics for the performance period is displayed (Figure 126). The PatientFile.csv, PPXStagingDataSubmittedExport\_yyyy\_mm\_dd\_hh\_ss\_ET.csv, and PatientCompletenessFile.csv files are available for practices to download from this screen. Users may also select 'Print' and then download and/or print the submission statistics as a PDF file.



Figure 126: Staging and Clinical Data Submission History Screen – Expanded

Submission

Pending Submissions

Submission History

Measure Result Submissions

Staging Data Submissions

Historical Staging Data Submissions

This section lists your submission history by Performance Period, including the staging completeness statistics, and the files that were submitted on your behalf to CMS. There may be multiple submissions entries for a Performance Period if a submission was withdrawn for corrections, and resubmitted again. The submissions are also available for printing, or PDF conversion, by clicking the 'Print' buttons.

Print All

▼ PP8

Print

▼ Data submitted on 04/14/2021, 8:14:03 AM EDT

Submitted File(s):

PatientFile.csv

PP8StagingDataSubmittedExport\_2021\_04\_14\_08\_14\_03\_ET.csv

PatientCompletenessFile.csv

Patient Registry Statistics for PP8

Number of Attributed Patients	81
Number of Attributed Patients with Incomplete Patient Information	0
Number of Attributed Patients with Incomplete Staging Information	18
Percent of Attributed Patients with Complete Data	77.8%



Once a user selects 'Print', a blue box will pop up in the bottom right hand corner signifying the report is being generated (Figure 127). Once the report has been generated, this box will alert the user that the report has successfully downloaded, and the user will be able to open or save the submission statistics.

Figure 127: Staging and Clinical Data Submission History Print Option

The screenshot displays the 'Submission History' tab within the 'Submission' section. It features a 'Print' button next to the 'Staging Data Submissions' header. Below this, a dropdown menu for 'PP8' is shown, with a 'Print' button next to it. The 'Submitted File(s)' section lists three files: 'PatientFile.csv', 'PP8StagingDataSubmittedExport\_2021\_04\_14\_08\_14\_03\_ET.csv', and 'PatientCompletenessFile.csv'. A table titled 'Patient Registry Statistics for PP8' is displayed, showing the following data:

Patient Registry Statistics for PP8	
Number of Attributed Patients	81
Number of Attributed Patients with Incomplete Patient Information	0
Number of Attributed Patients with Incomplete Staging Information	18
Percent of Attributed Patients with Complete Data	77.8%

A blue box in the bottom right corner indicates 'Printing...' and states 'Your report will be automatically downloaded when it is ready.'

#### 4.2.4.2.1 Staging Data Submitted Export Report

This report allows practices to see the staging and clinical data that was displayed in the Data Registry at the time of submission for the performance period. This report became available beginning with PP5 submissions, and for any previous performance periods re-submitted after the report availability date of November 14, 2019.

Patients that have no staging and clinical data reported will not be included in this report. These patients display "Pending Entry" or "No data has been added yet" on the Staging Information sub-tab of the patient grid. All other patients in the Data Registry, including patients that were not attributed for the performance period submission deadline the Staging Data Submitted Export report was generated for will be included in the Staging Data Submitted Export report.

To access the Staging Data Submitted Export report, follow [Step 9](#) and [Step 10](#) above.



The Staging Data Submitted Export report is comprised of one tab that contains the fields listed in Table 4. The tab will contain the performance period number corresponding to the date (e.g., PP4StagingDataSubmittedExport).

*Note: The retired fields listed are retired data elements that were reported prior to PP3, for ICD-10 code/Initial Diagnosis Dates that have not subsequently been updated to the current reporting requirements or updated when the cancer bundle the code belongs to was attributed, will display in the far-right columns of the report.*

**Table 4: Staging Data Submitted Export Report Data Fields**

<b>Field</b>
OCM_ID
HICN
MBI
Patient_First_Name
Patient_Last_Name
Initial_Diagnosis_Date
ICD-10_Cancer_Diagnosis_Code
Descriptor
OCM_Cancer_Bundle
Current_Clinical_Status
Current_Clinical_Status_Date
AJCC_Edition
Primary_Tumor
Nodal_Disease
Metastasis
Revised_ISS_Stage_Optional
Tumor_Type_Optional
Tumor_Grade_Optional
Resection_Optional
Clinical_Stage_Optional
EGFR_Activating_Mutation_Optional



