



Centers for Medicare & Medicaid Services

CMS Implementation Guide for Quality Reporting Document Architecture Category I

Hospital Quality Reporting Implementation Guide for 2022

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QRDA Guide Overview

1 Introduction

1.1 Overview

The Health Level Seven International (HL7) Quality Reporting Document Architecture (QRDA) defines constraints on the HL7 Clinical Document Architecture Release 2 (CDA R2). QRDA is a standard document format for the exchange of electronic clinical quality measure (eCQM) data. QRDA reports contain data extracted from electronic health records (EHRs) and other information technology systems. The reports are used for the exchange of eCQM data between systems for quality measurement and reporting programs.

This QRDA guide contains the Centers for Medicare & Medicaid Services (CMS) implementation guide to the *HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture Category I, Release 1, Standard for Trial Use (STU) Release 5.2, US Realm*, and any subsequent errata update¹, for the 2022 reporting year.

1.2 Organization of the Guide

Chapter 1 and Chapter 2 contain introductory material that pertains to this guide.

- Chapter 1: Introduction
- Chapter 2: Conformance Conventions Used in This Guide — describes the formal representation of templates and additional information necessary to understand and correctly implement the content found in this guide

Chapter 3 to Chapter 6 contain technical specifications for the QRDA I STU R5.2 CMS Implementation Guide for Hospital Quality Reporting

- Chapter 3: Overview
- Chapter 4: QRDA Category I Requirements — information on succession management, value sets, and time zones
- Chapter 5: QRDA Category I Validation — contains the formal definitions for the QRDA Category I Report:
 - Document-level template that defines the document type and header constraints specific to CMS reporting
 - Section-level templates that define measure reporting, reporting parameters, and patient data
 - Additional validations rules performed by the HQR system
- Chapter 6: Hybrid Measure/CCDE Voluntary Submission — guidance on hybrid measure/core clinical data element voluntary submission.

APPENDIX

- Chapters 7-16 provide references and resources, including a change log of changes made to the QRDA Category I base standard to produce the CMS Implementation Guide, a change log for the 2022 CMS QRDA IG for HQR programs from the 2021 CMS

¹ HL7 QRDA I R1 STU R5.2 and any subsequent errata update.

http://www.hl7.org/implement/standards/product_brief.cfm?product_id=35

QRDA IG, and validation rules for data types, National Provider Identifier (NPI), and Tax Identification Number (TIN).

2 Conformance Conventions Used in This Guide

2.1 Conformance Verbs (Keywords)

The keywords **SHALL**, **SHOULD**, **MAY**, **NEED NOT**, **SHOULD NOT**, and **SHALL NOT** in this guide are to be interpreted as follows:

- **SHALL**: an absolute requirement for the particular element. Where a **SHALL** constraint is applied to an Extensible Markup Language (XML) element, that element must be present in an instance, but may have an exceptional value (i.e., may have a `nullFlavor`), unless explicitly precluded. Where a **SHALL** constraint is applied to an XML attribute, that attribute must be present, and must contain a conformant value.
- **SHALL NOT**: an absolute prohibition against inclusion.
- **SHOULD/SHOULD NOT**: best practice or recommendation. There may be valid reasons to ignore an item, but the full implications must be understood and carefully weighed before choosing a different course.
- **MAY/NEED NOT**: truly optional; can be included or omitted as the author decides with no implications.

2.2 Cardinality

The cardinality indicator (0..1, 1..1, 1..*, etc.) specifies the allowable occurrences within a document instance. The cardinality indicators are interpreted with the following format "m...n" where m represents the least and n the most:

- 0..1 zero or one
- 1..1 exactly one
- 1..* at least one
- 0..* zero or more
- 1..n at least one and not more than n

When a constraint has subordinate clauses, the scope of the cardinality of the parent constraint must be clear. In Figure 1, the constraint says exactly one participant is to be present. The subordinate constraint specifies some additional characteristics of that participant.

Figure 1: Constraints Format – only one allowed

- | |
|--|
| <ol style="list-style-type: none"> 1. SHALL contain exactly one [1..1] participant (CONF:2777). <ol style="list-style-type: none"> a. This participant SHALL contain exactly one [1..1] @typeCode="LOC" (CodeSystem: 2.16.840.1.113883.5.90 HL7ParticipationType) (CONF:2230). |
|--|

In Figure 2, the constraint says only one participant “like this” is to be present. Other participant elements are not precluded by this constraint.

Figure 2: Constraints Format – only one like this allowed

- | |
|---|
| <ol style="list-style-type: none"> 1. SHALL contain exactly one [1..1] participant (CONF:2777) such that it <ol style="list-style-type: none"> a. SHALL contain exactly one [1..1] @typeCode="LOC" (CodeSystem: 2.16.840.1.113883.5.90 HL7ParticipationType) (CONF:2230). |
|---|

2.3 Null Flavor

Information technology solutions store and manage data, but sometimes data are not available; an item may be unknown, not relevant, or not computable or measurable. In HL7, a flavor of null, or `nullFlavor`, describes the reason for missing data. Please note that although `nullFlavor` may be allowed to be entered in a field, the absence of the actual data for data elements necessary for eCQM calculations may compromise calculation results.

Figure 3: nullFlavor Example

```
<raceCode nullFlavor="ASKU"/>
<!--coding a raceCode when the patient declined to specify his/her
race-->

<raceCode nullFlavor="UNK"/>
<!--coding a raceCode when the patient's race is unknown-->
```

Use null flavors for unknown, required, or optional attributes:

- **NI** No information. This is the most general and default null flavor.
- **NA** Not applicable. Known to have no proper value (e.g., last menstrual period for a male).
- **UNK** Unknown. A proper value is applicable, but is not known.
- **ASKU** Asked, but not known. Information was sought, but not found (e.g., the patient was asked but did not know).
- **NAV** Temporarily unavailable. The information is not available, but is expected to be available later.
- **NASK** Not asked. The patient was not asked.
- **MSK** There is information on this item available but it has not been provided by the sender due to security, privacy, or other reasons. There may be an alternate mechanism for gaining access to this information.
- **OTH** The actual value is not and will not be assigned a standard coded value. An example is the name or identifier of a clinical trial.

This list contains those null flavors that are commonly used in clinical documents. For the full list and descriptions, see the `nullFlavor` vocabulary domain in the HL7 standard, *Clinical Document Architecture, Release 2.0*².

Any **SHALL** conformance statement may use `nullFlavor`, unless the attribute is required or the `nullFlavor` is explicitly disallowed. **SHOULD** and **MAY** conformance statements may also use `nullFlavor`.

² HL7 CDA Release 2.0 Normative Edition
https://www.hl7.org/implement/standards/product_brief.cfm?product_id=496

QRDA I STU R5.2 CMS Implementation Guide for Hospital Quality Reporting

3 Overview

3.1 Background

This guide is a CMS Quality Reporting Document Architecture Category I (QRDA I) implementation guide to the *HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture Category I, Release 1, STU Release 5.2*, and any subsequent errata update, referred to as the HL7 QRDA I STU R5.2 in this guide. This guide describes additional conformance statements and constraints for EHR data submissions that are required for reporting information to the CMS for the Hospital Inpatient Quality Reporting Program 2022 Reporting Period.

The purpose of this guide is to serve as a companion to the base HL7 QRDA I STU R5.2 for entities such as Eligible Hospitals (EH), Critical Access Hospitals (CAH), and vendors to submit QRDA I data for consumption by CMS systems including for Hospital Quality Reporting (HQR).

Each QRDA Category I report contains quality data for one patient for one or more quality measures, where the data elements in the report are defined by the particular measure(s) being reported on. A QRDA Category I report contains raw applicable patient data. When pooled and analyzed, each report contributes the quality data necessary to calculate population measure metrics.

3.2 How to Read This QRDA I Guide

CMS will process Clinical Quality Measure (CQM) QRDA I documents originating from EHR systems. Submitted QRDA I documents for HQR in the 2022 reporting period must meet the conformance statements specified in this guide in addition to the conformance statements specified in the HL7 QRDA I STU R5.2. Only documents that are valid against the CDA Release 2 schema enhanced to support the *urn:hl7-org:sdtc* namespace (CDA_SDTC.xsd)³ will be accepted for processing. Documents that are invalid against this rule will be rejected.

This guide is based on following rules:

1. The HL7 QRDA I STU R5.2 provides information about QRDA data elements with conformance numbers and constraints. Some of these existing conformance restrictions have been modified in accordance with CMS system requirements. The "CMS_" prefix (e.g., CMS_0001) indicates the new conformance statements. The "_C01" postfix indicates that the conformance statement from the base HL7 QRDA I STU R5.2 standard is further constrained in this guide.
2. The original **SHALL/SHOULD/MAY** keywords along with conformance numbers from the HL7 QRDA I STU R5.2 for relevant data elements and attributes have been included in this guide for ease of reference. For brevity, the hierarchy of enclosing elements has not been shown.

³ CDA_SDTC.xsd is available as part of the HL7 QRDA I STU R5.2 with errata standard package (http://www.hl7.org/implement/standards/product_brief.cfm?product_id=35).

4 QRDA Category I Requirements

4.1 QRDA Category I Reporting

The HL7 QRDA I STU R5.2 base standard allows either one or multiple measures to be reported in a QRDA I document. For HQR, there should be one QRDA I report per patient for the facility CMS Certification Number (CCN).

4.2 eCQM, Hybrid Measure, and Value Set Specifications

The eCQM Specifications for Hospital Quality Reporting May 2021⁴, and any applicable addenda, must be used for the HQR programs for the 2022 Reporting Period.

The eCQM Value Sets for Eligible Hospitals May 2021⁵, and any applicable addenda, published at the Value Set Authority Center (VSAC) must be used for the HQR programs for the 2022 Reporting Period.

For hybrid measure/core clinical data element (CCDE) voluntary submission, this guide must be used for reporting of 2022 - 2023 data (measurement period July 1, 2022 through June 30, 2023) and to be submitted in 2023. The 2022 Reporting Period hybrid measure specifications must be used.⁶

4.3 Succession Management

This section describes the management of successive replacement documents for QRDA I reports. For example, a submitter notices an error in an earlier submission and wants to replace it with a corrected version.

4.3.1 QRDA I Report Document Succession Management for HQR

For HQR, the QRDA I document/id convention is not used for Document Succession Management. Rather, HQR allows file resubmission to update a previously submitted file. The most recently submitted and accepted production QRDA I file will overwrite the original file based on the exact match of five key elements identifying the file: CCN, CMS Program Name, EHR Patient ID, EHR Submitter ID⁷, and the reporting period specified in the Reporting Parameters Section. The new file must be cumulative and contain all the patient data for the same reporting period not only the corrected or new data. In the event that any of the five key identifiers are incorrect, the HQR system provides the user with the capability to delete a previously submitted file.

⁴ eCQI Resource Center, Eligible Hospital/Critical Access Hospital eCQMs web page. <https://ecqi.healthit.gov/eh-cah>. Select the EH/CAH eCQMs tab, then select 2022 Reporting Period.

⁵ Value Set Authority Center, VSAC Downloadable Resources web page.

<https://vsac.nlm.nih.gov/download/ecqm>. Select 2022 Reporting/Performance Period eCQM Value Sets.

⁶ eCQI Resource Center, Eligible Hospital/Critical Access Hospital eCQMs web page.

<https://ecqi.healthit.gov/eh-cah>. Select the Hybrid Measures tab, then select 2022 Reporting Period.

⁷ The EHR Submitter ID is the ID that is assigned by QualityNet to submitter entities upon registering into the system and will be used to upload QRDA I files. It is not submitted as an element in the QRDA I report. For vendors, the EHR Submitter ID is the Vendor ID; for hospitals, the EHR Submitter ID is the hospital's CCN.

4.3.2 Program Identifiers used in Succession Management

The CMS program name requirement for QRDA I submission is specified in [5.1.4 informationRecipient](#). Each QRDA I report **must** contain only one CMS program name, which shall be selected from the [QRDA I CMS Program Name value set \(2.16.840.1.113883.3.249.14.103\)](#) for the 2022 reporting period specified in this guide.

4.4 Value Sets

4.4.1 eCQM Specified Value Sets Take Precedence

There are some cases where the value sets specified in eCQMs for clinical quality data criteria do not align with the value sets of the corresponding data elements specified in the QRDA I standard, or they are subsets of the value sets that are specified in the QRDA I standard. In these cases, the value sets that are specified in eCQMs always take precedence. For example, the routeCode attribute is defined to be selected from the SPL Drug Route of Administration Terminology value set (2.16.840.1.113883.3.88.12.3221.8.7) in QRDA templates, but an eCQM criterion uses value set "Intravenous route" (2.16.840.1.113883.3.117.1.7.1.222). In this case, the "Intravenous route" (2.16.840.1.113883.3.117.1.7.1.222) value set shall take precedence over the "SPL Drug Route of Administration Terminology" (2.16.840.1.113883.3.88.12.3221.8.7) value set in constructing a QRDA I document.

4.4.2 Value Sets Codes Case Sensitive

Codes from some code systems contain alpha characters (e.g., the ONC Administrative Sex value set contains codes "F" for Female and "M" for Male). Case of these alpha characters will be validated by the HQR systems. How codes are displayed in the Vocabulary file (voc.xml) and VSAC and in the VSAC exports will serve as the source of truth for conducting the case validations for value sets specified in eCQM specifications. For example, for a particular code, if alpha characters in this code were shown as upper case in VSAC or the Vocabulary file (voc.xml), then the validation will require them to be upper case.

4.5 Time Zone

Time comparisons or elapsed time calculations are frequently involved as part of determining measure population outcomes.

Table 1: Time Zone Validation Rule

| CONF. # | Rules |
|----------|--|
| CMS_0121 | A Coordinated Universal Time (UTC time) offset should not be used anywhere in a QRDA Category I file or, if a UTC time offset is needed anywhere, then it *must* be specified *everywhere* a time field is provided. |

This time zone validation rule (Table 1) is performed on the following elements:

- effectiveTime/@value
- effectiveTime/low/@value
- effectiveTime/high/@value
- time/@value
- time/low/@value
- time/high/@value

There are two exceptions to this validation rule:

- The `effectiveTime` element of the `Reporting Parameters Act - CMS template` (CONF:CMS_0027 and CONF:CMS_0028) will not be validated using this time zone validation rule:


```
act[@templateId="2.16.840.1.113883.10.20.17.3.8.1"][@extension="2016-03-01"]/effectiveTime/low
act[@templateId="2.16.840.1.113883.10.20.17.3.8.1"][@extension="2016-03-01"]/effectiveTime/high
```
- The time zone validation rule is not performed on `birthTime/@value`

Figure 4: Time Zone Example

```
<!-- This is an example when timezone offset is provided -->
<encounter>
  <text>Encounter Performed: Hospital Measures-Encounter
  Inpatient</text>
  ...
  <effectiveTime>
    <!-- Attribute: admission datetime -->
    <low value="202203250930-0500"/>
    <!-- Attribute: discharge datetime -->
    <high value="202203291052-0500"/>
  </effectiveTime>
  ...
</encounter>
```

4.6 Submit eCQM Version Specific Measure Identifier ONLY

For the 2022 Reporting Period, only the eCQM Version Specific Measure Identifier is required to uniquely identify the version of an eCQM. The eCQM Version Specific Measure Identifier must be submitted in QRDA I.

