Frequently Asked Questions (FAQs) for Reporting of Patient-Reported Outcome (PRO) and Limited Risk Variable Data

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Centers for Medicare & Medicaid Services (CMS)

Comprehensive Care for Joint Replacement (CJR) Model
Reporting of Patient-Reported Outcome (PRO) and Limited Risk Variable Data

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Eligible Participant Hospitals

1. Which hospitals are eligible to participate in patient-reported outcome (PRO) and risk variable data collection in the Comprehensive Care for Joint Replacement (CJR) bundled payment model?

In the December 2017 final rule published by the Centers for Medicare & Medicaid Services (CMS), hospital participation in 33 of the 67 Metropolitan Statistical Areas (MSAs) originally included in CJR became voluntary. Additionally, all low-volume and rural hospitals in the remaining 34 MSAs were granted voluntary status. CMS held an opt-in election period during January 2018 for hospitals that were eligible for voluntary participation.

The list of participant hospitals and MSAs can be found on the CMS website at https://innovation.cms.gov/initiatives/cjr. Hospitals on this list are eligible to participate in the PRO and limited risk variable data submission component of CJR.

2. Can CJR participant hospitals submit PRO and risk variable data for procedures performed by surgeons participating in models other than CJR?

Yes, all hospitals can submit for the PRO and risk variable data component of the CJR model regardless of the provider's affiliation with another CMS model (for example, the Bundled Payments for Care Improvement [BPCI] initiative). The criteria for identifying which procedures are eligible for PRO and risk variable data submission are outlined in the Patient Selection Flowchart in Question 29 and as specified in the 2015 CJR final rule.

Rationale for PRO Data Collection

3. Why should my hospital collect and submit PRO data?

As part of the effort to support CMS's Meaningful Measures initiative goal of strengthening patient and family engagement as partners in their care, CMS is developing patient-reported outcome performance measures (PRO-PMs). This move is supported broadly in the orthopedic community; PROs capture changes in pain and function, the two most common reasons patients and surgeons pursue total hip and/or knee replacement. Getting a head start in PRO collection will prepare your hospital for the future. In addition, hospitals that successfully submit PRO and risk variable data will gain two points for their hospital's CJR composite quality score, which may increase their financial opportunity under the model.

4. Why is CMS incentivizing hospitals to collect PRO data?

As part of the Meaningful Measures initiative, CMS is in the process of transitioning to outcome measures, patient-centered outcome measures, and quality strategies that include patients' experiences. Patient-centered outcome measures provide hospitals with insight into the quality of care they are providing to their patients. As noted in the 2015 CJR final rule (Section III.C.5.b.(2), page 73359), successful PRO data submission will "provide participant hospitals with valuable information on functional outcomes that would assist [providers] in assessing an important patient-centered outcome, engaging other providers and suppliers in care redesign for [lower extremity joint replacement] LEJR episodes, as well as provide them with the potential for greater financial benefit from improved LEJR episode efficiencies." Any changes to existing outcome measures or the

addition of new outcome measures would be made through a future Notice of Proposed Rulemaking process.

Best Practices for Data Collection

5. Through what modalities can PRO data be collected?

Hospitals may choose to collect PRO data in a variety of ways that best meets their needs. Some modes previously used for patient-reported data collection include: in-person with the patient, via mail, telephone, or online (using an electronic interface).

6. What locations are appropriate for collecting PRO data?

The CJR model final rule does not specify where a hospital should collect PRO and risk variable data for this component of the CJR model. Some literature shows that patients' responses may be less susceptible to bias if collected outside of the clinical setting. However, there are benefits to collecting this data during hospital or physician visits, as this provides the opportunity for patients to ask questions, which may improve survey completeness and overall response rates.

Data Specifications for PRO and Risk Variable Data Collection

7. What data must my hospital submit to meet the CJR requirements for PRO data collection?

Hospitals need to submit the Veterans RAND 12 Item Health Survey (VR-12) or Patient-Reported Outcomes Measurement Information System (PROMIS) Global-10 generic PRO survey; and the Hip disability and Osteoarthritis Outcome Score (HOOS)/Knee injury and Osteoarthritis Outcome Score (KOOS) Joint Replacement (JR.) or HOOS/KOOS subscales PRO survey for patients undergoing eligible elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA) procedures. The PRO surveys must be collected for the same patients during the pre-operative (90 to 0 days before the procedure) and post-operative (270 to 365 days following the procedure) periods. The PRO surveys that a given patient completes at the pre-operative data collection period must be the same PRO surveys the same patient completes during the post-operative data collection period. In addition to the PRO surveys, hospitals must also submit the identifiers listed below so that pre- and post-operative data can be linked.

Finally, hospitals must submit risk variables which are only collected during the pre-operative data collection period. CMS also requests that hospitals submit additional hospital identification, performance year, and data collection information that will allow for identification and matching of pre-operative and post-operative data submissions. Table 1 and Table 2 summarizes the variables for the CJR PRO data collection. For the data specifications for each variable, please refer to the CJR PRO Data Dictionary available on *CJR Connect* under the Libraries tab.

Table 1. Variables for CJR PRO and Risk Variable Pre-Operative Data Collection

<table>
<tr><th colspan="5">Pre-Operative Data Collection</th></tr>
<tr><td colspan="2">VR-12</td><td>OR</td><td colspan="2">PROMIS-Global</td></tr>
<tr><td colspan="5"><u>AND</u></td></tr>
<tr><td colspan="2">HOOS/KOOS JR.</td><td rowspan="3">OR</td><td colspan="2">HOOS/KOOS subscales</td></tr>
<tr><td>HOOS JR.</td><td>KOOS JR.</td><td>HOOS subscales</td><td>KOOS subscales</td></tr>
<tr><td>• Pain (2 questions)
• Function, daily living (4 questions)</td><td>• Stiffness (1 question)
• Pain (4 questions)
• Function, daily living (2 questions)</td><td>• Pain (10 questions)
• Function, daily living (17 questions)</td><td>• Stiffness (2 questions)
• Pain (9 questions)
• Function, daily living (17 questions)</td></tr>
<tr><td colspan="5"><u>AND</u></td></tr>
<tr><td colspan="5">• Performance Year
• Medicare Provider Number, also known as CMS Certification Number (CCN)
• Medicare Identification: Medicare Health Insurance Claim (HIC) Number, Railroad Retirement Medicare Beneficiary Number, or Medicare Billing Identifier (MBI)
• Date of Birth
• Date of Collection
• Mode of Collection
• Person Completing Survey
• Race
• Ethnicity
• Patient-reported Health Literacy Screening (SILS2) Questionnaire
• Body Mass Index (BMI) or Height in cm and Weight in kg
• Pre-operative Use of Chronic (≥90 days) Narcotics
• Patient-reported Pain in Non-operative Lower Extremity Joint
• Patient-reported Back Pain (Oswestry Index Question)</td></tr>
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Table 2. Variables for CJR PRO and Risk Variable Post-Operative Data Collection