Field
ALK_Gene_Mutation _Optional
ROS1_Gene_Mutation _Optional
Estrogen_Receptor
Progesterone_Receptor
HER2_Amplification
KRAS_Mutation _Optional
NRAS_Mutation _Optional
BRAF_Mutation _Optional
Histology
Prognostic_Multi-Gene_Assay_Performed _Optional
MammaPrint_Result _Optional
Oncotype_Dx_Result _Optional
Prosigna_Result _Optional
BRCA1_Result _Optional
BRCA2_Result _Optional
IDH2_Result _Optional
FLT3_Result _Optional
dMMR_Result _Optional
Disease_Status_Retired
Oncotype_Dx_DCIS_Result_Retired
Remissions_Retired
Relapses_Retired
Create_Date
Staging_Status
Patient_Information_Status



Field
Attributed_PP#

Beginning with PP8 staging and clinical data submissions, the Staging Data Submitted Export Report was updated to include three additional columns that display the staging and reporting completeness for each ICD-10 code/Initial Diagnosis Date, at the time of staging and clinical data submission for that performance period as well as an attribution indicator. An explanation of each of the new columns is presented below:

- **Staging Status:** This column displays the completeness status for the staging and clinical data reported for the ICD-10 code/Initial Diagnosis Date.
  - If the ICD-10 code/Initial Diagnosis Date is complete for the most recently attributed performance period for that cancer bundle, this column will display “Complete”.
    - Example 1: A patient has 2 ICD-10 codes/Initial Diagnosis Dates for the same cancer bundle (CNS Tumor Group) which is attributed for PP8. C70.0 has all required data elements reported including a Current Clinical Status (CCS) during the PP8 episode dates. C70.1 has all required data elements reported including a CCS however the reported CCS is not within the PP8 episode dates.
      - C70.0 will display “Complete” in this column.
      - C70.1 will display “Incomplete Staging” in this column.
    - Example 2: A patient has C64.1 (Kidney Cancer Group) reported. This cancer bundle is attributed for PP8 and has all required data elements reported including a CCS. Multiple CCS values were reported with different dates, with only the CCS value “Responding” during the PP8 episode dates.
      - All rows for C64.1 will display “Complete” in this column, including the rows with CCS values that are not during the PP8 episode dates.
  - If the ICD-10 code/Initial Diagnosis Date is not complete for the most recently attributed performance period for that cancer bundle, this column will display “Incomplete Staging”.
    - Example 1: A patient has 2 ICD-10 codes/Initial Diagnosis Dates for different cancer bundles reported. C34.00 (Lung Cancer Group) was attributed for PP8 and has all required data elements reported including a CCS. The CCS



reported for C34.00 is not within the PP8 episode dates. C61 (Prostate Cancer Group) was never attributed and has complete staging information for all required data elements. The submitted performance period is PP8.

- C34.00 will display “Incomplete Staging” in this column.
  - C61 will display “Complete” in this column.
- Example 2: A patient has 2 ICD-10 codes/Initial Diagnosis Dates for different cancer bundles reported. C19 (Small Intestine/Colorectal Cancer Group) was attributed for PP6 and does not have all required data elements reported (Primary Tumor was not reported). C50.012 (Breast Cancer Group) was attributed for PP8 and has complete staging information. The submitted performance period is PP8.
  - C19 will display “Incomplete Staging” in this column because it was incomplete for the most recently attributed performance period for this cancer bundle.
  - C50.012 will display “Complete” in this column.
- **Patient Information Status:** This column displays the completeness status for the Patient Information reported for the patient.
  - If the Patient Information reported for the patient is complete, this column will display “Complete”.
  - If the Patient Information reported for the patient is incomplete, this column will display “Incomplete Patient Information”.
- **Attributed PP#:** This column indicates if the cancer bundle for the ICD-10 code is attributed for the submitted performance period.
  - If the ICD-10 code/Initial Diagnosis Date(s) is attributed to the submitted performance period, this column will display “Y”.
  - If the ICD-10 code/Initial Diagnosis Date(s) is not attributed to the submitted performance period, this column will display “N”
- Example: A patient has 2 ICD-10 codes/Initial Diagnosis Dates for different cancer bundles. C34.00 (Lung Cancer Group) was attributed for PP6. C61 (Prostate Cancer Group) was attributed for PP8. The submitted performance period was PP8.
  - Any row for C34.00 will display “N” in this column.
  - Any row for C61 will display “Y” in this column.