It is recommended that eCQM Version Numbers not be included in QRDA submissions. This is due to a known data type mismatch issue between the HL7 QRDA and Health Quality Measure Format (HQMF) standards for the *versionNumber* attribute. The QRDA I standard is based on HL7 CDA R2, which is derived from the HL7 Reference Information Model (RIM) Version 2.07. In RIM 2.07, the *versionNumber* attribute is specified as INT data type. HQMF R1 Normative, however, is derived from HL7 RIM, Version 2.44, where *versionNumber* is specified as ST data type. The version numbers for eCQM Specifications for Hospital Quality Reporting for the 2021 reporting period generated by the Measure Authoring Tool (MAT) are string values such as 8.2.000 instead of integers such as 8. If a version number such as 8.2.000 were submitted, the QRDA files will fail the CDA_SDTC.xsd schema validation and will be rejected by the receiving systems. If the *versionNumber* attribute is supplied as an INT value, the file will not be rejected, but the value will be ignored.

4.7 Templates Versioning and Validations

Both the base HL7 QRDA I STU R5.2 and the CMS QRDA I implementation guide have versioned the templates by assigning a new date value to the `templateId` extension attribute if changes were made to the previous version of the template. Details about CDA templates versioning in general are described in 4.1.3 Template Versioning of the HL7 QRDA I STU R5.2. For example, in HL7 QRDA I STU R5.2, the previous `Procedure Performed (V5)` template is now `Procedure Performed (V6)`, and its template identifier is "2.16.840.1.113883.10.20.24.3.64:2019-12-01". Both the `@root` and `@extension` are required as specified in the IG.

- SHALL** contain exactly one [1..1] `templateId` (CONF:4444-11262) such that it
- a. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.10.20.24.3.64"` (CONF:4444-11263).
 - b. **SHALL** contain exactly one [1..1] `@extension="2019-12-01"` (CONF:4444-27129).

Correct template versions that are specified by both the base HL7 QRDA I STU R5.2 and the 2022 CMS IG must be used for 2022 CMS QRDA I submissions. For instance, if a QRDA I file used `Procedure Performed (V5)` instead of `Procedure Performed (V6)`, this older version of the template will be ignored by the CMS receiving system. Data submitted using template versions that are not specifically required by the base HL7 QRDA I STU R5.2 and the 2022 CMS QRDA I IG will not be processed by the CMS receiving system; this could lead to unexpected results in measure calculations. Submitters should ensure correct template versions are used and be aware of the consequences if wrong versions are used.

5 QRDA Category I Validation

5.1 Document-Level Template: QRDA Category I Report - CMS

This section defines the document-level templates in a QRDA I document. All of the templates in the HL7 QRDA I STU R5.2 are Clinical Document Architecture (CDA) templates.

5.1.1 General Header

This template describes header constraints that apply to the QRDA Category I document.

Table 2: QRDA Category I Report - CMS (V7) Constraints Overview
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|---------------|-------|-------|-----------|---------------------------|---|
| templateId | 1..1 | SHALL | | CMS_0001 | |
| @root | 1..1 | SHALL | | CMS_0002 | 2.16.840.1.113883.10.20.24.1.3 |
| @extension | 1..1 | SHALL | | CMS_0003 | 2020-02-01 |
| id | 1..1 | SHALL | | 1198-5363 | |
| effectiveTime | 1..1 | SHALL | | 1198-5256 | US Realm Date and Time (DTM.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) |
| languageCode | 1..1 | SHALL | | 1198-5372 | urn:oid:2.16.840.1.113883.1.11.11526 (Language) |
| @code | 1..1 | SHALL | | CMS_0010 | en |

1. Conforms to QDM-Based QRDA (V7) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.2:2019-12-01).
2. **SHALL** contain exactly one [1..1] `templateId` (CONF:CMS_0001) such that it
 - a. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.10.20.24.1.3"` (CONF:CMS_0002).
 - b. **SHALL** contain exactly one [1..1] `@extension="2020-02-01"` (CONF:CMS_0003).
3. **SHALL** contain exactly one [1..1] `id` (CONF:1198-5363).
 - a. This `id` **SHALL** be a globally unique identifier for the document (CONF:1198-9991).
4. **SHALL** contain exactly one [1..1] US Realm Date and Time (DTM.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.4) (CONF:1198-5256).
5. **SHALL** contain exactly one [1..1] `languageCode`, which **SHALL** be selected from ValueSet Language urn:oid:2.16.840.1.113883.1.11.11526 **DYNAMIC** (CONF:1198-5372).
 - a. This `languageCode` **SHALL** contain exactly one [1..1] `@code="en"` (CONF:CMS_0010).

Figure 5: CMS 2021 QRDA I Document Header Example

```
<ClinicalDocument>
  <realmCode code="US"/>
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <!-- US Realm Header (V3) -->
  <templateId root="2.16.840.1.113883.10.20.22.1.1"
extension="2015-08-01"/>
  <!-- QRDA Category I Framework (V4) -->
  <templateId root="2.16.840.1.113883.10.20.24.1.1"
extension="2017-08-01"/>
  <!-- QDM-based QRDA (V7) -->
  <templateId root="2.16.840.1.113883.10.20.24.1.2"
extension="2019-12-01"/>
  <!-- QRDA Category I Report - CMS (V7) -->
  <templateId root="2.16.840.1.113883.10.20.24.1.3"
extension="2020-02-01"/>
  <!-- This is the globally unique identifier for this QRDA I
document -->
  <id root="90ac1923-1b8a-453c-b172-9ced6265062b"/>
  <code code="55182-0" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC" displayName="Quality Measure Report"/>
  <title>Good Health QRDA I Report</title>
  <!-- This is the document creation time -->
  <effectiveTime value="20220201"/>
  <confidentialityCode code="N" codeSystem="2.16.840.1.113883.5.25"
codeSystemName="HL7Confidentiality"/>
  <languageCode code="en"/>
  ...
</ClinicalDocument>
```

5.1.2 recordTarget

The `recordTarget` records the patient whose health information is described by the clinical document; it must contain at least one `patientRole` element.

Table 3: recordTarget Constraints Overview
ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|--------------------------|-------|-------|-----------|--|--|
| @extension | 1..1 | SHALL | | CMS 0103 | |
| @root | 1..1 | SHALL | | 4444-16858 | 2.16.840.1.113883.4.572 |
| @root | 1..1 | SHALL | | CMS 0053 | |
| @root | 1..1 | SHALL | | 4444-28698 | 2.16.840.1.113883.4.927 |
| addr | 1..* | SHALL | | 1198-5271 | US Realm Address (AD.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2) |
| administrativeGenderCode | 1..1 | SHALL | | CMS 0011 CMS 0029 | urn:oid:2.16.840.1.113762.1.4.1 (ONC Administrative Sex) |

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|-----------------|-------|--------|-----------|--|--|
| birthTime | 1..1 | SHALL | | 1198-5298 1198-5300_C01 1198-32418 | |
| ethnicGroupCode | 1..1 | SHALL | | 1198-5323 CMS_0032 CMS_0033 | urn:oid:2.16.840.1.114222.4.11.837 (Ethnicity) |
| id | 0..1 | SHOULD | | 4444-16857_C01 | |
| id | 1..1 | SHALL | | CMS_0009 | |
| id | 0..1 | SHOULD | | 4444-28697_C01 | |
| name | 1..1 | SHALL | | 1198-5284_C01 | US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) |
| patient | 1..1 | SHALL | | 4444-27570 | |
| patientRole | 1..1 | SHALL | | 4444-16856 | |
| raceCode | 1..1 | SHALL | | CMS_0013 CMS_0030 CMS_0031 | urn:oid:2.16.840.1.114222.4.11.836 (Race) |
| recordTarget | 1..1 | SHALL | | 4444-16598 | |
| sdtc:raceCode | 0..* | MAY | | CMS_0014 | urn:oid:2.16.840.1.114222.4.11.836 (Race) |

1. **SHALL** contain exactly one [1..1] `recordTarget` (CONF:4444-16598).
 - a. This `recordTarget` **SHALL** contain exactly one [1..1] `patientRole` (CONF:4444-16856).

HQR: Medicare HIC Number is not required for HQR but should be submitted if the payer is Medicare and the patient has an HIC number assigned.

- i. This `patientRole` **SHOULD** contain zero or one [0..1] `id` (CONF:4444-16857_C01) such that it
 1. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.4.572"` Medicare HIC number (CONF:4444-16858).

HQR: Patient Identification Number is required for HQR.

- ii. This `patientRole` **SHALL** contain exactly one [1..1] `id` (CONF:CMS_0009) such that it

1. **SHALL** contain exactly one [1..1] `@root` (CONF:CMS_0053).
Note: This is the provider's organization OID or other non-null value different than the OID for the Medicare HIC Number (2.16.840.1.113883.4.572) and the OID for the Medicare Beneficiary Identifier (2.16.840.1.113883.4.927).
2. **SHALL** contain exactly one [1..1] `@extension` (CONF:CMS_0103).
Note: The value of `@extension` is the Patient ID.

HQR: Medicare Beneficiary Identifier (MBI) is not required for HQR but should be submitted if the payer is Medicare and the patient has an MBI number assigned.

- iii. This patientRole **SHOULD** contain zero or one [0..1] `id` (CONF:4444-28697_C01) such that it
 1. **SHALL** contain exactly one [1..1]
`@root="2.16.840.1.113883.4.927"` Medicare Beneficiary Identifier (MBI) (CONF:4444-28698).
- iv. This patientRole **SHALL** contain at least one [1..*] US Realm Address (AD.US.FIELDDED) (`identifier: urn:oid:2.16.840.1.113883.10.20.22.5.2`) (CONF:1198-5271).
- v. This patientRole **SHALL** contain exactly one [1..1] `patient` (CONF:4444-27570).
 1. This patient **SHALL** contain exactly one [1..1] US Realm Person Name (PN.US.FIELDDED) (`identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1`) (CONF:1198-5284_C01).
 2. This patient **SHALL** contain exactly one [1..1] `administrativeGenderCode`, which **SHALL** be selected from ValueSet `ONC Administrative Sex` (`urn:oid:2.16.840.1.113762.1.4.1` **DYNAMIC** (CONF:CMS_0011).
 - a. If the patient's administrative sex is unknown, `nullFlavor="UNK"` **SHALL** be submitted (CONF:CMS_0029).
 3. This patient **SHALL** contain exactly one [1..1] `birthTime` (CONF:1198-5298).
 - a. **SHALL** be precise to day (CONF:1198-5300_C01).

For cases where information about newborn's time of birth needs to be captured.

- b. **MAY** be precise to the minute (CONF:1198-32418).
4. This patient **SHALL** contain exactly one [1..1] `raceCode`, which **SHALL** be selected from ValueSet `Race` (`urn:oid:2.16.840.1.114222.4.11.836` **DYNAMIC** (CONF:CMS_0013).
 - a. If the patient's race is unknown, `nullFlavor="UNK"` **SHALL** be submitted (CONF:CMS_0030).
 - b. If the patient declined to specify his/her race, `nullFlavor="ASKU"` **SHALL** be submitted (CONF:CMS_0031).
5. This patient **MAY** contain zero or more [0..*] `sdtc:raceCode`, which **SHALL** be selected from ValueSet `Race` (`urn:oid:2.16.840.1.114222.4.11.836` **DYNAMIC** (CONF:CMS_0014).
Note: If a patient has more than one race category, one race is

reported in raceCode, and additional races are reported using sdtc:raceCode.

6. This patient **SHALL** contain exactly one [1..1] **ethnicGroupCode**, which **SHALL** be selected from ValueSet **Ethnicity** urn:oid:2.16.840.1.114222.4.11.837 **DYNAMIC** (CONF:1198-5323).
 - a. If the patient's ethnicity is unknown, nullFlavor="UNK" **SHALL** be submitted (CONF:CMS_0032).
 - b. If the patient declined to specify his/her ethnicity, nullFlavor="ASKU" **SHALL** be submitted (CONF:CMS_0033).

Figure 6: recordTarget Example, QRDA Category I Report - CMS (V7)

```

<recordTarget>
  <patientRole>
    <!-- Patient Identifier Number. The root OID could be provider's
      organization OID or other value -->
    <id root="2.16.840.1.113883.123.123.1" extension="022354"/>
    <addr use="HP">
      <streetAddressLine>101 North Pole Lane</streetAddressLine>
      <city>Ames</city>
      <state>IA</state>
      <postalCode>50014</postalCode>
      <country>US</country>
    </addr>
    <telecom use="WP" value="tel:+1-781-271-3000"/>
    <patient>
      <name>
        <given>Jane</given>
        <family>Doe</family>
      </name>
      <administrativeGenderCode code="F"
        codeSystem="2.16.840.1.113883.5.1"/>
      <!-- If the patient administrative sex is unknown, use
        nullFlavor="UNK" -->
      <!-- <administrativeGenderCode nullFlavor="UNK"/> -->
      <birthTime value="19460102"/>
      <!-- raceCode "2131-1 (Other Race)" shall not be used for
        either raceCode or sdtc:raceCode -->
      <raceCode code="2106-3" codeSystem="2.16.840.1.113883.6.238"/>
      <!-- if the patient declined to specify his/her race, use
        nullFlavor="ASKU" -->
      <!-- <raceCode nullFlavor="ASKU"/> -->
      <!-- if the patient's race is unknown, use nullFlavor="UNK" -->
      <!-- <raceCode nullFlavor="UNK"/> -->
      <!-- Use sdtc:raceCode only if the patient has more than one
        race category -->
      <!-- <sdtc:raceCode code="2054-5"
        codeSystem="2.16.840.1.113883.6.238"/> -->
      <ethnicGroupCode code="2186-5"
        codeSystem="2.16.840.1.113883.6.238"/>
      <!-- if the patient declined to specify his/her ethnicity, use
        nullFlavor="ASKU" -->
      <!-- <ethnicGroupCode nullFlavor="ASKU"/> -->
      <!-- if the patient's ethnicity is unknown, use
        nullFlavor="UNK" -->
      <!-- <ethnicGroupCode nullFlavor="UNK"/> -->
    </patient>
  </patientRole>
</recordTarget>

```

5.1.3 Custodian

The **custodian** element represents the organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document.

Table 4: Custodian Constraints Overview

ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|----------------------------------|-------|-------|-----------|--|-------------------------|
| custodian | 1..1 | SHALL | | 4444-16600 | |
| assignedCustodian | 1..1 | SHALL | | 4444-28239 | |
| representedCustodianOrganization | 1..1 | SHALL | | 4444-28240 | |
| id | 1..1 | SHALL | | 4444-28241_C01 | |
| @root | 1..1 | SHALL | | 4444-28244 | 2.16.840.1.113883.4.336 |
| @extension | 1..1 | SHALL | | 4444-28245 CMS_0035 | |

1. **SHALL** contain exactly one [1..1] `custodian` (CONF:4444-16600).
 - a. This custodian **SHALL** contain exactly one [1..1] `assignedCustodian` (CONF:4444-28239).
 - i. This assignedCustodian **SHALL** contain exactly one [1..1] `representedCustodianOrganization` (CONF:4444-28240).

