Instructions for populating the 2020 MIPS Performance Period Self-Nomination QCDR Measure Submission Template

The QCDR measure submission template should ONLY be filled out by QCDRs who meet the 2020 definition of a QCDR and wish to submit QCDR measures for CMS consideration.
A QCDR may submit a maximum of 30 QCDR measures for review and approval by CMS for reporting.

Complete the fields for each proposed 2020 MIPS Performance Period QCDR Measure. **Please ensure that the measure description and specifications are checked for grammar and typographical errors before submission.**

Please follow these steps when completing the QCDR measure submission template:

1. Open the QCDR measure submission template and save it with your organization's name (i.e.,2020 QCDR Measure Submission_QCDRName_vX). Please update the version number, when an updated QCDR measure submission template is uploaded or attached.
2. Navigate to the "QCDR Information" tab. For existing QCDRs in good standing, please update row 3 (Self-Nomination ticket #:) and row 4 (Number of QCDR Measures submitted =). For new QCDRs, enter information for all the rows except for row 2 (QCDR Vendor ID (if applicable):). Your organization will be assigned a QCDR Vendor ID upon approval.
3. Navigate to the "2020 QCDR Measure Subm Template" tab. Complete all required fields denoted with an asterisk (*). The table below shows which columns are required or optional.
4. Upload or attach the 2020 QCDR measure submission template to your organization's 2020 self-nomination form. Please note that the 2020 QCDR measure submission template does not need to include all of the proposed QCDR measures to be uploaded or attached to your organization's 2020 self-nomination form. You may upload or attach an updated 2020 QCDR measure submission template with additional QCDR measures prior to the end of the 2020 self-nomination period which ends at **8 pm ET on September 3rd.**