#### 4.2.4.2.2 Patient Completeness File

After submission, each practice will receive a Completeness File which will be based on the attributed cancer bundle for the respective performance period for PP3 and future performance periods. The Completeness File will reflect the staging data at the time of the practice's submission.

The Completeness File includes column headers and data fields for: Practice ID, Practice Name, TIN, Unique Patient ID, HICN or MBI, Patient First Name, Patient Last Name, Patient DOB, Patient Gender, Patient Demographics Complete, Patient Staging Complete, and PP Reporting Completeness.

In the Patient Demographics Complete indicator field, a 'Y' value will be displayed for complete demographics or an 'N' value for incomplete demographics.

In the Patient Staging Complete indicator field, a 'Y' value will be displayed for complete staging or an 'N' value for incomplete staging.

For PP4 and future performance periods, the 'PP Reporting Completeness' indicator field will display a 'Y' value if both the 'Patient Demographics Complete' indicator and the 'Patient Staging Complete' indicator display 'Y'. This patient will count towards the minimum reporting completeness for the performance period.

### 4.2.5 Steps to Use the Data Registry – OCM Lab Environment

The Data Registry offers an OCM Lab Environment. The OCM Lab allows users to enter or upload patient and staging and clinical data into a test environment to gain familiarity with Data Registry functionality and review possible results prior to the actual staging data submission. Functionality between the OCM Lab Environment and the live OCM Registry is mirrored and thus looks very similar in several respects, however, there is only one 'All Registry Patients' Staging tab in which practices may work. The display and additional messaging will help users to distinguish between the two environments.

There will be no data crossover between the Lab environment and Live environment. Any data entered in the Lab Environment should be considered temporary and will be purged 15 days after every submission deadline.

**Note:** *Attribution data is not loaded in the Lab Environment. Effective with PP6 reporting, the Lab is available when the Data Registry is "View Only" while the attribution data is loaded.*



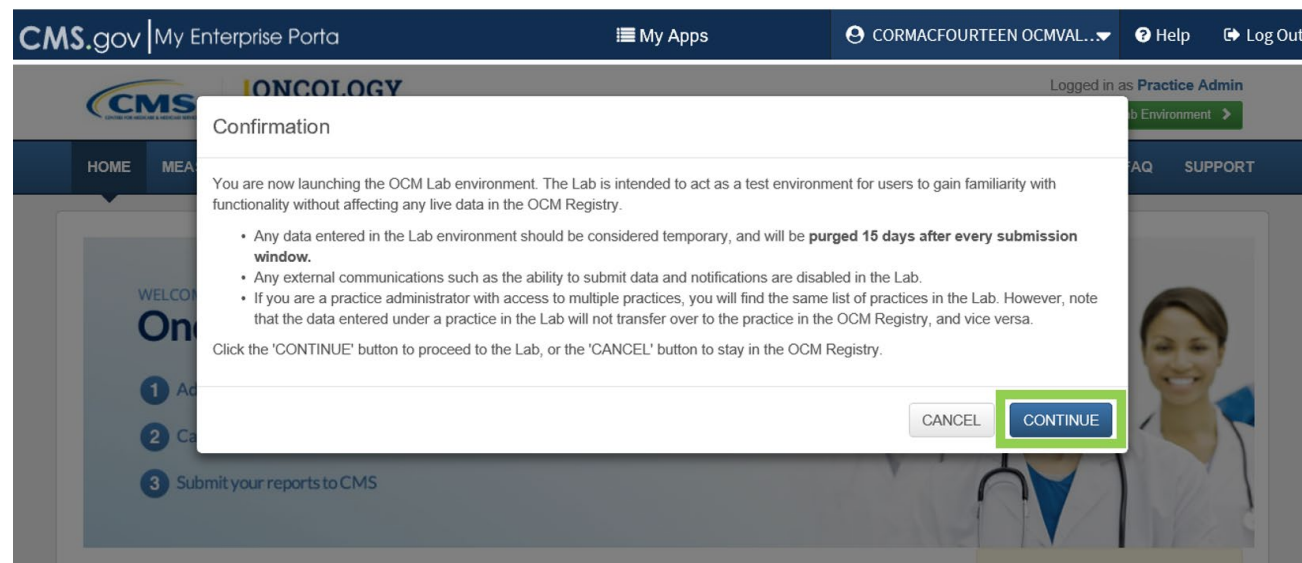
Step 1: Select the green “Launch Lab Environment” button on the top right of the OCMR Data Registry screen (Figure 128).