HQR: This `representedCustodianOrganization id/@root='2.16.840.1.113883.4.336'` coupled with the `id/@extension` represents the organization's Facility CMS Certification Number (CCN). CCN is required for HQR.

1. This `representedCustodianOrganization` **SHALL** contain exactly one [1..1] `id` (CONF:4444-28241_C01) such that it
 - a. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.4.336"` CMS Certification Number (CONF:4444-28244).
 - b. **SHALL** contain exactly one [1..1] `@extension` (CONF:4444-28245).

Note: A fixed CCN value 800890 shall be used for HQR test submission when no hospital is associated with a submitted QRDA document.

 - i. CCN **SHALL** be six to ten characters in length (CONF:CMS_0035).

Figure 7: CCN as Custodian Example, QRDA Category I Report - CMS (V7)

```

<!-- This is an example for QRDA I test submission to HQR.
CCN is required for HQR.-->
<custodian>
  <assignedCustodian>
    <representedCustodianOrganization>
      <!-- @extension attribute contains the submitter's CCN.
      @nullFlavor is not allowed. -->
      <id root="2.16.840.1.113883.4.336" extension="800890"/>
      <name>Good Health Hospital</name>
      <telecom value="tel:(555)555-1212" use="WP"/>
      <addr use="WP">
        <streetAddressLine>17 Daws Rd.</streetAddressLine>
        <city>Blue Bell</city>
        <state>MA</state>
        <postalCode>02368</postalCode>
        <country>US</country>
      </addr>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>

```

5.1.4 informationRecipient

The `informationRecipient` element records the intended recipient of the information at the time the document is created.

Table 5: informationRecipient Constraints Overview
 ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|----------------------|-------|-------|-----------|--------------------------------|---|
| informationRecipient | 1..1 | SHALL | | 4444-16703_C01 | |
| intendedRecipient | 1..1 | SHALL | | 4444-16704 | |
| id | 1..1 | SHALL | | 4444-16705_C01 | |
| @root | 1..1 | SHALL | | CMS_0025 | 2.16.840.1.113883.3.249.7 |
| @extension | 1..1 | SHALL | | CMS_0026 | urn:oid:2.16.840.1.113883.3.249.14.103 (QRDA I CMS Program Name) |

1. **SHALL** contain exactly one [1..1] `informationRecipient` (CONF:4444-16703_C01).
 - a. This `informationRecipient` **SHALL** contain exactly one [1..1] `intendedRecipient` (CONF:4444-16704).
 - i. This `intendedRecipient` **SHALL** contain exactly one [1..1] `id` (CONF:4444-16705_C01).
 1. This `id` **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.3.249.7"` (CONF:CMS_0025).
 2. This `id` **SHALL** contain exactly one [1..1] `@extension`, which **SHALL** be selected from ValueSet QRDA I CMS Program Name

urn:oid:2.16.840.1.113883.3.249.14.103 **STATIC** 2020-02-01 (CONF:CMS_0026).

Note: The value of @extension is CMS Program Name.

Table 6: QRDA I CMS Program Name

| Value Set: QRDA I CMS Program Name urn:oid:2.16.840.1.113883.3.249.14.103 | | | |
|---|-------------|-----------------------------------|---|
| Specifies the CMS Program for QRDA I report submissions. | | | |
| Code | Code System | Code System OID | Print Name |
| HQR_PI | CMS Program | urn:oid:2.16.840.1.113883.3.249.7 | Hospital Quality Reporting for the Promoting Interoperability Program |
| HQR_IQR | CMS Program | urn:oid:2.16.840.1.113883.3.249.7 | Hospital Quality Reporting for the Inpatient Quality Reporting Program |
| HQR_PI_IQR | CMS Program | urn:oid:2.16.840.1.113883.3.249.7 | Hospital Quality Reporting for the Promoting Interoperability Program and the Inpatient Quality Reporting Program |
| HQR_IQR_VOL | CMS Program | urn:oid:2.16.840.1.113883.3.249.7 | Hospital Quality Reporting for Inpatient Quality Reporting Program voluntary submissions |

Figure 8: informationRecipient Example, QRDA Category I Report - CMS (V7)

```

<!-- This example shows the @extension attribute with a value of
"HQR_PI", which indicates that this QRDA I report is submitted to the
Hospital Quality Reporting for the Promoting Interoperability Program
-->

<informationRecipient>
  <intendedRecipient>
    <!-- CMS Program Name is required. @nullFlavor is not allowed -->
    <id root="2.16.840.1.113883.3.249.7"
      extension="HQR_PI"/>
  </intendedRecipient>
</informationRecipient>
    
```

5.1.5 Participant (CMS EHR Certification ID)

The Certified Health Information Technology (IT) Product List (CHPL) is the authoritative and comprehensive listing of health IT certified through the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program. A CMS EHR Certification ID is a number generated by the CHPL and used for reporting to CMS. It represents a single product or combination of products in the CHPL. The EH selects a certified health IT product that meets 100% of the requirements for a complete EHR system, or combines multiple certified health IT products (Modules) to create a complete EHR product suite, as indicated in the CHPL chart on the CHPL website⁸.

⁸Certified Health IT Product List. <https://chpl.healthit.gov/>

CMS EHR Certification ID is different from the CHPL product number. In the CHPL, this would be the number that is generated when select EHR Certification ID for a suite of products that make up the hospital's EHR solution. If a product changes, then a different CMS EHR Certification ID will be generated. If there are no changes to the product(s) selected to create the CMS EHR Certification ID, the ID will remain the same. If the EHR product update has a new CHPL product number and occurs during the period of time between the beginning of data capture and export, then a new CMS EHR Certification ID would need to be generated to select the suite of all products used during the data capture and reporting period. The CMS EHR Certification ID is only unique to the product suite, if two different hospitals happen to use the same products, then they will both have the same CMS EHR Certification ID.

Table 7: Participant Constraints Overview

ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|------------------|-------|-------|-----------|--------------------------------|----------------------------|
| participant | 1..1 | SHALL | | 1198-10003_C01 | |
| associatedEntity | 1..1 | SHALL | | CMS_0004 | |
| id | 1..1 | SHALL | | CMS_0005 | |
| @root | 1..1 | SHALL | | CMS_0006 | 2.16.840.1.113883.3.2074.1 |
| @extension | 1..1 | SHALL | | CMS_0008 | |

1. **SHALL** contain exactly one [1..1] **participant** (CONF:1198-10003_C01).

HQR: CMS EHR Certification Number is required for HQR.

a. This participant **SHALL** contain exactly one [1..1] **associatedEntity** (CONF:CMS_0004).

i. This associatedEntity **SHALL** contain exactly one [1..1] **id** (CONF:CMS_0005).

1. This id **SHALL** contain exactly one [1..1]

@root="2.16.840.1.113883.3.2074.1" CMS EHR Certification ID (CONF:CMS_0006).

2. This id **SHALL** contain exactly one [1..1] **@extension** (CONF:CMS_0008).

Note: The value of @extension is the CMS EHR Certification ID.

5.1.6 documentationOf/serviceEvent

Table 8: documentationOf/serviceEvent Constraints Overview
 ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|-------------------------|-------|--------|-----------|----------------------------|-----------------------|
| documentationOf | 0..1 | MAY | | 4444-16579 | |
| serviceEvent | 1..1 | SHALL | | 4444-16580 | |
| performer | 1..* | SHALL | | 4444-16583 | |
| @typeCode | 1..1 | SHALL | | 4444-16584 | PRF |
| assignedEntity | 1..1 | SHALL | | 4444-16586 | |
| id | 0..1 | SHOULD | | 4444-16587 | |
| @root | 1..1 | SHALL | | 4444-28497 | 2.16.840.1.113883.4.6 |
| assignedPerson | 0..1 | MAY | | CMS 0019 | |
| name | 0..1 | MAY | | CMS 0020 | |
| representedOrganization | 1..1 | SHALL | | 4444-16591 | |
| id | 0..1 | SHOULD | | 4444-16592 | |
| @root | 1..1 | SHALL | | 4444-16593 | 2.16.840.1.113883.4.2 |
| name | 0..1 | MAY | | CMS 0022 | |

1. **MAY** contain zero or one [0..1] `documentationOf` (CONF:4444-16579) such that it
 - a. **SHALL** contain exactly one [1..1] `serviceEvent` (CONF:4444-16580).
 - i. This `serviceEvent` **SHALL** contain at least one [1..*] `performer` (CONF:4444-16583).
 1. Such `performers` **SHALL** contain exactly one [1..1] `@typeCode="PRF"` Performer (CONF:4444-16584).
 2. Such `performers` **SHALL** contain exactly one [1..1] `assignedEntity` (CONF:4444-16586).

This `assignedEntity id/@root='2.16.840.1.113883.4.6'` coupled with the `id/@extension` represents the individual provider's National Provider Identification number (NPI). A valid NPI is 10 numeric digits where the 10th digit is a check digit computed using the Luhn algorithm.

HQR: For HQR, NPI may not be applicable. If NPI is submitted for HQR, then the NPI **SHALL** conform to the constraints specified for NPI and the NPI must be in the correct format.

- a. This `assignedEntity` **SHOULD** contain zero or one [0..1] `id` (CONF:4444-16587) such that it
 - i. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.4.6"` National Provider ID (CONF:4444-28497).

- b. This assignedEntity **MAY** contain zero or one [0..1] **assignedPerson** (CONF:CMS_0019).
 - i. The assignedPerson, if present, **MAY** contain zero or one [0..1] **name** (CONF:CMS_0020).
Note: This is the provider's name.
- c. This assignedEntity **SHALL** contain exactly one [1..1] **representedOrganization** (CONF:4444-16591).

This representedOrganization id/@root='2.16.840.1.113883.4.2' coupled with the id/@extension represents the organization's Tax Identification Number (TIN). The provided TIN must be in valid format (9 decimal digits).

HQR: For HQR, TIN may not be applicable. If TIN is submitted for HQR, then it SHALL conform to the constraints specified for TIN. and the TIN must be in valid format (9 decimal digits).

- i. This representedOrganization **SHOULD** contain zero or one [0..1] **id** (CONF:4444-16592) such that it
 - 1. The id, if present, **SHALL** contain exactly one [1..1] **@root="2.16.840.1.113883.4.2"** Tax ID Number (CONF:4444-16593).
- ii. This representedOrganization **MAY** contain zero or one [0..1] **name** (CONF:CMS_0022).
Note: This is the organization's name, such as hospital's name.

Figure 9: documentationOf / serviceEvent Example - QRDA Category I Report – CMS (V7)

```

<documentationOf>
  <serviceEvent classCode="PCPR">
    ...
    <performer typeCode="PRF">
      <assignedEntity>
        <representedOrganization/>
      </assignedEntity>
    </performer>
  </serviceEvent>
</documentationOf>
    
```

5.1.7 component

Table 9: component Constraints Overview

ClinicalDocument (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.3:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|----------------|-------|-------|-----------|----------------------------|---|
| component | 1..1 | SHALL | | 4444-12973 | |
| structuredBody | 1..1 | SHALL | | 4444-17081 | |
| component | 1..1 | SHALL | | CMS_0056 | |
| section | 1..1 | SHALL | | CMS_0054 | Reporting Parameters Section - CMS (identifier: urn:hl7ii:2.16.840.1.113883.10.20.17.2.1.1:2016-03-01) |
| component | 1..1 | SHALL | | CMS_0057 | |
| section | 1..1 | SHALL | | CMS_0055 | Patient Data Section QDM (V7) - CMS (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.2.1.1:2020-02-01) |
| component | 1..1 | SHALL | | 4444-17082 | |
| section | 1..1 | SHALL | | 4444-17083 | Measure Section QDM (identifier: urn:oid:2.16.840.1.113883.10.20.24.2.3) |

1. **SHALL** contain exactly one [1..1] **component** (CONF: 4444-12973).
 - a. This component **SHALL** contain exactly one [1..1] **structuredBody** (CONF:4444-17081).
 - i. This structuredBody **SHALL** contain exactly one [1..1] **component** (CONF:CMS_0056) such that it
 1. **SHALL** contain exactly one [1..1] [Reporting Parameters Section - CMS](#) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.17.2.1.1:2016-03-01) (CONF:CMS_0054).

- ii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:CMS_0057) such that it
 1. **SHALL** contain exactly one [1..1] Patient Data Section QDM (V7) - CMS (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.2.1.1:2020-02-01) (CONF:CMS_0055).
- iii. This structuredBody **SHALL** contain exactly one [1..1] component (CONF:4444-17082) such that it
 1. **SHALL** contain exactly one [1..1] Measure Section QDM (identifier: urn:oid:2.16.840.1.113883.10.20.24.2.3) (CONF:4444-17083).

5.2 Section-Level Templates

5.2.1 Measure Section

This section contains information about the eCQM(s) being reported. It must contain entries with the identifiers of all the eCQMs so that corresponding QRDA Quality Data Model (QDM) data element entry templates to be instantiated in the Patient Data Section are identified. Each eCQM for which QRDA QDM data elements are being sent must reference eCQM version specific identifier (`QualityMeasureDocument/id`).

Only the list of conformance statements from the eCQM Reference QDM template (urn:oid:2.16.840.1.113883.10.20.24.3.97) that specifies how eCQM version specific measure identifier is referenced in the Measure Section are shown below. Please refer to the base HL7 QRDA I STU R5.2 standard for the full specification of Measure Section.