Column	Column Header	Required/Optional?	Instructions/Notes
A	PIMMS Tracking ID (PIMMS USE ONLY)	N/A	This is a unique ID that is used for PIMMS tracking purposes and internal use only.
B	Input Row Completeness	N/A	Provides the status of "Complete" or "Incomplete" for each row. "Incomplete" will display if all of the REQUIRED fields have not been populated for a given entry.
C	Error Messages for Required Fields	N/A	Provides the user with an error message(s) regarding missing REQUIRED information for each entry. Also, missing REQUIRED information for each entry will have the cell highlighted in red after five REQUIRED fields have been populated in the template for the specific proposed measure.
D	Measure Submission Status	Required	Indicate if the given entry is "Ready for PIMMS Team Review", a "Work in Progress" or "Withdrawn". Entries with a "Work in Progress" status will not be reviewed until the status is updated to "Ready for PIMMS Team Review".
E	Do you own this measure?	Required	Enter "Yes", "No" or "Co-owned" for this field. By selecting "No" you are attesting that you currently have the appropriate documentation (i.e., email, letter) giving your organization permission from the QCDR measure owner/steward to use the QCDR measure. Documentation to support permission will be verified. !! If your answer is no, you do not own the measure, please fill out Columns E,F, G, and H. For remaining columns, please enter "See owner specs".
F	If you do not own or co-own this measure with another QCDR(s), please indicate the owner or co-owners	Optional	Provide the name of the QCDR that owns this measure or the QCDR(s) that co-own this measure. **Example:** Centers for Medicare & Medicaid Services
G	If this is a previously CMS approved measure, please provide the CMS assigned measure ID	Required	Provide the QCDR measure ID assigned to the 2017/2018/2019 MIPS performance period approved measure included in the QCDR measure specifications. Enter "N/A" if not applicable. **Example:** ABC55
H	Measure Title	Required	Provide the measure title, which should begin with a clinical condition of focus, followed by a brief description of action. **Example:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan.
I	Measure Description	Required	Describe the measure in full detail. **Example:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
J	Denominator	Required	Describe the eligible patient population to be counted to meet the measures' inclusion requirements. **Example:** All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.
K	Numerator	Required	The clinical action that meets the requirements of the measure. **Example:** Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.
L	Denominator Exclusions	Required	An exclusion is anything that would remove the patient, procedure, or unit of measurement from the denominator. Enter "N/A" if not applicable. **Example:** Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy.
M	Denominator Exceptions	Required	Allow for the exercise of clinical judgement. Applied after the numerator calculation and only if the numerator conditions are not met. Enter "N/A" if not applicable. **Example:** Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. **OR** Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.
N	Numerator Exclusions	Required	An exclusion is anything that would remove the patient, procedure, or unit of measurement from the numerator, typically used in ratio or inverse proportional measures. Applied before the numerator calculation. Enter "N/A" if not applicable. **Example:** If the number of central line blood stream infections per 1,000 catheter days were to exclude infections with a specific bacterium, that bacterium would be listed as a numerator exclusion.
O	Data Source Used for the Measure	Required	Indicate the data source(s) used for the measure. This may include but is not limited to administrative claims data, facility discharge data, chronic condition data warehouse (CCW), claims, CROWNWeb, EHR (enter relevant parts), Hybrid, IRF-PAI, LTCH CARE data set, National Healthcare Safety Network (NHSN), OASIS-C1, paper medical record, Prescription Drug Event Data Elements, PROMIS, record review, Registry (enter which Registry), Survey, Other (describe source).
P	If applicable, please enter additional information regarding the data source used	Optional	Provide additional information when "Registry" and/or "Other" is selected. **Example:** ABC Registry
Q	QCDR Measure Type	Required	Select the measure type from the drop down list that describes the measure submitted for review.
R	If this is an existing measure with changes, do the changes impact the intent of the measure?	Optional	If yes, indicate if the variance is within your registry and/or from another source. If another source, please cite the source.
S	Please indicate what has changed to the existing measure and how the change impacts the intent of the previous version.	Optional	Provide details regarding the measure changes and how the changes impact the previous version of the QCDR measure. **Example:** 10% improvement in depression symptoms has been added to the numerator. The measure can no longer be benchmarked against the previous year.
T	Can the measure be benchmarked against the previous performance period data?	Optional	Enter "Yes" or "No" for this field.
U	If applicable, please indicate why the previous benchmark cannot be used.	Optional	Provide details regarding why the previous benchmark cannot be used. **Example:** The improvement addition to the numerator will make this measure an Outcome measure and therefore cannot be compared to the measure from last year.
V	NQF ID Number (if applicable)	Optional	Provide the assigned NQF ID number, if the submitted QCDR measure fully aligns the NQF endorsed version of the measure. If no NQF ID number, enter 0000. **Example:** 0418
W	Is the QCDR measure a high priority measure?	Required	Enter "Yes" or "No" to indicate if the measure is a high priority measure.
X	High Priority Type	Required	Indicate the high priority measure type.
Y	Measure Type	Required	Select which measure type applies to the measure belongs.
Z	NQS Domain	Required	Select which NQS domain applies to the measure.
AA	Care Setting	Required	Select which care setting(s) are included within the measure.
AB	What Meaningful Measure Area applies to this measure?	Required	Select ONLY one Meaningful Measure Area that best applies to the measure.
AC	Meaningful Measure Area Rationale	Required	Provide a rationale for the selected Meaningful Measure Area for the QCDR measure. **Example:** This measure identifies patients with depression and an appropriate follow-up treatment plan.