Figure 128: Launch OCM Lab Environment



Step 2: A pop-up will appear. Confirm your wish to enter the OCM Lab Environment by selecting “Continue” (Figure 129).

Figure 129: OCM Lab Confirmation Window





Step 3: You have now entered the OCM Lab Environment (Figure 130). The lab environment has a different color scheme and several reminders that the users are not in the live environment. Users can use the lab to enter staging and clinical data into the test environment as they normally would in the live environment by following the [Steps to Use the Data Registry – Staging Tab](#).

Figure 130: OCM Lab Environment Initial Screen

The screenshot displays the OCM Lab Environment Initial Screen. At the top, there is a navigation bar with 'CMS.gov My Enterprise Portal', 'My Apps', and a user profile 'CORMACFOURTEEN OCMVAL...'. A warning banner states: 'This is a lab environment. Data entered here is to be considered temporary, and will be purged 15 days after every submission window.' Below this, the 'STAGING' tab is selected. The main content area is titled 'OCM DEV UAT Practice 14' and contains two primary actions: 'Manually Enter Patient Data' with an 'ADD NEW PATIENT' button, and 'Upload Your Own File' with an 'UPLOAD SPREADSHEET' button. A 'View Previous Uploads' link is also present. The 'All Registry Patients' section includes a search bar and a table with columns: MBI/HICN, First Name, Last Name, Date Of Birth, Latest Attribution Status, Last Submitted, Last Updated, and Actions. A message at the bottom of the table states: 'You currently do not have any patient data. Please click one of the methods above to start adding data for your practice.' On the right side of the 'All Registry Patients' section, there are buttons for 'Purge Patient Data' and 'Export Reports'.

**Note:** A 'Purge Patient Data' button is available on the right side of the screen for users to purge all patient data that's been entered in the Lab Environment, should they want to manually purge the data. As mentioned previously, all data will be automatically purged 15 days after every submission deadline.

Step 4: When a user is in the Lab Environment, the "Exit Lab Environment" button will be able to be selected. When selected, the user will see the confirmation modal (Figure 131).

Figure 131: OCM Lab Environment – Exit Confirmation Modal

The screenshot shows the OCM Lab Environment Exit Confirmation Modal. The modal is titled 'Confirmation' and contains the following text: 'You are leaving the OCM Lab environment. You will be returning to the live OCM Registry. Any data entered in the OCM Registry should be considered real data and will be submitted to CMS. Click the 'CONTINUE' button to proceed to the OCM Registry, or the 'CANCEL' button to stay in the OCM Lab.' The modal has 'CANCEL' and 'CONTINUE' buttons at the bottom. The background shows the 'STAGING' tab and the 'Manually Enter Patient Data' section of the OCM Lab Environment.



## 5. Error Messages

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### 5.1 Error and Warning Messages List

The error and warning messages list show all the possible errors and warnings a user may encounter if inputs are incorrect in the files for upload. The list has been divided by error/warning possibilities in the OCMR Patient Upload File, OCMR Staging Upload Template, OCMR Staging Abstraction Tool, MBI Transition Upload Template, and Staging Data Gap Export Report. If any errors occur when uploading the OCMR Patient Upload File, OCMR Staging Upload Template, OCMR Staging Abstraction Tool, or Staging Data Gap Export Report, an error log will be available as a .txt file that will list the errors and/or warnings from processing the file. If any errors occur when uploading the MBI Transition Upload Template, a validation log will be available for download as a .txt file, and an invalid records file will be available for download as a .xlsx file.

**Note:** *When the MBI Transition Upload Template is uploaded resulting in validation errors, the validation log and invalid records file will only be available while the confirmation window is open. Users should save the validation log and invalid records file before closing the confirmation window. After the confirmation window is closed these files will no longer be available.*

For the OCMR Patient Upload File, OCMR Staging Upload Template, OCMR Staging Abstraction Tool, Staging Data Gap Export Report, and/or MBI Transition Upload Template error messages, please visit the OCM File Submission Guide, available on OCM Connect.

## 6. Frequently Asked Questions (FAQs)

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Additional FAQs about the Data Registry can be found in OCM Frequently Asked Questions, available on OCM Connect.

### 6.1 Data Registry Access

Q: How do I register for an EIDM account?

