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Disclaimer

This information was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to any source documents have been provided within the document for your reference.

This document was prepared as a tool to assist members of the Physician Quality Reporting System (PQRS) Group Practices and the Accountable Care Organizations (ACO) using the (PQRS) Group Practice Reporting Option (GPRO) Web Interface and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.
1. Introduction

This User Manual provides information on how to access the ACO GPRO Web Interface and the PQRS GPRO Web Interface, how to set the accessibility preferences, and how to customize the Web Interface by selecting a default page, and the desired disease modules or measure modules. The GPRO Web Interface will be used by the Physician Quality Reporting System (PQRS) Group Practices, Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), and Pioneer ACOs to submit clinical quality measures (CQMs) for consideration in meeting program requirements.

The term “Web Interface” shall be used hereafter to represent the ACO GPRO Web Interface used by MSSP or Pioneer ACOs or the GPRO Web Interface used by the PQRS Group Practices.

For more information on the ACO programs please visit the Accountable Care Organizations page of the CMS website. For more information on PQRS Group Practice Reporting Option program, please visit the Group Practice Reporting Option page of the CMS website. For more information on the measures used in the Web Interface and training information, please visit the GPRO Web Interface page of the CMS website.

This PDF is provided as a reference only. It is NOT 508 compliant. For a 508 compliant version of this content, please refer to the Online Content.

To access Online Help, please click GPRO Web Interface Online Help.

2. Overview

This document describes how to log on to the Web Interface that is used in the Physician Quality Reporting System (PQRS).

2.1. Conventions

This document provides screen prints and corresponding narrative to describe how to use the Web Interface.

Fields or buttons to be acted upon are indicated in bold in the action statement; links to be acted upon are indicated as links in underlined blue text in the action statement.

The term “user” is used throughout this document to refer to a person who requires and/or has acquired access to the Web Interface.

2.2. Cautions & Warnings

When you sign into this application, a warning screen appears with the Terms and Conditions of Use of the QualityNet Portal, content, and applications. Be sure to read the message completely, as it explains the penalties and consequences of misusing the system(s) and its contents. Acceptance of these terms/conditions is required to access the application.

3. Getting Started

In this section you will learn about the following:
Setup Considerations

Web Browser Setup Considerations

User Access Considerations

3.1. Setup Considerations
To effectively access the PQRS Portal, you must have:

- Microsoft® Internet Explorer Version 11.0 is recommended.
- A printer must be installed on your workstation to print.
- Before starting the Web Interface:
  - The Internet Option Enable native XMLHTTP Support must be activated.
  - The Internet Option Display all websites in Compatibility View must be disabled.
  - The Internet Option Show pictures must be enabled.

3.2. Web Browser Setup Considerations
In this section, you will learn how to configure the following:

Enabling Native XMLHTTP Support

Disabling the Compatibility View

3.2.1. Enabling Native XMLHTTP Support
Before starting the Web Interface, the web browser must be configured to support native XMLHTTP. Failure to activate this option will prevent navigation to the tabs on the Web Interface.

1. If the Tools option in Internet Explorer 11 is not shown, right click the toolbar area and enable the Command Bar. The Command Bar is depicted below:
2. Click the **Tools** option on the toolbar and select **Internet Options** from the drop-down as shown in the following image.

![Internet Options](image1)

3. Click the **Advanced** tab and verify the **Enable native XMLHTTP support** checkbox under the **Security** heading is checked. If it is not checked, please check the box. Click **OK**. The following image shows the **Internet Options** on the **Advanced Tab** with the **Enable native HTTP support** checkbox circled.

![Internet Options](image2)
3.2.2. Disabling Compatibility View

Before starting the Web Interface, the Compatibility View Internet option must be deactivated in the browser. Failure to deactivate this option will prevent some text from appearing on the tabs on the Web Interface.

If the Compatibility View option remains enabled, a warning message (shown below) will appear informing the User that the Compatibility View should be disabled. Then it needs to be disabled in the browser.

To disable the Compatibility View:

1. Select the Tools option on Internet Explorer 11 toolbar.

2. Ensure the Compatibility View is disabled. If the option is not disabled, click on the setting to deactivate it.

3. The Browser will be refreshed with the Compatibility View option turned off for the current browsing session.

The figure below shows the tools menu with the Compatibility View disabled.
To turn off the **Compatibility View** for all browser sessions:

1. Click the **Tools** option on the Internet Explorer 11 toolbar.
2. Click the Compatibility View Settings.

3. Check to see if the **Display all websites in Compatibility View** and the **Display intranet sites in Compatibility View** are disabled, if the option is enabled (checked), uncheck the boxes.

4. Click **Close**.

   The following figure shows the **Display all websites in Compatibility View** setting turned off.
3.2.3. User Access Considerations

In order to access the Web Interface, the user must have an active Enterprise Identity Management (EIDM) account that includes the appropriate GPRO Web Interface role. The role is Web Interface Submitter.

You can find information on applying for and updating your EIDM account via the Quick Reference Guides link (https://qualitynet.org/imageserver/prod_only/quick_reference_guide.html), which is located under the Sign In button on the PQRS portal. The page that opens when you click that link also includes links to specific user guides for each PQRS application.

Once you receive an email confirming that you have been approved for an EIDM account, you can begin to use the GPRO Web Interface.

4. Accessing the System

In this section, you will learn how to:

- Sign into the Web Interface
- System Time Out
- Define User Preferences
- Exit the Application
- Enable Accessibility Features
4.1. **Sign into the Web Interface**

To sign in to the portal and to access the Web Interface:

1. In your web browser, go to the PQRS Portal Home Page (QualityNet Portal).

2. From the home page, click **Sign In**. The **Sign In** screen appears. If you have an account, but have forgotten your password, please click the **Forgot your password?** link and follow the instructions.

3. The following screen appears. If you select the **I Accept** button, the sign on screen for the CMS Portal will appear. If you select the Decline button, the system your logon will be automatically cancelled.
4. Type your EIDM User Name and Password (not any QualityNet credentials you may have) in the **User Name** and **Password** fields and click **Log In**.

5. If you have forgotten your Password or User ID, click on the appropriate link and follow the instructions.
6. After reading the warning screen text, click the box next to I Accept the above Terms and Conditions and then click I Accept. The Welcome Page will appear.

If your EIDM account is associated to multiple communities, you must select the GPRO Submission link. If the MSSP ACO or PQRS Group Practice community is the only community associated to your EIDM account, you will be taken directly to the Web Interface. If the MSSP ACO or PQRS Group Practice community is not the only community associated to your EIDM account, the Site Navigation will appear. This is located in the left navigation field on your screen.

You must accept any Data Use Agreement disclaimers in order to access the Web Interface. The Data Use Agreements for the PQRS Group Practice Web Interface and the MSSP ACO Web Interface disclaimers are shown in the following image:
4.2. System Time Out

Any user signed on to the GPRO Web Interface who has performed no activity for 15 minutes will be timed out and must sign on again to get back into the system. This time period is determined by EIDM.

4.3. Define User Preferences

The Customization page appears when you access the Web Interface for the first time, and enables you to customize the application to meet your individual needs. These settings are tied to a specific TIN, but they only affect the user who entered the settings, so multiple users within the same TIN can have their own customizations.

The Web Interface can be customized at any time by the user. The Customization page appears when the user accesses the Web Interface for the first time. After the first login, the Accessibility or Preferences may be changed by selecting the Accessibility link above the global navigation or the Preferences link on the global navigation. Once the settings are changed, it will apply for all subsequent logins unless it is modified again.

The Accessibility Preferences page enables you to set Accessibility options you may need in order to use the Web Interface.

The User Preferences page enables you to specify the disease modules and/or individually sampled patient care measures you want to appear in the lists and reports indicated below. It also controls the option to turn off the Errors and Warnings screen when saving a patient. User Preference options include:

- Show patients under these module(s) checkbox enables you to specify which patients appear in the Patient List that appears on the Home page and within the Patient Summary Report list, the Pre-filled Elements Report list, the Check Entries Report, and the Comments Report.
• Show errors (if any) after saving radio button enables you to specify whether the **Errors and Warnings** pop-up appears when saving a patient. It is recommended that the default setting to have the **Errors and Warning** appear when saving a patient is enabled. (Note that Informational messages and critical errors will cause the pop-up to appear even when the popup is disabled.).

The **Default Page Selection** enables you to indicate which screen is shown when you log into the Web Interface. When the Home page is set as the default page, the user must select one or more modules. Default Page Selection options include:

• Home Page
• Export Data
• Upload Data
• Reports

To configure the User Preferences:

1. Log on to the Web Interface (see [Signing into the Web Interface](#)).
   - If this is your first time logging on, the **Customize GPRO Web Interface** page will appear before you can access the application. The following screen appears:
If this is not the first time you have logged on, to change the **User Preferences** or the Default Page Selection, click on **Preferences** from the global navigation bar. The preferences shown will reflect what had previously been selected and saved. The image below shows the screen that appears for subsequent entries to the Web Interface:
2. Modify the modules you wish to appear in the Web Interface under User Preferences if changes are desired. Only patient records for patients ranked in the modules selected on the User Preferences screen will appear on the Patient List. In addition, the following reports will only show data for patients ranked in the selected modules:

- Patient Summary Report
- Check Entries Report
- Measure Rates Report
- Pre-filled Elements Report
- Comments Report

3. Select whether or not you wish to show errors when you save the data.

4. Define a page to be the default home page.

5. Once you are done, click Save.

A pop-up dialog box will appear saying that “Your user preferences are saved.” Click OK.

Click the Save button to save your selections. When you click the Clear button, all your selections will reset to system default values, as follows:
• Show patients under these module(s) checkboxes are all unchecked.

• Set as my default page radio button set to **Yes**.

• Set as my default page radio button set to **Home Page**.

For more information, please refer to **Enable Accessibility Features**.

### 4.4. Exit the Application

To log out of the portal, click **Log Off** in the upper left hand corner of the Portal Navigation.

### 4.5. Enable Accessibility Features

In this section, you will learn about the following:

**Accessibility Preferences**

**Setting up Accessibility to Support Screen Reading**

**Customizing Font Size and Color to Support Accessibility Features**

**Data Abstraction Techniques for Accessible Technologies**

#### 4.5.1. Accessibility Preferences

Accessibility preferences enable you to modify the Web Interface settings to meet your individual accessibility needs. These settings are user-level and only affect your individual settings.

- **I use a screen reader** checkbox enables you to turn on/off the screen reader mode. Enabling the screen reader mode optimizes the Web Interface for the use of screen readers. This facilitates text usage for visually impaired users. Enabling this option when a screen reader is not being used will degrade the Web Interface. For example, access keys are disabled in screen reader mode in order to prevent conflicts with keys used by assistive technology.

- **I use high contrast colors** checkbox enables the Web Interface to support high-contrast–friendly visual content and compatibility with operating systems or browsers that have high-contrast features enabled. For example, the use of background images and background colors in high-contrast mode are changed to prevent the loss of visual information. The high-contrast mode only works when your browser’s or operating system’s high-contrast mode is also in effect. Also, some users might find it beneficial to use large-font mode along with high-contrast mode.

- **I use large fonts** checkbox enables the Web Interface to support browser-zoom–friendly content. In default mode, most text and many containers have a fixed font size to provide a consistent and defined look. In large-font mode, text and containers have a scalable font size. The Web Interface will be compatible with browsers that are set to larger font sizes and to work with browser-zoom capabilities if this feature is enabled. If the users are not using large-font mode or browser-zoom capabilities, the large-font mode should
be disabled. Also, some users might find it beneficial to use high-contrast mode along with the large-font mode.

4.5.2. Setting up Accessibility to Support Screen Reading
In order to use the Web Interface with Accessible technologies, JAWS 11 (or higher) the must be available.

The Web Interface Customization page or Accessibility Preferences must be configured for the screen reading software. To configure the Web Interface for the screen reading software, you indicate you are using a screen reader in the in the application’s Accessibility Preferences menu. Once the setting is changed, it will apply for all subsequent logins unless it is modified again.

To enable the application's accessibility options to support screen reading software:

1. Log on to the Web Interface (see Signing into the Web Interface).

2. If this is your first time logging into the Web Interface, the Customize GPRO Web Interface page will appear with the accessibility options.

3. Otherwise (if this is not the first time you logon), click Accessibility above the global navigation bar. Once Accessibility is selected, the Accessibility Preferences screen appears.
Whether it is the **Customize GPRO Web Interface** page or the **Accessibility Preferences** page, you will need to enable the screen reader by checking the **I use a screen reader** box. This will make Web Interface content accessible for users with visual impairments and enable the use of screen reader software such as JAWS.

4. Click **Save**, and then click **OK** on the confirmation pop-up. Changes on this page will be reflected in the application after navigating away from the **Accessibility Preferences** screen.

When the screen reader mode is enabled, the Web Interface screens will be modified to optimize the use of screen reader software such as JAWS. The screen changes include:

- Expanded menu items in the global navigation
- Link Icons, such as the Online Help icon, will be changed to plain text links
- Row selection radio buttons in lists
- Information icons containing alternate text will replace the popup hints

Examples of how enabling the screen reader mode will change the appearance of the Web Interface are shown in the first image. The next image shows the Web Interface without screen reading enabled.
4.5.2.1. Customizing the Font to Support Accessibility Features

You can also configure the tool to show large fonts or high contrast colors by selecting the appropriate compatibility settings.

1. Log on to the Web Interface (see Signing into the Web Interface).

2. Above the global navigation bar, click Accessibility. Once Accessibility is selected, the Accessibility Preferences screen appears.

3. To enlarge font and/or use high color contrasts, select the I use large fonts and/or I use high contrast colors option. This will enable high contrast colors and/or large fonts as soon as the setting is saved.

4. Click Save, and then click OK on the confirmation pop-up. If you selected to use a screen reader, the screens will be changed to reflect that setting after navigating away from the Accessibility Preferences screen. The image below shows an example of large fonts and high contrast colors:
4.5.3. Data Abstraction for Accessible Technologies

Data abstraction for the selected patients in the Web Interface should be done using the Extensible Markup Language (XML) export and upload functionality.

The XML files containing the data exported from the Web Interface may be imported into Microsoft Excel spreadsheets for modification. The modified data may then be exported from the MS Excel spreadsheet into the correct XML format so it may be uploaded into the Web Interface. The Physician Quality Reporting System (PQRS) & Accountable Care Organization (ACO) Group Practice Reporting Option (GPRO) GPRO Web Interface Extensible Markup Language (XML) Specification details the XML format and the steps on how to use MS Excel to abstract the patient data. The XML updates can also be done using custom programming or XML editors.

5. Web Interface Clinical Quality Measures

To obtain a list of Web Interface quality measures, see the 2015 GPRO Web Interface Measures List, 2015 GPRO Web Interface Narrative Specifications, and 2015 GPRO Web Interface Release Notes files on the GPRO Web Interface page of the CMS website.

The 2015 Supporting Documents for each module and the 2015 Measure flows are also available on the GPRO Web Interface page.

The following information is provided in this section:

- Definition of Terms
- Pre-filled Elements
- Data Status
- Timer
- Filtering and Sorting
- Parts of the Dashboard
- Region Identifier
- Group Status
- Patient Status
- Save Patient
- Cancel Patient
- Check Entries
- Patient Medical Record
5.1. Definition of Terms

These are the terms used in the GPRO Web Interface online help and in other documents.

- ACO - Accountable Care Organization
- Allowable Value - Allowable values are a predefined range of valid alphanumeric values for a data element in a database. When manually entering patient data in the Web Interface, the allowable values for measure components are listed in the pull-down menu for components with pre-defined answers. The allowable values for measure components that do not have pre-defined answers appear in a pop-up hint listing the allowable range.

When entering patient data using an XML file, the allowable values for each of the tags are listed in the XML Specification. If one of the tags contains an invalid value, the XML file will not be accepted.

For more information, see the GPRO XML Specification.

- CAD - Coronary Artery Disease is one of the disease modules for the GPRO Web Interface.
- CARE - Care Coordination/Patient Safety is one of the categories of modules for the GPRO Web Interface. CARE includes two measures modules which are treated as individual modules.
- Clinical Performance Measure - Clinical performance measures are used to gauge how well an entity (i.e., hospital, physician office) provides care to its patients. Measures are based on scientific evidence and can reflect guidelines, standards of care, or practice parameters. A clinical performance measure converts medical information from patient records into a rate or percentage that enables health care organizations to track their performance over time for quality improvement purposes.

- CMS - The Centers for Medicare & Medicaid Services is a federal agency within the U.S. Department of Health and Human Services (CMS Website).
- Completed - This status means the appropriate information for a given patient has been provided in order to calculate a measure or to remove the beneficiary from calculations for a measure. Patients will be marked as Complete in the Web Interface when confirmation that the Medical Record was found, the diagnosis has been confirmed in the disease modules, or the patient is qualified for the measure module, and all required
information has been provided. **Only consecutively confirmed and completed beneficiaries are used in analysis.**

- **Completed Modules** - A disease module or a measure module is completed when the minimum number of patients is confirmed and all required information is provided. For all PQRS Group Practices and ACOs, the minimum number of patients in a module that must be consecutively confirmed and completed is 248. If the number of eligible patients in the sample for the modules is less than the minimum number, 100% of the sample must be completed.

- **Confirmed** - Confirmed means the group has found the patient medical record and the patient is qualified for the measure module based on measure-specific criteria such as age, gender, and diagnosis.

- **Consecutive** - Consecutive refers to the order of patients in a disease or measure module starting the patient ranked #1 in the module and proceeding in numeric sequence: 1-2-3-4 etc.

- **Data Elements** - These are data or values for which the calculations or conclusions for the performance measures are based. These elements can be patient level data (i.e., birth date, gender) or the measure specific data elements. These elements are used by one specific measure or several measures in one specific measure set.

- **Date of Birth** - The date on which a patient was born. Changing a patient's date of birth may result in the system automatically setting the patient's status in a disease module or measure module to **Skipped**.

- **Denominator** - This value represents the population evaluated by the performance measure.

- **Denominator Criteria** – Denominator criteria are conditions that should remove a patient from the denominator of modules. Denominator criteria are established by the measure owners. They can only be assigned by the system. Not all measures have denominator criteria.