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• Date of Birth
• Date of Collection
• Mode of Collection
• Person Completing Survey
• Date of Admission to Anchor Hospitalization
• Date of Eligible Procedure</td></tr>
</table>

8. Where can hospitals access the PRO surveys?

The PRO surveys can be obtained through the following webpages:

- **HOOS:** http://www.koos.nu/
- **HOOS JR.:** https://www.hss.edu/hoos-jr-koos-jr-outcomes-surveys.asp
- **KOOS:** http://www.koos.nu/
- **KOOS JR.:** https://www.hss.edu/hoos-jr-koos-jr-outcomes-surveys.asp
- **VR-12:** http://www.bu.edu/sph/research/research-landing-page/vr-36-vr-12-and-vr-6d/
- **PROMIS-Global:** http://www.nihpromis.org/measures/availableinstruments

9. How should patients' responses to the PRO surveys and supplemental required questions be collected?

Hospitals have the option to administer the PRO surveys and supplemental required questions on paper, over the telephone (including data collected using interactive voice response), or electronically (such as web-based or through electronic health records [EHRs]).

While hospitals have the flexibility to choose the mode to administer or collect data, CMS requests that hospitals report on the "mode of collection" once during the pre-operative period and once during the post-operative period. When hospitals provide the "mode of collection," hospitals should provide the mode that is most representative of how all the required data (including PRO surveys) for the given pre/post-operative period were collected. If more than one mode was used during a data collection period, hospitals should report the predominant mode.

10. How did CMS determine which PRO surveys and candidate risk variables to collect?

CMS has worked with experts in the medical community, as well as other stakeholders, to carefully identify the PRO surveys and candidate risk variables that should be considered for inclusion in the future THA/TKA procedure patient-reported outcome performance measures (PRO-PMs).

CMS identified variables that could be captured using administrative claims data and excluded them from the list of data elements required for successful submission of PRO and risk variable data for the CJR model. This decision minimizes the data collection burden on hospitals, as CMS can link to these data using a few key identifiers.

The list of risk variables finalized in the 2015 CJR final rule incorporates feedback received during the proposed rule public comment period, including feedback received in a joint statement from multiple surgical specialty societies (Section III.D.3.a.(7), page 73497).

11. How should the data for the variables race and ethnicity be collected?

Race and ethnicity are required data elements that are collected pre-operatively. Race and ethnicity should be provided by the patient, rather than obtained from the patient's medical records.

12. How should the data for the variables height and weight be collected?

Height and weight (or alternatively, you can report the patient's BMI in place of height/weight) are required data elements that are collected pre-operatively. Height and weight can be collected by the provider during the patient's pre-operative/consult visit or obtained from the patient's medical records.

13. Our EMR recalculated the questionnaire values based on our own internal scale. Can we submit those values?

Please submit the values of the questionnaires/surveys as reported in the CJR PRO Data Dictionary and not the adjusted values reported by your Electronic Medical Record (EMR) or EHR system. This will allow for an accurate representation of your patients' improvement before and after total hip arthroplasty or total knee arthroplasty. Entry of data values into the CJR PRO Data Collection Template different than those expected will lead to misrepresentation of your patients' information.

14. Can we use a mix of PROMIS-Global and VR-12 for data collection and does it need to be the same survey for a patient pre-operatively and post-operatively?

Hospitals can choose to administer the PROMIS-Global, VR-12, or both to their patients for CJR PRO data collection, but they must use the same survey for pre-op data collection as they do for post-operative data collection for each patient.

PRO and Risk Variable Data Elements and Requirements for Reporting

15. One of the variables we need to submit has to do with pre-operative use of narcotics. What is the definition of the chronic narcotics variable?

The "use of chronic (≥90 day) narcotics" variable is defined as having any daily or regular intermittent dose of morphine (or hydromorphone/equivalent) for at least 90 days. These data can be collected within 90 days of the patient's elective primary THA/TKA procedure if the clinical care team expects the patient to remain on narcotics until surgery, at which time the patient will have been on narcotics for at least 90 days.

This definition intends to capture patients with severe pain requiring chronic narcotics prior to THA/TKA procedures and is somewhat subject to interpretation. We leave it to individual surgeons or healthcare providers (that is, clinicians interacting with the patient/the patient's medical record) to determine whether the medication the patient is on is a narcotic and whether very short replacement narcotic use warrants coding as chronic narcotic use for the purposes of collecting this variable. Lastly, providers should collect data that reflects overall narcotic use (or any narcotic use), not just narcotic use specific to joint pain.

16. My patient is multiracial/bi-racial; how should I collect their race variable? What if my patient does not want to disclose his/her race/ethnicity?

CMS acknowledges that some patients are multiracial or bi-racial and requests that the healthcare team asks their patients to either select the race descriptor with which their patients primarily identify or select "Other," an option for the race variable made available beginning in performance year (PY) 3. CMS also acknowledges that some patients may choose not to disclose their race and/or ethnicity. In this circumstance, CMS encourages the healthcare team to work with their patients to help them understand the importance of this information and how it will inform the development of an elective, primary THA/TKA procedures patient-reported outcome performance measure (PRO-PM) that can help promote care improvement for themselves and other patients with similar backgrounds.

17. Do I need to report all the PRO and risk variable data elements of my eligible patients?

Pre-operatively, hospitals must submit 100% of questions from one of two generic surveys (that is,

the VR-12 or PROMIS-Global); 100% of questions from the joint-specific HOOS/KOOS Jr. survey or the required HOOS/KOOS subscales; and risk variables and identifiers. Post-operatively, only the PRO questions and identifiers are required. The data elements are as follows:

Required pre- and post-operative PRO instruments:

- VR-12 ***OR*** PROMIS Global PROMs;
- HOOS/KOOS JR. ***OR*** HOOS/KOOS subscales
    - HOOS subscales: pain, and function, daily living
    - KOOS subscales: stiffness, pain, and function, daily living

Required identifiers with *all* (pre- and post-operative) submitted data:

- Medicare Identification (Health Insurance Claim Number [HICN] or Railroad Retirement Medicare Beneficiary Number, OR Medicare Billing Identifier [MBI])
- Date of Birth

Required identifiers with post-operative submitted data *only*:

- Date of Admission
- Date of Procedure

Required risk variables with pre-operative submitted data *only*:

- Race and Ethnicity
- Body Mass Index (BMI) or Height in cm and Weight in kg
- Patient-Reported Health Literacy Screening (SILS2) Questionnaire
- Pre-Operative Use of Narcotics
- Patient-Reported Pain in Non-operative Lower Extremity Joint
- Patient-Reported Back Pain (Oswestry Index Question)

While not required for successful submission, we ask hospitals to also submit the following data elements with pre-and post-operative submitted data to improve CMS's ability to match pre- and post-operative data and to improve CMS's understanding of PRO data.