Table 10: Measure Section (eCQM Reference QDM) Constraints Overview
organizer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.97)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|------------------|-------|-------|-----------|--------------------------|--|
| reference | 1..1 | SHALL | | 67-12808 | |
| @typeCode | 1..1 | SHALL | | 67-12809 | urn:oid:2.16.840.1.113883.5.1002 (HL7ActRelationshipType) = REFR |
| externalDocument | 1..1 | SHALL | | 67-12810 | |
| @classCode | 1..1 | SHALL | | 67-27017 | urn:oid:2.16.840.1.113883.5.6 (HL7ActClass) = DOC |
| id | 1..1 | SHALL | | 67-12811 | |
| @root | 1..1 | SHALL | | 67-12812 | 2.16.840.1.113883.4.738 |
| @extension | 1..1 | SHALL | | 67-12813 | |

1. **SHALL** contain exactly one [1..1] **reference** (CONF:67-12808) such that it

- a. **SHALL** contain exactly one [1..1] `@typeCode="REFR"` refers to (CodeSystem: HL7ActRelationshipType urn:oid:2.16.840.1.113883.5.1002 **STATIC**) (CONF:67-12809).
- b. **SHALL** contain exactly one [1..1] `externalDocument` (CONF:67-12810).
 - i. This `externalDocument` **SHALL** contain exactly one [1..1] `@classCode="DOC"` Document (CodeSystem: HL7ActClass urn:oid:2.16.840.1.113883.5.6) (CONF:67-27017).
 - ii. This `externalDocument` **SHALL** contain exactly one [1..1] `id` (CONF:67-12811) such that it
 1. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.4.738"` (CONF:67-12812).
Note: This OID indicates that the `@extension` contains the version specific identifier for the eCQM.
 2. **SHALL** contain exactly one [1..1] `@extension` (CONF:67-12813).
Note: This `@extension` SHALL equal the version specific identifier for eCQM (i.e., QualityMeasureDocument/id)

Figure 10: Measure Section Example

```

<section>
  <!-- This is the templateId for Measure Section -->
  <templateId root="2.16.840.1.113883.10.20.24.2.2"/>
  <!-- This is the templateId for Measure Section QDM -->
  <templateId root="2.16.840.1.113883.10.20.24.2.3"/>
  <code code="55186-1" codeSystem="2.16.840.1.113883.6.1"/>
  <title>Measure Section</title>
  <text>...</text>
  <!-- 1..* Organizers, each containing a reference to an
  eCQM -->
  <entry>
    <organizer classCode="CLUSTER" moodCode="EVN">
      <!-- This is the templateId for Measure Reference -->
      <templateId root="2.16.840.1.113883.10.20.24.3.98"/>
      <!-- This is the templateId for eMeasure Reference QDM -->
      <templateId root="2.16.840.1.113883.10.20.24.3.97"/>
      <statusCode code="completed"/>
      <reference typeCode="REFR">
        <externalDocument classCode="DOC" moodCode="EVN">
          <!-- This is the eCQM version specific identifier -->
          <id root="2.16.840.1.113883.4.738"
            extension="2c928082-7871-00de-0178-890c4bc30506"/>
        </externalDocument>
      </reference>
    </organizer>
  </entry>
  <entry>
    <organizer>
      ...
    </organizer>
  </entry>
</section>

```

5.2.2 Reporting Parameters Section – CMS

The Reporting Parameters Section provides information about the reporting time interval, and may contain other information that provides context for the patient data being reported.

Table 11: Reporting Parameters Section – CMS Constraints Overview
 section (identifier: urn:oid:2.16.840.1.113883.10.20.17.2.1.1:2016-03-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|------------|-------|-------|-----------|--------------------------|--|
| templateId | 1..1 | SHALL | | CMS_0040 | |
| @root | 1..1 | SHALL | | CMS_0041 | 2.16.840.1.113883.10.20.17.2.1.1 |
| @extension | 1..1 | SHALL | | CMS_0042 | 2016-03-01 |
| entry | 1..1 | SHALL | | CMS_0023 | |
| act | 1..1 | SHALL | | CMS_0024 | Reporting Parameters Act - CMS (identifier: urn:hl7ii:2.16.840.1.113883.10.20.17.3.8.1:2016-03-01) |

1. Conforms to Reporting Parameters Section `template` (identifier: urn:oid:2.16.840.1.113883.10.20.17.2.1).
2. **SHALL** contain exactly one [1..1] `templateId` (CONF:CMS_0040) such that it
 - a. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.10.20.17.2.1.1"` (CONF:CMS_0041).
 - b. **SHALL** contain exactly one [1..1] `@extension="2016-03-01"` (CONF:CMS_0042).
3. **SHALL** contain exactly one [1..1] `entry` (CONF:CMS_0023) such that it
 - a. **SHALL** contain exactly one [1..1] [Reporting Parameters Act - CMS \(identifier: urn:hl7ii:2.16.840.1.113883.10.20.17.3.8.1:2016-03-01\)](#) (CONF:CMS_0024).

5.2.2.1 Reporting Parameters Act – CMS

Table 12: Reporting Parameters Act - CMS Constraints Overview
 act (identifier: urn:oid:2.16.840.1.113883.10.20.17.3.8.1:2016-03-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|---------------|-------|-------|-----------|--|----------------------------------|
| templateId | 1..1 | SHALL | | CMS_0044 | |
| @root | 1..1 | SHALL | | CMS_0045 | 2.16.840.1.113883.10.20.17.3.8.1 |
| @extension | 1..1 | SHALL | | CMS_0046 | 2016-03-01 |
| effectiveTime | 1..1 | SHALL | | 23-3273 | |
| low | 1..1 | SHALL | | 23-3274 | |
| @value | 1..1 | SHALL | | CMS_0048 CMS_0027 | |
| high | 1..1 | SHALL | | 23-3275 | |
| @value | 1..1 | SHALL | | CMS_0050 CMS_0028 | |

1. **Conforms to Reporting Parameters Act template** (identifier: urn:oid:2.16.840.1.113883.10.20.17.3.8).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:CMS_0044) such that it
 - a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.17.3.8.1" (CONF:CMS_0045).
 - b. **SHALL** contain exactly one [1..1] **@extension**="2016-03-01" (CONF:CMS_0046).
3. **SHALL** contain exactly one [1..1] **effectiveTime** (CONF:23-3273).
 - a. This **effectiveTime** **SHALL** contain exactly one [1..1] **low** (CONF:23-3274).
 - i. This **low** **SHALL** contain exactly one [1..1] **@value** (CONF:CMS_0048).
 - ii. **SHALL** be precise to day (CONF:CMS_0027)
 - b. This **effectiveTime** **SHALL** contain exactly one [1..1] **high** (CONF:23-3275).
 - i. This **high** **SHALL** contain exactly one [1..1] **@value** (CONF:CMS_0050).
 - ii. **SHALL** be precise to day (CONF:CMS_0028)

Figure 11: Reporting Parameters Section - CMS and Reporting Parameters Act – CMS Example

```

<section>
  <templateId root="2.16.840.1.113883.10.20.17.2.1"/>
  <templateId root="2.16.840.1.113883.10.20.17.2.1.1"
extension="2016-03-01"/>
  <code code="55187-9" codeSystem="2.16.840.1.113883.6.1"/>
  <title>Reporting Parameters</title>
  <text>
    ...
    <list>
      <item>Reporting period: 01 Jan 2022 - 31 March 2022</item>
    </list>
    ...
  </text>
  <entry typeCode="DRIV">
    <act classCode="ACT" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.17.3.8"/>
      <templateId root="2.16.840.1.113883.10.20.17.3.8.1"
extension="2016-03-01"/>
      <id root="67e84480-1f84-4d04-9be3-cc3e8c2c6933"/>
      <code code="252116004" codeSystem="2.16.840.1.113883.6.96"
displayName="Observation Parameters"/>
      <effectiveTime>
        <low value="20220101"/>
        <high value="20220331"/>
      </effectiveTime>
    </act>
  </entry>
</section>

```

5.2.3 Patient Data Section QDM (V7) - CMS

The Patient Data Section QDM (V7) - CMS contains entries that conform to the QDM approach to QRDA. The four supplemental data elements (ONC Administrative Sex, Race, Ethnicity, and Payer) specified in the eQMs are required to be reported to CMS. While the administrative sex, race, and ethnicity data are sent in the document header, the payer supplemental data element is submitted using the Patient Characteristic Payer template contained in the patient data section. Therefore, the Patient Data Section QDM (V7) - CMS shall contain at least one Patient Characteristic Payer template and at least one entry template that is other than the Patient Characteristic Payer template. As for what entry templates and how many entry

templates should be included in the patient data section for the referenced eCQMs, it should adhere to the "smoking gun" philosophy described in the QRDA I standard. This guide follows the specifications of entry templates as defined in the base HL7 QRDA I STU R5.2 standard with errata.

Table 13: Patient Data Section QDM (V7) – CMS Constraints Overview
section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.2.1.1:2020-02-01)

| XPath | Card. | Verb | Data Type | CONF. # | Value |
|-------------|-------|-------|-----------|--|--|
| templateId | 1..1 | SHALL | | CMS_0036 | |
| @root | 1..1 | SHALL | | CMS_0037 | 2.16.840.1.113883.10.20.24.2.1.1 |
| @extension | 1..1 | SHALL | | CMS_0038 | 2020-02-01 |
| entry | 1..* | SHALL | | CMS_0051 CMS_0039 | |
| entry | 1..* | SHALL | | 4444-14430_C01 | |
| observation | 1..1 | SHALL | | 4444-14431 | Patient Characteristic Payer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.55) |

1. **Conforms to** Patient Data Section QDM (V7) **template** (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.2.1.1:2019-12-01).
2. **SHALL** contain exactly one [1..1] **templateId** (CONF:CMS_0036) such that it
 - a. **SHALL** contain exactly one [1..1] `@root="2.16.840.1.113883.10.20.24.2.1.1"` (CONF:CMS_0037).
 - b. **SHALL** contain exactly one [1..1] `@extension="2020-02-01"` (CONF:CMS_0038).
3. **SHALL** contain at least one [1..*] **entry** (CONF:CMS_0051) such that it
 - a. **SHALL** contain exactly one [1..1] entry template that is other than the Patient Characteristic Payer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.55) (CONF:CMS_0039).
4. **SHALL** contain at least one [1..*] **entry** (CONF:4444-14430_C01) such that it
 - a. **SHALL** contain exactly one [1..1] Patient Characteristic Payer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.55) (CONF:4444-14431).

Figure 12: Patient Data Section QDM (V7) – CMS Example

```

<section>
  <!-- Patient Data Section -->
  <templateId root="2.16.840.1.113883.10.20.17.2.4" />
  <!-- Patient Data Section QDM (V7) -->
  <templateId root="2.16.840.1.113883.10.20.24.2.1"
    extension="2019-12-01"/>
  <!-- Patient Data Section QDM (V7) - CMS-->
  <templateId root="2.16.840.1.113883.10.20.24.2.1.1"
    extension="2020-02-01"/>
  <code code="55188-7" codeSystem="2.16.840.1.113883.6.1"
    displayName="Patient Data"/>
  <title>Patient Data</title>
  <text>...</text>
  <entry typeCode="DRIV">
    ...
  </entry>
  <entry typeCode="DRIV">
    ...
  </entry>
  <!--supplemental data elements-->
  <!-- payer-->
  <entry typeCode="DRIV">
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.24.3.55"/>
      <id root="a83777f2-0753-4638-9bb4-9d0d4a559a52"/>
      <code code="48768-6" codeSystem="2.16.840.1.113883.6.1"
        codeSystemName="LOINC" displayName="Payment source"/>
      <statusCode code="completed" />
      <effectiveTime>
        <low value="20220101"/>
        <high value="20221231"/>
      </effectiveTime>
      <value xsi:type="CD" code="1"
        codeSystem="2.16.840.1.113883.3.221.5"
        codeSystemName="Source of Payment Typology"
        displayName="Medicare"/>
    </observation>
  </entry>
  ...
</section>

```

5.2.3.1 “Not Done” with a Reason

To report a QDM data element that is not done (when `negationInd="true"`) with a reason, such as "Medication Not Administered" with negation rationale attribute indicating it is due to patient reason, the following steps must be followed:

1. Must set the attribute `negataionInd="true"`
2. If QDM in eCQM specification is defined using a value set, for example, ["Medication, Not Ordered": "Warfarin"]:
 - Must provide `code/[@nullFlavor="NA"]`
 - Must provide the value set OID instead of a specific code from the value set. Set the code attribute `code/sdct:valueset="[VSAC value set OID]"`
 - Use `code/originalText` for the text description of the concept in the pattern "None of value set: [value set name]"

3. If QDM element in eCQM specification is defined using direct referenced code:
 - Must not provide `code/[@nullFlavor="NA"]`
 - Must provide the direct referenced code. Set the code attribute `code="[The Direct Referenced Code]"`
4. Must provide the reason for negation, such as a medical reason or a patient reason
 - Provide an **entryRelationship** to a Reason (V3) (templateId: 2.16.840.1.113883.10.20.24.3.88:2017-08-01") with an actRelationship type of "RSON" is required. See Reason Template Placement When Specifying "Not Done" with a Reason for more details.

Figure 13: Not Done Example for QDM Element Defined with Value Set

```

<!--Medication not administered, patient refusal: Drug declined by
patient - reason unknown. No "Low Dose Unfractionated Heparin for VTE
Prophylaxis" were administered -->
<substanceAdministration classCode="SBADM" moodCode="EVN"
negationInd="true">
  <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-
06-09"/>
  <templateId root="2.16.840.1.113883.10.20.24.3.42" extension="2019-
12-01"/>
  <id root="48cb49dc-2bf7-43e9-9824-8538665158f8" />
  <statusCode code="completed"/>
  ...
  <consumable>
    <manufacturedProduct classCode="MANU">
      <templateId root="2.16.840.1.113883.10.20.22.4.23"
extension="2014-06-09"/>
      <manufacturedMaterial>
        <code nullFlavor="NA"
sdtc:valueSet="2.16.840.1.113883.3.464.1003.196.12.1001">
          <originalText>None of the value set: Antibiotic Medications
for Pharyngitis</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <entryRelationship typeCode="RSON">
    <observation classCode="OBS" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.24.3.88"
extension="2017-08-01" />
      <code code="77301-0"
codeSystem="2.16.840.1.113883.6.1"
displayName="Reason care action performed or not"
codeSystemName="LOINC" />
      <value xsi:type="CD" code="182897004"
codeSystem="2.16.840.1.113883.6.96"
displayName="Drug declined by patient - side effects
(situation)"
codeSystemName="SNOMED CT"/>
    </observation>
  </entryRelationship>
</substanceAdministration>

```

5.2.3.2 Reporting "unit" for Result Value

If eCQM definition uses the "unit" in the measure logic for the "result" criteria, the patient QRDA document must report the result with the exact appropriate/required unit specified in the eCQM. For example, in the measure logic for maximum LDL-c result of less than 70 mg/dL,

Unified Code for Units of Measure (UCUM) code “mg/dL” is specified as “unit” by the eCQM definition.⁹ If the LDL-c result value is provided without the unit or with a different unit than specified by the eCQM, depending on the system processing the data, the case might not meet the measure’s requirement and fail the “result” logic.

If eCQM definition does not specify the “unit” in the measure logic for the “result” criteria, for example, ["Laboratory Test, Performed": "INR"] INRLabTest where INRLabTest.result > 3.0, then the laboratory test performed result must be reported using one of the two options:

- 1) represent INR result using data type REAL or Interval REAL (xsi:datatype="REAL" or xsi:datatype="IVL_REAL") for results such as INR=2.4 or INR>=4.5;
- 2) represent INR result using data type PQ with PQ.unit as UCUM codes {ratio} or {INR}.

For guidance on reporting result value “unit” for hybrid measures, please see [6.2 Reporting Result “unit” for Hybrid Measures](#).

5.3 HQR Validations

This section details additional validation rules specified by CMS for HQR. Submissions that do not conform to these constraints will result in files being rejected by the Hospital eCQM Reporting System.

5.3.1 Validation Rules for Encounter Performed

The effectiveTime low value (effectiveTime/low/@value) represents the Encounter Performed admission time, and the effectiveTime high value (effectiveTime/high/@value) represents the Encounter Performed discharge time.

The following are additional Encounter Performed validation rules for HQR QRDA I submissions.