- **Denominator Exception** - Denominator exceptions are those conditions that should remove a patient from the denominator only if the numerator criteria are not met. Denominator exceptions are established by the measure owners. Not all measures have denominator exceptions.

- **Denominator Exclusion** - Denominator exclusions are factors supported by the clinical evidence that should remove a patient from inclusion in the measure population. The patient is only removed from the disease module or measure module for which the denominator exclusion applies, not from all modules and measure modules.

- **Dialog Box** - A dialog box is a temporary window on the screen that contains a set of choices.

- **DM - Diabetes Mellitus** is one of the disease modules for the GPRO Web Interface.
• EHR - Electronic Health Records are electronic records of patient health information gathered and/or generated in any care delivery setting. This information includes patient demographics, progress notes, medication(s), vital signs, past medical history, immunizations, laboratory data, and radiology reports. The generation and subsequent transmission from point-to-point of electronic patient health information enables physicians to provide quality health management.

• Eligible - An eligible patient is one who meets all the measure owner’s requirements for inclusion in the performance denominator population. Eligibility criteria may include patient’s age as of the beginning of the measurement period, gender, or confirmation of additional conditions. The patient must be confirmed in the disease module or measure module and meet additional criteria:
  - CARE-3: the patient is eligible for the performance denominator population if the patient has been seen on at least one of the pre-populated visit dates.
  - CAD-7: the patient is eligible for the performance denominator population if the patient has LVSD or Diabetes.
  - HF-6: the patient is eligible for the performance denominator population if the patient has LVSD.

Additional information on eligibility criteria is available in the Narrative Measure Specifications, Measure Flows, and Supporting Documents in the Downloads section of the GPRO Web Interface web page.

• For Analysis - The patients counted toward the minimum number of patients required to meet satisfactory ACO reporting or Group Practice satisfactory reporting are available for analysis. The patients included in the For Analysis count include the consecutively confirmed and completed patients within the sixteen measure modules. The count of For Analysis patients starts with the patient ranked #1 in the module and continues for each consecutively ranked patient who is confirmed in the disease module or measure module. The count, which does not include skipped patients, stops when the first incomplete patient is reached.
  - The minimum number of For Analysis patients for a PQRS Group Practice, or an ACO is 248 in each of the 16 modules.
  - If the number of eligible patients in the sample for the modules is less than the minimum number, 100% of the sample must be completed.

• Gender - Changing a patient’s gender will automatically change the Patient’s PREV-5 Confirmation value to Not Confirmed – Gender, because the PREV-5 module covers Mammography Screening. This means that when all required data is provided, the patient will be marked as Skipped in PREV-5 because of ineligibility.

• Grid - Grids are table-like controls composed of rows and columns. They show lists of records for reporting in other forms. Below is an example of a grid.
- HF - Heart Failure is one of the disease modules for the GPRO Web Interface.
- HTN - Hypertension is one of the disease modules for the GPRO Web Interface.
- Incomplete Module - This indicates that at least one required element under a module has not been supplied, therefore the module is incomplete.
- IVD - Ischemic Vascular Disease is one of the disease modules for the GPRO Web Interface.
- Measure Exceptions - For process measures, the Consortium (AMA) provides three categories of reasons for which a patient may be excluded from the denominator of an individual measure. The measure steward determines which categories of reasons are allowed for an individual measure. Not all measures will have denominator exclusions.
  - Medical reasons include:
    - Not indicated (already received/Performed, other)
    - Contraindicated (patient allergic history, potential adverse drug reaction, etc.)
  - Patient reasons include:
    - Patient declined
    - Economic, social, or religious reasons
    - Other patient reasons
  - System reasons include:
    - Resources to perform the services not available
    - Insurance coverage/payer-related limitations
    - Other reasons attributable to health care delivery system
- MH - Mental Health is one of the disease modules for the GPRO Web Interface.
• Modules - Modules are the clinical quality modules being reported on by the abstraction of quality measures and meeting clinical quality performance standards for PQRS Reporting in the Web Interface. The modules include the six disease modules, the two Care Coordination/Patient Safety individually sampled measures, and the eight Preventive Care individually sampled measures. The Care Coordination/Patient Safety measures and Preventive Care measures are collectively referred to as measure modules. Each of the measure modules is sampled and treated as a module for completeness calculations.

• Not Confirmed - Patients whose diagnosis in a disease module or a measure module cannot be confirmed. Refer to appropriate supporting documents for allowable exclusions. The Not Confirmed diagnosis status has several variants:

  ▪ Not Confirmed – Age

    If you change a patient’s Date of Birth so that it falls outside the age criteria for a disease module or a measure module, the system will automatically change all the Confirmed values in the relevant modules or measures for that patient to Not Confirmed – Age, with no other values available to select. This means the patient will be marked as Skipped in those modules or measures because of ineligibility, even if you provide all required data.

    If you change the patient’s Date of Birth so that the patient’s age falls within the age criteria for a module or measure, the system will automatically change all the Confirmed values in the relevant modules or measures for that patient to a blank value, and the patient’s module or measure status will change to Incomplete. This means you must provide the required data in order to complete the patient.

  ▪ Not Confirmed – Denominator Criteria

    This status indicates the following:

    ➢ Patient is ranked in MH, MH Confirmed = Yes, PHQ-9 Test Performed? = “Yes” and Initial PHQ-9 Administered? = No the system will automatically skip the patient.

    ➢ Patient is ranked in MH and PHQ-9 Test Performed = Yes and PHQ-9 Test Score is <= 9, the system will automatically skip the patient.

    ➢ Patient ranked in CAD, CAD Confirmed = Yes, Has LVSD or Diabetes = No the system will automatically skip the patient.

    ➢ Patient ranked in HF, HF Confirmed = Yes, Has LVSD = No, the system will automatically skip the patient.

    If you change the response to one of the following:

    ➢ MH-1 Initial PHQ-9 Administered? to Yes.

    ➢ MH-1 PHQ-9 Test Score to <= 9,
- CAD Has LVSD or Diabetes to **Yes** or
- HF Has LVSD to **Yes**

...the system will automatically change all the **Confirmed** values in the relevant modules or measures for that patient to a blank value, and the patient’s module or measure status will change to **Incomplete**. This means you must provide the required data in order to complete the patient.

- **Not Confirmed – Diagnosis**

  This status indicates that a patient does not have a confirmed diagnosis for the disease or condition.

- **Not Confirmed – Gender**

  If you change a patient’s gender so that it falls outside the gender criteria for the PREV-5 module, the system will automatically change the patient’s PREV-5 Confirmation value to **Not Confirmed – Gender**. This means that when all required data is provided, the patient will be marked as Skipped in PREV-5 because of ineligibility.

  If you change a patient’s gender so that it falls within the gender criteria for the PREV-5 module, the system will automatically change the patient’s PREV-5 Confirmation value to a blank value and the patient’s PREV-5 status to **Incomplete**. The required data must be provided to complete the patient.

- **Not Confirmed – Medical Reasons**

  Several medical reasons may affect a patient’s confirmation status; see Measure Exclusions for more information.

- **Not Confirmed – No Qualifying Visits**

  If the response **No – Visit Outside Practice** is selected for all Visit Dates in CARE-3, the system will automatically change the patient’s CARE-3 Confirmation value to **Not Confirmed – No Qualifying Visits**. This means that the patient will be automatically skipped for CARE-3.

- **Numerator** - This value represents the portion of the denominator population that satisfies the conditions of the performance measure.

- **PREV - Preventive Care** is one of the categories of modules for the Web Interface. PREV includes eight measure modules, all of which are treated as separate modules.

- **Performance Measure** - A performance measure is a quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of an organization’s performance in relation to a specified process or outcome. It also provides specific clinical and technical information on a measure. The information includes: performance measure name, description, numerator/denominator, included populations, excluded populations, data elements, and sampling criteria.
- **Performance Rate** - This value is calculated by dividing the numerator by the denominator resulting in a number that is converted into a percentage.

- **PHI** - Protected Health Information

- **PII** - Personally Identifiable Information

- **Pre-filled Elements** - Measure elements populated from claims prior to abstraction and available in the Web Interface at the start of the submission period will be pre-filled. See [Pre-filled Elements](#) and [Indicators](#) for more information.

- **Rank** - A read-only numeric value assigned to a patient that indicates his/her order in a disease module or measure modules. Patients sampled into the Web Interface are given a particular order or position which is used in determination of adequate reporting of data.

- **Supporting Documents** - These documents comprehensively define the data elements/variables and allowable values. Also included are instructions, as well as inclusion and exclusion sections for each data element. Said instructions and inclusions and exclusions assist the abstractors in their ability to assign the most suitable (valid) allowable value for each element. These definitions provide a common set of guidelines for use by all medical records or clinical data system abstractors to promote consistency of abstraction. The [GPRO Supporting Documents](#) can be found on the [CMS Website](#).

- **Upload Data** - Uploading data is the process of updating data in the Web Interface using an XML file in a specified format which is created outside the Web Interface.

- **XML** - Extensible Markup Language (XML) is a set of rules for encoding documents in a format that is both human-readable and machine-readable.

### 5.2. Pre-Filled Elements

A Pre-filled Element is a quality measure element determined from claims. If any claim for the patient indicates the quality process was performed, the element is populated for the patient when the data is loaded into the database. Inpatient and outpatient claims from all providers servicing the patient are evaluated to determine if the quality process was performed. Because all claims for the patient are evaluated, the service may have been provided to the patient by a provider outside the Tax Identification Number (TIN).

The PREV-7 Immunization Received may be pre-filled for a patient. If there is a claim indicating the patient received the immunization, the measure answer will be pre-filled with **Yes**. The following message indicating that the data was pre-filled will appear below the PREV-7 measure answers if the patient is ranked in PREV-7:

*Immunization Received is pre-filled based on an outpatient claim from this Group Practice.*

The CARE-3 Visit Date is pre-filled for a patient based on outpatient claims. No message indicating if the data was prefilled will display because dates cannot be added or modified.
5.2.1. User Changes

When the database is prepopulated using data from claims, it can be determined if certain processes were performed either within the Group Practice or ACO or outside the Group Practice or ACO. This information about the source of data (metadata) is stored in the database and made available through the Web Interface. The Web Interface always uses this metadata in determining what text to display in designating the source of the pre-filled elements. This means that the Web Interface pre-filled text for the element remains constant even if its value has been changed.

5.3. Data Status

Data Status refers to the condition of the module regarding the completeness of its data for an individual patient. Values are Complete, Incomplete, Skipped, or Not Ranked. The Data Status of each module along with the module confirmation is used to determine if the minimum number of patients to be abstracted has been reached.

5.3.1. Complete Modules

If a patient is ranked in a module, the system will mark the patient as complete in the disease module or measure module if either of the following conditions is met:

- **Medical Record Found = Yes**, the patient has a confirmed condition in the disease module (CAD, DM, HF, HTN, IVD, MH), and all of the required elements in the module are supplied.

- **Medical Record Found = Yes**, the patient is qualified for the individually sampled CARE or PREV measure (CARE-2 CARE-3, PREV-5, PREV-6, PREV-7, PREV-8, PREV-9, PREV-10, PREV-11, or PREV-12), and all required elements in the measure are supplied.

Note: As long as all required questions or elements have been responded to, the measure module is considered complete. If the response provided is a skip reason, the measure module is considered complete however when calculating performance, it will be considered a skip. For more information, please refer to Skipped Modules.

5.3.2. Incomplete Modules

If a patient is ranked in a module, the system will mark the patient as incomplete in the module if any of these conditions is met:

- No data has been entered for the patient; this is the default state for a patient ranked in the module.

- The Medical Record Found answer is not supplied.

- Medical Record Found = Not Qualified for Sample and the Reason and Date are not supplied.

- **Medical Record Found = Yes** and the confirmation of the disease diagnosis is missing in a disease module (CAD, DM, HF, HTN, IVD, or MH).
• **Medical Record Found = Yes** and the confirmation that the patient is qualified for the CARE or PREV measure (CARE-2, CARE-3, PREV-5, PREV-6, PREV-7, PREV-8, PREV-9, PREV-10, PREV-11, or PREV-12) is not supplied.

• The patient has a confirmed condition in a disease module or is confirmed as qualified for the measure and at least one of the required elements in the module is missing.

• The patient has a confirmed condition in the module and at least one of the required elements in the module is invalid. NOTE: Where a blood pressure reading is required and is available (e.g. both systolic and diastolic are non-zero values), the diastolic blood-pressure value must be less than the diastolic blood-pressure value. If the diastolic blood-pressure value is not less than the systolic value, the system will mark the patient as Incomplete in the associated module (DM).

### 5.3.3. Skipped Modules

If a patient is ranked in a module, the system will mark the patient as skipped in all modules in which the patient is ranked if any of the following conditions is met:

• Medical Record Found = No.

• Medical Record Found = Not Qualified for Sample and a Reason and Date are supplied. Not Qualified for Sample reasons are:
  - In Hospice
  - Moved out of Country
  - Deceased
  - HMO Enrollment

• Medical Record Found = Yes and the CARE, CAD, DM, HF, HTN, IVD, MH, or PREV Confirmation is set either to Not Confirmed - Diagnosis or to No – Other CMS Approved Reason.

• If a patient is ranked in a module, the system will mark the patient as skipped in an individual module if one of the following conditions is met for the module:
  - Medical Record Found = Yes and the CAD, DM, HF, HTN, IVD, or MH Confirmation is set to Not Confirmed - Diagnosis or No – Other CMS Approved Reason.
  - **Medical Record Found = Yes** and the CARE-2, CARE-3, MH, PREV-5, PREV-6, PREV-7, PREV-8, PREV-9, PREV-10, PREV-11 or PREV-12 Confirmation is set to **No – Other CMS Approved Reason**.
  - Medical Record Found = Yes and HTN Confirmation, PREV-5 Confirmation, PREV-6 Confirmation, PREV-9 Confirmation, PREV-11 Confirmation, or Prev-12 Confirmation is set to Denominator Exclusion.
• If the PQRS Group Practice or ACO is not able to confirm any of the pre-filled CARE-3 office visit dates and selects the response **No - Visit Outside Practice** for all dates for a patient, the system will automatically set the CARE-3 Confirmation to **Not Confirmed - No Qualifying Visits**, and the patient will be skipped for CARE-3.

Note that CARE-3 is an episode based measure, therefore if some but not all of the visits are confirmed, the patient is still eligible for the CARE-3 measure and all confirmed visits will be included in the denominator.

• The system will automatically mark the patient as **Skipped** if the Date of Birth is modified and the resulting age makes the patient ineligible for one or more of the modules in which they are ranked. Only patients with an eligible Date of Birth in the CMS system are sampled into the modules.

• The system will automatically mark the patient as skipped in the PREV-5 module if the gender of the patient is modified. Only patients indicated as female in the CMS system are sampled into the PREV-5 measure module.

• The system will automatically mark the patient as **Skipped** and changed the measure confirmation from yes to **Not Confirmed – Denominator Criteria** for the following:
  - MH-1 - PHQ-9 Test Performed? = **Yes** and PHQ-9 Index Test > 9 = **No**.
  - MH-1 - PHQ-9 Test Performed? = **No**.
  - CAD – Has LVSD or Diabetes = **No**.
  - HF – Has LVSD = **No**.

### 5.3.4. Not Ranked Modules

The patient will be marked as **Not Ranked** in a module if the patient was not selected for the module’s sample. The **Not Ranked** data status is set when the patient data is loaded into the database and cannot be modified.

### 5.3.5. Timing of Updates

The data status of modules is updated in one of the following scenarios:

• After the changes to the patient record are saved

• After uploading data using the XML Upload Data functionality

Initially, all modules in which the patient is ranked are marked as **Incomplete**, and all modules in which the patient is not ranked are set to **Not Ranked**.

### 5.3.6. Indicators

The Patient data status has four indicators:

• A **Complete** module is a green checkmark.
• An **Incomplete** module is a red X.
• A **Skipped** module is a green S.
• A **Not Ranked** module is a green NR.

The status of patient modules is used when counting the complete modules for the group as well as the modules available for analysis.

For more information, please refer to [Totals Report](#).

### 5.4. Timer

The Web Interface has a timer that monitors the amount of time spent abstracting information for each patient. The timer indicates the total number of hours, minutes, and seconds any user has spent on that patient using the Web Interface. The time is not updated when a patient is updated by an XML file upload.

The timer turns on when you make changes to the patient's information (e.g. changing a value in a drop-down menu or text box).

The timer icon color is red when the timer is on.

The updated total time spent on each patient is saved when the user clicks **Save Patient** after making the changes. Saving the patient will stop the timer until additional changes are made. Note: the timer does not track XML updates.

Clicking **Cancel** will reset the timer to the time when the patient was last saved.

### 5.5. Filtering and Sorting

Learn how to filter by:

- **Patient List**
- **Other Tables**
- **Wild Cards**

#### 5.5.1. Patient List

The patients in the Patient List are limited to those ranked in the modules selected on the Initial **Customization** page or on the **Preferences** page. The patients in those modules can be filtered within the Patient List with user entered filters. The Patient List may also be sorted. The default sort option for the Patient List is the **Medicare ID**.

Use the **Apply Filters** and **Clear Filters** buttons to apply and clear entered filter criteria respectively. The **Clear Filters** button is useful when multiple filters have been used or if the filter text box is not on the currently visible part of the Patient List.

Alternately, enter or delete a value in the filter text box and press the **Enter** key with the cursor in one of the filter text boxes to apply the entered/removed filter.
You can filter the Patient List by using the text boxes at the top of each column.

Some columns do not restrict the types of information that may be entered in the filter text box. In such cases there is no pop-up hint when you click in the field. Examples of columns that do not restrict entry are the Medicare ID and Patient, Provider, or Clinic name columns.

Some columns do restrict filter criterion to specific patterns that are applicable to the type of data in the column. In such a case, a hint appears when you click in the filter input field. The pop-up hint indicates the valid values which may be entered in the filter text box.

