# Table of Contents

Eligible Professional’s Guide to the Michigan Medicaid EHR Incentive Program 2013 .................. 1  
Version 1.0, Released .......................................................................................................................... 1  
About this document ............................................................................................................................. 4  
   Updates to this document ..................................................................................................................... 4  
   Revision history .................................................................................................................................. 4  
Introduction and background .................................................................................................................. 5  
Walking the “Path to Payment” by way of this EP guide ................................................................. 5  
   Are you one of the eligible professional types? ................................................................................. 6  
   Are you non-hospital based? ............................................................................................................ 6  
   How do you determine Medicaid eligible patient volume? ............................................................ 7  
Does your Medicaid eligible patient volume meet eligibility thresholds? ....................................... 9  
   Summary of Medicaid eligible patient volume thresholds .............................................................. 10  
What options exist for calculating patient volume thresholds? ....................................................... 10  
   Out-of-state Medicaid encounters ................................................................................................. 10  
   Calculating based on individual EP encounter data only ............................................................... 11  
   Calculating based on group encounter data/group proxy option ................................................. 11  
   Including MCO panel-assigned patients ...................................................................................... 12  
   Special criteria for FQHCs and RHCs calculating encounter data .............................................. 12  
   Needy individual encounters ....................................................................................................... 13  
   Eligible patient volume using needy individual encounters ..................................................... 13  
What is meaningful use (MU)? ........................................................................................................ 14  
   Three MU stages ............................................................................................................................ 14  
   Certified electronic health record technology (CEHRT) .............................................................. 14  
   Adoption, Implementation, Upgrading (AIU) – Program year one ................................................ 15  
   AIU defined ................................................................................................................................. 15  
   MU reporting period .................................................................................................................... 15  
   Percent of encounters required in CEHRT- Program year 2 and beyond ................................... 16  
What are the meaningful use (MU) objectives/measures? ................................................................ 16  
   MU objectives/measures .................................................................................................................. 16  
   Core ............................................................................................................................................ 16  
   Menu Objectives ............................................................................................................................ 17
About this document

This document is provided as an informational guide for eligible professionals (EP) enrolling in the Michigan Medicaid EHR Incentive Program. Additional information can be found at:

- Michigan Department of Community Health: Medical Services Administration policy bulletins [http://www.michigan.gov/mdch/](http://www.michigan.gov/mdch/)

Updates to this document

The first Eligible Professional’s Guide to the Medicaid EHR Incentive Program Version 1.0 was released on 12/21/2010. While revised regularly, significant policy changes and the continued evolution of the Michigan Medicaid EHR Incentive Program rendered Version 1.0 and its subsequent revisions inadequate. Version 2.0 released on 8/01/2012 represented a significant update, but applied only to the 2012 program year. This Version 3.0 contains significant new guidance from CMS, and applies exclusively to program year 2013. It represents the Michigan Department of Community Health’s current policy for program year 2013. As the incentive program continues to evolve toward 2014 and Stage 2 MU, this document will be revised as needed. Providers are encouraged to periodically check the website and sign up for the e-mail lists at [http://www.michiganhealthit.org/](http://www.michiganhealthit.org/).

Revision history

<table>
<thead>
<tr>
<th>Version</th>
<th>Release</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>12/21/2010</td>
<td>Original EP Guide</td>
</tr>
<tr>
<td>2.0</td>
<td>08/01/2012</td>
<td>Significant updates applying to program year 2012</td>
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<tr>
<td>3.0</td>
<td>02/06/2013</td>
<td>Significant updates applying to program year 2013</td>
</tr>
</tbody>
</table>
Introduction and background

The Centers for Medicare & Medicaid Services (CMS) have offered, through provisions in the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to certain medical providers participating in Medicaid. Medicaid incentives up to $63,750 are available to those Medicaid providers who meet eligibility requirements and meaningfully use a certified electronic health record technology (CEHRT).