- i. The system **SHALL** reject QRDA I files if the Encounter Performed Discharge Date is null (CONF: CMS_0060).
- ii. The system **SHALL** reject QRDA I files if the Encounter Performed Discharge Date (effectiveTime/high value) is after the upload date (discharge date is in the future) (CONF: CMS_0061).
- iii. The system **SHALL** reject QRDA I files if the Encounter Performed Admission Date (effectiveTime/low value) is after the Encounter Performed Discharge Date (effectiveTime/high value) (CONF: CMS_0062).
- iv. The system **SHALL** reject QRDA I files if there are no Encounter Performed Discharge Dates within the reporting period found in the QRDA (CONF: CMS_0063).

5.3.2 Other HQR Validations

Table 14: Other Validation Rules for HQR Programs

| CONF. # | Validation Performed | Description of Error Message and File Rejection |
|----------|---------------------------------|--|
| CMS_0066 | CCN (NULL) cannot be validated. | CCN value does not appear in HQR lookup of valid CCNs. CCN is Null, resulting in this message. |

⁹ The Clinical Quality Language (CQL) specification defines a number of built-in units for timing, such as “week”, “weeks”, and “year”. eCQMs logics in CQL are expressed using these built-in units. For the 2022 reporting period, submitting either “week” and “weeks” or their corresponding UCUM representation “wk” will be accepted by the receiving system.

| CONF. # | Validation Performed | Description of Error Message and File Rejection |
|----------|--|--|
| CMS_0067 | Submitter (%s) is not authorized to submit for this provider (%s) | Lookup performed and found that the Submitter (vendor) has not been authorized to submit data on behalf of the hospital (using the CCN in the QRDA I file). |
| CMS_0068 | Provider is not allowed to use dummy CCN number (800890) for submissions | Only vendors can use the dummy CCN. |
| CMS_0069 | Dummy CCN (800890) cannot be used for production submissions | Dummy CCN can only be used for Test Data submissions. |
| CMS_0070 | Submission date is not within the submission period. | The validation process compares the upload date with the Production Date Range values stored in internal table. If the upload date is outside the acceptable range(s), which for the 2022 Reporting Period is yet to be finalized, this message is returned. |
| CMS_0071 | Data submitted is not a well formed QRDA XML. | Document violates syntax rule in the XML specification, e.g., missing start/end tag or prime elements missing or not properly nested or not properly written. <u>Processing stops immediately on file.</u> |
| CMS_0072 | QRDA file does not pass XML schema validation (CDA_SDTC.xsd). | QRDA structure does not pass CDA_SDTC.XSD schema check. <u>Processing continues</u> on file to identify other Errors/Warnings. |
| CMS_0073 | The document does not conform to QRDA document formats accepted by CMS | <p>Document is not in QRDA Category I STU Release 5.2 format -- does not contain all four of the required header templatedIds including both of the R5.2 templatedIds and extensions:</p> <p>HL7 R5.2:</p> <pre><templatedId root="2.16.840.1.113883.10.20.22.1.1" extension="2015-08-01"/></pre> <pre><templatedId root="2.16.840.1.113883.10.20.24.1.1" extension="2017-08-01"/></pre> <pre><templatedId root="2.16.840.1.113883.10.20.24.1.2" extension="2019-12-01"/></pre> <p>2021 CMS QRDA I IG:</p> <pre><templatedId root="2.16.840.1.113883.10.20.24.1.3" extension="2020-02-01"/></pre> <p>This error is also produced for empty file or other non-XML file type (e.g., PDF). <u>Processing stops immediately on file.</u></p> |
| CMS_0074 | The Version Specific Measure Identifier is not valid for the current program year. | The Version Specific Measure Identifier for an eCQM being reported is a required element in the QRDA file (i.e., XPath is QualityMeasureDocument/id/@root). The HQR eCQM receiving system will only accept the "2021 version" of eCQMs for the CY 2022 reporting period. |

| CONF. # | Validation Performed | Description of Error Message and File Rejection |
|----------|--|--|
| | | Each eCQM has an associated Version Specific Measure Identifier corresponding to the “2021 version of eCQM specifications” for the CY 2022 reporting period. Only those Version Specific Measure Identifiers for the current reporting year will be accepted. If any submitted version specific identifier does not match one of the defined set of the Version Specific Measure Identifier for the current reporting year, the file will be rejected. |
| CMS_0075 | Admission Date is not properly formatted. | Fails validation check for Encounter Performed Admission Date (effectiveTime/low value) as specified in Table 15: Valid Date/Time Format for HQR |
| CMS_0076 | Discharge Date is not properly formatted. | Fails validation check for Encounter Performed Discharge Date (effectiveTime/high value) as specified in Table 15: Valid Date/Time Format for HQR |
| CMS_0077 | Reporting Period Start Date (low value) is after the End Date (high value). | Fails validation check. Reporting Parameters Act effectiveTime low (Reporting Period Start Date) is after effectiveTime high (Reporting Period End Date). |
| CMS_0078 | QRDA file size exceeds (10) MB. | QRDA file size exceeds 10 MB. |
| CMS_0079 | Reporting Period Effective Date Range does not match one of the Program's calendar year Discharge Quarters. | The Reporting Parameter Section effective date range must exactly match one of the HQR allowable calendar year discharge quarters. |
| CMS_0082 | CMS EHR Certification ID does not meet year/version criteria | The EHR system needs to be certified to 2015 Edition for CY2022/PY2024. |
| CMS_0083 | CMS Certification ID format is not valid | CMS EHR Certification ID must be 15 alpha numeric characters in length. |
| CMS_0084 | Either the Patient HICN or MBI is required for hybrid measure/Core Clinical Data Elements (CCDE) submissions | QRDA files for hybrid measure/CCDE submissions must contain a HICN or MBI. |
| CMS_0085 | CMS program name and Measure ID are not compatible | CMS program name for hybrid measure/CCDE submissions must be HQR_IQR_VOL. |
| CMS_0086 | Measure type is not consistent across QRDA files within the batch | Files containing hybrid measure/CCDE submissions and eCQM cannot be submitted within the same batch. |

5.3.3 Date and Time Validation

Table 15: Valid Date/Time Format for HQR

| Attribute | Date and Time Format Validation Rules | Examples |
|--|---|---|
| <p><Encounter> <EffectiveTime> <low>(Admission Date) <high>(Discharge Date)</p> | <p>Valid Date/Time Format: YYYYMMDDHHMM YYYYMMDDHHMMSS YYYYMMDDHHMMSSxUUUU where YYYY - year - range 1900 to 9999 MM - month - range 01 to 12 DD - day - range 01 to 31 (note: true to month and leap years) HH - hour - range 0 to 23 MM - minutes - range 0-59 SS - seconds - range 0-59 x - plus or minus sign UUUU - UTC time shift -1200 thru+1400</p> | <p>For example, 202201301130</p> |
| <p>BirthTime</p> | <p>Valid Date/Time Format: YYYYMMDD YYYYMMDDHHMM YYYYMMDDHHMMSS where YYYY - year - range 1900 to 9999 MM - month - range 01 to 12 DD - day - range 01 to 31 (note: true to month and leap years) HH - hour - range 0 to 23 MM - minutes - range 0-59 SS - seconds - range 0-59</p> | <p>For example, 19910428 202104202115 (newborn)</p> |
| <p>Reporting Period <EffectiveTime> <low>(Start Date) <high>(End Date)</p> | <p>Valid Date/Time Format: YYYYMMDD where YYYY - year - range 1900 to 9999 MM - month - range 01 to 12 DD - day - range 01 to 31 (note: true to month and leap years)</p> | <p>For example, partial date/time such as 2022 or 202203 are not allowed.</p> |

| Attribute | Date and Time Format Validation Rules | Examples |
|---------------------------------|--|--|
| EffectiveTime (US Realm Header) | Valid Date/Time Format: YYYYMMDDHHMMSSxUUUU YYYYMMDDHHMMxUUUU YYYYMMDDHHxUUUU YYYYMMDDxUUUU YYYYMMDD YYYYMMDDHH YYYYMMDDHHMM YYYYMMDDHHMMSS where YYYY - year - range 1900 to 9999 MM - month - range 01 to 12 DD - day - range 01 to 31 (note: true to month and leap years) x - plus or minus sign UUUU - UTC time shift -1200 thru+1400 | For example, 20220130 is valid. |
| NA | Leap year calculation is validated. | For example, 20200229 is valid, because 2020 is a leap year. |
| NA | The UTC time shift range is -1200 thru +1400. Time shifts outside this range are invalid. The last two digits are 'minutes' so they must be in the range of 00 to 59. | For example, -1262 is invalid because 62 is outside the range of 00 to 59. |

5.3.4 Validation XPath

Table 16: Validation XPath

| Validation Item | CONF. # | CDA Template Name and CDA Element XPath |
|-----------------------------|--|--|
| Admission Date | CMS_0062 CMS_0075 | Encounter Performed ../../encounter/effectiveTime/low |
| Discharge Date | CMS_0060 CMS_0061 CMS_0062 CMS_0063 CMS_0076 | Encounter Performed ../../encounter/effectiveTime/high |
| Reporting Period Start Date | CMS_0063 CMS_0077 CMS_0027 | /ClinicalDocument/component/structuredBody/component/section[@templateId="2.16.840.1.113883.10.20.17.2.1"]/entry/act[@templateId="2.16.840.1.113883.10.20.17.3.8.1"]/effectiveTime/low |

| Validation Item | CONF. # | CDA Template Name and CDA Element XPath |
|-------------------------------------|----------------------------------|---|
| Reporting Period End Date | CMS_0063 CMS_0079 CMS_0028 | /ClinicalDocument/component/structuredBody/component/section[@templateId="2.16.840.1.113883.10.20.17.2.1"]/entry/act[@templateId="2.16.840.1.113883.10.20.17.3.8.1"]/effectiveTime/high |
| Version Specific Measure Identifier | CMS_0074 | /ClinicalDocument/component/structuredBody/component/section[@templateId="2.16.840.1.113883.10.20.24.2.2"]/entry/organizer[@templateId="2.16.840.1.113883.10.20.24.3.97"]/reference/externalDocument/id[@root="2.16.840.1.113883.4.738"]/@extension |
| Birth Time | 1198-5300_C01 1198-32418 | /ClinicalDocument/recordTarget/patientRole/patient/birthTime |
| effectiveTime (US Realm Header) | 1198-5256 | /ClinicalDocument/effectiveTime |
| CMS Program Name | CMS_0064 | /ClinicalDocument/informationRecipient/intendedRecipient/id/@extension |

6 Hybrid Measure/CCDE Voluntary Submission

This section provides guidance on how to submit the encounter id associated with a core clinical data element and report result “unit” for hybrid measure voluntary submission.

6.1 Submitting the encounter id associated with a CCDE

Association of the data element to the encounter id uses the Related To (2.16.840.1.113883.10.20.24.3.150:2017-08-01) template in conjunction with the Laboratory Test, Performed (V5) (2.16.840.1.113883.10.20.24.3.38:2019-12-01) and the Physical Exam, Performed (V5) (2.16.840.1.113883.10.20.24.3.59:2019-12-01) templates respectively.

Hybrid measure voluntary submission reporting requirements:

- For each of the core clinical data elements specified in a hybrid measure, the measure specification returns the specific encounter id that a core clinical data element result is associated with.

For example, when reporting the first resulted sodium value and datetime, it should also provide the encounter id that the sodium result is associated with in the same Laboratory Test, Performed (V5) template. The encounter id must reference an existing instance of Encounter, Performed template’s `encounter/id` contained in the same QRDA I file.

Figure 14 shows an example Encounter Performed instance with `encounter/id`. In this example, the encounter id has both a root and an extension that uniquely identifies a specific episode of care: `<id root="4836d196-85d5-480c-b640-e470790eec7d" extension="123"/>` (note that the value provided for root and extension are for demonstration purpose only).

Figure 14: Encounter Performed Example

```
<act classCode="ACT" moodCode="EVN">
  <!--Encounter performed Act (V3) -->
  <templateId root="2.16.840.1.113883.10.20.24.3.133"
extension="2019-12-01"/>
  <code code="ENC" codeSystem="2.16.840.1.113883.5.6"
displayName="Encounter" codeSystemName="ActClass"/>
  <entryRelationship typeCode="SUBJ">
    <encounter classCode="ENC" moodCode="EVN">
      <templateId root="2.16.840.1.113883.10.20.22.4.49"
extension="2015-08-01"/>
      <!-- Encounter Performed (V5) -->
      <templateId root="2.16.840.1.113883.10.20.24.3.23"
extension="2019-12-01"/>
      <!-- The encounter id of this particular encounter that
the clinical core data element is associated with. -->
      <id root="4836d196-85d5-480c-b640-e470790eec7d"
extension="123"/>

```

Example XMLs in Table 17 demonstrate how to reference an existing `encounter/id` (see Figure 14) in a Laboratory Test, Performed (V5) and Physical Exam, Performed (V5) by including the Related To template. Note that the `sdtc:id` provided must reference and match the existing `encounter/id` for both the root and id attributes if both are present, for instance, `<sdtc:id root="4836d196-85d5-480c-b640-e470790eec7d" extension="123"/>`.