Requested identifiers with *all* (pre- and post-operative) submitted data:

- Medicare Provider Number (also known as CMS Certification Number, or CCN)
- Performance Year
- Mode of Collection
- Date of Collection
- Survey Respondent (if other than the patient)

For a list of the PRO and risk variable data elements, refer to Table 1 and Table 2. For the data specifications for each variable, please refer to the CJR PRO Data Dictionary available on *CJR Connect* under the Libraries tab.

18. Why is CMS requesting that hospitals submit Performance Year and Medicare Provider Number (also known as CMS Certification Number, or CCN) variables with PRO data?

CMS has requested that hospitals submit Performance Year and Medicare Provider Number (also known as CMS Certification Number, or CCN) to help match procedures to submitted PRO data and to increase CJR participant hospitals' chances for a successful PRO determination, earning two points towards their composite quality scores. As such, we have designated Performance Year and Medicare

Provider Number as "core data elements" in the PRO Data Collection Template.

While not required elements in the CJR Final Rule, CMS requests that hospitals submitting PRO data submit Performance Year and CCN for each procedure. Entry of the correct value for the Performance Year variable in the PRO Data Collection Template enables the macros in the template to limit data entry for the Date of Collection and Procedure Date variables to only those dates appropriate for the entered performance year. This action significantly limits hospitals from entering incorrect data, which could affect a successful PRO submission.

Submitting the CCN for each procedure is important because it is used is to identify hospitals that submit PRO data. This identification is necessary to ensure that a hospital with a successful PRO data submission is awarded the additional points for their composite quality scores. The CCN is also one of the variables used for matching a hospital's pre-operative data and post-operative data. The use of the CCN will be increasingly important in the matching process as CMS begins to assign Medicare Beneficiary Numbers (MBIs) to beneficiaries in April 2018 to replace Health Insurance Claim Numbers (HICNs). The CCN variable will be used to help match procedures for which the pre-operative data are identified by a HICN and the post-operative data are identified by an MBI for the same beneficiary.

19. For how many patients do I need to capture PRO and risk variable data to fulfill the successful data collection criteria?

Participating hospitals must meet the PRO and risk variable data reporting requirements (Table 3) for each PY in order to fulfill the successful data reporting criteria outlined in the 2015 CJR final rule. Post-operative data must match to the patients on which the hospital submitted data pre-operatively in the prior performance year to fulfill the successful data collection. See Question 20 and Question 21 for further details on the criteria for post-operative data submission.

Table 3. Minimum Case Requirements for Eligible Procedures in Each Performance Year (PY) for Successful Data Collection

Performance Year	Eligible THA/TKA Procedures Performed During	PRO Submission Requirements
1	July 1, 2016 – August 31, 2016	≥ 50% or ≥ 50 eligible procedures
2	September 1, 2016 – June 30, 2017	≥ 60% or ≥ 75 eligible procedures
3	July 1, 2017 – June 30, 2018	≥ 70% or ≥ 100 eligible procedures
4	July 1, 2018 – June 30, 2019	≥ 80% or ≥ 200 eligible procedures
5	July 1, 2019 – June 30, 2020	≥ 80% or ≥ 200 eligible procedures

20. Since the pre- and post-operative data must be collected on the same set of patients, will my hospital be able to meet the next performance year's successful submission criteria if we did not submit or were not able to capture enough pre-operative data?

As finalized in the 2015 CJR final rule, to meet the successful submission criteria of PYs 2 through 5 of the CJR model, hospitals are required to submit complete post-operative data on the patients they collected pre-operative data on during the prior year AND submit complete pre-operative data on eligible procedures based on the PRO case or percent requirement for that performance year (see Table 3 for PRO submission requirements). For this reason, CMS cannot award partial quality points to hospitals that only submit pre-operative or post-operative data for a given performance year. Hospitals are always welcome to submit PRO data in any performance year, but they must submit the

data as stated in the final rule in order to be considered as successfully submitting PRO and risk variable data and receive points towards their composite quality scores. Because of this requirement, we strongly urge hospitals interested in collecting PRO and risk variable data to start collecting these data, especially pre-operative data if your hospital is just starting out, as soon as possible to enable your hospital to be considered for successful submission in subsequent years of the model.

21. Do the successful criteria include the number/percentage of eligible cases that CMS is able to match pre- and post-operatively? In other words, if a hospital collected pre-operative data on a patient but was unable to collect post-operative data on that same patient, can a hospital still meet the successful criteria?

The success criteria do include the number/percentage of eligible procedures that have pre-operative and post-operative data that can be matched. For example:

- In PY 4, post-operative data must be submitted on the same patients as the PY 3 pre-operative data so that CMS has matched pre- and post-operative data for at least 70% or at least 100 of the total eligible THA/TKA procedures performed during the PY 3 timeframe, July 1, 2017 and June 30, 2018.
- In PY 5, post-operative data must be submitted on the same patients as the PY 4 pre-operative data so that CMS has matched pre- and post-operative data for at least 80% or at least 200 of the total eligible THA/TKA procedures performed during the PY 4 timeframe, July 1, 2018 and June 30, 2019.

In anticipation of potential challenges that may result from collecting post-operative data on all patients for whom pre-operative data were collected, hospitals should consider collecting data for **more than** the minimum requirement of procedures during the pre-operative data collection timeframe. CMS encourages hospitals to account for potential challenges with response rates when setting internal pre-operative PRO survey response goals, as well as to plan for the gradual increase in the minimum case requirement for successful PRO collection across PYs 3, 4, and 5.

22. Which data elements do you need to re-collect for patients who had bilateral procedures?

In cases of eligible bilateral knee/hip replacements (performed on both hips or both knees on the same day), you do not need to recollect PRO data unless the responses vary between joints, and only need to recollect the Patient-reported Pain in Non-operative Lower Extremity Joints risk variable.

Additionally, to clarify, these cases count as two procedures in the CJR reporting of PRO and risk variable data. Hospitals should report these as unique cases in the CJR PRO Data Collection Template to receive credit for both procedures (the Procedure Type (P_TYPE) variable in the CJR PRO Data Collection Template allows for selection of 1=Left Hip Replacement, 2=Right Hip Replacement, 3=Left Knee Replacement, 4=Right Knee Replacement).