CMS goals for this program include:

1) Enhancing care coordination and patient safety
2) Reducing paperwork and improving efficiencies
3) Facilitating electronic information sharing across providers, payers, and state lines, and
4) Enabling data sharing using state Health Information Exchanges (HIEs) and the National Health Information Network (NHIN)

Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce the costs of healthcare nationwide. This begins with the individual healthcare provider’s use of a CEHRT.

The Michigan Department of Community Health (MDCH) will work closely with federal and state partners to ensure the Michigan Medicaid EHR Incentive Program fits into both Michigan’s Health Information Technology (HIT) Plan and the national goals outlined above.

Walking the “Path to Payment” by way of this EP guide

Participation in the Michigan Medicaid EHR Incentive Program will require a healthcare provider, or as termed in this document an eligible professional (EP), to collect a significant amount of data and to meet a number of requirements. A provider is not truly an “EP” until these requirements are met.

This EP guide is provided to walk an EP down the path towards his or her first incentive payment and, should he or she choose to continue in subsequent years, all six incentive payments available to those eligible. In this document, requirements will be introduced in an order that allows the EP to determine his or her potential eligibility in a logical manner. The intention is to save the time of those who may be found ineligible early on. As an EP progresses through this guide, and it becomes clear that he or she will meet initial requirements, more detailed and complete information will follow.

Questions that will be answered along the path to payment:

- Are you one of the eligible professional (EP) types?
- Are you non-hospital based?
- How do you determine Medicaid eligible patient volume?
- Does your Medicaid patient volume meet eligibility thresholds?
What options exist for calculating patient volume thresholds?

What is certified electronic health record technology (CEHRT)?

What does it mean to adopt, implement, or upgrade to CEHRT in year 1?

What are meaningful use (MU) requirements for years 2 and 3?

How do I register for the Michigan Medicaid EHR Incentive Program?

What incentives do I receive after all this work?

It is important to note that this program is for the individual EP. The individual EP must meet the necessary requirements, have access to a CEHRT, attest to program adherence and if found eligible, receive payment. The individual EP may also be audited, so EPs should be active in the process and provide accurate information to avoid recoupment of incentive dollars by the state of Michigan.

Are you one of the eligible professional types?

EPs must be Michigan Medicaid providers who physically practice in the state and belong to one of the following professional types:

- Physicians
  - Medical Doctor (M.D.)
  - Doctor of Osteopathic Medicine (D.O.)
- Dentists (D.D.S.)
- Optometrists (O.D.)
- Nurse Practitioners (NP)
- Certified Nurse-Midwives (CNM)
- Physician Assistants (PA) practicing in a PA-led Federally Qualified Health Center (FQHC) or a PA-led Rural Health Clinic (RHC). PA-led includes:
  - When a PA is the primary provider in a clinic;
  - When a PA is the clinical or medical director (or in a similar role with similar responsibilities) at a clinical site of practice; or
  - When a PA is the owner of an RHC.

Any PA practicing in a PA-led site is eligible provided that he/she meets all of the other requirements including the eligible patient volume.

Are you non-hospital based?

EPs must be non-hospital based. “Non-hospital based,” is determined by looking at encounter percentages, a number produced by dividing a numerator by a denominator. The numerator is an EP’s total hospital encounters and the denominator is an EP’s total encounters including hospital encounters.

\[
\text{Total hospital encounters} \quad \frac{\text{Total encounters}}{}\]

Non-hospital based is currently defined as a medical professional who provides less than 90% of their encounters in a hospital setting during the eligibility reporting period.
Definition of terms for calculating non-hospital based status:

**Eligibility reporting period:** A continuous representative 90-day period within the 12 months preceding the date of EP registration/attestation or within the previous calendar year (January 1st through December 31st) during which time the EP captures encounter data required for the non-hospital based calculation.

**Encounter:** An encounter occurs when a medical service is rendered to an individual on a date falling within the 90-day eligibility reporting period. Multiple claims for the same patient, on the same day, count as only one encounter for each rendering EP.

**Hospital encounter:** A hospital encounter occurs when a medical service is rendered to an individual on a date falling within the 90-day eligibility reporting period using Place of Service code (POS) 21 inpatient, and/or POS 23 emergency department. Multiple claims for the same patient, on the same day, count as only one encounter for each rendering EP.