The Completeness filter for each module requires you to enter one of the following:

- 1 to filter for Complete patients in the module
- 2 to filter for Incomplete patients in the module
- 12 to filter for Skipped patients in the module
- 13 to filter for Not Ranked patients in the module

For the module Rank Filter, enter a rank number or range that is less than or greater than a rank number. The following are examples of the rank filter:

- 10 – Shows only the patient ranked 10 in the module where the filter was entered.
- <10 – Shows patients with a rank of 0 to 9 in the module where the filter was entered.
- >10 – Shows patients with a rank of 11 or higher in the module where the filter was entered.
- >0 – Shows all ranked patients in the module where the filter was entered. When a patient was not selected for a module sample, their rank in that module will be zero (0).

Filtering on multiple columns is possible. When multiple columns are filtered, the data must meet both conditions to appear in the list. An example of using multiple filters would be to filter by all patients in a module who were patients at a specific clinic and who are still incomplete. This would be done by entering the desired clinic ID in the Clinic ID column filter and 2 in the Completeness column filter for the specific module.

Sort the columns in the Patient List by using the arrows in the column heading. The sorting arrows appear when the cursor is moved over the column heading. Each arrow has an indicator of how the column will be sorted. The columns will sort in ascending or descending order. You can sort on only one column at a time. Note: if you have sorted a column, the arrows indicating the sort order on that column will remain visible until you sort on a different column.

A sort may be used with or without a filter. Using the filter and the sort together is useful when determining which patients need required data in order to meet reporting requirements. The Patient List can be sorted by rank order in a module and also filtered by Incomplete patients in that module.

Trouble Shooting for Filtering and Sorting
• If you feel that the system is not showing all the patients you expect to see, check the following:
  
  o Review the modules that have been selected on the Preferences screen. Every module not selected to appear on the Preferences screen can reduce the number of patients displayed on the Patient List. The Patient List only shows patients ranked in the modules selected.

  o If you are using multiple filters, you may inadvertently exclude patients you wish to appear. Select the Clear Filters button to remove all filters and show all patients ranked in modules selected to appear on the Preferences screen. Next, add the filters desired one at a time and review the selected patients after each filter has been applied.

• To eliminate displaying all not ranked patients (rank value = 0) while sorting, filter the rank of 0 out by keying “>0” in the Rank columns (only show patient records with a rank 1 or greater) then sort your patients.

5.5.2. Other Tables

For all tables except the Patient List table, press the Enter key to apply filtering. You must press the Enter key after entering or removing text in the filter text box; changing the content of the filter text box does not automatically update the results.

Sort the columns in the other tables using the arrows in the column heading. The sorting arrows appear when the cursor is moved over the column heading. Each arrow has an indicator of how the column will be sorted. The columns will sort in ascending or descending order. You can only sort one column at a time. A sort may be used with or without a filter. Note: if you have sorted a column, the arrows indicting the sort order on that column will remain visible until you sort on a different column.

5.5.3. Wild Cards

The filter text boxes enable you to filter the results using exact values or wild cards (i.e., % or *) combined with a single character or a string. Note that if you wish to filter by a string that is not at the beginning of the field value, you must precede the string with a wild card.

Example:

• 2013 or 2013* - These will search for values that begin with 2013 and the results could have more characters following it; 2013 and 2013579 will both appear in the results.

• *341* - This will search for the value that is anywhere in the string.

5.6. Parts of Dashboard

The following screen images show the major parts of the Dashboard. A description of the fields is in the table below the image.
1 GPRO Navigation

Use these links to navigate through the Web Interface. Included are Home, Reports, Export Data, Upload Data, Add/Edit, Locked Records, List Users, Submit and Preferences.

2 Patient List

View the patients for your Group Practice TIN or Primary ACO TIN. The list shows the patient’s rank in each module and the completion status for each module. The list can be limited to patients in selected modules through the use of settings on the User Preferences page. The list can be filtered or sorted by each of the columns containing data.

3 Filter

Limit the visible data using exact values or wild cards (i.e. % or *) with a single character or a string. For additional information on filtering the list, see Filtering and Sorting.

4 Sort

Sort a column in ascending or descending order. For additional information on sorting the list, see Filtering and Sorting.

5 Apply Filters Button

Apply filter values entered in the filter text box above one or more columns.

6 Clear Filters Button

Remove filter values entered in the filter text box above one or more columns.
<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Refresh Patient List Button</td>
<td>Refresh the list of patients and completeness indicators. When multiple users are updating patients in the same list, refreshing the list will provide the current status for patients updated by the other users. The Patient List is automatically refreshed when the home page is accessed or when cancelling an existing edit.</td>
</tr>
<tr>
<td>8</td>
<td>Status bar</td>
<td>Shows the group completeness status if no patient is selected. Once a patient is selected in the patient list, this section shows the selected patient's completeness status.</td>
</tr>
<tr>
<td>9</td>
<td>Refresh Status Button</td>
<td>Refresh the Group Status Dashboard with the current completeness data.</td>
</tr>
<tr>
<td>10</td>
<td>Module</td>
<td>Contains the tabs for demographics, disease modules, and measure modules.</td>
</tr>
</tbody>
</table>

5.7. Region Identifier

This message appears at the top of the screen to define whether the data shown is for training (and therefore not to be submitted to CMS) or is production data to be submitted to CMS. This appears at the top of each screen for measures, modules, and reports.
Any of the following five messages can appear in this area. Each message is preceded with the GPRO Group Representative (GPRO Web Interface or ACO GPRO Web Interface) and followed by dashes.

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Submission for &lt;current measurement period&gt; ends on &lt;end date&gt; at &lt;end time&gt; PT</td>
<td>This message indicates the dates and times that the Web Interface system will be available for submission in production.</td>
</tr>
<tr>
<td>2</td>
<td>LIMITED FUNCTIONALITY – Patient List Exports ends on &lt;end date&gt; at &lt;end time&gt; PT</td>
<td>This message indicates the dates and times that the Web Interface system is available for users to export patient lists.</td>
</tr>
<tr>
<td>3</td>
<td>TRAINING VERSION ends on &lt;end date&gt; at &lt;end time&gt; PT</td>
<td>This message indicates the date and time that the training version of the Web Interface will end.</td>
</tr>
<tr>
<td>4</td>
<td>LIMITED FUNCTIONALITY – Report Access ends on &lt;end date&gt; at &lt;end time&gt; PT</td>
<td>This message indicates the date and time the production region terminates access to the Web Interface online reports.</td>
</tr>
<tr>
<td>5</td>
<td>THIS DATA IS FOR TRAINING PURPOSES ONLY. Data not transmissible to CMS and does not count toward your submission for GPRO Web Interface Reporting.</td>
<td>This message reminds users that they are in the training region and that any submissions generated will not be transmitted to CMS. This message appears on the Submit screen and the Submit status report.</td>
</tr>
</tbody>
</table>

5.8. **Group Status**

Group Status refers to the condition of the group's completed modules.

- **Analysis** is the number of consecutively confirmed and completed patients in the module. The count of patients in **Analysis** starts with the first ranked patient in the module and increments until the first incomplete patient in the module is found. The count does not include skipped patients.

- **Complete** is the number of confirmed and complete patients in the module that the group has completed in any order. This number may be higher than the **Analysis** number if patients are not completed in order starting with the first ranked patient.

- **Skipped** is the number of skipped patients in the module in any order. The count of skipped patients includes:
  - Patients with Medical Record Found set to **No**.
  - Patients with Medical Record Found set to **Not Qualified for Sample** due to:
In Hospice
- Moved out of the Country
- Deceased
- HMO Enrollment

- Patients with the disease module confirmation or measure confirmation set to:
  - No – Other CMS Approved Reason
  - Not Confirmed – Diagnosis (MH, DM, HF, HTN, and IVD)
  - Not Confirmed - Denominator Exclusion (HTN, PREV-5, PREV-6, PREV-9, PREV-11, and PREV-12)
  - Not Confirmed – Gender (PREV-5)
  - Not Confirmed – Age
  - Not Confirmed – No Qualifying Visits (CARE-3)
  - Not Confirmed – Denominator Criteria (CAD, HF, and MH-1)

Note that the Not Confirmed – Gender, Not Confirmed – Age, Not Confirmed – Qualifying Criteria, Not Confirmed – No Qualifying Visits, and Not Confirmed – Denominator Criteria skip reasons are automatically set by the system only when appropriate.

When Analysis has reached the required number of consecutively confirmed and completed patients in that module, a checkmark appears indicating that the module meets the requirements for ACO or Group Practices satisfactory reporting.

The Status Bar appears for the Group Status when you are on the Home page and have not selected a patient from the Patient List. Once you select a patient from the list, the Status Bar switches to the Patient Status.

Click Refresh Status to refresh the data shown in the Group Status. This is especially useful when multiple people are simultaneously updating patients within the same group. The Group Status automatically updates when you first access the Home page, when you switch to the Group Status from the Patient Status, or when you navigate to the Home page from another screen.

For more information, please refer to Data Status.
5.9. Patient Status

The Patient Status shows read-only information about the patient currently selected in the Patient List.

The following are the list of items shown in this area of the screen:

<table>
<thead>
<tr>
<th>#</th>
<th>Part</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group Status</td>
<td>Switches the Status Bar from the Patient Status to the Group Status. Once you start editing the selected patient, the Group Status button will not be available for selection. See the topic on Group Status for more information.</td>
</tr>
<tr>
<td>2</td>
<td>Save Patient</td>
<td>Saves the changes made to the patient information. The Save Patient button is only available when changes have been made to the patient's data. See the topic on Save Patient for more information.</td>
</tr>
<tr>
<td>3</td>
<td>Cancel</td>
<td>Cancels changes made to patient information. The Cancel button is only available when changes have been made to the patient's data. See the topic on Cancel Patient for more information.</td>
</tr>
<tr>
<td>4</td>
<td>Check Entries</td>
<td>Validates the patient information for errors. The Check Entries button is always available when the Patient Status is appears. The Check Entries button is always available when a patient has been selected. See the topic on Check Entries for more information.</td>
</tr>
<tr>
<td>5</td>
<td>Timer</td>
<td>The amount of time spent modifying information for the patient is provided. See the topic on Timer for more information.</td>
</tr>
<tr>
<td>6</td>
<td>Demographics</td>
<td>List of demographic information (First name, Last name, Gender, Date of Birth, Medicare ID and Medical Record Number). The Medical Record Number is not loaded into the database, but may be provided during patient abstraction.</td>
</tr>
</tbody>
</table>

![Image of Patient Status](image-url)
<table>
<thead>
<tr>
<th>#</th>
<th>Part</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Current Mode</td>
<td>Specifies whether you are Browsing or Editing a patient record. The mode is Editing when changes have been made to the patient record, but the changes have not been saved. The mode is Browsing if no changes have been made to the patient record or when the changes have been saved.</td>
</tr>
<tr>
<td>8</td>
<td>Locked By</td>
<td>Indicates the name of the user who is currently modifying patient information. Only the user who has a lock on the patient's record is can modify it. If another user has the patient's record locked, the user's name will appear in red. If no one is modifying the record, the text is ---. See the topic on Locked Records for more information.</td>
</tr>
<tr>
<td>9</td>
<td>Updated</td>
<td>Indicates the date the patient data was last updated by saving the patient's data on the screen or by uploading an XML file containing data. If the patient's data has not been updated, the text is ---.</td>
</tr>
<tr>
<td>10</td>
<td>Updated By</td>
<td>Indicates the last user to update the patient data, either by entering data and saving it on the screen or by uploading an XML file containing data. If the patient's data has not been updated, the text is ---.</td>
</tr>
<tr>
<td>11</td>
<td>Completeness Indicator</td>
<td>Indicates whether all required information for the patient has been provided. See the topic on Indicators for more information.</td>
</tr>
<tr>
<td>12</td>
<td>Rank</td>
<td>Indicates the rank number of the patient under a module. The rank is a read-only numeric value assigned to a patient that indicates his/her order in a disease module or measure module. Patients sampled into the Web Interface are given a particular order or position which is used in determination of adequate reporting of data. If a patient was not selected for a module, the rank will be 0 (zero). All patients will be ranked in one or more modules.</td>
</tr>
<tr>
<td>13</td>
<td>Dx</td>
<td>Indicates whether the patient has been diagnosed with the disease based on the information from claims. Note that it is possible for a patient with a diagnosed disease not to be ranked under that disease module. The Dx column of all CARE and PREV modules will always be blank as these modules do not require a diagnosis.</td>
</tr>
</tbody>
</table>

For more information, please refer to Data Status.

5.10. **Save Patient**

To save the changes made to the current patient, click Save Patient on the Patient Status. Saving the patient's information will also validate the information and provide notice of any missing data or errors.
If there is a critical error in the patient's information, the changes will not be saved. The patient's information will not be saved until the critical errors are corrected and you click the Save Patient button again. Any of these conditions are considered a Critical Error and will prevent the changes from being saved:

- The patient's last name was deleted. The last name is pre-populated and can be changed but not deleted.
- The patient's first name was deleted. The first name is pre-populated and can be changed but not deleted.
- The patient's birth date was deleted or changed to an invalid date. The birth date is pre-populated with a valid date and can be changed to another valid date, but it cannot be deleted or changed to an invalid date.
- A provided date of service is not in the measurement year (01/01/2015 to 12/31/2015).
- A provided value is not in the valid range for the measure. Examples of the fields with a validated range are HbA1c, Blood Pressure Systolic and Diastolic, LDL-C, PHQ-9 Test Score and PHQ-9 Follow-Up Score values.

If one of the above conditions is encountered, an error will appear notifying you of the critical error.

Any non-critical errors, warnings, and informational messages that appear when saving the patient's data will not prevent the changes from being saved. You are not required to correct the warnings before saving the patient's data, but you must provide the missing data before the patient will be marked as Skipped or Complete.

The appearance of non-critical errors and warnings can be controlled on the User Preferences screen. The default setting is to show any errors and warnings when the Save Patient button is clicked. Critical errors and Informational messages always appear and cannot be controlled on the Preferences screen. Informational messages appear when the system sets one of the automatic skip reasons based on information provided for the patient.

Once you save the changes, the Save Patient and Cancel buttons will not be available. They will be available after a change has been made to the patient's information.

For more information, please refer to:

- Parts of Dashboard
- Patient Status
- Canceling Changes
- User Preferences

5.11. Cancel Patient

To discard unsaved changes made to patient information, click Cancel on the Patient Status. Before the changes are discarded, a dialog box will appear asking you to confirm the action.
The changes will be discarded only when you click **OK**. If you close the Web Interface while in edit mode or if the application times out for inactivity without first saving, the changes will not be saved and the patient record will be in locked status.

A sample **Confirmation Dialog Box** before changes are discarded is shown below:

```
Cancel
Are you sure you want to discard your changes?
OK Cancel
```

Canceling the changes redirects you to the Group Status and the Patient List with no patient selected. The Group Status and the Patient List are updated with current status for all patients.

For more information, please refer to **Saving Changes**.

### 5.12. Check Entries

The Web Interface has a data validator that checks patient data for errors. To access the data validator, click **Check Entries** on the Patient Status. The validator will then determine if there are missing values, invalid values, or inconsistencies. This feature performs the following:

- Checks for missing required elements.
- Displays the list of errors, warnings and informational messages.

Check Entries does not save any patient data; it only validates all of the patient’s values, whether displayed on the screen or included in tabs that are not currently selected. Check Entries will indicate any critical errors that would prevent the data from being saved when **Save Patient** is clicked.

#### 5.12.1. Checked Elements

The elements are validated using the parent-child relationship. If the parent element is missing or invalid, the child element or “sub-element” is not checked. If the parent element is provided but, based on its value, it is unnecessary to check for the sub-element, the sub-element is not checked. For example, in **DM-2: Hemoglobin A1c Poor Control – if HbA1c Test Performed?** is blank or is **No**, then the **Date Drawn and HbA1c Value** elements are not necessary and will not be checked.

#### 5.12.2. Validation Conditions

These are the four conditions the data validator looks for:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warning</td>
<td>Indicates that there are inconsistencies in the element and a related element. Warnings do not prevent the patient from being marked as complete in the associated module if all other data is complete.</td>
</tr>
<tr>
<td>Problem</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Error</td>
<td>Indicates the element is missing or is invalid.</td>
</tr>
<tr>
<td>Critical</td>
<td>This error prevents the changes from being saved. If any of the following elements is missing, a critical error will occur:</td>
</tr>
<tr>
<td></td>
<td>• First name</td>
</tr>
<tr>
<td></td>
<td>• Last name</td>
</tr>
<tr>
<td></td>
<td>• Date of birth</td>
</tr>
<tr>
<td></td>
<td>• Date outside of program year range for the date fields</td>
</tr>
<tr>
<td></td>
<td>• Measure result value that is outside the range for the test</td>
</tr>
<tr>
<td></td>
<td>If a critical error is found when you click Save Patient, the Errors and Warnings pop-up dialog will always be shown regardless of the settings in the Preferences form.</td>
</tr>
<tr>
<td>Informational</td>
<td>Indicates the condition is not considered an error but provides information that affects the record status, e.g. changing the gender of a patient who is ranked in the PREV-5 measure module from female will cause the system to automatically mark the patient as skipped in PREV-5.</td>
</tr>
<tr>
<td></td>
<td>If an informational message is required when you click Save Patient, the Errors and Warnings pop-up dialog will always be shown regardless of the settings in the Preferences form.</td>
</tr>
</tbody>
</table>

### 5.12.3. Timing of Validation

The data is checked for completeness when you click **Check Entries** or before the changes are saved when you click **Save Patient**.

### 5.12.4. Effect to Data Status

Errors in any element will cause the **Data Status** to be marked as **Incomplete**. If a value entered is not a valid value, the system will indicate that the value is incorrect by highlighting the data entry field with a red border and an error message will appear when you click in the data entry field. Any value so indicated will not be saved to the database until corrected. Warnings or errors for missing data do not have this effect and will allow provided data to be saved to the database.

### 5.12.5. Finding Errors

If you launch the validator by clicking **Check Entries**, the **Errors and Warnings** pop-up dialog will appear. The **Errors and Warnings** pop-up dialog can be configured on the **Preferences** page to appear whenever you save the changes and errors or warnings exist. You can find the
source of error in the dialog by highlighting the error row and clicking **Find Error**. These actions will close the form and set the focus on the element in question. As a shortcut, you can double-click on the row.