Lastly, the Patient-reported Pain in Non-operative Lower Extremity Joints risk variable in these cases should be reported despite the “Non-operative” descriptor in the element name. Thus, in the case of a bilateral knee replacement and pre-operative risk variable collection, where the pain in the left knee is “Moderate” (2) and the right knee is “Severe” (3), for example, the Patient-Reported Pain in Non-operative Lower Extremity Joints element for the left knee procedure (row) would be marked with ‘3’, and the Patient-Reported Pain in Non-operative Lower Extremity Joints element for the right knee procedure (row) would be marked with ‘2’.

Generic and Joint-specific PRO Surveys

23. Do hospitals have to collect responses to all of the questions in the PROMIS-Global, VR-12, and/or HOOS/KOOS JR. or HOOS/KOOS subscales?

As finalized in the 2015 CJR final rule, all questions in the chosen surveys must be answered to be considered complete. For example, one of the generic surveys that hospitals can use is the Veterans RAND 12 Item Health Survey (VR-12). Hospitals who elect to use this survey instrument must report patient responses to all of the questions (the name of the survey can be misleading since there are actually 14 questions in the survey).

24. What do I do if the numbering in the PROMIS-Global or VR-12 surveys does not match the numbering in the CJR PRO Data Dictionary and Data Collection Template?

Some question numbers from the PROMIS-Global or VR-12 surveys are different from question assignments in the CJR PRO Data Dictionary; however, the individual questions and the order in which they appear in the surveys are the same as those found in the Data Dictionary. Please note, key words for each question are also identified in the Data Dictionary to assure correct data entry.

25. Have there been changes made to the PROMIS-Global survey?

The version available during PY 1 was the PROMIS-Global version 1.1. There is now a PROMIS-Global version 1.2. For the data specifications for each variable in the two versions of the PROMIS-Global survey, please refer to the CJR PRO Data Dictionary available on *CJR Connect* under the Libraries tab.

26. What do I do if the numbering in the HOOS/KOOS JR. or HOOS/KOOS subscales surveys does not match the numbering in the CJR PRO Data Dictionary and Data Collection Template?

The CJR PRO Data Dictionary shows that the HOOS/KOOS Jr. survey questions are contained within the Subscale survey questions. The question numbers in the actual HOOS/KOOS JR. surveys do not line up with the number assignments in the Data Dictionary and Collection Template, however the order of the questions is consistent between the full survey and the Data Dictionary and CJR PRO Data Collection Template.

27. Are there translated versions of the surveys?

The HOOS and KOOS subscales and the PROMIS GLOBAL v. 1.2 are available in numerous languages, including Spanish. The VR-12 is available in Spanish, Chinese, and German. The HOOS JR. and KOOS JR. are not yet available in languages other than English.

28. Is PRO data collection using the HOOS/KOOS physical function short form or PROMIS-Global short form eligible for PRO submission?

The HOOS/KOOS physical function short forms and PROMIS-Global short form do not qualify for successful submission in the CJR model. The data elements found within these forms are not the same as those found in the forms used for the CJR PRO data submission. To meet the PRO survey requirements and be eligible for successful submission, your hospital needs to administer the appropriate versions of the HOOS/KOOS and PROMIS-Global, which can be obtained through the following webpages:

- **HOOS:** http://www.koos.nu/
- **HOOS Jr.:** https://www.hss.edu/hoos-jr-koos-jr-outcomes-surveys.asp
- **KOOS:** http://www.koos.nu/
- **KOOS Jr.:** https://www.hss.edu/hoos-jr-koos-jr-outcomes-surveys.asp
- **PROMIS-Global:** http://www.nihpromis.org/measures/availableinstruments

Eligible Patients for PRO and Risk Variable Data Collection

29. For which patients should my hospital collect PRO and risk variable data?

PRO eligible patients overlap with, but are distinct from, patients included in CJR model episode specified by MS-DRGs 469 and 470 (Lower Extremity Joint Replacement) and defined in section III.B. of the 2015 CJR final rule. The PRO and limited risk variable data collection cohort is harmonized with the CMS THA/TKA Complications measure cohort. Therefore, not every patient included in the CJR model is eligible for PRO and risk variable data collection.

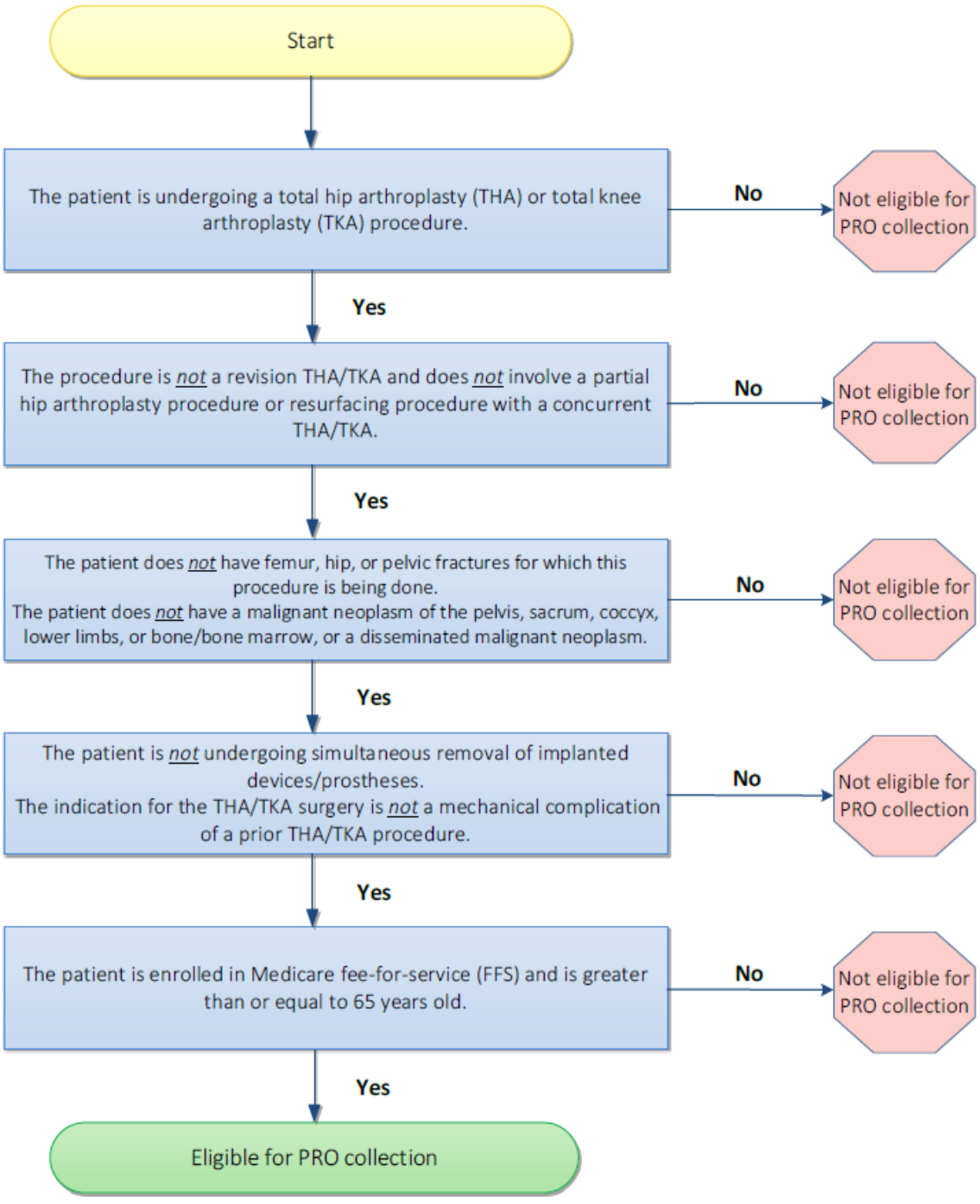
Eligible PRO data collection patients are specified primarily clinically (see Figure 1):