Table 17: Associating an Existing Encounter Id with a Core Clinical Data Element

| Core Clinical Data Element | QRDA Template | Guidance |
|---|---|--|
| Bicarbonate Creatinine Glucose Hematocrit Platelet count Potassium Sodium White blood cell count | Laboratory Test, Performed (V5) (2.16.840.1.113883.10.20.24.3.38:2019-12-01) | <pre> <!-- Laboratory Test, Performed(V5) --> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.24.3.38" extension="2019-12-01"/> <id root="83216def-91de-46dd-b96c-032aa8cb8823"/> <code xsi:type="CD" code="2947-0" codeSystem="2.16.840.1.113883.6.1" displayName="Sodium [Moles/volume] in Blood" codeSystemName="LOINC"/> <statusCode code="completed"/> <!-- QDM Attribute: Relevant dateTime --> <effectiveTime value="20210615113000"/> <!-- QDM Attribute: Result --> <entryRelationship typeCode="REFR"> <!-- Result (V4) --> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.22.4.2" extension="2015-08-01"/> <templateId root="2.16.840.1.113883.10.20.24.3.87" extension="2019-12-01"/> <id root="3fad091f-7b4e-4661-b61c-53f9a825198b"/> <code code="2947-0" displayName="Sodium [Moles/volume] in Blood" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/> <statusCode code="completed"/> <!-- QDM Attribute: Result dateTime --> <effectiveTime value="20210615113000"/> <value xsi:type="PQ" value="135" unit="mmol/L"/> </observation> </entryRelationship> <!-- Related To --> <sdtc:inFulfillmentOf1 typeCode="FLFS"> <sdtc:templateId root="2.16.840.1.113883.10.20.24.3.150" extension="2017-08-01"/> <sdtc:actReference classCode="ENC" moodCode="EVN"> <!-- The id references and matches the Encounter, Performed encounter id (both root and extension if both are present)this core clinical data element is associated with. --> <sdtc:id root="4836d196-85d5-480c-b640- e470790eec7d" extension="123"/> </sdtc:actReference> </sdtc:inFulfillmentOf1> </observation> </pre> |

| Core Clinical Data Element | QRDA Template | Guidance |
|---|---|--|
| Heart rate Oxygen saturation Respiratory rate Systolic blood pressure Temperature Weight | Physical Exam, Performed (V5) (2.16.840.1.113883.10.20.24.3.59:2019-12-01) | <pre> <!-- Physical Exam, Performed(V5) --> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.22.4.13" extension="2014-06-09"/> <templateId root="2.16.840.1.113883.10.20.24.3.59" extension="2019-12-01"/> <id root="09982a50-a3f7-422b-9eb2-d9e26ad6448b"/> <code xsi:type="CD" code="8480-6" codeSystem="2.16.840.1.113883.6.1" displayName="Systolic blood pressure" codeSystemName="LOINC"/> <statusCode code="completed"/> <!-- QDM Attribute:Relevant dateTime --> <effectiveTime value="20210729090000"/> <!-- QDM Attribute: Result --> <value xsi:type="PQ" value="120" unit="mm[Hg]"/> <!-- Related To --> <sdtc:inFulfillmentOf1 typeCode="FLFS"> <sdtc:templateId root="2.16.840.1.113883.10.20.24.3.150" extension="2017-08-01"/> <sdtc:actReference classCode="ENC" moodCode="EVN"> <!-- The id references and matches the Encounter, Performed encounter id (both root and extension if both are present) this core clinical data element is associated with. --> <sdtc:id root="4836d196-85d5-480c-b640- e470790eec7d" extension="123"/> </sdtc:actReference> </sdtc:inFulfillmentOf1> </observation> </pre> |

6.2 Reporting Result “unit” for Hybrid Measures

For hybrid measure voluntary submissions, it is recommended for the submitters to submit “unit” of the laboratory test result or physical exam result for each of the core clinical data elements using appropriate UCUM codes, but submitters may submit units in the forms used in their EHRs for the 2022 reporting period.

APPENDIX

7 Troubleshooting and Support

7.1 Resources

The following provide additional information:

- **eCQI Resource Center** is the one-stop shop for the most current resources to support electronic clinical quality improvement: <https://ecqi.healthit.gov/>
- **National Library of Medicine (NLM) Value Set Authority Center (VSAC)** contains the official versions of the value sets used for eCQMs: <https://vsac.nlm.nih.gov/>
- **Electronic Clinical Quality Measure specification feedback system** is a tool offered by CMS and ONC for Health Information Technology for implementers to submit issues and request guidance on eCQM logic, specifications, and certification: <https://oncprojecttracking.healthit.gov/>

7.2 Support

Table 18: Support Contact Information

| Contact | Org. | Phone | Email | Role | Responsibility |
|---------------------|------|--------------|--|-------------------|--|
| CMS IT Service Desk | CMS | 866-288-8912 | gnetsupport@hcqis.org | Help desk support | 1 st level user support & problem reporting |

7.3 Errata or Enhancement Requests

Table 19: Errata or Enhancement Request Location

| Contact | Organization | URL | Purpose |
|------------------|--------------|---|---|
| HL7 Jira Tracker | HL7 | https://jira.hl7.org | Document errors or enhancement request to the HL7 standard. Create a Jira tracker by selecting project “CDA Specification Feedback” and specification “Quality Reporting Document Architecture Category I (CDA)” |

8 Null Flavor Validation Rules for Data Types

CDA, Release 2 uses the HL7 V3 Data Types, Release 1 abstract and XML-specific specification. Every data element either has a proper value or it is considered NULL. If and only if it is NULL, a "null flavor" provides more detail on why or in what way no proper value is supplied. The table below provides clarifications to proper nullFlavor use for a list of common data types used by this guide.

Table 20: Null Flavor Validation Rules for Data Types

| Data Type | CONF. # | Rules |
|----------------------------------|----------|--|
| Boolean (BL) | CMS_0105 | Data types of BL SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor (CONF:CMS_0105). |
| Coded Simple (CS) | CMS_0106 | Data types of CS SHALL have either @code or @nullFlavor but SHALL NOT have both @code and @nullFlavor (CONF:CMS_0106). |
| Coded Descriptor (CD) | CMS_0107 | Data types of CD or CE SHALL have either @code or @nullFlavor but SHALL NOT have both @code and @nullFlavor (CONF:CMS_0107). |
| Coded With Equivalent (CE) | | |
| Instance Identifier (II) | CMS_0108 | Data types of II SHALL have either @root or @nullFlavor or (@root and @nullFlavor) or (@root and @extension) but SHALL NOT have all three of (@root and @extension and @nullFlavor) (CONF:CMS_0108). |
| Integer Number (INT) | CMS_0109 | Data types of INT SHALL NOT have both @value and @nullFlavor (CONF:CMS_0109). |
| Physical Quantity (PQ) | CMS_0110 | Data types of PQ SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor. If @value is present then @unit SHALL be present but @unit SHALL NOT be present if @value is not present (CONF:CMS_0110). |
| Real Number (REAL) | CMS_0111 | Data types of REAL SHALL NOT have both @value and @nullFlavor (CONF:CMS_0111). |
| String (ST) | CMS_0112 | Data types of ST SHALL either not be empty or have @nullFlavor (CONF:CMS_0112). |
| Point in Time (TS) | CMS_0113 | Data types of TS SHALL have either @value or @nullFlavor but SHALL NOT have @value and @nullFlavor (CONF:CMS_0113). |
| Universal Resource Locator (URL) | CMS_0114 | Data types of URL SHALL have either @value or @nullFlavor but SHALL NOT have both @value and @nullFlavor (CONF:CMS_0114). |

9 NPI and TIN Validation Rules

Table 21: NPI Validation Rules and Table 22: TIN Validation Rules list the validation rules performed on the NPI and TIN.

Table 21: NPI Validation Rules

| CONF. # | Rules |
|----------|---|
| CMS_0115 | The NPI should have 10 digits. |
| CMS_0116 | The NPI should be composed of all digits. |
| CMS_0117 | The NPI should have a correct checksum, using the Luhn algorithm. |
| CMS_0118 | The NPI should have @extension or @nullFlavor, but not both. |

Table 22: TIN Validation Rules

| CONF. # | Rules |
|----------|--|
| CMS_0119 | When a Tax Identification Number is used, the provided TIN must be in valid format (9 decimal digits). |
| CMS_0120 | The TIN SHALL have either @extension or @nullFlavor, but not both. |

10 Reason Template Placement When Specifying “Not Done” with a Reason

The Processing Consideration section in Volume 1 of the HL7 QRDA I STU R5.2 provides guidance on the placement of the Reason (V3) template when specify the reason for “Not Done”.

In summary, the Reason (V3) template will be nested directly within the element containing the **negationInd** attribute. When a parent template and a child template both allow negation, then the parent template must be negated and contain the Reason (V3) template. For example, for “Medication, Not Discharged”, the parent Discharge Medication (V5) template (2.16.840.1.113883.10.20.24.3.105:2019-12-01) must have **negationInd="true"** and contain the Reason (V3) template indicating reason for negation.

The table below provides detailed guidance for the location of the Reason (V3) template for each negated QDM data element that were used by the eCQM specifications for Hospital Quality Reporting for the 2022 reporting period.

Table 23: Placement of Reason (V3) Template for Negated QDM Data Element

| Negated QDM Data Element | QRDA Template(s) | Guidance |
|--------------------------|--|--|
| Device, Not Applied | Device Applied (V6) (2.16.840.1.113883.10.20.24.3.7:2019-12-01) | <p>XPath for "Device, Not Applied" Reason Code:</p> <pre> ./procedure[templateId/@root="2.16.840.1.113883.10.20.24.3.7"][templateId/@extension="2019-12-01"][@negationInd="true"]/entryRelationship[@typeCode="RSON"]/observation[templateId/@root="2.16.840.1.113883.10.20.24.3.88"][templateId/@extension="2017-08-01"]/value[@xsi:type="CD"]/ </pre> <p><!-- Device Applied (V6) --> <procedure classCode="PROC" moodCode="EVN" negationInd="true" > <templateId root="2.16.840.1.113883.10.20.22.4.14" extension="2014-06-09"/> <templateId root="2.16.840.1.113883.10.20.24.3.7" extension="2019-12-01"/> ... <!-- Reason (V3) for device not applied --> <entryRelationship typeCode="RSON"> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.24.3.88" extension="2017-08-01"/> ... </observation> </entryRelationship> </procedure></p> |

| Negated QDM Data Element | QRDA Template(s) | Guidance |
|----------------------------|---|---|
| <p>Device, Not Ordered</p> | <p>Device Order Act (V3) (2.16.840.1.113883.10.20.24.3.130:2019-12-01)</p> <p>Device Order (V5) (2.16.840.1.113883.10.20.24.3.9:2019-12-01)</p> <p>Note: Reason (V3) for not done is contained directly within the Device Order Act (V3) template</p> | <p>XPath for "Device, Not Ordered" Reason Code:</p> <pre> ./act[templateId/@root="2.16.840.1.113883.10.20.24.3.130"][templateId/@extension="2019-12-01"][@negationInd="true"]/entryRelationship[@typeCode="RSON"]/observation[templateId/@root="2.16.840.1.113883.10.20.24.3.88"][templateId/@extension="2017-08-01"]/value[@xsi:type="CD"]/ </pre> <p><!-- Device Order Act (V3) --> <act classCode="ACT" moodCode="EVN" negationInd="true"> <templateId root="2.16.840.1.113883.10.20.24.3.130" extension="2019-12-01"/> <code code="SPLY" codeSystem="2.16.840.1.1.113883.5.6" displayName="Supply"/> <!-- Device Order (V5) --> <entryRelationship typeCode="SUBJ"> <supply classCode="SPLY" moodCode="RQO"> <templateId root="2.16.840.1.113883.10.20.22.4.43" extension="2014-06-09"/> <templateId root="2.16.840.1.113883.10.20.24.3.9" extension="2019-12-01"/> ... </supply> </entryRelationship> <!-- Reason(V3) for device not ordered --> <entryRelationship typeCode="RSON"> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.24.3.88" extension="2017-08-01"/> ... </observation> </entryRelationship> </act></p> |

| Negated QDM Data Element | QRDA Template(s) | Guidance |
|------------------------------|--|---|
| Medication, Not Administered | Medication Administered (V5) (2.16.840.1.113883.10.20.24.3.42:2019-12-01) | <p>XPath for "Medication, Not Administered" Reason Code:</p> <pre> ./substanceAdministration[templateId/@root="2.16.840.1.113883.10.20.24.3.42"][templateId/@extension="2019-12-01"][@negationInd="true"]/entryRelationship[@typeCode="RSON"]/observation[templateId/@root="2.16.840.1.113883.10.20.24.3.88"][templateId/@extension="2017-08-01"]/value[@xsi:type="CD"/> </pre> <p><!-- Medication Administered (V5) --> <substanceAdministration classCode="SBADM" moodCode="EVN" negationInd="true" > <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09"/> <templateId root="2.16.840.1.113883.10.20.24.3.42" extension="2019-12-01"/> ... <!-- Reason (V3) for medication not administered --> <entryRelationship typeCode="RSON"> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.24.3.88" extension="2017-08-01"/> <code code="77301-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Reason care action performed or not"/> <value xsi:type="CD" code="397745006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Medical contraindication (finding)"/> </observation> </entryRelationship> </substanceAdministration> </p> |

| Negated QDM Data Element | QRDA Template(s) | Guidance |
|-----------------------------------|--|--|
| <p>Medication, Not Discharged</p> | <p>Discharge Medication (V5) (2.16.840.1.113883.10.20.24.3.105:2019-12-01)</p> <p>Note: Reason (V3) for not done is contained directly within the Discharge Medication (V5) template</p> | <p>XPath for "Medication, Not Discharged" Reason Code:</p> <pre> ./act[templateId/@root="2.16.840.1.113883.10.20.24.3.105"][templateId/@extension="2019-12-01"][@negationInd="true"]/entryRelationship[@typeCode="RSON"]/observation[templateId/@root="2.16.840.1.113883.10.20.24.3.88"][templateId/@extension="2017-08-01"]/value[@xsi:type="CD"]/ </pre> <p><!-- Discharge Medication (V5) --></p> <pre> <act classCode="ACT" moodCode="RQO" negationInd="true"> <templateId root="2.16.840.1.113883.10.20.24.3.105" extension="2019-12-01"/> <code code="75311-1" codeSystem="2.16.840.1.1.113883.6.1" displayName="Discharge medications"/> <!-- Medication Activity (V2) --> <entryRelationship typeCode="SUBJ"> <substanceAdministration classCode="SBADM" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.22.4.16" extension="2014-06-09"/> <id root="f8a9729a-ba09-4dc6-a430-bde2c6137d3c"/> ... </substanceAdministration > </entryRelationship> <!-- Reason (V3) for medication not discharged --> <entryRelationship typeCode="RSON"> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.24.3.88" extension="2017-08-01"/> ... </observation> </entryRelationship> </act> </pre> |

| Negated QDM Data Element | QRDA Template(s) | Guidance |
|--------------------------|---|--|
| Medication, Not Ordered | Medication Order (V6) (2.16.840.1.113883.10.20.24.3.47:2019-12-01) | <p>XPath for "Medication, Not Ordered" Reason Code:</p> <pre> ./substanceAdministration [templateId/@root="2.16.840.1.113883.10.20.24.3.47"] [templateId/@extension="2019-12-01"] [@negationInd="true"]/entryRelationship[@typeCode="RSON"]/observation[templateId/@root="2.16.840.1.113883.10.20.24.3.88"] [templateId/@extension="2017-08-01"]/value[@xsi:type="CD"]/ </pre> <p><!-- Medication Order (V6) --></p> <pre> <substanceAdministration classCode="SBADM" moodCode="RQO" negationInd="true"> <templateId root="2.16.840.1.113883.10.20.22.4.42" extension="2014-06-09"/> <templateId root="2.16.840.1.113883.10.20.24.3.47" extension="2019-12-01"/> ... <!-- Reason (V3) for medication not ordered --> <entryRelationship typeCode="RSON"> <observation classCode="OBS" moodCode="EVN"> <templateId root="2.16.840.1.113883.10.20.24.3.88" extension="2017-08-01"/> ... </observation> </entryRelationship> </substanceAdministration> </pre> |

11 Ensuring Data Uniqueness

The presence of duplicated data in a QRDA I file not only could potentially lead to increased data processing time, but most importantly, might cause incorrect processing and therefore produce unexpected measure results when calculated by other entities. The Processing Consideration section in Volume 1 of the HL7 QRDA I STU R5.2 provides guidance for ensuring data uniqueness in a QRDA I file. Submitted QRDA I files for HQR in the 2022 reporting period should follow the ensuring data uniqueness guidance specified in the base standard.