AD	Inverse Measure	Required	Indicate if the measure is an inverse measure. This is measure where a lower calculated performance rate for this type of measure would indicate better clinical care or control. The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases.
AE	Proportional Measure	Required	Indicate if the measure is a proportional measure. This is a measure where the score is derived by dividing the number of cases that meet a criterion for quality (the numerator) by the number of eligible cases within a given time frame (the denominator). The numerator cases are a subset of the denominator cases (e.g., percentage of eligible women with a mammogram performed in the last year).
AF	Continuous Variable Measure	Required	Indicate if the measure is a continuous variable measure. This is a measure where a measure score in which each individual value for the measure can fall anywhere along a continuous scale and can be aggregated using a variety of methods such as the calculation of a mean or median (e.g., mean time to thrombolytics, which aggregates the time in minutes from a case presenting with chest pain to the time of administration of thrombolytics). CMS encourages QCDRs to construct the numerators to be proportional by establishing an expected benchmark based on guidelines or national performance data. Applying MIPS scoring methodology has proven to be challenging for non-proportional measures because variability in the data points makes decile creation based on a mathematical analysis very unpredictable.
AG	Ratio Measure	Required	Indicate if the measure is a ratio measure. This is a measure where a score that may have a value of zero or greater that is derived by dividing a count of one type of data by a count of another type of data. The key to the definition of a ratio is that the numerator is not in the denominator (e.g., the number of patients with central lines who develop infection divided by the number of central line days). Rates closer to 1 represent the expected outcome.
AH	If Continuous Variable and/or Ratio is chosen, what is the range of the score(s)?	Optional	If not a continuous variable and/or ratio measure enter N/A. **Example:** 0-100%
AI	Number of performance rates to be calculated and submitted	Required	Indicate the number of performance rates submitted for the measure. If only one is calculated, enter '1'.
AJ	Performance Rate Description(s)	Optional	Provide a brief description for each performance rate to be calculated and submitted. **Example:** This measure will be calculated with 7 performance rates: 1) Overall Percentage for patients (aged 5-50 years) with well-controlled asthma, without elevated risk of exacerbation 2) Percentage of pediatric patients (aged 5-17 years) with well-controlled asthma, without elevated risk of exacerbation 3) Percentage of adult patients (aged 18-50 years) with well-controlled asthma, without elevated risk of exacerbation 4) Asthma well-controlled (submit the most recent specified asthma control tool result) for patients 5 to 17 with Asthma 5) Asthma well-controlled (submit the most recent specified asthma control tool result) for patients 18 to 50 with Asthma 6) Patient not at elevated risk of exacerbation for patients 5 to 17 with Asthma 7) Patient not at elevated risk of exacerbation for patients 18 to 50 with Asthma
AK	Indicate an Overall Performance Rate if more than 1 performance rate is submitted	Required	Specify which of the submitted rates will represent an overall performance rate for the measure or how an overall performance rate could be calculated based on the data submitted [for example, simple average of the performance rates submitted or weighted average (sum of the numerators divided by the sum of the denominators), etc.
AL	Risk-Adjusted	Required	Indicate if the measure is risk-adjusted.
AM	If risk-adjusted, indicate which score is risk-adjusted	Required	Indicate the score that is risk-adjusted for the measure.
AN	Is the QCDR measure able to be abstracted?	Required	Please attest that the measure element can be abstracted and is feasible.
AO	Please provide any test data on reliability/validity	Optional	If test data on reliability/validity is not available enter N/A.
AP	Clinical Recommendation Statement	Required	Provide a concise statement regarding the clinical recommendation for this QCDR measure including the current clinical guideline the measure is derived. **Example:** Adolescent Recommendation (12-18 years) "The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360).
AQ	Provide the rationale for the QCDR measure	Required	Provide a concise statement regarding the rationale for the QCDR measure. **Example:** Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt, Brody 2014). 2014 U.S. survey data indicate that 2.8 million (11.4 percent) adolescents aged 12 to 17 had a major depressive episode (MDE) in the past year and that 15.7 million (6.6 percent) adults aged 18 or older had at least one MDE in the past year, with 10.2 million adults (4.3 percent) having one MDE with severe impairment in the past year (Center for Behavioral Health Statistics and Quality, 2015).
AR	Provide measure performance data and variance rate, if available	Required	Provide measure performance data and variance rate, if available. CMS provided provisional approval with the expectation that evidence of a performance gap would be provided. Please provide the average performance rate, variance range and the number of eligible clinicians and/or TINs submitting the measure within your self-nomination. Provisionally approved QCDR measures that do not have performance data or performance data does not support a gap, the measure will likely not be approved for use in the 2020 performance period of MIPS. CMS provided provisional approval with the expectation that evidence of a performance gap would be provided. **Example:** 2019 Performance data shows 150 individual submissions with a mean rate of performance 71.2%
AS	Provide the study citation to support performance gap for the measure, if measure performance data is not available	Optional	Provide the study citation for the measure to support the performance gap. A study citation may be used to demonstrate a performance gap, if measure performance data is not available. Citations should be the most current available or within 5 years. In the event, a provisionally approved QCDR measure does not have performance data available, please provide a recent study to support a performance gap. **Example:** Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, 2010, p. 948)
AT	Please indicate applicable specialty/specialties	Required	Indicate the specialty/specialties the measure applies to (i.e., Anesthesiology, Neurology, Urology, etc.). **Example:** Mental/Behavioral Health
AU	Preferred measure published clinical category	Required	Please provide a preferred clinical or specialty category (i.e., Diabetes, Substance Use/Management). Please note that if a preferred measure published clinical category is not provided, one will be assigned to the measure by CMS. **Example:** Mental/Behavioral Health
AV	QCDR Notes	Optional	Provide any additional notes that would assist in the review or clarification of the QCDR measure.
AW	CMS Measure Feedback	N/A	QCDR measure review feedback will be entered in this column. Feedback will be dated with the most current feedback at the top of the cell. Please note that the column will be locked until CMS has provided their feedback.
AX	Vendor Measure Response	N/A	Vendor provides their response to the QCDR measure review feedback provided by CMS. Response(s) should be dated with the most current feedback at the top of the cell. Please note that this column will be locked until CMS has provided their feedback.
AY	QCDR Measure Reconsideration Meeting Summary	N/A	This column will be populated for each QCDR measure that is discussed during the resolution meeting between CMS, PIMMS MIPS Team and the vendor.
AZ	Final CMS Measure Decision	N/A	This column will be populated or updated for each QCDR measure that is discussed during the resolution meeting between CMS, PIMMS MIPS Team and the vendor.