- Elective, primary THA and/or TKA procedures;
- Medicare Fee-For-Service beneficiaries aged 65 or over; or
- They can include patients of providers enrolled in the Bundled Payments for Care Improvement (BPCI) initiative or other similar models.

Patients undergoing revisions or with hip, femur or pelvic fractures, bony metastases, or requiring hardware removal are not eligible.

Of note, a hospital will need to assess a patient's eligibility for inclusion in the data collection on the day of or prior to the total THA/TKA procedure (before billing codes are submitted). Therefore, hospitals will primarily use clinical criteria to exclude patients. CMS recommends identifying eligible patients for PRO data collection by using the Patient Selection Flowchart (Figure 1), a resource which is available for download on *CJR Connect* or the CMS Measure Methodology webpage, in the "Hip and Knee Arthroplasty Patient-Reported Outcomes" folder, instead of relying on ICD-10 codes for identification. See Question 30 for more information regarding using claims codes to identify eligible patients for PRO and risk variable data collection.

Figure 1. Patient Selection Flowchart for Determining Eligible Elective Primary THA/TKA Procedures



30. Is the PRO and limited risk variable data collection cohort the same as that of the CMS THA/TKA Complications measure cohort? Can I use the ICD-10 codes from the Complications cohort to help identify patients for data collection?

The PRO and limited risk variable data collection cohort is harmonized with the CMS THA/TKA Complications measure cohort. Thus, the International Classification of Diseases Tenth Revision, Clinical Modification (ICD-10) codes used to define the Complications measure cohort can be used to help identify patients for PRO data collection. The Complications measure is reevaluated annually and the codes defining the cohort are posted in April of each year, coinciding with the release of the proposed Medicare Hospital Inpatient Prospective Payment Systems (IPPS) rule. Current Complications measure cohort definition codes are presented in Table 4 and can be found in the THA/TKA Complications measure updates and specifications reports on the QualityNet THA/TKA Measure Methodology webpage.

Although the ICD-10 codes can be used to help hospitals confirm that their patients are appropriate for data collection prior to submission, hospitals are strongly encouraged to refer to Figure 1, the Patient Selection Flowchart, to determine eligible patients because hospitals will need to assess a patient's eligibility for inclusion in data collection on the day of or prior to the THA/TKA procedure (before billing codes are identified/submitted).

Table 4. THA/TKA Complications Measure Cohort ICD-10 Codes (Public Reporting Year 2019)*

ICD-10 Code	Description
0SR9019	Replacement of Right Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SR901A	Replacement of Right Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SR901Z	Replacement of Right Hip Joint with Metal Synthetic Substitute, Open Approach
0SR9029	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR902A	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR902Z	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SR9039	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SR903A	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SR903Z	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SR9049	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR904A	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach

*Note: not all patients with the codes in Table 4 will qualify as elective primary THA/TKA procedures. Refer to the Patient Selection Flowchart (Figure 1) for additional criteria for selecting eligible patients.

ICD-10 Code	Description
0SR904Z	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SR9069	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR906A	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR906Z	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRB019	Replacement of Left Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SRB01A	Replacement of Left Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SRB01Z	Replacement of Left Hip Joint with Metal Synthetic Substitute, Open Approach
0SRB029	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB02A	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB02Z	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SRB039	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRB03A	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRB03Z	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SRB049	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB04A	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB04Z	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SRB069	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB06A	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB06Z	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach

ICD-10 Code	Description
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRC069	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRC06A	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRC06Z	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRC0JA	Replacement of Right Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRD069	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRD06A	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRD06Z	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRD0JA	Replacement of Left Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach

31. If a hospital has zero eligible procedures, how does this affect their overall score?

If a hospital does not perform any eligible THA/TKA procedures for PRO data collection in a given performance year, then they are not eligible to receive an additional two points towards their composite quality score.

32. What if we cannot reach patients to complete post-operative questionnaires?

CMS acknowledges that some patients may be difficult to reach to collect responses for their post-operative data collection. CMS encourages the healthcare team to work with their patients to help them understand the importance of this information and how it will inform the development of an elective, primary THA/TKA patient-reported outcome performance measure (PRO-PM) that can help promote care improvement for themselves and other patients.

In order to plan for potential difficulties in obtaining post-operative data on all patients, hospitals are strongly encouraged to collect pre-operative and risk variable data for more procedures than the

required minimum. Doing this will increase a hospital's chances of successful submission of post-operative data even if they are unable to collect post-operative data from one or more patients.

Please note, pre-operative data that are not matched to post-operative data will not count as a successful submission in the subsequent performance year.

33. How are patients included in PRO collection if they are having a staged or same-day procedure on the same joints or on different joints?

Eligible staged or same-day (simultaneous) THA/TKA procedures performed on either both hips or both knees, or on different joints, count as two procedures in the CJR reporting of PRO and risk variable data. Hospitals can report different joint replacement procedures for the same patient as unique cases (put each procedure in its own row) in the CJR PRO Data Collection Template to receive credit for both procedures.

For staged procedures performed on **both hips or both knees**, if the second eligible THA/TKA procedure occurs within 90 days of the date of pre-operative PRO and risk variable data collection for the first eligible THA/TKA procedure, you do not need to re-collect PRO data and only need to re-collect the Patient-Reported Pain in Non-operative Lower Extremity Joints variable. This same guidance applies to same-day (or simultaneous) procedures performed on either both hips or both knees.

For staged procedures performed on **different joints** (for example, the first eligible procedure is for a left hip and the second is for a right knee replacement), if the second eligible procedure occurs within 90 days of the date of the pre-operative PRO and risk variable data collection for the first eligible procedure, you must re-collect the PRO data for the specific type of joint replacement (use either the HOOS or KOOS Subscale or JR. survey); and the risk variable, Patient-Reported Pain in Non-operative Lower Extremity Joint. You do not need to re-collect the other risk variable data and can simply report these data for both procedures in the CJR PRO Data Collection Template. This same guidance applies to same-day (or simultaneous) procedures performed on different joints.