- Each reported QDM data element contains all of the attributes (e.g., discharge status, facility location, etc.) required by all measures, which are reported in the file, in the same QRDA template for the same instance.
- Not to duplicate QDM data element by including `sdtc:valueSet`. (Note that `sdtc:valueset` is still required for Not Done events where attribute `negationInd="true"` and should only be used when submitting a Not Done event.)

Table 24 lists the key elements for determining data uniqueness.

Table 24: Key Elements for Determining Data Uniqueness

| QDM Data Type | Key Elements |
|--|--|
| Data types except Encounter | <p>Precondition: same QRDA template</p> <ul style="list-style-type: none"> • Id element—combination of <code>@root</code> and <code>@extension</code> (if <code>@extension</code> is present) <ul style="list-style-type: none"> ◦ <code>act/id</code> ◦ <code>observation/id</code> ◦ <code>procedure/id</code> ◦ <code>substanceAdministration/id</code> ◦ <code>supply/id</code> |
| Encounter containing inpatient code (each episode of care) | <p>Precondition: same QRDA template</p> <ul style="list-style-type: none"> • Encounter id element (<code>encounter/id</code>)— combination of <code>@root</code> and <code>@extension</code> (if <code>@extension</code> is present) • Encounter code (<code>encounter/code</code>) • Admission date time (<code>encounter/effectiveTime/low</code>) • Discharge date time (<code>encounter/effectiveTime/high</code>) <p>Each episode of care (EOC) shall have one unique inpatient encounter id and if there are other types of encounters present (e.g., ED) during the same episode of care, they shall have their own unique encounter ids. If there is data for multiple episodes of care within the same QRDA Category I file, then each episode of care shall have its own unique inpatient encounter id. Should there be another reference to an encounter/EOC in a QRDA Category I file, then users should reference the previously reported encounter id of that inpatient encounter instance or EOC.</p> |
| Other Encounter (Encounter containing codes other than inpatient code) | <p>Precondition: same QRDA template</p> <ul style="list-style-type: none"> • Encounter id element (<code>encounter/id</code>)—combination of <code>@root</code> and <code>@extension</code> (if <code>@extension</code> is present) • Encounter code (<code>encounter/code</code>) |

12 CMS QRDA I Implementation Guide Changes to QRDA I STU R5.2 Base Standard

This table lists all changes made to the base HL7 QRDA I STU R5.2 contained in this implementation guide. The "Base Standard" is the *HL7 Implementation Guide for CDA Release 2: Quality Report Document Architecture, Category I, STU Release 5.2* and any subsequent errata update.

Table 25: Changes Made to the QRDA I STU R5.2 Base Standard

| CONF. # | Section | Base Standard | Changed To |
|----------------------------------|---------|--|--|
| n/a | 5.1.1 | n/a | Conforms to QDM-Based QRDA (V7) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.1.2:2019-12-01). |
| CMS_0001 CMS_0002 CMS_0003 | 5.1.1 | n/a | SHALL contain exactly one [1..1] templateId (CONF:CMS_0001) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.24.1.3" (CONF:CMS_0002). SHALL contain exactly one [1..1] @extension="2020-02-01" (CONF:CMS_0003). |
| CMS_0010 | 5.1.1 | n/a | This languageCode SHALL contain exactly one [1..1] @code="en" (CONF:CMS_0010). |
| 4444-16857_C01 | 5.1.2 | This patientRole MAY contain zero or one [0..1] id (CONF:4444-16857) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.572" Medicare HIC number (CONF:4444-16858). | This patientRole SHOULD contain zero or one [0..1] id (CONF:4444-16857_C01) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.572" Medicare HIC number (CONF:4444-16858). |

| CONF. # | Section | Base Standard | Changed To |
|----------------------------------|---------|---|---|
| CMS_0009 CMS_0053 CMS_0103 | 5.1.2 | n/a | <p>This patientRole SHALL contain exactly one [1..1] id (CONF:CMS_0009) such that it</p> <p>SHALL contain exactly one [1..1] @root (CONF:CMS_0053). Note: This is the provider's organization OID or other non-null value different from the OID for the Medicare HIC Number (2.16.840.1.113883.4.572) and the OID for the Medicare Beneficiary Identifier (2.16.840.1.113883.4.927).</p> <p>SHALL contain exactly one [1..1] @extension (CONF:CMS_0103). Note: The value of @extension is the Patient ID.</p> |
| 4444-28697_C01 | 5.1.2 | <p>This patientRole MAY contain zero or one [0..1] id (CONF:4444-28697) such that it</p> <p>SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.927" Medicare Beneficiary Identifier (MBI) (CONF:4444-28698).</p> | <p>HQR: Medicare Beneficiary Identifier (MBI) is not required for HQR but should be submitted if the payer is Medicare and the patient has an MBI number assigned.</p> <p>This patientRole SHOULD contain zero or one [0..1] id (CONF:4444-28697_C01) such that it</p> <p>SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.927" Medicare Beneficiary Identifier (MBI) (CONF:4444-28698).</p> |
| 1198-5284_C01 | 5.1.2 | <p>This patient SHALL contain at least one [1..*] US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5284).</p> | <p>This patient SHALL contain exactly one [1..1] US Realm Person Name (PN.US.FIELDDED) (identifier: urn:oid:2.16.840.1.113883.10.20.22.5.1.1) (CONF:1198-5284_C01).</p> |
| CMS_0011 CMS_0029 | 5.1.2 | <p>This patient SHALL contain exactly one [1..1] administrativeGenderCode, which SHALL be selected from ValueSet Administrative Gender (HL7 V3) urn:oid:2.16.840.1.113883.1.11.1 DYNAMIC (CONF:1198-6394).</p> | <p>This patient SHALL contain exactly one [1..1] administrativeGenderCode, which SHALL be selected from ValueSet ONC Administrative Sex urn:oid:2.16.840.1.113762.1.4.1 DYNAMIC (CONF:CMS_0011).</p> <p>If the patient's administrative sex is unknown, nullFlavor="UNK" SHALL be submitted (CONF:CMS_0029).</p> |

| CONF. # | Section | Base Standard | Changed To |
|----------------------------------|---------|--|---|
| 1198-5300_C01 | 5.1.2 | <p>This patient SHALL contain exactly one [1..1] birthTime (CONF:1198-5298).</p> <p>SHOULD be precise to day (CONF:1198-5300).</p> <p>For cases where information about newborn's time of birth needs to be captured.</p> <p>MAY be precise to the minute (CONF:1198-32418).</p> | <p>This patient SHALL contain exactly one [1..1] birthTime (CONF:1198-5298).</p> <p>SHALL be precise to day (CONF:1198-5300_C01).</p> <p>For cases where information about newborn's time of birth needs to be captured.</p> <p>MAY be precise to the minute (CONF:1198-32418).</p> |
| CMS_0013 CMS_0030 CMS_0031 | 5.1.2 | <p>This patient SHALL contain exactly one [1..1] raceCode, which SHALL be selected from ValueSet Race Category Excluding Nulls urn:oid:2.16.840.1.113883.3.2074.1.1.3 DYNAMIC (CONF:1198-5322).</p> | <p>This patient SHALL contain exactly one [1..1] raceCode, which SHALL be selected from ValueSet Race urn:oid:2.16.840.1.114222.4.1.1.836 DYNAMIC (CONF:CMS_0013).</p> <p>If the patient's race is unknown, nullFlavor="UNK" SHALL be submitted (CONF:CMS_0030).</p> <p>If the patient declined to specify his/her race, nullFlavor="ASKU" SHALL be submitted (CONF:CMS_0031).</p> |
| CMS_0014 | 5.1.2 | <p>This patient MAY contain zero or more [0..*] sdtc:raceCode, which SHALL be selected from ValueSet Race urn:oid:2.16.840.1.113883.1.11.14914 DYNAMIC (CONF:1198-7263).</p> | <p>This patient MAY contain zero or more [0..*] sdtc:raceCode, which SHALL be selected from ValueSet Race urn:oid:2.16.840.1.114222.4.1.1.836 DYNAMIC (CONF:CMS_0014).</p> <p>Note: If a patient has more than one race category, one race is reported in raceCode, and additional races are reported using sdtc:raceCode.</p> |
| CMS_0032 CMS_0033 | 5.1.2 | <p>This patient SHALL contain exactly one [1..1] ethnicGroupCode, which SHALL be selected from ValueSet Ethnicity urn:oid:2.16.840.1.114222.4.1.11.837 DYNAMIC (CONF:1198-5323).</p> | <p>This patient SHALL contain exactly one [1..1] ethnicGroupCode, which SHALL be selected from ValueSet Ethnicity urn:oid:2.16.840.1.114222.4.1.1.837 DYNAMIC (CONF:1198-5323).</p> <p>If the patient's ethnicity is unknown, nullFlavor="UNK" SHALL be submitted (CONF:CMS_0032).</p> <p>If the patient declined to specify his/her ethnicity, nullFlavor="ASKU" SHALL be submitted (CONF:CMS_0033).</p> |

| CONF. # | Section | Base Standard | Changed To |
|--|---------|--|--|
| 4444-28241_C01 | 5.1.3 | This representedCustodianOrganization SHOULD contain zero or one [0..1] id (CONF:4444-28241) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.336" CMS Certification Number (CONF:4444-28244). | This representedCustodianOrganization SHALL contain exactly one [1..1] id (CONF:4444-28241_C01) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.4.336" CMS Certification Number (CONF:4444-28244). |
| CMS_0035 | 5.1.3 | n/a | CCN SHALL be six to ten characters in length (CONF:CMS_0035). |
| 4444-16703_C01 | 5.1.4 | MAY contain zero or more [0..*] informationRecipient (CONF:4444-16703). | SHALL contain exactly one [1..1] informationRecipient (CONF:4444-16703_C01). |
| 4444-16705_C01 CMS_0025 CMS_0026 | 5.1.4 | This intendedRecipient SHALL contain at least one [1..*] id (CONF:4444-16705). | This intendedRecipient SHALL contain exactly one [1..1] id (CONF:4444-16705_C01). This id SHALL contain exactly one [1..1] @root="2.16.840.1.113883.3.249.7" (CONF:CMS_0025). This id SHALL contain exactly one [1..1] @extension, which SHALL be selected from ValueSet QRDA I CMS Program Name urn:oid:2.16.840.1.113883.3.249.14.103 STATIC 2020-02-01 (CONF:CMS_0026). Note: The value of @extension is CMS Program Name. |

| CONF. # | Section | Base Standard | Changed To |
|--|---------|--|---|
| 1198-10003_C01 CMS_0004 CMS_0005 CMS_0006 CMS_0008 | 5.1.5 | MAY contain zero or more [0..*] participant (CONF:1198-10003) such that it | <p>SHALL contain exactly one [1..1] participant (CONF:1198-10003_C01).</p> <p>HQR: CMS EHR Certification ID is required for HQR.</p> <p>The participant SHALL contain exactly one [1..1] associatedEntity (CONF:CMS_0004).</p> <p>This associatedEntity SHALL contain exactly one [1..1] id (CONF:CMS_0005) such that it</p> <p style="padding-left: 20px;">This id SHALL contain exactly one [1..1] <code>@root="2.16.840.1.113883.3.2074.1"</code> CMS EHR Certification ID (CONF:CMS_0006).</p> <p style="padding-left: 20px;">This id SHALL contain exactly one [1..1] @extension (CONF:CMS_0008).</p> <p style="padding-left: 20px;">Note: The value of <code>@extension</code> is the CMS EHR Certification ID.</p> |
| CMS_0019 CMS_0020 | 5.1.6 | n/a | <p>This assignedEntity MAY contain zero or one [0..1] assignedPerson (CONF:CMS_0019).</p> <p>The assignedPerson, if present, MAY contain zero or one [0..1] name (CONF:CMS_0020).</p> <p>Note: This is the provider's name.</p> |
| CMS_0022 | 5.1.6 | n/a | <p>This representedOrganization MAY contain zero or one [0..1] name (CONF:CMS_0022).</p> <p>Note: This is the organization's name, such as hospital's name.</p> |
| CMS_0056 CMS_0054 | 5.1.7 | n/a | <p>This structuredBody SHALL contain exactly one [1..1] component (CONF:CMS_0056) such that it</p> <p style="padding-left: 20px;">SHALL contain exactly one [1..1] Reporting Parameters Section - CMS (identifier: <code>urn:h17ii:2.16.840.1.113883.10.20.17.2.1.1:2016-03-01</code>) (CONF:CMS_0054).</p> |

| CONF. # | Section | Base Standard | Changed To |
|---|----------------|---------------|---|
| <p>CMS_0057 CMS_0055</p> | <p>5.1.7</p> | <p>n/a</p> | <p>This structuredBody SHALL contain exactly one [1..1] component (CONF:CMS_0057) such that it</p> <p>SHALL contain exactly one [1..1] Patient Data Section QDM (V7) - CMS (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.2.1.1:2020-02-01) (CONF:CMS_0055).</p> |
| <p>CMS_0040 CMS_0041 CMS_0042 CMS_0023 CMS_0024</p> | <p>5.2.2</p> | <p>n/a</p> | <p>Conforms to Reporting Parameters Section template (identifier: urn:oid:2.16.840.1.113883.10.20.17.2.1).</p> <p>SHALL contain exactly one [1..1] templateId (CONF:CMS_0040) such that it</p> <p>SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.17.2.1.1" (CONF:CMS_0041).</p> <p>SHALL contain exactly one [1..1] @extension="2016-03-01" (CONF:CMS_0042).</p> <p>SHALL contain exactly one [1..1] entry (CONF:CMS_0023) such that it</p> <p>SHALL contain exactly one [1..1] Reporting Parameters Act - CMS (identifier: urn:hl7ii:2.16.840.1.113883.10.20.17.3.8.1:2016-03-01) (CONF:CMS_0024).</p> |
| <p>CMS_0044 CMS_0045 CMS_0046</p> | <p>5.2.2.1</p> | <p>n/a</p> | <p>Conforms to Reporting Parameters Act template (identifier: urn:oid:2.16.840.1.113883.10.20.17.3.8).</p> <p>SHALL contain exactly one [1..1] templateId (CONF:CMS_0044) such that it</p> <p>SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.17.3.8" (CONF:CMS_0045).</p> <p>SHALL contain exactly one [1..1] @extension="2016-03-01" (CONF:CMS_0046).</p> |

| CONF. # | Section | Base Standard | Changed To |
|--|----------------|--|---|
| <p>CMS_0048 CMS_0027 CMS_0050 CMS_0028</p> | <p>5.2.2.1</p> | <p>SHALL contain exactly one [1..1] effectiveTime (CONF:23-3273). This effectiveTime SHALL contain exactly one [1..1] low (CONF:23-3274). This effectiveTime SHALL contain exactly one [1..1] high (CONF:23-3275).</p> | <p>SHALL contain exactly one [1..1] effectiveTime (CONF:23-3273). This effectiveTime SHALL contain exactly one [1..1] low (CONF:23-3274). This low SHALL contain exactly one [1..1] @value (CONF:CMS_0048). SHALL be precise to day (CONF:CMS_0027) This effectiveTime SHALL contain exactly one [1..1] high (CONF:23-3275). This high SHALL contain exactly one [1..1] @value (CONF:CMS_0050). SHALL be precise to day (CONF:CMS_0028)</p> |
| <p>CMS_0036 CMS_0037 CMS_0038</p> | <p>5.2.3</p> | <p>n/a</p> | <p>Conforms to Patient Data Section QDM (V7) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.24.2.1:2019-12-01) . SHALL contain exactly one [1..1] templateId (CONF:CMS_0036) such that it SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.24.2.1.1" (CONF:CMS_0037). SHALL contain exactly one [1..1] @extension="2020-02-01" (CONF:CMS_0038).</p> |
| <p>CMS_0051 CMS_0039</p> | <p>5.2.3</p> | <p>n/a</p> | <p>SHALL contain at least one [1..*] entry (CONF:CMS_0051) such that it SHALL contain exactly one [1..1] entry template that is other than the Patient Characteristic Payer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.55) (CONF:CMS_0039).</p> |
| <p>4444-14430_C01</p> | <p>5.2.3</p> | <p>MAY contain zero or more [0..*] entry (CONF:4444-14430) such that it</p> | <p>SHALL contain at least one [1..*] entry (CONF:4444-14430_C01) such that it SHALL contain at least one [1..*] Patient Characteristic Payer (identifier: urn:oid:2.16.840.1.113883.10.20.24.3.55) (CONF:4444_14431).</p> |

13 Change Log for 2022 CMS QRDA I Implementation Guide from the 2021 CMS QRDA Implementation Guide

Table 26 summarizes the changes made in this 2022 CMS QRDA I Implementation Guide since the release of 2021 CMS QRDA I Implementation Guide.