A sample **Errors and Warnings** pop-up dialog box with a list of errors found is below:

A sample **Errors and Warnings** pop-up dialog box with no errors found is shown below. Note that this only appears after clicking **Check Entries**. The pop-up dialog does not appear if there are no errors or warnings when clicking **Save Patient**.
5.13. **Patient Medical Record**

When you select a patient from the Patient List, the Patient Medical Record section on the Home page appears.

The Patient Medical Record confirms you are able to find the patient's medical record. The Patient Medical Record may also be used to skip the patient in all modules in which the patient is ranked. The **Medical Record Found** field must have a value for the patient to be marked as **Complete** or **Skipped**.

If you are able to find the patient's medical record, you will select **Yes** from the **Medical Record Found** pull-down menu. Selecting **Yes** enables the confirmation for all modules in which the patient is ranked.

If you are unable to find the patient's medical record, you will select **No** from the **Medical Record Found** pull-down menu. Selecting **No** marks the patient as **Skipped** for all modules in which the patient is ranked.

If you are able to find the patient’s medical record, but the patient is no longer qualified for the sample, you will select **Not Qualified for Sample** from the **Medical Record Found** pull-down menu. If the patient is not qualified for the sample, you must provide the reason and date the patient became ineligible for the sample. If you select **Not Qualified for Sample** and provide the **Reason** and **Date** the patient became ineligible, the patient will be marked as **Skipped** for all modules in which the patient is ranked.

The reasons a patient can be skipped because they are no longer qualified for the sample are:
• **In Hospice** - Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care).

• **Moved out of Country** - Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period.

• **Deceased** - Select this option if the patient died during the measurement period.

• **HMO Enrollment** - Select this option if the patient was enrolled in an HMO at any time during the measurement period.

Enter the date (in MM/DD/YYYY format) the patient became ineligible for the sample during the measurement period (if the date is unknown, enter 12/31/2015).

If a patient is skipped because the medical record was not found or the patient is no longer qualified for the sample, the patient does not count toward the minimum number of patients required in any module in which the patient is ranked. Additional patients, on a one-to-one basis for each skipped module, must be completed for each skipped patient.

5.14. **Home**

Click **Home** in the navigation bar to return to the dashboard. If you are already on dashboard page, the **Home** link is not available for selection.

For more information, please refer to the **Parts of Dashboard**.

5.15. **Reports**

The **Reports** page or pull-down menu on the navigation bar maintains the links to the available Web Interface reports. If you select **Reports** as the default page selection on the **Preferences** page, the **Reports** page will be your default page.

• **Patient Summary Report**…

• **Check Entries Report**…

• **Sample Check Entries Report**…

• **Totals Report**…

• **Measure Rates Report**…

• **Pre-filled Elements Report**…

• **Activity Logs Report**

• **Submit Status Report**

• **Comments Report**…
The periods (…) at the end of the report name indicate you must make a selection from a list screen before the desired report will appear.

You will be taken directly to the report screen when selecting a report that does not have periods at the end of the name.

5.15.1. Patient Summary Report
The Patient Summary Report maintains all the information provided for the selected patient.

To open the Patient Summary Report, click Reports >> Patient Summary Report from the Global Navigation Bar.

The top of the page shows the patient selection list. The patients in the list are controlled by the selected modules in the Preferences settings. If you have not selected any modules in Preferences, all patients in all modules appear. If you have selected one or more modules in Preferences, only the patients in the selected module(s) appear.
The patient list may be filtered and sorted. After entering text to use for filtering, press the Enter key to activate the filter. After removing text for filtering, press the Enter key to generate an unfiltered list. For additional information on filtering or sorting the list, see Filtering and Sorting.

From the patient list, select one or more patients for the report. To create a report for multiple patients, highlight the rows for the patients (shift+click on first and then the last patient or shift+arrow down or control+click to select non-adjacent patients).

- To view the report for the selected patient(s) click Preview.
To print a report after previewing the data for the selected patients, click View Printable Report to get a printer-friendly version of the report. Use the browser print operations to print the report.

Note that your system may not support selection of all patients in the list for printing, so you may need to limit the selection to fewer records. The limit is based on the size of the reports for individual patients and the available memory for printing.

To go directly to the printable version of the report (i.e. bypass the preview report), click Print Selected after selecting the desired patients.

The report for each patient consists of a number of sections, organized similarly to the structure of the Dashboard. Every patient has, as the top two sections, Demographics and Medical Record Found. The Demographics section, in addition to the information from the Demographics tab on the Dashboard, also contains a table of all disease modules and measure modules along with the respective patient’s rank and completion status for that disease module or measure module. After the Demographics and Medical Record Found sections, the Patient
Summary Report has a section for each disease module or measure module in which the patient is ranked. Sections for disease modules or measure modules in which the patient is not ranked do not appear.

Each section shows the data that is currently stored in the database for that patient. This may include data made irrelevant due to other answers. For example, if you saved data for the CAD disease module, and then changed the CAD Confirmation to Not Confirmed – Diagnosis, the Patient Summary Report will still show the saved CAD answers along with a CAD Confirmation answer of Not Confirmed – Diagnosis.

5.15.2. Check Entries Report

The Check Entries Report provides the same information as selecting every patient for your group and clicking the Check Entries button. Because of the time it takes to generate this report, a report generation section is added to the Report page.

**Note:** The Check Entries Report contains data current at the time the report was generated. If you have changed data since a report was generated, you should generate a new report to get the most current data.

To open this report, click Reports >> Check Entries Report from the Global Navigation Bar.

The top of the page contains a list of the last ten generated Check Entries reports. Each entry shows the date the report was generated, the name of the individual who requested the report, the status of the report generation, and the modules included in the report as selected in Preferences when the report was run. If no reports have been generated for your group practice TIN or ACO Primary TIN, the table will indicate No Check Entries Reports have been generated.

Under the list are two buttons, Generate Report and Preview. Above the list and along the right margin is the Refresh button, which you can click to verify if the most recent report request is complete.
To generate a new Check Entries Report, click the **Generate Report** button. A new entry is created with a status of **Request Received**. At this time, you may wait or navigate to a different area of the Web Interface. You may click **Refresh** to refresh the report list. You should note that a Check Entries Report can take several minutes to complete.

If a report in the list has the status of **Complete**, you will be able to click on the report entry to select it. Once you select a report entry, the **Preview** button becomes available. Clicking **Preview** causes the application to retrieve the selected report and present it. A pop-up dialog box appears stating the report is in the process of being prepared. Once the report is ready, the pop-up dialog box disappears and the report appears.

### 5.15.3. Sample Check Entries Report

The Check Entries Report consists of a header with the format of Check Entries Report – [Date and Time report was generated] – [Organization Name] and a table containing the errors and warnings found by the application for the patients in your group. The errors and warnings are limited to the modules indicated in the **Modules in Report** column. The table is similar to the **Errors and Warnings** dialog that appears when **Save** or **Check Entries** is clicked.
The Check Entries Report contains all the patient data validation errors, warnings, and informational messages for all patients in the selected modules based on the patient data in the database. There is no method to restrict the number of patients to run the report against, so even if your group has successfully completed the minimum number of patients required for a successful submission, any remaining incomplete patients will still appear in the Check Entries Report.

The entries in the Check Entries Report table are similar to the ones that appear in the Errors and Warnings dialog, with the following differences:

- The Medicare ID is added to help identify the patient with which the error or warning is associated.
- The Module name associated with the error or warning is removed to save space on the table.
- Provider Names for a patient are added for filtering capability.
- You cannot click on an error or warning and be taken to the Dashboard.

The Check Entries Report table can be filtered and sorted using standard Filtering and Sorting procedures. To request a printer-friendly version of the Check Entries Report, click View Printable Report. Note that because of the potential size of the report, the printer-friendly version may not show all of the entries in the table. The printable version of the report contains the 1000 errors or warnings currently displayed.
Due to the size limitations noted above, the best use of the Check Entries Report is to find missing or inconsistent data after most of the data for your patients has been entered.

5.15.4. Totals Report

The Totals Report is composed of several reports for each module. It shows the total number of completed and incomplete records per module and determines if the minimum requirement is met. See the description of each report below.

Note: The Totals Report contains data current at the time the report was generated. If you have changed data since a report was generated, you should generate a new report to get the current data.

To open this report, click Reports >> Totals Report from the Global Navigation Bar.

The top of the page contains a list of the last ten generated Totals Reports. Each entry shows the date the report was generated, the user name of the individual who requested the report, and the status of the report. If no reports have been generated for your group practice TIN or ACO Primary TIN, the table will indicate No Totals Reports have been generated. Under the list are two buttons, Generate Report and Preview. Above the list and along the right margin is the Refresh button, which you can click to verify if the most recent report request is complete.

To generate a new Totals Report, click Generate Report. A new entry is created with a status of Request Received. At this time, you may wait or navigate to a different area of the Web Interface. You may click Refresh to refresh the report list. You should note that a Totals Report can take several minutes to complete.
If a report in the list has the status of **Complete**, you will be able to click the report entry row to select it. Once you select a report, the **Preview** button becomes available. Clicking **Preview** causes the application to retrieve the selected report and present it. A pop-up message appears stating the report is in the process of being prepared. Once the report is ready, the pop-up message disappears and the report appears.

A sample Totals Summary Report showing the summary the DM module is shown below:

![Totals Summary Report](image)

### 5.15.4.1. Hints

- The Report Type tab indicates whether you are viewing the Totals Summary Report or the Details Report. The Totals Summary Report view shows the completion status for each module. This enables you to view the status for successful data abstraction at the time the report was generated as well as the usage of the various skip reasons. Note that the totals reflect the patients being evaluated in rank order and many of the totals stop counting when an incomplete patient record is encountered (see the footnotes of the Totals Summary Report for additional details). To see the list of patients included in the total on a line, either click the desired **Details >>** link, double-click on the desired row, or click on the desired row and then click **Details** tab.

- To view the list of patients in a report (e.g., CARE-2: All Incomplete), click the **Details** link or, as a short cut, double-click on that row.

- The **For Analysis** field can be used to identify patients that are incomplete:

  The total for **For Analysis** is the number of patients, starting with rank #1, where the record is confirmed and complete in consecutive order. The count stops with the first incomplete patient in the module. If patients ranked #1 through #33 are confirmed and complete but patient ranked #34 is incomplete the Detail will display patients ranked #1 through #33 only regardless of how many patients ranked greater than #34 are confirmed and completed. The **All Confirmed** and **Complete** field will show the count of all patients confirmed and complete regardless of the order they are in.
• The instructions in the Comments column provide information on skipped records and completeness in the module.

• The comment “threshold of 10% has been exceeded” is only a warning for the user to check that skip reasons are properly used. The Detail will show the patients with the skip reason for your review.

• To get a printer-friendly version of the Totals Summary Report, click the View Printable Report button while the Totals Summary Report is visible.

5.15.4.2. Reports
Totals Report

The table below lists the line item on the Totals Summary reports and the available Details Report and sub-sections in each module.

Note: The Totals Report contains data current at the time the report was generated. If you have changed data since a report was generated, you should generate a new report to get the current data.

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ranked Patients</td>
<td>All ranked (sampled) patients in the module.</td>
</tr>
<tr>
<td></td>
<td>This report includes the following sub-sections:</td>
</tr>
<tr>
<td></td>
<td>• All Confirmed and Complete</td>
</tr>
<tr>
<td></td>
<td>• All Skipped</td>
</tr>
<tr>
<td></td>
<td>• All Incomplete</td>
</tr>
<tr>
<td></td>
<td>Note that these three sub counts appear in any order and need not be consecutive.</td>
</tr>
<tr>
<td></td>
<td>If no patients are sampled for a module, N/A will appear in the Total field.</td>
</tr>
<tr>
<td>All Confirmed and Complete</td>
<td>All ranked patients marked as Complete in the module, calculated when:</td>
</tr>
<tr>
<td></td>
<td>• Medical Record Found set to Yes</td>
</tr>
<tr>
<td></td>
<td>• Module Confirmation set to Yes</td>
</tr>
<tr>
<td></td>
<td>• All required measure data provided</td>
</tr>
<tr>
<td>Report Title</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>All Skipped</td>
<td>All ranked patients in a module marked as <strong>Skipped</strong> for any reason in the module.</td>
</tr>
<tr>
<td>All Incomplete</td>
<td>All ranked patients in a module marked as <strong>Incomplete</strong> in the module.</td>
</tr>
</tbody>
</table>
| Consecutively Completed or Skipped | The number of patients, starting at rank #1, meeting the requirements to be counted as **Confirmed and Completed** or **Skipped**. The count stops with the first incomplete patient in the module. Consecutively **Completed** or **Skipped** is also the sum of Medical Record Not Found + Not Confirmed + Denominator Exclusion + Not Qualified for Sample + For Analysis + No - Other CMS Approved Reason + For Analysis. This report includes the following sub-sections:  
  - Medical Record Not Found  
  - Not Confirmed  
  - Denominator Exclusion  
  - Not Qualified For Sample  
  - No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that a help Desk Ticket # addressing the use of this skip reason for the patient be provided in the Help Desk Ticket # field.)  
  - For Analysis  
<p>| Medical Record Not Found           | Consecutively skipped patients where the Medical Record Found is set to <strong>No</strong>.                                                                                                                                                                        |</p>
<table>
<thead>
<tr>
<th>Report Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Confirmed</td>
<td>Consecutively completed or patients where the Medical Record Found is set to <strong>Yes</strong>, but the disease module confirmation element is set to <strong>Not Confirmed</strong> for any reason. This sub-section includes the following categories:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Not Confirmed - Diagnosis</td>
</tr>
<tr>
<td></td>
<td>- Not Confirmed - Gender</td>
</tr>
<tr>
<td></td>
<td>- Not Confirmed – Age</td>
</tr>
<tr>
<td></td>
<td>- Not Confirmed – No Qualifying Visits</td>
</tr>
<tr>
<td></td>
<td>- Not Confirmed – Denominator Criteria</td>
</tr>
<tr>
<td>Not Confirmed - Diagnosis</td>
<td>Consecutively skipped patients where the Medical Record Found is set to <strong>Yes</strong>, but the disease module confirmation element is set to <strong>Not Confirmed – Diagnosis</strong>.</td>
</tr>
<tr>
<td>Not Confirmed - Gender</td>
<td>Consecutively completed or skipped patients where the Medical Record Found is set to <strong>Yes</strong>, but the measure module confirmation element has been automatically set by the system to <strong>Not Confirmed – Gender</strong> because the patient’s gender was changed from Female (applies only to PREV-5).</td>
</tr>
<tr>
<td>Not Confirmed - Age</td>
<td>Consecutively skipped patients where the Medical Record Found is set to <strong>Yes</strong>, but the disease module or measure module confirmation element has been automatically set by the system to <strong>Not Confirmed – Age</strong> because a change to the patient’s Date of Birth has made them age ineligible for the module or measure.</td>
</tr>
<tr>
<td>Not Confirmed – No Qualifying Visits</td>
<td>Consecutively skipped patients in the CARE module where the Medical Record Found is set to <strong>Yes</strong>, the Patient Seen confirmation for all visits has been set to No – Visit Outside Practice, the CARE-3 confirmation element has been automatically set by the system to <strong>Not Confirmed – No Qualifying Visits</strong>.</td>
</tr>
<tr>
<td>Report Title</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Not Confirmed – Denominator Criteria | Consecutively skipped patients where the Medical Record Found is set to Yes but the disease module or measure module confirmation element has been automatically set by the system to Not Confirmed – Denominator Criteria because of the following response:  
  - CAD-7 – Has LVSD or Diabetes = No  
  - HF-6 – Has LVSD = No  
  - MH-1 – Initial PHQ-9 Administered? = No  
  - MH-1 - PHQ-9 Test Performed? = Yes and PHQ-9 Test Score is <= 9  |
| Denominator Exclusion              | Consecutively skipped patients where the Medical Record Found is set to Yes, but the disease module or measure module confirmation element is set to Denominator Exclusion.                                                                                                                                                                              |
| Not Qualified For Sample           | Consecutively completed or skipped patients where the Medical Record Found is set to Not Qualified For Sample for any of the allowable reasons. Not Qualified for Sample is the total of In Hospice + Moved out of Country + Deceased + HMO Enrollment. This report includes the following sub-sections:  
  - In Hospice  
  - Moved Out of Country  
  - Deceased  
  - HMO Enrollment  |
<p>| In Hospice                         | Consecutively skipped patients where the Medical Record Found is set to Not Qualified For Sample and the Reason is set to In Hospice.                                                                                                                                                                                                         |
| Moved Out of Country               | Consecutively skipped patients where the Medical Record Found is set to Not Qualified For Sample and the Reason is set to Moved Out of Country.                                                                                                                                                                                                |
| Deceased                           | Consecutively completed or skipped patients where the Medical Record Found is set to Not Qualified For Sample and the reason is set to Deceased.                                                                                                                                                                                                     |</p>
<table>
<thead>
<tr>
<th>Report Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Enrollment</td>
<td>Consecutively skipped patients where the Medical Record Found is set to <strong>Not Qualified For Sample</strong> and the Reason is set to <strong>HMO Enrollment</strong>.</td>
</tr>
</tbody>
</table>
| No - Other CMS Approved Reason | Consecutively skipped patients where the Medical Record Found is set to **Yes** and the module confirmation element is set to **No - Other CMS Approved Reason**.  
Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that a help Desk Ticket # be provided in the Help Desk Ticket # field. |
| For Analysis                 | Consecutively confirmed and completed patients, starting with the patient ranked #1 in the module, where the Medical Record Found is set to **Yes** and the module confirmation element is set to **Yes**, and all required measure values have been provided. The count of **For Analysis** patients stops when at the first incomplete patient.  
The **For Analysis** Comments will show text indicating if the minimum number of consecutively confirmed and completed patients has been met for the module. ACOs and Group Practices must have 248 consecutively confirmed and completed patients in each module. If the module has fewer than 248 eligible patients, 100% of the patients must be completed to meet satisfactory reporting.  
NOTE: When you analyze the performance rate for measures, you may find that not all patients available for analysis are included in the denominator. For the Totals Report, the Web Interface only counts the confirmed and completed patients in the module. It does not evaluate other criteria like age, gender, or the selected item in a measure (Yes/No/No-Medical Reasons, etc.). |
## 5.15.4.3. Report Comments

These are the messages that may appear in the Comments column of the Totals Report Summary.