34. If my patient had a joint replacement procedure on the last day of a performance year and then had the opposite (or another) joint replacement procedure within 90 days of the first procedure in the following performance year, what data do we need to collect?

Data collection guidance for eligible staged procedures on either both hips or both knees, or on different joints that are performed within 90 days of each other can found in Question 34.

If the procedure (regardless if it is part of a staged plan) was performed within the eligible procedure window for a given PY, hospitals will need to collect pre-operative data and submit them in that given performance year. For example, if the first eligible staged procedure was performed on the last day in PY 1, then hospitals must collect pre-operative data for this procedure and submit the data in PY 1 to be considered for successful submission in PY 1. For the second procedure that is in PY 2 and occurred within 90 days of the first procedure, hospitals must collect pre-operative data for this second procedure and submit the data in PY 2 to be considered for successful submission in PY 2 of the CJR model. Post-operative data must then be collected on the patients within nine months to one year after the first procedure and the second procedure and submitted in the appropriate performance year of the model.

35. Are THA/TKA procedures performed at an outpatient or observation stay setting not eligible

for PRO and risk variable collection?

Only eligible elective primary THA/TKA procedures performed during inpatient hospitalizations are included in the PRO and risk variable data collection.

36. My hospital will perform more than the required eligible THA/TKA procedures during the performance year data collection timeframe. How should we sample our patients?

The CJR final rule does not specify how participant hospitals are to sample eligible procedures for PRO and risk variable data reporting.

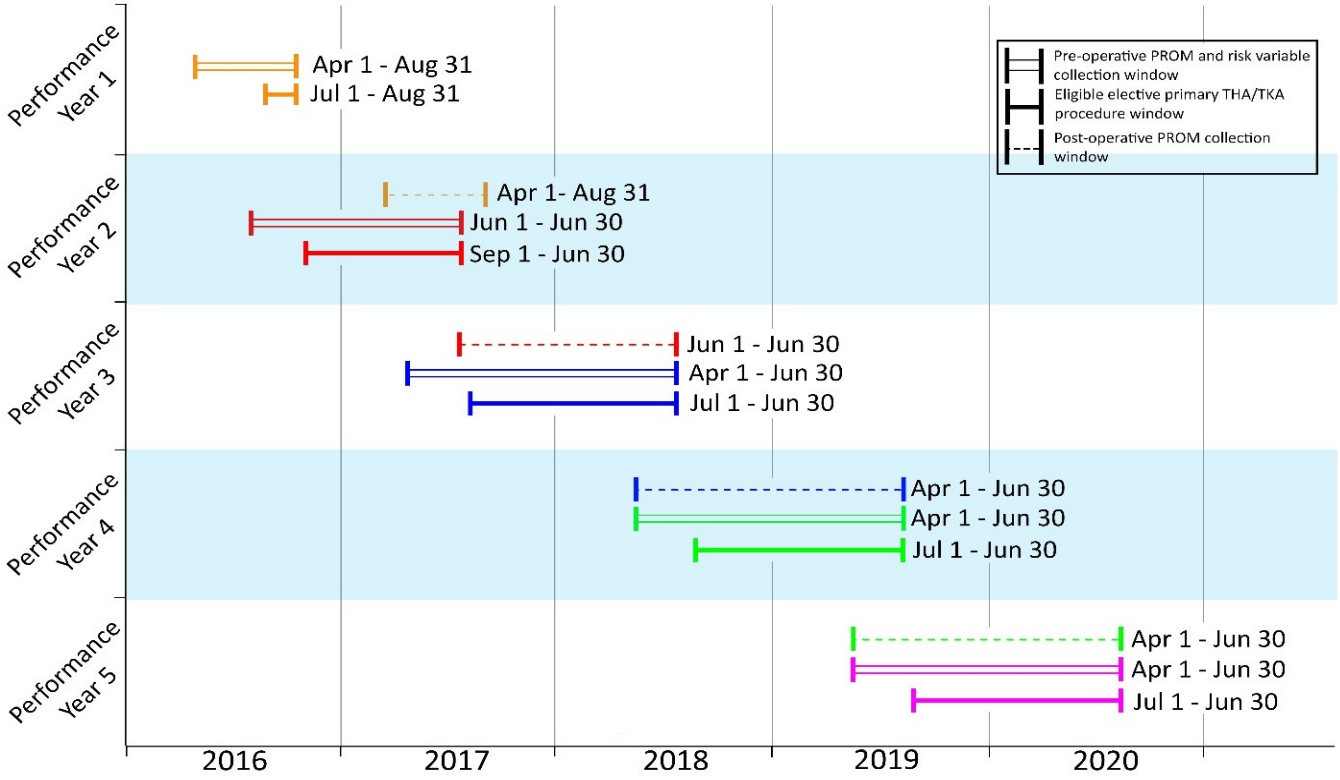
Please note, hospitals are strongly encouraged to collect pre-operative and risk variable data for more procedures than the required minimum. Doing this will increase a hospital's chances of successful submission: 1) in the present performance year, in case any of the procedures for which PRO data are submitted are considered ineligible, and 2) in the subsequent performance year, in case they are unable to collect post-operative data from one or more patients for which they have already collected pre-operative data.

PRO and Risk Variable Data Collection Timeframe

37. When should my hospital collect this data for CJR?

Hospitals should collect a patient's pre-operative data 90 days to 0 days prior to the patient's procedure. The hospital will then need to collect this patient's post-operative data 270 to 365 days after the patient's procedure. The time period for collecting pre- and post-operative data on eligible procedures for each performance year is presented in Figure 2. Figure 2 provides dates for the pre- and post-operative collection time periods for each performance year (double-barred and dashed lines, respectively). It also includes the defining dates for the period of eligible elective primary THA/TKA procedures in each performance year (solid lines).

Figure 2. Timeline for PRO and Risk Variable Data Collection by Performance Year



38. Can hospitals obtain the pre-operative data on the day of the procedure if they obtain it prior to the procedure?

Yes, pre-operative data can be collected up to 90 days before or on the day of the procedure.

39. What are the deadlines for PRO and risk variable data submission?

PRO and risk variable data is to be submitted "within 60 days of the end of the most recent data collection period" as stated in the 2015 CJR final rule (Section III.D.3.a.(9), page 73499). The last day of the data collection period for PY 5, for example, is June 30, 2020, which means that hospitals will have between July 1, 2020 to August 31, 2020 to submit their PRO and risk variable data for this performance year.

The data submission deadlines for each performance year of CJR are shown in Table 5. Table 5 provides the due dates for successful PRO and risk variable data ***submission***. It also reinforces that, in PYs 2-5, hospitals will submit post-operative data for the prior performance year's patients and pre-operative and risk variable data for the current year's patients in order to qualify as having successfully submitted PRO data.