- Visit <https://portal.cms.gov>.
- Select New User Registration under CMS Secure Portal. Note: If you already have an EIDM account you can skip this step and log in using your existing user information.
- Accept the Terms & Conditions, supply the requested information, and create a username and password.
- Confirm your new account by validating receipt of an automated email sent by the EIDM system.

Q: Who should be requesting access to the OCM Data Registry? Is access limited to data custodians and practice POCs?

Anyone at the practice who would like access to the OCM Data Registry can submit a request.



**Q: Is there a maximum number of users for the Data Registry? Is there a maximum number of practice administrators?**

There is no maximum number of users in the Data Registry and there is no limit to the number of users that can have the Practice Administrator Role.

## **6.2 Data Upload and Submission**

**Note:** *The OCM File Submission Guide can be used as a supplement to the User Manual for additional guidance regarding data upload and submission.*

**Q: What methods are available for reporting data in the OCM Registry?**

Aggregate measure results must be submitted via manual entry in the Measures tab.

Staging and clinical data may be reported via:

1. Manual data entry
2. File Upload (Patient Upload File, OCMR Staging Upload Template, OCMR Staging Abstraction Tool, and Staging Data Gap Export Report) via the Staging tab. File templates are available on OCM Connect and on the Staging tab after selecting "Upload Spreadsheet".

Practices can use a combination of different forms of data submission. For example, a practice can submit data through file upload and then make edits to the data through manual entry.

**Q: Can we submit data on behalf of multiple practices or for all entities in a pool?**

Practice Administrators or Data Registry POCs can submit data for the entire practice at one time. If you have access to multiple practices, each practice will need to submit data individually.

**Q: Am I still required to submit quality data for the timeframe or measurement periods impacted by COVID-19?**

In a response to COVID-19 aggregate quality measure reporting will be optional for PP7, PP8, PP9, and PP10. If a practice has elected to not report aggregate quality measure results for OCM-4a, OCM-4b, AND OCM-5 for the affected measurement periods the practice must manually enter the value of "8888" in the denominator and numerator (and denominator exclusions and exceptions, if applicable) for each measure in the OCM Data Registry to indicate non-reporting by the submission deadline for the measurement period. Practices must report all three measures if they elect to report for a measurement period, otherwise the practice-reported measures will not be used for AQS.

If a practice participating in one or two-sided risk elects not to report aggregate measure results for either of the measurement periods used to determine the AQS in PP7, PP8, PP9, and PP10, the practice's AQS and Performance Multiplier will be based on claims-based and patient survey measures only. Refer to Table 7 in the OCM PBP Methodology document which shows the measurement periods that will be used in the scoring of the practice-reported measures for each performance period.

Staging and clinical data reporting will be optional for PP6, PP7, PP8, PP9, and PP10. If a practice has elected to not report staging and clinical data for the affected performance periods (PP6, PP7, PP8, PP9, and PP10), one of the practice's Primary or Secondary POCs will need to notify CMMI of that decision by contacting [OCMSupport@cms.hhs.gov](mailto:OCMSupport@cms.hhs.gov) prior to the submission deadline for the performance period.



If a practice elects to not report staging and clinical data in PP7, PP8, PP9, and PP10, the metastatic adjustment will not be included in the reconciliation calculation. That is, the practice's benchmark would not be adjusted for metastatic status of its beneficiaries. (The benchmarking methodology would be the same as in PP6.) In order to receive the metastatic adjustment starting in PP7, practices must report staging and clinical data on at least 75% of their attributed beneficiaries. <https://www.cms.gov/files/document/covid-innovation-model-flexibilities.pdf>

Q: When I go to the Measures Tab, the Measures are read-only, how do I add data?

If a given measurement period is read-only, this means that the submission window for that measurement period has not yet opened, and the OCM Quality Measures are listed for your preview only. Please note that the submission window for a given measurement period will be open for 3 months after the measurement period ends.

Example: The submission window for the July - December 2020 MP will be open from 1/1/2021 through 3/31/2021.

Q: How do I submit my measure data after I have added the aggregate measure result values on the Measures Tab?

Once the aggregate measure result values have been entered and saved on the Measures tab, navigate to the "Submission" tab to proceed with submitting measure data. After navigating to the "Submission" tab, select the "Pending Submissions" sub-tab. Any measurement periods that are pending submission will be displayed here. Users can select the "View Measure Results" button to review a report of the aggregate measure result values that have been entered, and the performance rates that will be submitted to CMS.