QCDR Organization Name:

QCDR Vendor ID
(if applicable):

Self-Nomination ticket #:

Number of QCDR Measures
submitted =

PIMMS Tracking ID (PI	Input Row Completeness
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Error Messages for Required Fields	Measure Submission Status*

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*If "NO", see instructions tab

Do you own this measure?*	If you do not own or co-own this measure with a	If this is a previously CMS

Measure Title*	Measure Description*

Denominator*	Numerator*

Denominator Exclusions*	**Denominator Exceptions***

Numerator Exclusions*	Data Source Used for the Measure*

If applicable, please enter additional information	QCDR Measure Type*

If this is an existing measure with changes, do the chan

Please indicate what has changed to the existing measure and how the	**Can the measure be benchmarked against the p**

If applicable, please Indicate why the prev	NQF ID Number(if appli	Is the QCDR measure a h	High Priority Ty

New for 2020

Measure Type*	NQS Domain*	Care Setting*

Which Meaningful Measure Area applies	Meaningful Measure Area Rationale*

Inverse Measure*	**Proportional Measure***

Continuous Variable N	Ratio Measure*	If Continuous Variable and/or Rati	Number of performa

New for 2020

Performance Rate Description(s)	Indicate an Overall Performance Rate

New for 2020

Risk-Adjusted*	If risk-adjusted, indica	Is the QCDR measu

Please provide any test data on reliability/validity	**Clinical Recommendation Statement***

New for 2020	New for 2020
Provide the rationale for the Q	**Provide measure performance data and vari**

New for 2020

Provide the study citation to support performance	Please indicate applicable specialty/specialtie

Preferred measure published clinical category*

New for 2020

QCDR Notes	CMS QCDR Measure Feedback

Vendor QCDR Measure Response	QCDR Measure Reconsideration M

Final CMS Measure Decision