Table 5. Deadlines for CJR PRO and Risk Variable Data Submission by Performance Year

	PY 1	PY 2	PY 3	PY 4	PY 5
Deadline	October 31, 2016	October 31, 2017	August 31, 2018	August 31, 2019	August 31, 2020
Data Being Submitted	Pre-Operative Data on PY 1 Patients	Post-Operative Data on PY 1 Patients *AND* Pre-Operative Data on PY 2 Patients	Post-Operative Data on PY 2 Patients *AND* Pre-Operative Data on PY 3 Patients	Post-Operative Data on PY 3 Patients *AND* Pre-Operative Data on PY 4 Patients	Post-Operative Data on PY 4 Patients *AND* Pre-Operative Data on PY 5 Patients

For the number or percent of eligible procedure requirements for each performance year, please refer back to Table 3.

40. Does the entire submission have to be completed in one transfer? For example, we have the majority of records complete but are following up on missing information for some other patients' demographics. May we submit the complete records now and the balance when that information is available as long as it is before the deadline?

CMS recommends that hospitals submit all PRO data in one file. If you need to make updates to the data, you can update your data and resubmit *prior to* the submission deadline. If you plan to update your files, please remember to include the version number of the file so that when an updated version is uploaded, we will be able to track this update; otherwise we will use the last file that was uploaded to determine successful submission.

Process for PRO and Risk Variable Data Submission for CJR Performance Years 3 to 5

41. My hospital is not yet registered for Managed File Transfer (MFT). How do we register?

To create a Managed File Transfer (MFT) account, first you must register for Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) access. New users can create a HARP account by visiting https://harp.qualitynet.org. For more information, please see the HARP Registration Instructions on *CJR Connect* under the Libraries tab. Once HARP access is granted, new users can log into their HARP account and register for MFT by visiting https://harp.qualitynet.org. For more information, please see the MFT Registration Instructions on *CJR Connect* under the Libraries tab.

42. If access to MFT has already been obtained for use in another CMS program, then re-registration for MFT if not required for the purposes for PRO data submission in the CJR model. How should we submit data in CJR performance year 5?

In PY 5 of the CJR model, all PRO and risk variable data should be collected and submitted in the CJR PRO Data Collection Template, an Excel (.xlsm) macro-enabled file. The most recent template is available on *CJR Connect* under the Libraries tab.

In PY 5, hospitals will use MFT to submit their PRO and risk variable data. This method is replacing the previous method, *QualityNet* Secure File Transfer (SFT). Details on how to submit the template

for PY 5 data submission can be found in the CJR PRO Guidance for Managed File Transfer available on *CJR Connect* under the Libraries tab.

43. Can PRO and risk variable data for multiple CCNs be submitted in one file, or must they be submitted as separate files?

For PYs 3-5, data for multiple CMS Certification Numbers (CCNs), previously known as a Medicare Provider Numbers, can be submitted in one file. Refer to Question 48 for details on naming and submitting a file containing data for multiple CCNs.

CJR PRO Data Collection Template for CJR Performance Years 3 to 5

44. Are there different CJR PRO Data Collection Template (Excel) spreadsheets for pre-operative and post-operative data, or will hospitals add the post-operative data to the same Excel spreadsheet submitted for the pre-operative data?

There is only one CJR PRO Data Collection Template (Excel) spreadsheet for pre-operative and post-operative data. You can find the latest version on *CJR Connect* under the Libraries tab. Pre- and post-operative data should be submitted together in one file.

45. Is there a method for registries or vendors to assist hospitals with uploading the PRO and risk variable data using *MFT*?

Since CJR PY 2, vendors could submit data on behalf of the hospitals. Hospitals will need to contact a vendor to sign a contract. Vendors will need to register for a HARP ID and MFT access in order to upload on behalf of hospitals. Instructions can be found on *CJR Connect*. Each vendor can create up to two accounts.

Hospitals are not required to submit their data to a joint replacement registry to meet the CJR successful submission criterion.

46. What is the correct format for the PRO data?

In PY 5 of the CJR model, all PRO and risk variable data should be collected and submitted in the CJR PRO Data Collection Template, an Excel (.xlsm) macro-enabled file.

47. How should I name my PRO data file?

For PY 5, hospitals need to use this file naming format or convention:
CJR_PY5_PROVID_MM_DD_YYYY_vXX.xlsm.

- The completed CJR PRO Data Collection Template should be renamed using “save as”.
- For “PROVID”, hospitals need to provide their hospitals’ Medicare Provider Number or CCN (6-digit; for example, 123456).
- For “MM_DD_YYYY”, hospitals need to provide the month, day, and year that represents the date that the file was submitted to enable file tracking (Along with an updated version number as noted immediately below).
- For “X” in “vXX”, hospitals need to provide the version number of their file, in the event

they are submitting updated versions (for example, v01 or v02)

- An example of what a hospital's PRO data file name can look like is: CJR_PY5_123456_07_31_2020_v1.xlsm.

Since PY 3, hospital systems, health systems and vendors will be able to submit a single file with records from more than one CCN. For PRO data files containing records with multiple CCNs, the following file naming format should be used: **CJR_PY5_PROVIDmulti_MM_DD_YYYY_vXX**.xlsm

- The completed CJR PRO Data Collection Template should be renamed using "save as".
- For "PROVIDmulti", identify the Medicare Provider Number or CCN (6-digit; for example, 456789) for one of the CCNs represented in the file, followed by the letters "multi" for multiple (for example, 456789multi).
- For "MM_DD_YYYY", hospitals need to provide the month, day, and year that represents the date that the file was submitted to enable file tracking (Along with an updated version number as noted immediately below).
- For "X" in "vXX", hospitals need to provide the version number of their file, in the event they are submitting updated versions (for example, v01 or v02).
- An example of what the name of a PRO data file containing records from multiple CCNs can look like is: CJR_PY5_456789multi_07_31_2020_v1.xlsm.

48. Is manual entry of data required, or can data be electronically captured and reformatted to meet the CJR PRO Data Collection Template format requirements?

CMS does not stipulate the method your hospital must use to collect the PRO and risk variable data or enter it into the CJR PRO Data Collection Template for submission. Hospitals are encouraged to use the data collection processes that work best for them. However, hospitals should note that manual data entry into the macro-enabled template makes evident the validation rules for each data element and guides data entry by preventing the user from entering invalid data (for example, only allows applicable dates into date fields). In addition, manual entry enables column "CY" of the template ("core elements missed") which identifies for the user whether any of the required core data elements are missing from the template for each procedure entered. Hospitals that choose not to enter data manually must ensure that the data populating the template conforms to the data specifications for each variable in the Template as per the CJR PRO Data Dictionary.