New for 2013, a hospital based EP who can demonstrate that he or she is funding the acquisition, implementation, and maintenance of a certified EHR technology, without receiving reimbursement from an eligible hospital or Critical Access Hospital (CAH), and use such CEHRT at a hospital in lieu of using the hospital's CEHRT, can be determined non-hospital based and eligible for incentive payments. Application for this determination will be through CMS.

Encounters are not to be confused with discharges. Any EP providing hospital services (POS 21 & 23) at any time during the eligibility reporting period must provide encounter data from all practice locations so the percentage can be accurately calculated.

**How do you determine Medicaid eligible patient volume?**
Medicaid eligible patient volume is determined by looking at encounter percentages, a number produced by dividing a numerator by a denominator. The numerator is generally an EP’s total Medicaid encounters and the denominator is generally an EP’s total encounters including Medicaid.

\[
\frac{\text{Medicaid encounters}}{\text{Total encounters}}
\]

Definitions for terms necessary to calculate Medicaid eligible patient volume:

**Eligibility reporting period:** A continuous representative 90-day period within the 12 months preceding the date of EP registration/attestation or within the previous calendar year (January 1st through December 31st) during which the EP demonstrates that he or she has maintained adequate Medicaid eligible patient volume to be eligible for the Medicaid EHR Incentive Program. Encounters used for calculating eligibility must fall within this 90-day period. It is the same period used in the hospital-based calculation.
**Total encounters:** For the purposes of calculating EP eligible patient volume, an encounter occurs when a medical service is rendered to an individual on a date falling within the 90-day eligibility reporting period. Multiple claims for the same patient, on the same day, count as only one encounter.

Additionally, please consider the following provisions:

- Michigan does not include in encounter calculations charity care by non-profit health care providers/clinics. Only EPs in FQHCs or RHCs can do so.
- Not every payer pays for the same care in the same way. Global billing is one example frequently used in prenatal care and/or surgery and surgery post-op. Some payers pay for the *individual* office visits while other payers bundle the costs for all visits into a single delivery payment. In the latter case, Michigan considers each episode of care (i.e., office visit) that occurs during the eligibility reporting period to be an “encounter.”

**All encounters meeting the above definition (including Medicaid encounters) are to be included in the total encounters (denominator) for calculating EP eligible patient volume.**

**Medicaid encounters:** For purposes of calculating EP eligible patient volume, a Medicaid encounter occurs when an EP provides a medical service to a Medicaid enrolled patient on a date falling within the 90-day eligibility reporting period. This includes “zero-pay” claims. Medicaid zero-pay claims that can be counted as Medicaid encounters include:

- Claims denied because service limits are maxed out
- Claims denied because the service is not covered under Michigan Medicaid
- Claims denied because another payer’s payment exceeded the Medicaid amount
- Claims denied for failure to submit in a timely manner

All of the above can be counted as Medicaid encounters as long as the patient was enrolled in Michigan Medicaid on the date of service. Multiple Medicaid claims for the same patient, on the same day, count as only one encounter for each rendering EP.

Medicaid is defined as any program administered by the state authorized under Title XIX or a Medicaid extension program authorized under Title XXI, of the Social Security Act. This includes both fee-for-service and managed care. It does not include any other non-Medicaid extension programs authorized under Title XXI of the Social Security Act, including the Children’s Health Insurance Program (CHIP).