To submit measures data, select the "Submit Measure Results" button. The entered aggregate measure result values and performance rates that will be submitted to CMS will be shown. When the results are finalized and ready to be submitted, select the "Submit Report" button at the bottom of the "Performance Summary Report" screen. Review the confirmation modal pop-up that advises practices that the results cannot be edited once they're submitted, and if ready to submit, select the "Submit" button. Once this button is selected, the aggregate measure results submission will be processed.

Q: Why is one of my patients displaying twice in the OCM Data Registry?

If a practice has a patient that was reported to the OCM Data Registry using two different patient identifiers, thereby creating two different patient records, the records are considered to be "duplicate patient records".

One way that a duplicate patient record may have been created is if a practice reports a patient with a HICN in the Data Registry, and then staging data is uploaded using the patient's MBI without first updating the HICN in the original patient record to the patient's MBI manually, or by using the MBI Transition Upload Template. As a result, both records for this patient will be displayed in the Data Registry.

Q: Am I able to manually address my duplicate patient records?

Practices now have the ability to view and address duplicate patient records, and the staging and clinical data reported for each duplicate record, by utilizing the Self-Service Duplicate Patient Management Tool.

When duplicate patient records exist for a practice, a duplicate patient banner message will be displayed on the Staging page. When the "click here" hyperlink shown in the duplicate patient banner is selected, the link will navigate the user to the Duplicate Records Patient List page. Each set of duplicate patient records that has been identified for a practice will be



shown on this page, and instructional text will be listed to inform users how to utilize the Self-Service Duplicate Patient Management Tool.

After using this tool to review the duplicate records, practices may choose to identify the patient record that should be kept, and which of the duplicate patient records should be deleted from the Data Registry.

Q: Are all staging and clinical data elements required for a diagnosis to be staging complete?

All data elements included in the staging and clinical data specifications for a diagnosis, unless identified as optional, are required for the diagnosis to be 'staging complete' in the OCM Data Registry. If any required staging and clinical data elements for a reported diagnosis are not complete, the OCM Data Registry will flag the patient as staging incomplete until the missing data are reported.

Q: Will Data Registry users be able to modify or delete staging and clinical data submissions after processing?

Once a practice submits staging and clinical data for a performance period prior to the submission deadline, or after auto-submission when the submission deadline has passed, the staging and clinical data reported to CMMI for the performance period cannot be updated. Practices can make updates to the staging and clinical data to be used for future performance periods, if the patient is attributed in the future.

Q: Is it possible to see sample upload files?

You will find a sample Patient Upload File, OCMR Staging Upload Template, and OCMR Staging Abstraction Tool file on OCM Connect and within the OCMR Upload Definition File available on OCM Connect and on the Staging tab after selecting "Upload Spreadsheet".

Q: When uploading data is there a limit to the file size or record count per file?

Yes.

- For the Patient Upload File, 50,000 lines per file.
- For the OCMR Staging Upload Template, the OCMR Staging Abstraction Tool and the Staging Data Gap Export Report, the recommended maximum file size is no more than 3,000 rows.

If you wish to include more rows of data, multiple files may be uploaded to the OCM Data Registry.

Please note that the MBI Transition Upload Template does not have a file size limit.

Q: If there is an error or warning for one or more rows in a file, will the rest of the file data still process and save? If we upload a file and there is an error can we resolve the error using manual entry instead of uploading a corrected file?

Yes – the remaining data in the file that did not trigger an error will be processed and saved. The user can fix the error by either correcting the data in the file and re-uploading it, or manually entering data into the Data Registry.

Q: What do the messages in the error log mean?

For a detailed explanation of all error and warning messages contained in error logs that are generated from the OCMR Patient Upload File, OCMR Staging Upload Template, OCMR Staging Abstraction Tool, Staging Data Gap Export Report, and MBI Transition



Upload Template, please visit the OCM File Submission Guide, available on OCM Connect.

Q: If the file upload fails with a Failed status, did any of my data get added to the Registry?

An uploaded file with a status of Failed indicates that the entire file failed to upload and will need to be uploaded again, after correcting the error(s) that caused the file upload to fail.

Q: Is there a specific format that OCM would like us to title the documents?

No. There is no specific file naming format required.

Q: How do I utilize the Staging Data Gap Export Report?