<table>
<thead>
<tr>
<th>Text</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;skip rate&gt;% - threshold of 10% not exceeded.</td>
<td>Indicates the percentage of patients skipped within the consecutively confirmed and completed or skipped patients. This message only appears in the Medical Record Not Found, Not Confirmed, Denominator Exclusion, Not Qualified for Sample, or No - Other CMS Approved Reason row if skipped patients exist and the rate is less than the threshold of 10%.</td>
</tr>
<tr>
<td>You have reached the skip threshold for this module. Please ensure you are using appropriate skip reasons and continue your abstraction.</td>
<td>Indicates the percentage of patients skipped within the consecutively completed or skipped patients. This message only appears in the Medical Record Not Found, Not Confirmed, Denominator Exclusion, Not Qualified for Sample, or No - Other CMS Approved Reason row if the rate meets or exceeds the threshold of 10%.</td>
</tr>
<tr>
<td>There are no consecutively confirmed and completed patients. The count starts with the first ranked patient in the module.</td>
<td>Indicates that there are no patient records for analysis. Note that you may have confirmed and completed patients, but these patients will not be counted for analysis if there are lower ranked, but incomplete, patients in the module. The count starts with the first ranked patient in the module and stops at the first patient marked as Incomplete. This message only appears on the For Analysis row.</td>
</tr>
<tr>
<td>The minimum number of consecutively confirmed and completed patients for this module has not been met.</td>
<td>This indicates that the minimum requirement of consecutively confirmed and completed patients for a module has not been met. Note that you may have confirmed and completed patients, but these patients will not be counted for analysis if there are lower ranked, but incomplete, patients in the module. The count starts with the first ranked patient in the module and stops at the first patient marked as Incomplete. This message only appears on the For Analysis row.</td>
</tr>
</tbody>
</table>
The minimum number of consecutively confirmed and completed patients for this module has been met.

<table>
<thead>
<tr>
<th>Text</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicates that the number of consecutively confirmed and completed patients for the module meets the requirements for reporting.</td>
<td></td>
</tr>
<tr>
<td>This message only appears on the For Analysis row.</td>
<td></td>
</tr>
<tr>
<td>This message must appear for all 16 modules to meet the Web Interface reporting requirements.</td>
<td></td>
</tr>
</tbody>
</table>

Notes:

The skip rate is calculated on the number of consecutively confirmed and completed or skipped patients. If the number of skipped patients is greater than or equal to 10% of the consecutively confirmed and completed or skipped patients, clarifications may be sought regarding the high rate.

The Details Report shows, for a selected detail report type, a list of patients who belong to this selection. To return to the Totals Summary Report view, click the Summary tab. To change to a different Totals Details Report view, return to the Summary tab and then click the desired Details link.

To get a printer-friendly version of the Totals Details Report, click the View Printable Report button while the Totals Details Report is visible.

A sample of detailed Totals Report showing the list of records with an incomplete CARE-2 module is shown below:
5.15.5. Measure Rates Report

The Measure Rates Report provides the performance rates of the clinical quality measures for your group practice TIN or ACO Primary TIN.

Note: The Measure Rates Report contains data current at the time the report was generated. If you have changed data since a report was generated, you should generate a new report to get the current data.

To open this report, click Reports >> Measure Rates Report on the Global Navigation Bar.

The Measures Rate Report is shown below:

The top of the page contains a list of the last ten generated Measure Rates Reports. Each entry shows the date the report was generated, the user name of the individual who requested the report, and the status of the report. If no reports have been generated for your group practice TIN or ACO Primary TIN, the table will indicate No Measure Rates Reports have been generated. Under the list are two buttons, Generate Report and Preview. You can click the Refresh button to verify if the most recent report request is complete.

To generate a new Measure Rates Report, click the Generate Report button. A new entry is created with a status of Request Received. At this time, you may wait or navigate to a different area of the Web Interface. You may click Refresh to refresh the report list. You should note that a Measure Rates Report can take several minutes to complete.

If a report in the list has the status of Complete, you can click on the report entry to select it. Once you select a report entry, the Preview button becomes available. Clicking Preview
causes the application to retrieve the selected report and present it. A pop-up dialog box appears stating the report is in the process of being prepared. Once the report is ready, the pop-up dialog box disappears and the report appears.

The Measure Rates Report Summary view lists every measure along with performance metrics for the measure. The description for each metric column is provided in the footnotes.

Note: The CARE-3 measure is visit-based. This means that the counts in the Total Eligible, Denominator Exceptions, Denominator, Measure Not Met, Measure Met, and Measure Rate columns are based on all visit events, whereas the other measures are patient-based. The count of visits may not be equal to the number of patients ranked in CARE-3. A patient with multiple visits may have visits are not eligible for the measure or eligible visits that are counted as meeting the measure and other visits counted as not meeting the measure.

The criteria for the performance metrics are derived from the 2015 GPRO Web Interface Measures List, Narrative Measure Specifications and the 2015 Measure Flows for ACO and Group Practices Web Interface Users. These documents are available on the GPRO Web Interface page of the CMS website.

To get a printer-friendly version of the Measure Rates Report, click the View Printable Report while the summary view is visible.

A sample Measure Rates Report Details showing the list of patients with Total Measure Complete for the CARE module is depicted below:

Footnotes also appear in this report. The footnotes are shown below with a description of each footnote below the image:
• **Total Eligible** - the number of consecutively confirmed and completed Patients/Visits eligible for the measure (meets inclusion criteria). The count of eligible patients starts with the patient ranked #1 in the module and increments for each confirmed and complete patient who meets the inclusion criteria. The count does not include skipped patients and it stops when it reaches the first incomplete patient. Performance rates are based on consecutively confirmed and completed patients, but certain disease modules and measure modules have additional criteria for inclusion. Those additional criteria are:

  - CARE-3:
    - Patient Seen = Yes
    - Medication Review = Yes
  - CAD-7: Has Diabetes or LVSD = Yes
  - DM-16: Has IVD = Yes
  - HF-6: Has LVSD = Yes

Note that all patients confirmed for the CAD module are eligible for the CAD Composite measure. All patients confirmed for the DM module where the DM Composite Denominator Exclusion is not checked are eligible for the DM Composite measure. Although each of the composite measures has a component with additional eligibility criteria, the patient is still included in the composite measure calculations even if they do not meet the measure criteria. If the patient does not have Diabetes or LVSD for CAD-7, the measure counts as meeting the component criteria for the associated composite Measure.

• **Denominator Exceptions** - the number of eligible patients that were taken out of the Denominator for medical, patient or system exception reasons (where applicable).

• **Denominator** - total eligible Patients/Visits minus Denominator Exceptions.

• **Measures Not Met** - the number of eligible Patients/Visits that did not meet the measure criteria.

• **Measure Met** - the number of eligible Patients/Visits that met the measure criteria.

• **Measure Rate** - Measure Met divided by Denominator multiplied by 100%.
DM-2 is an inverse measure, so a lower rate indicates better performance/control.

- **Total Complete** - the number of Patients that have been completed for the measure in any order in the module.

- **Total Incomplete** - the number of Patients that are incomplete for the measure in any order in the module.

- **CARE-3:**
  - The following columns for CARE-3 are counted at the encounter (Visit Date) level not at the patient level:
    - Total Eligible (1)
    - Denominator Exceptions (2)
    - Denominator (3)
    - Measure Not Met (4)
    - Measure Met (5)
    - Measure Rate (6)

  - The patient must be eligible in order to be included in the CARE-3 denominator and checked for Measure Met.
    - This means that both Medical Record Found and CARE-3 Confirmation must equal **Yes**. If either of these two fields is not **Yes**, none of the visits will be considered eligible.

  - If the responses for one or more of the patient’s office visits are not completed, the patient is marked as Incomplete.

  - See examples below, for explanations of the CARE-3 calculations:

    | Total Eligible (1) | Denominator Exceptions (2) | Denominator (3) | Measure NotMet (4) | Measure Met (5) | Measure Rate (6) | Total Complete (7) | Total Incomplete (8) |
    |-------------------|-----------------------------|-----------------|-------------------|----------------|-----------------|-------------------|---------------------|
    | 750               | 35                          | 715             | 178               | 322            | 45.03           | 253               | 363                 |

The above example is for 248 consecutively completed and confirmed patients with a total of 750 visit dates. Total patient sample is 616.

- The Medical Record Found and CARE-3 Confirmation for patients ranked 1 to 248.

- Of the 760 visit dates, 10 visit dates have the **Patient Seen** answer set to **No – Visit Outside Practice**. The visits are not counted in the **Total Eligible** count.

- **Patient Seen** and **Medication Review** fields have responses for all patients of those 35 Medical Reviews were **No – Denominator Exception – Medical Reasons**.
- The **Total Complete** column count is higher than the 248 count of consecutively confirmed and complete patients. This occurs when there are patients who have been completed, but are not consecutive. This is useful when identifying patients ranked 248 or lower who are incomplete, which will stop the count of consecutively confirmed and completed.

To view details on the report (e.g. CARE-2: Incomplete), click the `>>` link for the desired metric. The Measure Rates Report Details contains a list of the patients that are included in the selected measure metric. To get a printer-friendly version of the Measure Rates Report Details, click the **View Printable Report** button while it is visible.

### 5.15.6. Pre-filled Elements Report

The Pre-filled Elements Report is a patient-level report that shows the original and current value of the pre-filled elements.

To open this report, click **Reports >> Pre-filled Elements Report** from the Global Navigation Bar.

![Pre-filled Elements Report](image)

The top of the page contains the patient selection list. The patients in the list are controlled by the selected modules in the Preferences settings. If you have not selected any modules in Preferences, all patients for your TIN will appear. If you have selected one or more modules in Preferences, only the patients in the selected module(s) appear.

The list of patients may be filtered and sorted. After entering text to use for filtering, press the Enter key to activate the filter. After removing text for filtering, press the Enter key to generate an unfiltered list. For additional information on filtering or sorting the list, see **Filtering and Sorting**.
From the patients list, select one or more patients for the report. To create a report for multiple patients, highlight the rows for the patients (shift+click on first and then the last patient or shift+arrow down or control+click to select non-adjacent patients).

- To view the report for the selected patient(s), click Preview.
- To print a report after previewing the data for the selected patients, click the View Printable Report button to get a printer-friendly version of the report. Use the browser print operations to print the report.
- To go directly to the printable version of the report (i.e. bypass the preview report), click Print Selected after selecting the desired patients.

The Pre-Filled Elements Report for a selected patient consists of a table with the measure name, the element name, the source of the pre-filled value (only for PREV-7), the pre-filled value, the current value and a Yes/No value for whether the current value is changed from the pre-filled value.

The table below lists the elements that are pre-filled.

<table>
<thead>
<tr>
<th>Module</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>First Name</td>
</tr>
<tr>
<td>Demographics</td>
<td>Last Name</td>
</tr>
<tr>
<td>Demographics</td>
<td>Gender</td>
</tr>
<tr>
<td>Demographics</td>
<td>Birth Date</td>
</tr>
</tbody>
</table>
### Module | Element Description
--- | ---
Demographics | Provider Name 1
Demographics | Provider Name 2
Demographics | Provider Name 3
Demographics | Clinic ID
PREV-7 | Immunization Received

This line only appears in the report if the patient is ranked in PREV-7.

A sample Pre-filled Elements Report is shown below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Element</th>
<th>Pre-filled</th>
<th>Pre-filled Value</th>
<th>Current Value</th>
<th>Changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>First10336</td>
<td>First10336</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>Last10336</td>
<td>Last10336</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td>02/08/1932</td>
<td>02/08/1932</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Provider Name 1</td>
<td>Last000461, First000461</td>
<td>Last000461</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Provider Name 2</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Provider Name 3</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Clinic ID</td>
<td>486341644</td>
<td>486341644</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>PREV-7</td>
<td>Immunization Received</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

#### 5.15.7. Activity Logs Report

The Activity Logs Report provides a list of activities performed by anyone who has logged into the Web Interface for your TIN during the submission period. The report helps to determine when patient data was updated or track user activities.

To open this report, click **Reports >> Activity Logs Report** from the Global Navigation Bar.

A sample of the Activity Logs Report Page is shown below:
The list of activities may be filtered and sorted on any of the columns. Examples of how sorting or filtering would be to filter by a user to see all the patients who were updated by that user, or to sort by activity to see all patients updated by XML. After entering text to use for filtering, press the **Enter** key to activate the filter. After removing text for filtering, press the **Enter** key to generate an unfiltered list. For additional information on filtering or sorting the list, see Filtering and Sorting.

Some examples of activities listed in the report are:

- Preferences Changed
- Record Added for Clinics or Providers
- Record Unlocked
- Record Updated
- Record Updated by XML
- Submit Completed Data
- User Logged On
- XML File Processed

### 5.15.8. Submit Status Report

The Submit Status Report contains the status of the group's final data submission.

To open this report, click **Reports >> Submit Status Report** on the Global Navigation Bar.
A sample Submit Status Report showing the status of each module is depicted below:

The data you have submitted has been received by CMS but DOES NOT meet the requirements for PQRS GPRO Web Interface reporting. Please continue updating patients to complete reporting.

See table below for completion details.

<table>
<thead>
<tr>
<th>Module</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE-2: Falls</td>
<td>CARE-2 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>CARE-3: Documentation of Current Medications in the Medical Record</td>
<td>CARE-3 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>CAD: Coronary Artery Disease</td>
<td>CAD IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>DM: Diabetes Mellitus</td>
<td>DM IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>HF: Heart Failure</td>
<td>HF IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>HTN: Hypertension</td>
<td>HTN IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>IVD: Ischemic Vascular Disease</td>
<td>IVD IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>MH: Mental Health</td>
<td>MH IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-5: Breast Cancer Screening</td>
<td>PREV-5 is complete.</td>
</tr>
<tr>
<td>PREV-6: Colorectal Cancer Screening</td>
<td>PREV-6 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-7: Influenza Immunization</td>
<td>PREV-7 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-8: Pneumonia Vaccination Status for Older Adults</td>
<td>PREV-8 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-9: BMI Screening and Follow-Up</td>
<td>PREV-9 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-10: Tobacco Use: Screening and Cessation Intervention</td>
<td>PREV-10 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-11: Screening for High Blood Pressure and Follow-Up</td>
<td>PREV-11 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
<tr>
<td>PREV-12: Screening for Chronic Depression and Follow-Up Plan</td>
<td>PREV-12 IS NOT complete. Please continue updating patients to complete reporting.</td>
</tr>
</tbody>
</table>

The most recent data submission status is retrieved and provided. The top of the report will state Submit Status Report for [Organization Name] – [Date and Time of last submission]. If there is no record of a data submission, the date and time will be replaced with **No Submission Performed** and the report will contain **Data submission has not been performed**.

The text that appears between the report title and the grid will tell you if you have met the requirements for reporting. There are five possible messages:

- “The final data for <Your Organization Name Here> has not been submitted to CMS. Please use the Submit screen to indicate your data submission is complete.” This message appears when a data submission has not been performed.

- “The data you have submitted has been received by CMS but DOES NOT meet the requirements for ACO GPRO reporting. Please continue updating patients to complete reporting. See table below for completion details.” This message appears for ACOs that have not met requirements for reporting.
• “The data you have submitted has been received by CMS but DOES NOT meet the requirements for PQRS GPRO satisfactory reporting. Please continue updating patients to complete reporting. See table below for completion details.” This message appears for PQRS Group Practices that have not met requirements for reporting.

• “The data you have submitted has been received by CMS and MEETS the requirements for ACO GPRO reporting. See table below for completion details.” This message appears for ACO GPROs that have met requirements for reporting.

• “The data you have submitted has been received by CMS and MEETS the requirements for PQRS GPRO satisfactory reporting. Please note: Some group practices are required to complete CAHPS for PQRS. If your group is required to do so, successful completion of CAHPS for PQRS is required to avoid negative PQRS Payment Adjustment. See table below for completion details.” This message appears for PQRS Group Practices that have met requirements for reporting.

The main portion of the report consists of the list of disease modules and measure modules and the relevant completion status comment. The four possible comments are:

• “The minimum number of consecutively confirmed and completed patients for this module has not been met.”

• “There are no consecutively confirmed and completed patients. The count starts with the first ranked patient in the module.”

• “The minimum number of consecutively confirmed and completed patients for this module has been met.”

• “NA – no patients have been sampled for <module name>.”

This list has the same format as the list on the Submit page. Note that the data is generated from the most recent successful submission and that a submission in progress is not noted. You can click the Refresh button to regenerate the report with the most recent available data.

The submission status and the completion status in each of the 16 modules are retrieved from the data you submitted to CMS when you clicked the Submit Data to CMS button on the Submit screen. CMS uses the information in the report to determine if you completed your submission and you have met the requirements for reporting.

To obtain a printer-friendly version of the Submit Status Report, click the View Printable Report button in the upper right corner.

5.15.9. Comments Report

The Comments Report draws together all the comments that exist within the beneficiary records for the modules you have chosen on the User Preferences screen.

To open this report, click Reports >> Comments Report from the Global Navigation Bar.
The top of the page contains a list of the last ten generated Comments Reports. Each entry shows the date the report was generated, the user name of the individual who requested the report, the status of the report, and the modules included in the report as selected in Preferences when the report was run. If no reports have been generated for your group practice TIN or ACO Primary TIN, the table will indicate **No Comments Reports have been generated.** Under the list are two buttons, **Generate Report** and **Preview**. Above the list and along the right margin is the **Refresh** button, which you can click to verify if the most recent report request is complete.

To generate a new Comments Report, click the **Generate Report** button. A new entry is created with a status of **Request Received**. At this time, you may wait or navigate to a different area of the Web Interface. You may click **Refresh** to refresh the report list.

If a report in the list has the status of **Complete**, you will be able to click on the report entry to select it. Once you select a report entry, the **Preview** button becomes available. Clicking **Preview** causes the application to retrieve the selected report and present it.