The chart below lists the Title XIX Medicaid programs and Title XXI Medicaid extension programs in Michigan. Any encounter paid under one of these programs should be included in the numerator of the eligible patient volume calculation.
<table>
<thead>
<tr>
<th>Benefit Plan name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABW</td>
<td>Adult Benefits Waiver Program</td>
</tr>
<tr>
<td>ABW-ESO</td>
<td>Adult Benefits Waiver (Emergency Services)</td>
</tr>
<tr>
<td>ABW-MC</td>
<td>Adult Benefits Waiver Program (Managed Care)</td>
</tr>
<tr>
<td>ALMB</td>
<td>Additional Low Income Medicare Beneficiary</td>
</tr>
<tr>
<td>BMP</td>
<td>Beneficiary Monitoring Program</td>
</tr>
<tr>
<td>CWP</td>
<td>Children’s Home and Community Based Services Waiver</td>
</tr>
<tr>
<td>SED</td>
<td>Children’s Serious Emotional Disturbance Waiver Program</td>
</tr>
<tr>
<td>SED-DHS</td>
<td>Children’s Serious Emotional Disturbance Waiver-DHS</td>
</tr>
<tr>
<td>CMH</td>
<td>Community Mental Health</td>
</tr>
<tr>
<td>ESRD</td>
<td>End Stage Renal Disease</td>
</tr>
<tr>
<td>Plan First</td>
<td>Family Planning Waiver</td>
</tr>
<tr>
<td>HK-EXP</td>
<td>Full Fee-for-Service Healthy Kids - Expansion</td>
</tr>
<tr>
<td>MA</td>
<td>Full Fee-for-Service Medicaid</td>
</tr>
<tr>
<td>HSW</td>
<td>Habilitation Supports Waiver Program</td>
</tr>
<tr>
<td>HK-EXP-ESO</td>
<td>Healthy Kids Expansion Emergency Services</td>
</tr>
<tr>
<td>MI Choice</td>
<td>Home and Community Based Waiver Services</td>
</tr>
<tr>
<td>Hospice</td>
<td>Hospice</td>
</tr>
<tr>
<td>Hospice-18</td>
<td>Hospice Medicare Benefit Plan</td>
</tr>
<tr>
<td>INCAR-ABW</td>
<td>Incarceration--ABW</td>
</tr>
<tr>
<td>INCAR-ESO</td>
<td>Incarceration – Emergency Services</td>
</tr>
<tr>
<td>INCAR-MA</td>
<td>Incarceration – MA</td>
</tr>
<tr>
<td>INCAR-MA-E</td>
<td>Incarceration – MA – Emergency Services</td>
</tr>
<tr>
<td>INCAR</td>
<td>Incarceration – Other</td>
</tr>
<tr>
<td>ICF/MR-DD</td>
<td>Intermediate Care Facility for Mentally Retarded – DD</td>
</tr>
<tr>
<td>MA-MC</td>
<td>Medicaid Managed Care</td>
</tr>
<tr>
<td>MA-ESO</td>
<td>Medical Assistance Emergency Services</td>
</tr>
<tr>
<td>Spendown</td>
<td>Medical Spend-down</td>
</tr>
<tr>
<td>MOMS</td>
<td>Maternity Outpatient Medical Services</td>
</tr>
<tr>
<td>NH</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>PIHP</td>
<td>Prepaid Inpatient Health Plan</td>
</tr>
<tr>
<td>PACE</td>
<td>Program All-Inclusive Care for Elderly</td>
</tr>
<tr>
<td>QDWI</td>
<td>Qualified Disabled Working Individual</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary – All Inclusive</td>
</tr>
<tr>
<td>SLMB</td>
<td>Special Low Income Medicare Beneficiary</td>
</tr>
<tr>
<td>SPF</td>
<td>State Psychiatric Hospital</td>
</tr>
<tr>
<td>SA</td>
<td>Substance Abuse</td>
</tr>
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**Does your Medicaid eligible patient volume meet eligibility thresholds?**

With the encounter, Medicaid encounter, and eligibility reporting periods defined, an EP can calculate the required Medicaid eligible patient volume thresholds. These thresholds use encounter data from the 90-day eligibility report period. The eligibility threshold is a minimum of a 30% Medicaid eligible patient volume for most EPs and 20% for pediatricians.
Medicaid eligible patient volume is calculated using total Medicaid encounters in the numerator and total patient encounters in the denominator. EPs that “practice predominantly” at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), while required to meet a 30% threshold, may include “needy individual” encounters (e.g., Medicaid in addition to MI Child, charity care, sliding fee, etc.) in their numerators and denominators.