The Staging Data Gap Export Report is a report that allows practices to export all reported staging and clinical data currently in the Data Registry for every patient identified as staging incomplete on the sub-tab, regardless of the filter on the Patient List at the time the report is requested. If the patient also has incomplete Patient Information in addition to missing staging and clinical data, those data gaps will be displayed in the Staging Data Gap Export Report as well. The report will display 'DATA GAP' for missing data elements that are required, and 'OPTIONAL DATA GAP' for missing data elements that are optional. This upload file will allow users to update the report to populate valid values for any of the data gaps, and upload the updated file to the OCM Data Registry.

To export the Staging Data Gap Export Report, navigate to the current open performance period Attribution sub-tab (e.g., PP7 Attribution, PP8 Attribution, etc.), or the All Patients in Registry sub-tab, and select the 'Export Reports' button, and then 'Export Gap Report.'

After downloading the report, users can update the file with valid values from the OCM Staging and Clinical Data Specifications applicable for the performance period. Users then must save and then upload the file by following the same process that is used to upload other staging data files (Staging Abstraction Tool and Staging Template).

Q: Where can I find my current Completeness Percentage for the PP?

To view the percentage of "complete" attributed patient records for a practice, first navigate to the "Submission" tab. Locate the open performance period under "Staging Data Submission", and select the "View Current Status" button to review the Patient Registry Statistics of the staging and clinical data collected in the Data Registry. The numbers displayed for patients with incomplete staging information evaluates if at least one diagnosis code within the performance period's attributed cancer bundle is complete. This number is then used to calculate the percent of attributed patients with complete data for the Performance Period.

Q: Where can I find the data that I've uploaded previously?

To view all previously uploaded files for a practice, navigate to the "Staging" tab, and select the "View Previous Uploads" link on the right side of the page. The user will then be presented with an "Upload History" modal. This modal contains all previously uploaded OCMR Patient Upload Files, OCMR Staging Upload Templates, OCMR Staging Abstraction Tools, Staging Data Gap Export Reports, and MBI Transition Upload Templates for a practice, in addition to the processing status, number of errors, and any errors logs generated for each upload.

Please note the error logs for the MBI Transition Upload Template are not available in this modal, and must be downloaded at the time the file is uploaded.



Q: I just submitted my staging and clinical data, and can no longer see the "PPX Attribution" tab. Why is it no longer displaying?

The attribution tab for an open performance period (i.e. PP7 Attribution, PP8 Attribution, etc.) will not display in the Registry once the staging data for that performance period has been submitted to CMS.

Q: Where can I find my data that has been submitted already?

To locate previously submitted data, navigate to the "Submission" tab, and select the "Submission History" tab. From here, users can view all previously submitted Measure Result Submissions and Staging Data Submissions.

- The Measure Result Submissions sub-tab provides access to historical measure result submissions by measurement period, including the measures results and files that were submitted to CMS.
- The Staging Data Submissions sub-tab provides access to historical staging data submissions by performance period, including patient registry statistics and files that were submitted to CMS.



## 6.3 MBI Transition

### Q: How do I transition a patient with a HICN to MBI?

When a practice obtains the MBI for a patient that has previously been entered into the registry with a HICN, users can modify the patient record to remove the HICN and add the MBI through two means: manual entry or via upload.

**Manual Entry:** To manually update a HICN to an MBI, navigate to the Staging tab, and locate the patient record to be updated on the All Patients in Registry Tab, or an attribution sub-tab. Select the "Actions" button, then "Edit Patient" from the drop-down. Finally, select the "MBI" field, and manually update the patient record with the MBI and save.

**Via Upload:** To update a HICN to an MBI via upload, navigate to the Staging tab, and select the "Perform Bulk Actions" button, then select "Transition Patients to MBI" from the drop-down. Users can select "Data Template" to download the "MBI Transition Upload Template", or "Definition File" to download the "MBI Transition Upload Template Definition" file, which includes the file definitions for the "MBI Transition Upload Template". Users can populate the valid patient identifiers in the "MBI Transition Upload Template", and upload that file to the Data Registry. Upon successful upload, the MBI will now be displayed for the patient record.

Please note the error file will only display immediately after uploading and will not be accessible later, please review all errors if an error log is generated.

Additionally, please reference the "Updating Data Registry Patients from HICN to MBI" document located on OCM Connect for more information on transitioning patient records from HICN to MBI.