A sample Comments Report showing the comments added to each module or measure is depicted below:
The top of the report will state Comments Report – [Date and Time report was generated] – [Organization Name]. The main portion of the report consists of a table listing the disease modules and measure modules, and their respective comments, for the patients in your group. (The report displays the most recent comments.) This list is sorted by Medicare ID; you may filter or sort the data by columns to locate the desired information more efficiently. For additional information on filtering or sorting the list, see Filtering and Sorting.

To request a printer-friendly version of the Comments Report, click the View Printable Report button.

5.16. Export Data

The data stored in the Web Interface can be exported in an XML file. Only the data for your group practice TIN or ACO Primary TIN are included in the file. If you need to export data for more than one TIN or Primary TIN, you must log onto the Web Interface for each group and then export the data for the TINs separately.
To export the data into an XML file:

- Click one of the Data Sets in **Export Data Set**. There are five Data Sets available for export into an XML file:
  - Patient Ranking
  - Patients
  - Patient Medication
  - Providers
  - Clinics

- Click the modules to export in **Export Patients in Module(s)** (For Patient Ranking and Patients only).
  - If the selected Data Set is **Patient Ranking** or **Patients Data Set**, the checkboxes for the modules are available for selection. One or more modules must be selected.
    - When exporting the Patient Ranking or Patients Data Set, only the patients ranked in the selected modules are included in the XML file.
  - If the selected Data Set is **Patients**, you will not be able to select the CARE-3 module. To get the CARE-3 Medications information, select the Patient **Medication Data Set**.
  - If the selected Data Set is Patient **Medication**, **Providers**, or ** Clinics**, the checkboxes for the modules are not available.
    - When exporting the Patient Medication data set, only the patients ranked in CARE-3 are exported.
    - The Data Set for the **Providers** and **Clinics** is not associated to a module.

- Click the checkbox to export all data for a ranked patient (Optional for Patients).
  - The checkbox Export all data for patients ranked in the selected modules(s) is only available when the Data Set is Patients.
  - Select the checkbox to export the patient's data for all the modules in which the patient is ranked when the other module checkboxes are not selected.
    - Selecting the checkbox is useful when some of the modules are exported, but all data for all patients ranked in the selected modules is desired. Selecting this option may result in duplication of data for patients ranked in multiple files.
  - Deselect the checkbox to export the patient’s data for only the selected modules when the patient is ranked in additional modules that are not selected.
Deselecting the checkbox is useful when modules are exported one at a time and duplication of data for patients in multiple modules is not desired.

- Click **Generate XML** button.
  - Click the **Generate XML** button to send the request to create the XML file.
  - An entry for the request will be added to the Export Data Results table.
  - The status of the XML file request can be viewed while on the **Export Data** screen by clicking **Refresh**.
  - The status of the XML file request will appear when navigating to the **Export Data** screen or when logging on to the system.

- Download the generated XML file.
  - If the Data Set selected is **Patient Ranking** or **Patients**, the names of the selected modules will appear in the **Comments** column of the Export Data Results table.
  - When the Status of the file is **Complete**, the file name in the table will appear as a hyperlink.
  - Click the file name and then select the option to open or save the file in the Windows download pop-up.

Three of the Data Sets can be exported for information only. The other two files can be exported, updated with the patient data, and then uploaded in to the Web Interface.

- Data that can only be exported:
  - **Patient Ranking**

  The Patient Ranking Data Set contains the list of patients for the PQRS Group Practice’s TIN or the ACO’s Primary TIN that were sampled to pre-populate the database. The information for each patient includes the Medicare ID, first and last name, gender, date of birth, first and last names and NPIs for the top three providers for the patient, clinic, and rank for each module in which the patient was sampled.

  You may select one or all modules to export. When selecting individual modules, only those patients ranked in the selected modules will be exported.

  You may create a list of patients with the patient's rank in each of the modules in which the patient was sampled which can be used when working outside the Web Interface to obtain information about the patient’s quality measures.

  - **Providers**

  The Providers Data Set is the list of providers in the database for the PQRS Group Practice’s TIN or the ACO’s Primary TIN. The list contains the pre-populated providers and any providers added during the submission period. The information for
each provider contains the National Provider Identification (NPI), first and last name, Employer Identification Number (EIN), and an indicator if the provider was pre-populated or added by the user. The provider’s credentials are not pre-populated, but if the credentials have been added, the credentials will also be included if the Data Set is exported after the credentials are added.

When a Patient XML file or a Patient Medication XML file is uploaded and the uploaded file is adding or modifying one of the providers for a patient, only the providers that exist in the database at the time of the upload may be used in the XML file.

You may create a list of providers that exist in the database to determine if the updated or new provider for the patient exists before uploading the file.

For more information, see Add/Edit Providers, Upload Data, or the Web Interface XML Specification.

- Clinics

The Clinics Data Set is the list of clinics in the database for the PQRS Group Practice’s TIN or the ACO’s Primary TIN. The list contains the pre-populated clinics and any clinics added during the submission period. The information for each clinic contains the clinic identifier, clinic name, and an indicator if the clinic was pre-populated or added by the user. The two address lines, city, state, and Zip code are not pre-populated, but if the address information has been added, the address information will also be included if the Data Set is exported after the address information is added.

When a Patient XML file or a Patient Medication XML file is uploaded and the uploaded file is adding or modifying the clinic for a patient, only the clinics that exist in the database at the time of the upload may be used in the XML file.

You can create a list of clinics that exist in the database to determine if the updated or new clinic for the patient exists before uploading the file.

For more information, see Add/Edit Clinics, Upload Data, or the Web Interface XML Specification.

- Data that can be exported and uploaded:

  - Patients

The Patient Data Set contains the list of patients for the PQRS Group Practice’s TIN or the ACO’s Primary TIN that were sampled to pre-populate the database. The information for each patient includes the Medicare ID, first and last name, gender, date of birth, top three provider NPIs for the patient, clinic identifier, medical record found confirmation, rank, module confirmation, and quality measure data for each module in which the patient was sampled.

You may select one or all modules to export. (Note that CARE-3 cannot be selected and the CARE-3 data will not be included in the Patient XML, only in the Patient
Medication XML file.) When selecting individual modules, only those patients ranked in the selected modules will be exported. If you have enabled the checkbox to include all data for the patient, the exported XML file will also contain the rank, confirmation, and measure data for any other module in which those patients are ranked.

When the Patient Data Set is exported, it contains all the data in the database for the patient for the selected modules. In addition, the XML file contains empty XML tags for data that has not yet been updated in the selected modules in which the patient is ranked.

If the Patients Data Set is exported at the beginning of the submission period, the XML file will contain the PREV-7 pre-filled elements available during the patient sampling.

You may update and upload the exported Patients XML file into the Web Interface. Update the XML file using a text editor or an XML editor to populate the empty tags or update the existing tags. You may also import the XML file into an Excel file for editing or use your own custom software to generate XML files.

For more information, see Pre-filled Elements, Upload Data, or the Web Interface XML Specification.

- Patient Medication

The Patient Medication Data Set contains the list of patients for the PQRS Group Practice’s TIN or the ACO’s Primary TIN that were sampled to pre-populate the database. The information for each patient includes the Medicare ID, medical record found confirmation, CARE-3 Confirmation, visit dates, visit confirmation and medications documented measure data for each visit date. (Note that data is repeated for each visit in the file for up to 12 visits.) Pre-filled visit dates are included in the exported XML and must be included in the uploaded XML file with the associated quality measure data. Visit dates cannot be changed, added, or deleted in the upload.

The Export Data Results table provides the status of the XML requests and access to the generated XML files for the PQRS Group Practice’s TIN or the ACO’s Primary TIN. If no XML files have been generated for the TIN, the table will appear the text No XML files have been generated.

Once XML files have been generated, the table will contain the following information:

- The Date column contains the date and time of the request to generate the XML file was received.
  - The XML file contains data in the database at the time the XML file was generated.
  - Once data is updated, a new XML file must be generated to export the updated data.
- The User Name column contains the user name of the individual generating the XML file.
- The File Name column contains the default name of the generated XML file.
  - The default name of the generated XML file is the name of the Data Set selected to export. The file name may be changed when you save the file.
  - Once the file has been generated and the status is **Complete**, the file name changes to a hyperlink that may be used to download the XML file.
  - The generated files are stored in the database and are available to download at a later point. They are current when generated and updates to data will require generating a new file.

- The Status column contains the information on the request to generate an XML file.
  - After clicking **Generate XML**, the request is entered as a new line in the table with the status set to **Request Received**.
  - When the XML file generation is complete, the Status changes to **Complete**.
  - The Status of the XML file is updated by clicking **Refresh**.

- The Comments column contains the names of the modules selected when the exported Data Set is **Patient Ranking** or **Patients**.

### 5.17. Upload Data

Upload data is only used for XML uploads. It is used for both Patients and Patient Medication XML uploads.

To Upload an XML data file:
Select **Upload Data Set** to upload. Two data sets may be uploaded:

- **Patients** - The Module Rank, Medicare ID, First Name, Last Name, Gender, and Date of Birth are included in the exported XML to provide complete information for the patient, but the values cannot be changed in the upload. First Name, Last Name, Gender and Date of Birth can be changed using Web Interface Dashboard.

  The Medicare ID is the key to the patient’s data and must be included in the file. The other demographics and rank fields are optional.

- **Medications** - Care 3 module rank, Medicare ID, First Name, Last Name, Gender, Date of Birth, and Pre-filled Patient Seen on This Date dates are included in the exported XML to provide complete information for the patient, but the values cannot be changed in the upload.

  The Medicare ID and Patient Seen on This Date are the keys to the patient’s data and must be included in the file. The other demographics and rank fields are optional.

  - Click **Browse** to select an XML file to upload.
  - Click **Upload**.
    - Click **Upload** to send the request to upload the data in the XML file.
    - An entry for the request is added to the Upload Data Results table.
    - The status of the XML file request can be viewed by clicking **Refresh**.
    - The status of the XML file request appears when navigating to the Upload Data screen or when logging on to the system.

The Upload Data Results table provides the status of the file upload process. Clicking **Refresh** updates the table with the latest file-processing status. The possible status messages are:

- Request Received
- On server
- Processing request
- Upload successful
- Upload with errors
- Invalid file structure

Processing is complete when any of the last three status messages appears. The first four values in the status column are always read only; the last two are formatted as a hyperlink. Click on hyperlink generates a File Upload Errors screen with the errors associated to the file.
Upload guidelines include the following:

- The file name cannot exceed 35 characters.
- The file size cannot exceed 80MB.
- Any upload will overwrite the existing data in the database.
- You may upload as many as three Patients XML files and three Patient Medications XML files for concurrent processing.
- The GPRO Web Interface XML Specifications are available from the link above the Upload Data Results table.
- If the uploaded file has byte order mark (BOM) characters, the file will not be processed, and the status will be updated to **Invalid File Structure**. Please refer to the GPRO Web Interface XML Specification for instructions on how to save a file without BOM characters.
- XSD files available in the Web Interface XML Specifications can be used to create a Microsoft Excel template to import and export XML files. See the Web Interface XML Specifications for step-by-step directions on how to create the template.
- If the XML file is created from a valid Microsoft Excel template, a namespace (ns1:) and a default header will be added to the file. If the ns1: and the default header are not replaced by valid XML tags as described in the Web Interface XML Specification, the application will not process the file and will set the upload status to **Invalid File Structure**. Header files with the correct values are available for download from the GPRO Web Interface XML Specification.
- If a Microsoft Excel template is created using XML file without first mapping the appropriate XSD files, a default mapping will be created. When the Microsoft Excel template with default mapping is used to export the XML file for upload, the upload might fail due to invalid order of tags. In this case, the status will be set to **Invalid File Structure**. Please refer to the Web Interface XML Specification for guidance on how to create a Microsoft Excel template using the downloadable XSD files to import and export XML data.

A sample File Upload Error - Invalid XML File is depicted below:
• If any of the tags in the uploaded file has an invalid value, the application will not process the file, and the status is changed to **Invalid File Structure**. Please refer to the Web Interface XML Specification for valid values in the tag.

A sample File Upload Error - Invalid values is depicted below:

![Invalid File Structure screenshot](image)

- If a file is uploaded with a Medicare ID, Provider NPI or Clinic ID that does not exist in the database, the application will process the file for all valid patients and will file errors for invalid patients. In this case, the Upload status will be **Upload with Errors**.

- If a file is uploaded with a TIN that does not match the TIN you used when logging in, the application will not process the file and the upload status will be **Upload Failed**.

### 5.17.1. Process

The Web Interface does not directly interact with any EHR system. In order to upload existing data into the Web Interface, the EHR system needs to export it into an XML file in the specified XML format. The Web Interface will then read the XML file, check it for errors, and upload the data.

### 5.17.2. Upload Rules and Requirements

#### 5.17.2.1. Electronic Health Record Export Requirements

##### 5.17.2.1.1. Dataset

If you are exporting from your EHR, you must export each dataset (patient and patient medications) from the EHR system into a separate XML file. There is no file naming standard that needs to be followed, though the extension for XML files must be `.xml`. It is a good idea to name the file so that the filename indicates its contents. For example, for an XML file containing the list of patients, name it `Patients.xml` and for the one containing the patient medications, name it `Patient_Medication.xml`.

##### 5.17.2.1.2. Date Range

The valid date range is from January 1, 2015 to December 31, 2015 (format MM/DD/YYYY). All dates entered in the application must be within this range, with the exception of date of birth. The date range must be specified to determine the correct dates to include in the EHR export. For example, you need to export patient medications, then the visit dates must be between January 1, 2015 and October 31, 2015. Note that the visit dates are pre-populated during the patient sampling, and the dates for the patients must exist in the Web Interface to be processed.
in the XML file. Similarly, you want to export patients (not the medications), and then the dates when the medications were reviewed must be within the January 1, 2015 to December 31, 2015 date range.

5.17.2.1.3. XML Elements
See the Web Interface XML Specification for the names of the XML elements and their valid values. Below are the requirements regarding the elements in the XML file.

- The patient’s Medicare ID is required and must exist in the source file.
- There must be no duplicate data sets for a patient in the Patient XML. If the patient has multiple visits for CARE-3, the patient data may be duplicated in the Patient Medications XML.
- There must be no extra XML elements in a dataset. For example, an XML element tag that is not in the XML specification will cause an error.
- The XML file must use encoding UTF-8 without BOM

5.17.2.2. Rules

5.17.2.2.1. General Rules

- Critical errors will prevent all records from being uploaded.
- Non-critical errors and warnings will be logged, but will not prevent the valid values from being uploaded.
- No record can be deleted during the upload process. In order to delete a record or value in a record, the user must manually access the patient record at issue in the GPRO Web Interface and select the space at the bottom of the dropdown box for the record to be deleted. If the field does not have a dropdown box, the user must manually delete the value in the field.
- No patient is added during the upload process.

5.17.2.2.2. Patient Dataset Rules

- If the Medicare Identifier to be uploaded is not found in the database for your TIN, the data associated to that Medicare ID will not be uploaded. If other valid Medicare IDs exist in the file, the valid IDs will be uploaded. The error messages in the File Upload Results table will list the invalid Medicare IDs.
- The patient information in the database is only updated during the upload process. No record is added.
- If the patient is not ranked in a module, data associated to the module should not be included in the file for the patient. Any data included for modules in which the patient is not ranked will be ignored and no error or warning will be raised.
5.17.2.2.3. **Patient Medication Dataset Rules**

- If the Medicare Identifier to be uploaded is not found in the database, the medication review will not be updated. If other valid Medicare IDs exist in the file, the valid IDs will be uploaded. The error messages in the File Upload Results table will list the invalid Medicare IDs.

- If the visit date to be uploaded exists in the database, the existing record is updated with the uploaded values. If the visit date to be uploaded is not found in the database for the patient, the invalid date will not be uploaded. If other valid dates for the patient exist in the file, data for the valid dates will be uploaded. The error messages in the File Upload Results table will list the invalid visit dates.

- If the patient is not ranked in CARE-2, data for this patient should not be included in the file. Any data included for modules in which the patient is not ranked will be ignored and no error or warning will be raised.

5.18. **Add/Edit Clinic**

5.18.1. **Add Clinic**

To add a clinic:

- To add an additional clinic, click Add/Edit >> Clinic from the Global Navigation Bar.

- Enter the Clinic ID, Clinic Name, Address, City, State (drop-down menu) and the Zip Code.

- Click Save

5.18.2. **Edit Clinic**

To edit a clinic:
To edit a clinic, highlight the Clinic to be changed from the Clinics table.

• Click Edit Clinic.

• Update the clinic data.

• Click Save.

5.19. Add/Edit Providers

5.19.1. Add Provider
To add a provider:

• To add an additional Provider, click Add/Edit >> Provider from the Global Navigation Bar.

• Enter the Provider #, Last Name, First Name, EIN and Credentials.

• Click Save.

5.19.2. Edit Provider
To edit a provider:

• To edit a provider, highlight the Provider to be changed from the Providers table.

• Click Edit Provider.

• Update the provider information.

• Click Save.
5.20. **Locked Records**

The Web Interface has a locking feature that prevents multiple users from modifying the same patient’s record at the same time.

However, there may be instances where a record needs to be unlocked. For example, User A starts editing Patient X’s record. The Web Interface locks this record so no other user can modify it. User A is timed out after 15 minutes of inactivity and the Web Interface closes before User A saves Patient X’s data. As a result, Patient X’s record cannot be modified by another user unless User A unlocks the record or continues editing the record and saves the edits. After 24 hours of time lapse since Patient X’s record is locked, any user can unlock it if User A is unavailable to unlock the record.

5.21. **List Users**

The List Users screen provides a list of the first and last names of all users who have logged into the Web Interface for your TIN.

5.22. **Submit**

The Submit action can be performed multiple times during the submission period however it **must** also be the very last action you take during the GPRO Web Interface submission period, otherwise your final data will not be sent to CMS. The act of submitting your data notifies CMS that your patient sample has been updated or completed. In addition to notifying CMS of the
data status, clicking the Submit Data to CMS button on the Submit screen calculates and stores the Completeness and Performance Rates.