Table 26: Changes Made for 2022 CMS QRDA I IG from 2021 CMS QRDA I IG

| Section Heading | 2022 CMS QRDA I IG | 2021 CMS QRDA I IG |
|--|--|---|
| Base Standard | No change. The base standard remains the same as the 2021 CMS QRDA I IG. HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture Category I, Release 1, Standard for Trial Use (STU) Release 5.2, US Realm, and any subsequent errata update. | HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture Category I, Release 1, Standard for Trial Use (STU) Release 5.2, US Realm, and any subsequent errata update |
| Disclaimer | Added the following to the disclaimer. Note: Implementation Guides may be updated after initial publication to address stakeholder or policy requirements. Be sure to revisit the eCQI Resource Center for updated resources prior to use. | Disclaimer |
| 4 QRDA Category I Requirements | Updated to reference the 2022 reporting period throughout. No changes to the requirements. | Section 4 |
| 4.2 eCQM, Hybrid Measure, and Value Set Specifications | Updated the section title to include Hybrid Measure. Updated the eCQI resource center link for EH/CAH eCQMs in the footnote and indicated to select the 2022 reporting period. Added language and footnote for Hybrid Measures specifications. | Section 4.2 eCQM and Value Set Specifications |
| 4.2 eCQM, Hybrid Measure, and Value Set Specifications | For hybrid measure/core clinical data element (CCDE) voluntary submission, this guide must be used for reporting of 2022 - 2023 data (measurement period July 1, 2022 through June 30, 2023) and to be submitted in 2023. | For hybrid measure/core clinical data element (CCDE) voluntary submission, this guide must be used for reporting of 2021 - 2022 data (measurement period July 1, 2021 through June 30, 2022) and to be submitted in 2022. |

| Section Heading | 2022 CMS QRDA I IG | 2021 CMS QRDA I IG |
|---|--|---|
| 5.1.7 component | Corrected a typo error in Table 9. Column “Value” for Patient Data Section QDM (V7) – CMS template extension. The correct extension is 2020-02-01. | Table 9. Patient Data Section QDM (V7) in column “Value” showed an incorrect extension as 2019-02-01. |
| 5.2.1 Measure Section | Figure 10. Measure Section Example Updated to use a 2022 reporting period eCQM version specific UUID as an example. | Figure 10. Measure Section Example Example used is a 2021 reporting period eCQM version specific UUID. |
| 5.2.3.2 Reporting “unit” for Result Value | <p>Revised language:</p> <p>For example, in the measure logic for maximum LDL-c result of less than 70 mg/dL, Unified Code for Units of Measure (UCUM) code “mg/dL” is specified as “unit” by the eCQM definition.⁹</p> <p>Added new footnote:</p> <p>The Clinical Quality Language (CQL) specification defines a number of built-in units for timing, such as “week”, “weeks”, and “year”. eCQMs logics in CQL are expressed using these built-in units. For the 2022 reporting period, submitting either “week” and “weeks” or their corresponding UCUM representation “wk” will be accepted by the receiving system.</p> | For example, in the measure logic for maximum LDL-c result of less than 70 mg/dL, “mg/dL” is used as “unit” by the eCQM definition. |
| 5.2.3.2 Reporting “unit” for Result Value | <p>Revised language:</p> <p>If eCQM definition does not specify the “unit” in the measure logic for the “result” criteria, for example, [“Laboratory Test, Performed”: “INR”] INRLabTest where INRLabTest.result > 3.0, then the laboratory test performed result must be reported using one of the two options:</p> <ol style="list-style-type: none"> 1) represent INR result using data type REAL or Interval REAL (xsi:datatype=“REAL” or xsi:datatype=“IVL_REAL”) for results such as INR=2.4 or INR>=4.5; 2) represent INR result using data type PQ with PQ.unit as UCUM codes {ratio} or {INR}. | If eCQM definition does not use the “unit” in the measure logic for the “result” criteria, for example, [“Laboratory Test, Performed”: “INR”] INRLabTest where INRLabTest.result > 3.0, then the laboratory test performed result must be reported as data type REAL or Interval REAL (xsi:datatype=“REAL” or xsi:datatype=“IVL_REAL”) for results such as INR=2.4 or INR>=4.5. |

| Section Heading | 2022 CMS QRDA I IG | 2021 CMS QRDA I IG |
|--|--|---|
| 5.2.3.2 Reporting “unit” for Result Value | <p>Added the following language:</p> <p>For guidance on reporting result value “unit” for hybrid measures, please see 6.1 Reporting Result “unit” for Hybrid Measures.</p> | n/a |
| 5.3.1 Validation Rules for Encounter Performed | <p>Updated the error description of CMS_0063 to clarify this error triggers file rejection.</p> <p>The system SHALL reject QRDA I files if there are no Encounter Performed Discharge Dates within the reporting period found in the QRDA.</p> | <p>CMS_0063</p> <p>There are no Encounter Performed Discharge Dates within the reporting period found in the QRDA.</p> |
| 5.3.2 Additional HQR Validations | <p>Updated to reference the 2022 Reporting Period in the error description of CMS_0070</p> <p>The validation process compares the upload date with the Production Date Range values stored in internal table. If the upload date is outside the acceptable range(s), which for the 2022 Reporting Period is yet to be finalized, this message is returned.</p> | <p>CMS_0070</p> <p>The validation process compares the upload date with the Production Date Range values stored in internal table. If the upload date is outside the acceptable range(s), which for the 2021 Reporting Period is yet to be finalized, this message is returned.</p> |

| Section Heading | 2022 CMS QRDA I IG | 2021 CMS QRDA I IG |
|--|---|--|
| 5.3.2 Additional HQR Validations | <p>Updated to reference the 2021 version of eCQMs and 2022 reporting period in the error description of CMS_0074</p> <p>The Version Specific Measure Identifier for an eCQM being reported is a required element in the QRDA file (i.e., XPath is QualityMeasureDocument/id/@root). The HQR eCQM receiving system will only accept the "2021 version" of eCQMs for the CY 2022 reporting period. Each eCQM has an associated Version Specific Measure Identifier corresponding to the "2021 version" of eCQM specifications for the CY 2022 reporting period. Only those Version Specific Measure Identifiers for the current reporting year will be accepted. If any submitted version specific identifier does not match one of the defined set of the Version Specific Measure Identifier for the current reporting year, the file will be rejected.</p> | <p>CMS_0074</p> <p>The Version Specific Measure Identifier for an eCQM being reported is a required element in the QRDA file (i.e., XPath is QualityMeasureDocument/id/@root). The HQR eCQM receiving system will only accept the "2020 version" of eCQMs for the CY 2021 reporting period. Each eCQM has an associated Version Specific Measure Identifier corresponding to the "2020 version" of eCQM specifications for the CY 2021 reporting period. Only those Version Specific Measure Identifiers for the current reporting year will be accepted. If any submitted version specific identifier does not match one of the defined set of the Version Specific Measure Identifier for the current reporting year, the file will be rejected.</p> |
| 5.3.2 Additional HQR Validations | <p>Updated to CY2022/PY2024 in the error description of CMS_0082</p> <p>The EHR system needs to be certified to 2015 Edition for CY2022/PY2024.</p> | <p>CMS_0082</p> <p>The EHR system needs to be certified to 2015 Edition for CY2021/PY2023.</p> |
| 5.3.2 Additional HQR Validations | <p>Added validation rule CMS_0083</p> <p>CMS Certification ID format is not valid</p> | <p>n/a</p> <p>(Note that CMS_0083 is used by the HQR system, but was missing in the table)</p> |
| 6 Hybrid Measure/CCDE Voluntary Submission | <p>This section provides guidance on how to submit the encounter id associated with a core clinical data element and report result "unit" for hybrid measure voluntary submission.</p> <p>Note: The remaining content are in 6.1 Submitting the encounter id associated with a CCDE and 6.2 Reporting Result "unit for Hybrid Measures</p> | <p>This section provides guidance on how to submit the encounter id associated with a core clinical data element for hybrid measure voluntary submission.</p> |

| Section Heading | 2022 CMS QRDA I IG | 2021 CMS QRDA I IG |
|--|---|---|
| 6.1 Submitting the encounter id associated with a CCDE | Added a sub-section heading 6.1 Submitting the encounter id associated with a CCDE | n/a |
| 6.1 Submitting the encounter id associated with a CCDE | Removed the Hybrid Measure for Voluntary Submission table. | Table 17: Hybrid Measure for Voluntary Submission |
| 6.1 Submitting the encounter id associated with a CCDE | For each of the core clinical data elements specified in a hybrid measure, the measure specification returns the specific encounter id that a core clinical data element result is associated with. | For each of the core clinical data elements specified in the CMS529v1, the measure specification returns the specific encounter id that a core clinical data element result is associated with. |
| 6.1 Submitting the encounter id associated with a CCDE | <p>Changed the wording from “must” to “should”, because files will not be rejected if a CCDE is not associated with an encounter id.</p> <p>For example, when reporting the first resulted sodium value and datetime, it should also provide the encounter id that the sodium result is associated with in the same Laboratory Test, Performed (V5) template.</p> | For example, when reporting the first resulted sodium value and datetime, it must also provide the encounter id that the sodium result is associated with in the same Laboratory Test, Performed (V5) template. |
| 6.1 Submitting the encounter id associated with a CCDE | Added “Platelet count” to the Core Clinical Data Element column of Table 17: Associating an Existing Encounter Id with a Core Clinical Data Element. | Table 18: Associating an Existing Encounter Id with a Core Clinical Data Element |
| 6.2 Reporting Result “unit for Hybrid Measures | Added this section to provide guidance on reporting result unit for hybrid measures. | n/a |
| 7.3 Errata or Enhancement Requests | Changed to use the HL7 Jira Tracker system to submit errata or enhancements requests. | http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=283 |
| 14 Acronyms | Added UCUM. | n/a |
| 16 References | Added references for the HL7 Jira Tracker system and the CDA R2 Normative Edition. | Section 16 |

14 Acronyms

This section describes acronyms used in this guide.

| Acronym | Literal Translation |
|---------|---|
| ASKU | Asked, but not known |
| CCDE | Core Clinical Data Element |
| CDA | Clinical Document Architecture |
| CMS | Centers for Medicare & Medicaid Services |
| CONF | conformance |
| CQM | Clinical Quality Measure |
| STU | Standard for Trial Use |
| eCQI | electronic Clinical Quality Improvement |
| eCQM | electronic Clinical Quality Measure |
| EHR | Electronic Health Record |
| FAP | Final Action Processing |
| HIC | Health Insurance Claim |
| HL7 | Health Level Seven |
| HL7 V3 | Health Level 7 Version 3 |
| HQMF | Health Quality Measure Format |
| HQR | Hospital Quality Reporting |
| ID | identifier |
| IQR | Inpatient Quality Reporting |
| IT | Information technology |
| LOINC | Logical Observation Identifiers Names and Codes |
| MBI | Medicare Beneficiary Identification Number |
| n/a | not applicable |
| NA | Not applicable |
| NLM | National Library of Medicine |
| NPI | National Provider Identification Number |
| OID | Object Identifier |

| Acronym | Literal Translation |
|---------|--|
| ONC | Office of the National Coordinator for Health Information Technology |
| PI | Promoting Interoperability |
| QDM | Quality Data Model |
| QRDA | Quality Reporting Data Architecture |
| QRDA I | Quality Reporting Data Architecture Category I |
| TIN | Tax Identification Number |
| UCUM | Unified Code for Units of Measure |
| UNK | Unknown |
| UTC | Coordinated Universal Time |
| VSAC | Value Set Authority Center |
| XML | Extensible Markup Language |

15 Glossary

| Term | Definition |
|--|--|
| Electronic health record (EHR) | Electronic Health Record (EHR) is also known as the electronic patient record, electronic medical record, or computerized patient record. As defined by Healthcare Information Management and Systems Society, “the electronic health record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and imaging reports.” |
| Electronic Clinical Quality Measure (eCQM) | An electronic clinical quality measure (eCQM) is a clinical quality measure that is expressed and formatted to use data from electronic health records (EHR) and/or health information technology systems to measure healthcare quality, specifically data captured in structured form during the process of patient care. So they can be reported from an EHR, the Health Quality Measure Format (HQMF) is used to format the eCQM content using the Quality Data Model (QDM) to define the data elements and Clinical Quality Language (CQL) to express the logic needed to evaluate a provider or organization’s performance. |
| XML Path Language (XPath) | This notation provides a mechanism that will be familiar to developers for identifying parts of an XML document. XPath syntax selects nodes from an XML document using a path containing the context of the node(s). The path is constructed from node names and attribute names (prefixed by an '@') and concatenated with a '/' symbol. |

16 References

Certified Health IT Product List. <https://chpl.healthit.gov/>

eCQI Resource Center. <https://ecqi.healthit.gov/>

HL7 Implementation Guide for CDA Release 2: Quality Reporting Document Architecture, Category I, Release 1, Standard for Trial Use Release 5.2 (QRDA I STU R5.2), and subsequent errata update. http://www.hl7.org/implement/standards/product_brief.cfm?product_id=35

HL7 Clinical Document Architecture (CDA) Release 2.0 Normative Edition.
https://www.hl7.org/implement/standards/product_brief.cfm?product_id=496

HL7 Jira Tracker system. <https://jira.hl7.org>

ONC, Electronic Clinical Quality Measure issue reporting system.
<https://oncprojecttracking.healthit.gov/>

U.S. National Library of Medicine, Value Set Authority Center. <https://vsac.nlm.nih.gov>