49. The template is not accepting the new patient identifiers (MBI) in the Medicare Identification (MEDID) column. What should I do?

There are two possible Medicare Fee-For-Service identifiers a patient may have:

1) Health Insurance Claim Number (HICN), including the Railroad Retirement Board number (for example, 123456789A) {to be entered in the MEDID column}.

2) MBI (for example, 1EG4-TE5-MK73) {to be entered without dashes in the MBI column}

The PRO Data Collection Template uses macros to give hospitals the best chance of entering required data elements successfully. The macros utilized in the MEDID column of the template will ensure that only the correctly formatted 10-12 digit (HIC Number) or a 7-12 digit Railroad Retirement Board number can be entered. If the number you are trying to enter looks more like the patient's Medicare Beneficiary Number (MBI), please enter it, without the dashes, in the column

next to MEDID labeled MBI. The 11-digit MBI has replaced the social security number (SSN)-based HIC Number on the new Medicare cards. For more information about the MBI, please visit: www.cms.gov/medicare/new-medicare-card/ or https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf.

Defining Successful Reporting of PRO and Risk Variable Data

50. If my hospital does not participate or does not meet the successful submission criteria, will my hospital be penalized and/or not be eligible for reconciliation payment?

Submission of PRO and risk variable data is not required for reconciliation payment eligibility in any year of the CJR model. However, CJR participant hospitals that successfully submit PRO and risk variable data per the requirements in section III.D.3.a.(9) of the 2015 CJR final rule may increase their financial opportunity under the model, since those that successfully submit these data can receive two points toward their composite quality score.

51. If my hospital receives a notification from *MFT* confirming that our message containing our submitted file was read or an email indicating our file was downloaded, does this mean that our hospital has met the PRO and risk variable submission criteria and will receive the additional two quality points?

No, a notification from MFT confirming that your message containing your submitted file was read or an email indicating your file was downloaded does not mean that the submission was successful. Successful submission, which qualifies a CJR model participant hospital to receive two points towards the hospital's composite quality score, will be determined during reconciliation for the performance year.

52. Do you base your percentage of success off the number of pre-operative submissions the year before or do you base them off the total number of eligible patients from the year before? For example, if I submitted 120 patients last year (PY 4) and I captured 100 patients this year, would my success rate be 100/120=83% success? Or, if there were a total number of 150 eligible patients the year before, would I calculate 100/150=67% success.

The denominator for post-operative data collection is based on the total number of eligible procedures performed during the previous performance year. For PY 5 data submission, the post-operative denominator will be the number of eligible procedures performed at your location during PY 4 (July 1, 2018 to June 30, 2019). In addition to being complete and successful themselves, post-operative PRO submissions must also match to a complete and successful pre-operative data submission for the same procedure.

In your hypothetical question above, if there were 150 eligible procedures performed at your hospital during PY 4, and in PY 5 you submitted complete and successful PRO data for 100 patients that matched to patients that had complete and successful submissions for their PY 4 pre-operative submission, we would calculate your success at 100 procedures or 67%, and you would be unsuccessful in your PY 5 post-operative data submission.

To increase the chances of success within a PY and future PYs, hospitals are encouraged to submit data that exceeds the post-operative and pre-operative threshold requirements.

Post-Submission Follow-Up with Hospitals

53. Following data submission, what information will CMS provide to hospitals that participate in reporting of PRO and risk variable data?

CMS will notify hospitals on whether their institution meets the successful criteria for the reporting of PRO and risk variable data component of the CJR model for each performance year of the model in their reconciliation reports. As CMS continues to develop the THA/TKA PRO-PM, CMS will make all key methodological considerations and decisions transparent to the public through conventional measure development pathways (such as technical expert panels, public comment periods, and stakeholder calls).

54. Will CMS publicly display hospitals' participation in the reporting of PRO and risk variable data?

CMS will acknowledge hospitals that successfully submitted PRO and risk variable data per the requirements in section III.D.3.a.(9) of the 2015 CJR final rule on the *Hospital Compare* website. Detailed data results will not be publicly reported.

Additional Resources

55. What other resource documents are available for individuals seeking more information on CJR's PRO and risk variable data reporting and patient-reported outcome measures?

CMS has created additional resources for CJR hospitals interested in participating in the reporting of PRO and risk variable data. These resources, described in the following list, are available on *CJR Connect* under the Libraries tab or on CMS's Measure Methodology webpage in the "Hip and Knee Arthroplasty Patient-Reported Outcomes" folder. As needed, CMS will continue to add future resources for stakeholders to the *CJR Connect* site or to the Measure Methodology webpage.

- For more information regarding the rationale for collecting PRO data and the basic requirements to participate, please refer to the CJR PRO Data Collection Overview document.
- For information about each performance year's data collection and submission timeframe, please view the CJR PRO Data Collection Timeline & Submission Deadlines document.
- For information on the CJR PRO and risk variable data specifications for collection, please refer to the CJR PRO Data Collection Template and CJR PRO Data Dictionary files, along with their user guides.
- For hospitals electing to use the Veterans RAND 12 (VR-12) survey to fulfill the use of a generic PRO survey requirement, CMS has provided the "CJR PRO Veterans RAND 12 (VR-12) Read Me" on *CJR Connect*. The Read Me file contains a template letter and abstract for hospitals to fill out and submit when requesting the VR-12 survey.
- For outreach materials to provide to your patients, please find the CJR PRO Brochure for Patients and CJR PRO Postcard for Patients. These materials are education and reminder resources for hospitals to download, customize, and provide to patients.

56. I have additional CJR-related questions. What resources are available to CJR participant hospitals?

For more information about the CJR model, please visit the CMS Comprehensive Care for Joint Replacement Model webpage at https://innovation.cms.gov/initiatives/cjr. On this site, you can download the Quality Supplemental document and other CJR resources.

For questions about the CJR model, please direct your inquiries to the CMS CJR Model Support Team at CJRSupport@cms.hhs.gov.

For the 2015 CJR model final regulation, please visit the Federal Register website at https://www.federalregister.gov/documents/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals.

For PRO and risk variable data collection resources, please visit:

- The *CJR Connect* site at https://app.innovation.cms.gov/CJRConnect/CommunityLogin. PRO data collection resources are available in the PRO Data Collection content pack in the Libraries tab for download; or
- The CMS Measure Methodology website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html. PRO data collection resources are found in the "Hip and Knee Arthroplasty Patient-Reported Outcomes" folder for download. For questions or technical support using HARP/MFT, please direct your inquiries to the QualityNet Service Desk contact:
    - Email: qnetsupport@hcqis.org
    - Phone: 1-866-288-8912 (TTY 1-877-715-6222) from 7:00 AM to 7:00 PM CT Monday through Friday