If you change or add to your data after performing a submission to CMS, the changes must also be submitted to CMS. After the changes have been made, click the Submit Data to CMS button again. If you make changes to your data but do not click the Submit Data to CMS button again, those changes will not be sent to CMS and you run a serious risk of adversely affecting the completeness and performance calculations due to incomplete or inaccurate data.

All updates must be submitted to CMS prior to the close of the submission period.

<table>
<thead>
<tr>
<th>Module Completion Status for Cotton-O’Neil Clinic Revocable Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>CARE-2: Falls</td>
</tr>
<tr>
<td>CARE-3: Documentation of Current Medications in the Medical Record</td>
</tr>
<tr>
<td>CAD: Coronary Artery Disease</td>
</tr>
<tr>
<td>DM: Diabetes Mellitus</td>
</tr>
<tr>
<td>HF: Heart Failure</td>
</tr>
<tr>
<td>HTN: Hypertension</td>
</tr>
<tr>
<td>IVD: Ischemic Vascular Disease</td>
</tr>
<tr>
<td>MH: Mental Health</td>
</tr>
<tr>
<td>PREV-5: Breast Cancer Screening</td>
</tr>
<tr>
<td>PREV-6: Colorectal Cancer Screening</td>
</tr>
<tr>
<td>PREV-7: Influenza Immunization</td>
</tr>
<tr>
<td>PREV-8: Pneumonia Vaccination Status for Older Adults</td>
</tr>
<tr>
<td>PREV-9: BMI Screening and Follow-Up</td>
</tr>
<tr>
<td>PREV-10: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>PREV-11: Screening for High Blood Pressure and Follow-Up</td>
</tr>
<tr>
<td>PREV-12: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
</tbody>
</table>

Before submitting the final data, it is strongly advised that you review the Totals Report and the Measure Rates Report. The Totals Report will detail the Completeness for each module. The Measure Rates Report will detail the Performance Rate for each measure.

The Submit Data to CMS button is available after you have clicked the certification checkbox.

**5.22.1. Submit Screen Table**

Text above the Module Completion Status table provides an indicator that your data meets the reporting requirements. There are four possible messages:
• “The data you have submitted DOES NOT meet the requirements for ACO GPRO reporting. Please continue updating patients to complete reporting. See the table below for completion details.” This message appears for ACOs that have not met requirements for reporting.

• “The data you have submitted DOES NOT meet the requirements for PQRS GPRO satisfactory reporting. Please continue updating patients to complete reporting. See the table below for completion details.” This message appears for PQRS Group Practices that have not met requirements for reporting.

• “The data you have abstracted MEETS the requirements for ACO GPRO reporting. See the table below for completion details.” This message appears for ACO GPROs that have met requirements for reporting.

• “The data you have abstracted MEETS the requirements for PQRS GPRO satisfactory reporting. Please note: Some group practices are required to complete CAHPS for PQRS. If your group is required to do so, successful completion of CAHPS for PQRS is required to avoid negative PQRS Payment Adjustment. See the table below for completion details.” This message appears for PQRS Group Practices that have met requirements for reporting.

A table of the modules with a comment for each indicating the completeness of the module is on the Submit screen. There are four possible comments:

• “<Module or measure short name> IS NOT complete. Please continue updating patients to complete reporting.” This means you have some patients consecutively confirmed and completed patients in the module, but have not yet met the minimum reporting requirements for the module in question.

• “There are no consecutively confirmed and completed patients. The count starts with the first ranked patient in the module.” This means that no patient has been consecutively confirmed or completed for the module in question. Although you may have some confirmed and completed patients, there are lower ranked, but incomplete, patients in the module.

• “<Module or measure short name> is complete.” This means that the required number of patients have been consecutively confirmed and completed for the module in question.

• N/A – no patients have been sampled for <module or measure short name>.” This means that no patients were selected during the sampling process for the module in question.

In order to meet satisfactory reporting for the program year, all modules must have the comment:

“The data you have submitted MEETS the requirements for ACO GPRO Web Interface satisfactory reporting.” or “The data you have submitted MEETS the requirements for PQRS GPRO Web Interface satisfactory reporting.”
5.22.2. How to Submit

To submit your data to CMS:

- Verify that all modules meet the minimum requirements.
- Read the certification text and click the checkbox.
- Click the **Submit Data to CMS** button below the certification text.

Generate and review the Submission Status Report to verify that the submission was received by CMS. This report will require a few minutes to be generated.

Patient data is saved to the database when you click the **Save** button after updating the patient on the **Home** page. Patient data is also saved to the database when an XML file is uploaded. The saved data is used to calculate the Completeness and Performance Rates when you click the **Send Data to CMS** button.

If any patient data is updated and saved to the database after you click **Send Data to CMS**, the data must be re-submitted. Failure to resubmit after changing patient data will result in a mismatch between your final Completion and Performance Rates and the Completion and Performance Rates provided to CMS.

**All updates must be submitted to CMS prior to the close of the submission period.**

For more information, please refer to **Totals Report**, **Measure Rates Report**, or **Submission Status Report**.

6. Module Overview

There are many modules to report on. This section briefly discusses those modules and contains information on how to upload data into the Web Interface. The following modules are discussed:

- **Demographics**
- **Care Coordination Patient Safety**
- **Coronary Artery Disease**
- **Diabetes Mellitus**
- **Heart Failure**
- **Hypertension**
- **Ischemic Vascular Disease**
- **Mental Health**
- **Preventative Care**
6.1. Demographics

In this topic, find information on the following:

**Required Information**

**Optional Information**

**General Comments**

**Additional Information**

6.1.1. Required Information

If you change a patient’s Gender to **Male** or **Unknown**, the system will automatically change the patient’s PREV-5 Confirmation value to **Not Confirmed – Gender**. This means that when all required data is provided, the patient will be marked as **Skipped** in PREV-5 because of ineligibility.

If you change a patient’s Gender to **Female**, the system will automatically change the patient’s PREV-5 Confirmation value to a blank value and the patient’s PREV-5 status to **Incomplete**. The required data must be provided to complete the patient.

If you change a patient’s **Date of Birth** so that it falls outside the age criteria for a module or measure, the system will automatically change all the **Confirmed** values in the relevant modules or measures for that patient to **Not Confirmed – Age**, with no other values available to select. This means the patient will be marked as **Skipped** in those modules or measures because of ineligibility, even if you provide all required data.

If you then change the patient’s **Date of Birth** a second time so that the patient’s age is again valid for a module or measure, the system will automatically change all the **Confirmed** values in the relevant modules or measures for that patient to a blank value, and the patient’s module or measure status will change to **Incomplete**. This means you must provide the required data in order to complete the patient.

The table below lists required data for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare ID</td>
<td>Medicare ID is pre-populated and cannot be changed.</td>
</tr>
<tr>
<td>First Name</td>
<td>First name will be pre-populated.</td>
</tr>
<tr>
<td>Last Name</td>
<td>Last name will be pre-populated.</td>
</tr>
</tbody>
</table>
### Module Overview

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| Gender         | Gender will be pre-populated.  
|                | Valid values are:  
|                |   • Male  
|                |   • Female  
|                |   • Unknown  
| Date of Birth  | Date of Birth will be pre-populated. |

### 6.1.2. Optional Information

The table below lists optional data for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Record Found</td>
<td>Medical Record Number is an optional field.</td>
</tr>
<tr>
<td>Other ID</td>
<td>Other ID is an optional field.</td>
</tr>
<tr>
<td>Provider Name 1</td>
<td>The top three providers for the patient as determined during the sampling.</td>
</tr>
<tr>
<td>Provider Name 2</td>
<td>The top three providers for the patient as determined during the sampling.</td>
</tr>
<tr>
<td>Provider Name 3</td>
<td>The top three providers for the patient as determined during the sampling.</td>
</tr>
<tr>
<td>Clinic ID</td>
<td>A default Clinic ID will be pre-populated, if possible, during patient sampling.</td>
</tr>
</tbody>
</table>
6.1.3. General Comments

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Comments (optional)</td>
<td>The <strong>General Comments</strong> section in the <strong>Demographics</strong> tab enables you to take notes about a patient. The <strong>General Comments</strong> field has a maximum of 140 characters. Any text in this field will appear on the Comments Report. For comments that are specific to a module, use the <strong>Comments</strong> field under each module.</td>
</tr>
</tbody>
</table>

6.1.4. Additional Information

For information on Measure Data Definition, see the [2015 GPRO Web Interface Measures List](#), [Narrative Measure Specifications](#), and [Release Notes](#) files on the [CMS website](#).

6.2. Care Coordination/Patient Safety

In this topic, find information on the following:

**CARE-2: Falls**

**CARE-3: Documentation of Current Medications in the Medical Record**

Additional Information

6.2.1. CARE-2: Falls

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARE-2 Confirmation</td>
<td>Pull-down menu is available for selection when the patient is ranked in CARE-2 and the <strong>Medical Record Found</strong> is <strong>Yes</strong>.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
</tbody>
</table>
## Screening for Future Fall Risk

Pull-down menu is available for selection when the patient is ranked in CARE-2 and the **Medical Record Found** is **Yes**, and the **CARE-2 Confirmation** is **Yes**.

Valid values are:
- Yes
- No
- No – Denominator Exception - Medical Reasons
- <blank>

## Comments (optional)

The Comments input text field is available when the patient is ranked in CARE-2, the **Medical Record Found** is **Yes**, and a selection has been made to the CARE-2 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.

### 6.2.2. CARE-3: Documentation of Current Medications in the Medical Record

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| CARE-3 Confirmation | Pull-down menu is available for selection when the patient is ranked in CARE-3 and the **Medical Record Found** is **Yes**. CARE-3 is an episode based measure. Valid values are:  
- Yes  
- No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that a help Desk Ticket # be provided in the Help Desk Ticket # field)  
- Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)  
- <blank> |
<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option “No – Other CMS Reason”. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
<tr>
<td>Visit Date</td>
<td>Pre-populated visit dates determined during patient sampling. The system can display up to 12 visit dates.</td>
</tr>
<tr>
<td>Patient Seen</td>
<td>Available for selection if the patient is ranked in CARE-3, the Medical Record Found is Yes, and the CARE-3 Confirmation is Yes.</td>
</tr>
<tr>
<td></td>
<td>If No – Visit Outside Practice is selected for all Visit Dates, the system will automatically set the CARE-3 Confirmation to Not Confirmed - No Qualifying Visits and the patient will be skipped in CARE-3.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No – Visit Outside Practice</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Medication Documented, Updated, or Reviewed</td>
<td>Available for selection if the patient is ranked in CARE-3, the Medical Record Found is Yes, the CARE-3 Confirmation is Yes, and Patient Seen on This Date is Yes.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No</td>
</tr>
<tr>
<td></td>
<td>• No – Denominator Exception – Medical Reasons</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Comments (optional)</td>
<td>The Comments input text field is available when the patient is ranked in CARE-3, the Medical Record Found is Yes, and a selection has been made to the CARE-3 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>
6.2.3. Additional Information

For information on Measure Data Definition, see the 2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes files on the CMS website.

6.3. Coronary Artery Disease

In this topic, find information on the following:

CAD Confirmation

CAD-7: Diabetes/LVSD and ACE-I/ARB

Additional Information

6.3.1. CAD Confirmation

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD Confirmed</td>
<td>The CAD Confirmed pull-down is available for selection when the patient is ranked in CAD and the Medical Record Found is Yes.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
</tbody>
</table>

6.3.2. CAD-7: Diabetes/LVSD and ACE-I/ARB

The table below lists the fields for this disease module:
### Has Diabetes or LVSD

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pull-down menu is available for selection when the patient is ranked in CAD, the Medical Record Found is Yes, and CAD Confirmed is Yes. If No is selected, the system will automatically mark the patient as Skipped. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>&lt;blank&gt;</td>
</tr>
</tbody>
</table>

### Has ACE-I/ARB

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pull-down menu is available for selection when the patient is ranked in CAD, the Medical Record Found is Yes, and CAD Confirmed is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>No – Denominator Exception - Medical Reasons</td>
</tr>
<tr>
<td></td>
<td>No – Denominator Exception - Patient Reasons</td>
</tr>
<tr>
<td></td>
<td>No – Denominator Exception - System Reasons</td>
</tr>
<tr>
<td></td>
<td>&lt;blank&gt;</td>
</tr>
</tbody>
</table>

### 6.3.3. Comments

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments (optional)</td>
<td>The Comments input text field is available when the patient is ranked in CAD Module, the Medical Record Found is Yes, and a selection has been made to the CAD Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>

### 6.3.4. Additional Information

For information on Measure Data Definition, see the 2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes files on the CMS website.
6.4. Diabetes Mellitus

In this topic, find information on the following:

DM Confirmation

DM-2: Hemoglobin HbA1c Poor Control

DM-7: Eye Exam

Comments

Additional Information

6.4.1. DM Confirmation

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM Confirmed</td>
<td>The DM Confirmed pull-down is available for selection when the patient is ranked in DM and the Medical Record Found is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
</tbody>
</table>
### 6.4.2. DM-2: Hemoglobin HbA1c Poor Control

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Test Performed?</td>
<td>Pull-down menu is available for selection when the patient is ranked in DM, the Medical Record Found is Yes, and DM Confirmed is Yes. Valid values are: Yes, No, &lt;blank&gt;</td>
</tr>
<tr>
<td>Date Drawn</td>
<td>Date Drawn is available for entry when the patient is ranked in DM, the Medical Record Found is Yes, and HbA1c Test Performed? is Yes. Valid values are: Date between 01/01/2015 and 12/31/2015</td>
</tr>
<tr>
<td>HbA1c Value</td>
<td>HbA1c Value is available for entry when the patient is ranked in DM, the Medical Record Found is Yes, and HbA1c Test is Yes. Valid values are: Number between 0 and 25. You may enter an optional decimal point followed by one or two digits for the value. If you enter a number without a decimal, the system will append &quot;.0&quot; to the value.</td>
</tr>
</tbody>
</table>
6.4.3. DM-7 Eye Exam

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| Retinal Eye Exam Performed     | Pull-down Menu is available for selection when the patient is ranked in DM, the Medical Record Found is Yes, and DM Confirmed is Yes. Valid values are:  
  - Yes  
  - No  
  - <blank> |

6.4.4. Comments

<table>
<thead>
<tr>
<th>Label (optional)</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td>The Comments input text field is available when the patient is ranked in DM Module, the Medical Record Found is Yes, and a selection has been made to the DM Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>

6.4.5. Additional Information

For information on Measure Data Definition, see the 2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes files on the CMS website.

6.5. Heart Failure

In this topic, find information on the following:

HF Confirmation

HF-6: LVSD and Beta-Blocker Therapy for LVSD

Comments

Additional Information
### 6.5.1. HF Confirmation

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF Confirmed</td>
<td>The HF Confirmed pull-down is available for selection when the patient is ranked in HF and the Medical Record Found is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
</tbody>
</table>
### 6.5.2. HF-6: LVSD and Beta-Blocker Therapy for LVSD

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| Has LVSD       | Pull-down menu is available for selection when the patient is ranked in HF, the **Medical Record Found** is Yes, and **HF Confirmed** is Yes. When **No** is selected, the system will automatically mark the patient as **Skipped**. Valid values are:  
  - Yes  
  - No  
  - <blank> |
| Beta-Blocker   | Pull-down menu is available for selection when the patient is ranked in HF, the **Medical Record Found** is Yes, **HF Confirmed** is Yes, and **Has LVSD** is Yes. Valid values are:  
  - Yes  
  - No  
  - No – Denominator Exception - Medical Reasons  
  - No – Denominator Exception - Patient Reasons  
  - No – Denominator Exception - System Reasons  
  - <blank> |

### 6.5.3. Comments

<table>
<thead>
<tr>
<th>Label (optional)</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td>The Comments input text field is available when the patient is ranked in the HF Module, the <strong>Medical Record Found</strong> is Yes, and a selection has been made to the HF Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>
6.5.4. Additional Information

For information on Measure Data Definition, see the 2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes files on the CMS website.

6.6. Hypertension

In this topic, find information on the following:

HTN Confirmation

HTN-2: Controlling High Blood Pressure

Comments

Additional Information

6.6.1. HTN Confirmation

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTN Confirmed</td>
<td>The HTN Confirmed pull-down is available for selection when the patient is ranked in HTN and the Medical Record Found is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed – Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Denominator Exclusion</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
</tbody>
</table>
### Help Desk Ticket #
CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option **No – Other CMS Reason**. The Help Desk Ticket # is to be entered in this field once approval is received.

### 6.6.2. HTN-2: Controlling High Blood Pressure

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| Most Recent BP Documented?    | Pull-down menu is available for selection when the patient is ranked in HTN, the **Medical Record Found** is **Yes**, and **HTN Confirmed** is **Yes**. Valid values are:  
  - Yes  
  - No  
  - <blank> |
| Date Taken                    | Date Taken is available for entry when the patient is ranked in HTN, the **Medical Record Found** is **Yes**, **HTN Confirmed** is **Yes**, and **Most Recent BP Documented?** is **Yes**. Valid values are:  
  - Date between 01/01/2015 and 12/31/2015 |
| Systolic                      | Systolic is available for entry when the patient is ranked in HTN, the **Medical Record Found** is **Yes**, **HTN Confirmed** is **Yes**, and **Most Recent BP Documented?** is **Yes**. Valid values are:  
  - Number between 0 and 350 |
### 6.6.3. Comments

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments (optional)</td>
<td>The Comments input text field is available when the patient is ranked in HTN Module, the Medical Record Found is Yes, and a selection has been made to the HTN Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>

### 6.6.4. Additional Information

For information on Measure Data Definition, see the [2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes](https://www.cms.gov) files on the CMS website.

### 6.7. Ischemic Vascular Disease

In this topic, find information on the following:

- **IVD Confirmation**
- **IVD-2: Use of Aspirin or Another Antithrombotic**
- **Comments**
- **Additional Information**
6.7.1. IVD Confirmation

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVD Confirmed</td>
<td>The IVD Confirmed pull-down is available for selection when the patient is ranked in IVD and the Medical Record Found is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
</tbody>
</table>

6.7.2. IVD-2: Use of Aspirin or Another Antithrombotic

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin/Antithrombotic Therapy</td>
<td>Pull-down menu is available for selection when the patient is ranked in IVD, the Medical Record Found is Yes, and IVD Confirmed is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
</tbody>
</table>
6.7.3. Comments

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments (optional)</td>
<td>The Comments input text field is available when the patient is ranked in the IVD Module, the Medical Record Found is Yes, and a selection has been made to the IVD Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>

6.7.4. Additional Information

For information on Measure Data Definition, see the [2015 GPRO Web Interface Measures List](#), [Narrative Measure Specifications](#), and [Release Notes](#) files on the [CMS website](#).

6.8. Mental Health

In this topic, find information on the following:

- **MH Confirmation**
- **MH – 1 Depression Remission at 12 Months**
- **Comments**
- **Additional Information**
6.8.1. MH Confirmation

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Confirmed</td>
<td>The MH Confirmed pull-down is available for selection when the patient is ranked in MH and the Medical Record Found is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed – Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• No – Denominator Exclusion</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed – Denominator Exclusion</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
</tbody>
</table>

| Help Desk Ticket #     | CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received. |

6.8.2. MH – 1: Depression Remission at Twelve Months

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 Test Performed?</td>
<td>Pull down Menu contains:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Label</td>
<td>Element Description</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| PHQ-9 Index Test > 9 | Pull down Menu contains:  
- Yes  
- No  
- <blank> |
| PHQ-9 Index Date | Date can be entered using the date picker popup or manually. |
| PHQ-9 Index Test Score |  
- Value must be greater than 9 and less than or equal to 27  
- If a value for the PHQ-9 Test Score is > 29, the score will not be saved and the patient will be marked as incomplete |
| PHQ-9 Follow-Up Test Performed? | Pull down Menu contains:  
- Yes  
- No  
- <blank> |
| PHQ-9 Test <5 | Pull down Menu contains:  
- Yes  
- No  
- <blank> |
| PHQ-9 Test Date |  
- Date can be entered using the date picker pop-up or manually.  
- Note: The following message will display if there is a date in the PHQ-9 Index Date field: “Based on the date entered for PHQ-9 Index Date, the valid date range for the PHQ-9 Follow-Up Date is MM/DD/YYYY to MM/DD/YYYY.” The MM/DD/YYYY dates are calculated by the system using the date parameters in the GPRO Web Interface Data Guidance. |
### Module Overview

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 Follow-Up Test Score</td>
<td>• Value must be less than 5</td>
</tr>
<tr>
<td></td>
<td>• If a value for the PHQ-9 Follow-Up Score is &gt;4, the score will not be saved and the patient will be marked as Incomplete.</td>
</tr>
</tbody>
</table>

#### 6.8.3. Comments

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments (optional)</td>
<td>The Comments input text field is available when the patient is ranked in the MH Module, the Medical Record Found is Yes, and a selection has been made to the MH Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will appear on the Comments Report.</td>
</tr>
</tbody>
</table>

#### 6.8.4. Additional Information

For information on Measure Data Definition, see the [2015 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes files](https://cmswebsite) on the CMS website.

#### 6.9. Preventative Care

In this topic, find information on the following:

- **PREV-5**: Breast Cancer Screening
- **PREV-6**: Colorectal Cancer Screening
- **PREV-7**: Influenza Immunization
- **PREV-8**: Pneumonia Vaccination Status for Older Adults
- **PREV-9**: BMI Screening and Follow-Up Plan
- **PREV-10**: Tobacco Use: Screening Cessation Intervention
- **PREV-11**: Screening for High Blood Pressure and Follow-Up
- **PREV-12**: Screening for Clinical Depression and Follow-Up Plan

Additional Information
### 6.9.1. PREV-5: Breast Cancer Screening

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| PREV-5 Confirmation    | Pull-down menu is available for selection when the patient is ranked in PREV-5 and the **Medical Record Found** is **Yes**. Valid values are:  
  | Yes                                                                 | Denominator Exclusion                                                                                         | No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)  
  | Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)                                                                                   | Not Confirmed - Gender (Note: this option is not available unless the patient’s gender is changed to a value other than Female.) |
| Help Desk Ticket #     | CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option **No – Other CMS Reason**. The Help Desk Ticket # is to be entered in this field once approval is received. |
| Screening Performed    | Pull-down menu is available for selection when the patient is ranked in PREV-5, the **Medical Record Found** is **Yes**, and the **PREV-5 Confirmation** is **Yes**.  
  | Yes                                                                 | No                                                                 | <blank>                                                                 |
|                        |                                                                                                                                         |                                                                                                                  |
Comments (optional)  
The Comments field may be used for further comment or documentation specific to the PREV-5 module. The field is available when the patient is ranked in PREV-5, the Medical Record Found is Yes, and a selection has been made to PREV-5 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report.

6.9.2. PREV-6: Colorectal Cancer Screening

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| PREV-6 Confirmation    | Pull-down menu is available for selection when the patient is ranked in PREV-6 and the Medical Record Found is Yes.  
                           | Valid values are:  
                           | • Yes  
                           | • Denominator Exclusion  
                           | • No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)  
                           | • Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)  
                           | • <blank>  
| Help Desk Ticket #     | CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received. |
Screening Is Current

Pull-down menu is available for selection when the patient is ranked in PREV-6, the Medical Record Found is Yes, and the PREV-6 Confirmation is Yes.

Valid values are:
- Yes
- No
- <blank>

Comments (optional)
The Comments field may be used for further comment or documentation specific to the PREV-6 module. The field is available when the patient is ranked in PREV-6, the Medical Record Found is Yes, and a selection has been made to PREV-6 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report.

6.9.3. PREV-7: Influenza Immunization

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREV-7 Confirmation</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-7 and the Medical Record Found is Yes.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>- Yes</td>
</tr>
<tr>
<td></td>
<td>- No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>- Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>- &lt;blank&gt;</td>
</tr>
<tr>
<td>Label</td>
<td>Element Description</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option <strong>No – Other CMS Reason</strong>. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
</tbody>
</table>
| Immunization Received    | Pull-down menu is available for selection when the patient is ranked in PREV-7, the **Medical Record Found** is **Yes**, and the **PREV-7 Confirmation** is **Yes**. Valid values are:  
  - Yes  
  - No  
  - No – Denominator Exception - Medical Reasons  
  - No – Denominator Exception - Patient Reasons  
  - No – Denominator Exception - System Reasons  
  - <blank>  
Note that Immunization Received may be pre-filled for a patient; if a claim exists indicating the patient received the immunization. See the **Pre-filled Elements** for more information. |
| Comments (optional)      | The Comments field may be used for further comment or documentation specific to the PREV-7 module. The field is available when the patient is ranked in PREV-7, the **Medical Record Found** is **Yes**, and a selection has been made to PREV-7 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report. |
### 6.9.4. PREV-8: Pneumonia Vaccination Status for Older Adults

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREV-8 Confirmation</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-8 and the Medical Record Found is Yes. Valid values are:</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>Not Confirmed - Age (Note: this option is not available unless the patient’s age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>&lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
<tr>
<td>Vaccination Received</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-8, the Medical Record Found is Yes, and the PREV-8 Confirmation is Yes.</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>&lt;blank&gt;</td>
</tr>
<tr>
<td>Comments (optional)</td>
<td>The Comments field may be used for further comment or documentation specific to the PREV-8 module. The field is available when the patient is ranked in PREV-8, the Medical Record Found is Yes, and a selection has been made to PREV-8 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report.</td>
</tr>
</tbody>
</table>
6.9.5. **PREV-9: BMI Screening and Follow-Up Plan**

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREV-9 Confirmation</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-9 and the Medical Record Found is Yes.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Denominator Exclusion</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
<tr>
<td>Calculated BMI</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-9, the Medical Record Found is Yes, and the PREV-9 Confirmation is Yes.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No</td>
</tr>
<tr>
<td></td>
<td>• No – Denominator Exception - Medical Reasons</td>
</tr>
<tr>
<td></td>
<td>• No – Denominator Exception - Patient Reasons</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Label</td>
<td>Element Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| BMI Normal          | Pull-down menu is available for selection when the patient is ranked in PREV-9, Medical Record Found is set to Yes, the PREV-9 Confirmation is Yes, and Calculated BMI is Yes. Valid values are:  
  - Yes  
  - No  
  - <blank> |
| Follow-Up Plan      | Pull-down menu is available for selection when the patient is ranked in PREV-9, Medical Record Found is set to Yes, the PREV-9 Confirmation is Yes, Calculated BMI is Yes, and BMI Normal is No. Valid values are:  
  - Yes  
  - No  
  - <blank> |
| Comments (optional) | The Comments field may be used for further comment or documentation specific to the PREV-9 module. The field is available when the patient is ranked in PREV-9, the Medical Record Found is Yes, and a selection has been made to PREV-9 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report. |
### 6.9.6. PREV-10: Tobacco Use: Screening and Cessation Intervention

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREV-10 Confirmation</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-10 and the <strong>Medical Record Found</strong> is <strong>Yes</strong>.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option <strong>No – Other CMS Reason</strong>. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-10, the <strong>Medical Record Found</strong> is <strong>Yes</strong>, and the PREV-10 Confirmation is <strong>Yes</strong>.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• No</td>
</tr>
<tr>
<td></td>
<td>• Not Screened/Unknown</td>
</tr>
<tr>
<td></td>
<td>• No – Denominator Exception - Medical Reasons</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
</tbody>
</table>
### Cessation Counseling Intervention

Pull-down menu is available for selection when the patient is ranked in **PREV-10**, **Medical Record Found** is set to **Yes**, the **PREV-10 Confirmation** is **Yes**, and **Tobacco Use** is **Yes**.

Valid values are:

- Yes
- No
- <blank>

### Comments (optional)

The Comments field may be used for further comment or documentation specific to the **PREV-10** module. The field is available when the patient is ranked in **PREV-10**, the **Medical Record Found** is **Yes**, and a selection has been made to **PREV-10 Confirmation**. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report.

---

#### 6.9.7. PREV-11: Screening for High Blood Pressure and Follow-Up

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
</table>
| PREV-11 Confirmation | Pull-down menu is available for selection when the patient is ranked in **PREV-11** and the **Medical Record Found** is **Yes**.  

Valid values are:

- Yes
- Denominator Exclusion
- No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)
- Not Confirmed - Age (Note: this option is not available unless the patient's age is changed to fall outside the acceptable range.)
- <blank>
<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option <strong>No – Other CMS Reason</strong>. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
</tbody>
</table>
| Blood Pressure Screening      | Pull-down menu is available for selection when the patient is ranked in **PREV-11**, the **Medical Record Found** is **Yes**, and the **PREV-11 Confirmation** is **Yes**.  
Valid values are:  
  - Yes  
  - No – Denominator Exception - Medical Reasons  
  - No – Denominator Exception - Patient Reasons  
  - <blank>                                            |
| Blood Pressure Normal         | Pull-down menu is available for selection when the patient is ranked in **PREV-11**, **Medical Record Found** is set to **Yes**, the **PREV-11 Confirmation** is **Yes**, and **Calculated BMI** is **Yes**.  
Valid values are:  
  - Yes  
  - No  
  - <blank>                                            |
| Follow-Up Plan                | Pull down menu is available for selection when the patient is ranked in **PREV-11**, **Medical Record Found** is set to **Yes**, and **Blood Pressure Screening** is **No**.  
Valid values are:  
  - Yes  
  - No  
  - <blank>                                            |
### Comments (optional)

The Comments field may be used for further comment or documentation specific to the PREV-11 module. The field is available when the patient is ranked in PREV-11, the Medical Record Found is Yes, and a selection has been made to PREV-11 Confirmation. The Comments field has a maximum of 140 characters. Any text in this field will display on the Comments Report.

### 6.9.8. PREV-12: Screening for Clinical Depression and Follow-Up Plan

The table below lists the fields for this disease module:

<table>
<thead>
<tr>
<th>Label</th>
<th>Element Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREV-12 Confirmation</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-12 and the Medical Record Found is Yes.</td>
</tr>
<tr>
<td></td>
<td>Valid values are:</td>
</tr>
<tr>
<td></td>
<td>• Yes</td>
</tr>
<tr>
<td></td>
<td>• Denominator Exclusion</td>
</tr>
<tr>
<td></td>
<td>• No - Other CMS Approved Reason (Note: this option should only be selected when an approval has been received from CMS in the form of a response to a QualityNet Help Desk inquiry. CMS has requested that the Help Desk Ticket # be provided in the Help Desk Ticket # field.)</td>
</tr>
<tr>
<td></td>
<td>• Not Confirmed - Age (Note: this option is not available unless the patient’s age is changed to fall outside the acceptable range)</td>
</tr>
<tr>
<td></td>
<td>• &lt;blank&gt;</td>
</tr>
<tr>
<td>Help Desk Ticket #</td>
<td>CMS requires the user to submit a Help Desk ticket requesting approval to use the confirmation option No – Other CMS Reason. The Help Desk Ticket # is to be entered in this field once approval is received.</td>
</tr>
<tr>
<td>Label</td>
<td>Element Description</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clinical Depression Screening</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-12, the Medical Record Found is Yes, and the PREV-12 Confirmation is Yes. Valid values are: • Yes • No • No – Denominator Exception - Medical Reasons • No – Denominator Exception - Patient Reasons • &lt;blank&gt;</td>
</tr>
<tr>
<td>Positive for Clinical Depression</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-12, the Medical Record Found is Yes, the PREV-12 Confirmation is Yes, and the Clinical Depression Screening is Yes. Valid values are: • Yes • No • &lt;blank&gt;</td>
</tr>
<tr>
<td>Follow-Up Plan</td>
<td>Pull-down menu is available for selection when the patient is ranked in PREV-12, the Medical Record Found is Yes, the PREV-12 Confirmation is Yes, the Clinical Depression Screening is Yes, and the Positive for Clinical Depression is Yes. Valid values are: • Yes • No • &lt;blank&gt;</td>
</tr>
</tbody>
</table>
### 6.9.9. Additional Information

For information on Measure Data Definition, see the [2015 GPRO Web Interface Measures List](https://www.cms.gov/GPROMeasures), [Narrative Measure Specifications](https://www.cms.gov/GPROMeasures), and [Release Notes](https://www.cms.gov/GPROMeasures) files on the CMS website.

### 7. Troubleshooting & Support

A variety of resources are available that offer more information about any topic, from Quality Measures and Performance Standards to screen element explanations (available in the Online Help feature built into the Web Interface).

#### 7.1. Notable Websites

Quality Measures and Performance Standards are available on the CMS Web page dedicated to the [Quality Measures and Performance Standards](https://www.cms.gov/GPROMeasures) for the Shared Savings Program.

Information about the [Web Interface Group Practice Reporting Option](https://www.cms.gov/GPROMeasures) is available on the CMS Web Page dedicated to Web Interface GPROs.

#### 7.2. Tech Support

Additional technical support resources are available through the QualityNet Help Desk. For contact information, please refer to the table below.

<table>
<thead>
<tr>
<th>Contact</th>
<th>Org</th>
<th>Phone</th>
<th>Email</th>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
</table>

![Table of troubleshoot elements and descriptions]
### 7.3. Special Considerations: Copyright and Trademark Information

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- Current Procedural Terminology is a registered trademark of the American Medical Association.

- Applicable Federal Acquisition Regulations/Defense Federal Acquisition Regulations apply to government use.

- Fee schedules, relative value units, conversion factors and/or related components are not assigned by the American Medical Association, are not part of CPT, and the American Medical Association is not recommending their use. The American Medical Association does not directly or indirectly practice medicine or dispense medical services. The American Medical Association assumes no liability for data contained or not contained herein.

- This user manual was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
This section describes the acronyms used in this document.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CQM</td>
<td>Clinical Quality Measures</td>
</tr>
<tr>
<td>EIDM</td>
<td>Enterprise Identity Management</td>
</tr>
<tr>
<td>GPRO</td>
<td>Group Practice Reporting Option</td>
</tr>
<tr>
<td>MSSP</td>
<td>Medicare Shared Savings Program</td>
</tr>
<tr>
<td>PQRS</td>
<td>Physician Quality Reporting System</td>
</tr>
<tr>
<td>TIN</td>
<td>Tax Payer Identification Number</td>
</tr>
<tr>
<td>XML</td>
<td>Extensible Mark Up Language</td>
</tr>
<tr>
<td>XMLHTTP</td>
<td>Extensible Mark Up Language Hypertext Transfer Protocol</td>
</tr>
</tbody>
</table>
Glossary

Accountable Care Organizations - ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

Advance Payment Initiative - a supplementary incentive program for selected participants in the Shared Savings Program.

Electronic Health Record – Electronic Health Records are electronic records of patient health information gathered and/or generated in any care delivery setting. This information includes patient demographics, progress notes, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. This provides the ability to pass information from care point to care point providing the ability for quality health management by physicians.

Group Practice Reporting Option (GPRO) – Group Practice Reporting Option describes the Group Practices that are participating in this reporting option. To qualify for this reporting option, Group Practices must go through a vetting process.

Physician Quality Reporting System (PQRS) – Physician Quality Reporting System: A quality reporting system that includes an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services provided during the specified program year.

Pioneer ACO Model – a population-based payment incentive for health care organizations and providers already experienced in coordinating care for patients across care settings.


Tax Identification Number – An identification number used by the Internal Revenue Service in the administration of tax laws.

Primary Tax Identification Number – the parent or primary TIN used by the ACOs. It may consist of one or more Participating TINs. The ACO reporting is done at the Primary TIN level.

Section 508 - The law that mandates all electronic media that is used, purchased, developed, or maintained by the Federal Government be accessible to people with disabilities.
## Referenced Documents

<table>
<thead>
<tr>
<th>Document Name</th>
<th>Document Number and/or URL</th>
<th>Issuance Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Shared Savings Program Website</td>
<td><a href="http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html">http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html</a></td>
<td>May 2013</td>
</tr>
</tbody>
</table>
## Record of Changes

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>04/24/2015</td>
<td>Baseline version for PY2015</td>
</tr>
<tr>
<td>2.0</td>
<td>12/17/2015</td>
<td>Updated for GPRO Web Interface Release</td>
</tr>
<tr>
<td>2.1</td>
<td>01/05/2016</td>
<td>Minor Revisions for Consistency and Accuracy</td>
</tr>
</tbody>
</table>