**Summary of Medicaid eligible patient volume thresholds**

a) A minimum 30% patient volume attributable to encounters having Michigan Medicaid enrolled patients

b) For pediatricians, a minimum 20% patient volume attributable to encounters having Michigan Medicaid enrolled patients

c) For those who practice predominantly in an FQHC or RHC, a minimum 30% needy individual patient volume is required (needy individuals include Medicaid encounters in addition to MI Child, charity care, sliding fee, etc.)

If a pediatrician has greater than 20% but less than 30% Medicaid eligible patient volume, his or her annual incentive cap is reduced to 2/3 the full incentive. Pediatricians who achieve a 30% Medicaid eligible patient volume are eligible to receive the full incentive.

**Pediatrician:** For the purposes of the EHR Incentive Program only, Michigan Medicaid defines a pediatrician as:

A Medical Doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must hold a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree and hold a current, in good-standing, board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).

-OR-

A Medical Doctor who diagnoses, treats, examines, and prevents diseases and injuries in children, and must hold a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree. Also, at least 50% of the EPs total patient population must be 18 years old and under.

**What options exist for calculating patient volume thresholds?**

**Out-of-state Medicaid encounters**

An EP has the option to include encounters from other states in his or her Medicaid patient volume thresholds. The inclusion of out-of-state encounters will initiate an eligibility verification audit; Medicaid staff may contact the other state Medicaid programs to confirm encounter data. While done on a case by case basis, this may delay payment.
Calculating based on individual EP encounter data only

Individual EPs may choose one (or more) clinical sites of practice in order to calculate and meet the requirement for 30% Medicaid patient volume. If choosing more than one practice site, the EP would add Medicaid encounter data from each site to find the numerator and add total encounter data from each site to find the denominator.

This calculation does not need to be across all of an EP’s sites of practice. However, at least one of the locations where the EP is adopting or meaningfully using CEHRT should be included in the patient volume. In other words, if an EP practices in multiple locations, one with CEHRT and one without, the EP should be sure to include the patient volume of the site having CEHRT.

EPs registering with individual data having Medicaid managed care panel-assigned patients and/or work predominantly in an FQHC or RHC have additional options for calculating patient volume which are described later.

EPs seeing the same patient on the same day may apply that encounter in each provider’s individual patient volume calculation.

A NP or PA rendering service and their associated supervising physician may both include an encounter for the same patient on the same day in their individual encounter calculation so long as it can be proven through an auditable data source.

Calculating based on group encounter data/group proxy option

As mentioned in the Introduction, the Michigan Medicaid EHR Incentive Program is for the individual EP. However, one concession has been made to help those EPs working within a group, called the group proxy option. An EP is allowed to use the entire clinic or group practice’s eligible patient volume as a proxy to his or her own individual eligible patient volume. For the purposes of this program, a clinic or group is a collection of healthcare practitioners organized as one legal entity under one Tax Identification Number (TIN).

The organization may be made up of multiple NPIs (as is the case with many FQHCs), but if they are all one legal entity paid under one tax ID then the eligible patient volume may be calculated in aggregate for all NPIs in the organization or at each NPI location. EPs that elect this option are required to provide the group NPI of the practice or practices they are using as their proxy. This will facilitate verification and possible audit.

In order to use this proxy option, all of the following criteria must be met:

1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP. For example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation;

2) There is an auditable data source to support the clinic's patient volume determination; and

3) The practice and EPs must use one methodology in each year. In other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic while others use the clinic-level data. The clinic or practice must use the entire practice's patient volume and not limit it in any way. This includes encounters from non-EPs.
Whereas multiple EPs registering individually may each claim an encounter when each provides services to the same patient on the same day, this is not the case when using the group proxy option.

If the EP works both in the clinic used as proxy and an outside clinic, then the clinic/practice level encounter data includes only those encounters associated with that clinic/practice used as proxy. It is not an option to include managed care panel-assigned patients when using the proxy option.

**Including MCO panel-assigned patients**

An EP who is a primary care provider registering with individual data and has Medicaid managed care organization (MCO) or medical home patients assigned, has the option to include encounters by patient panel-assignment in his or her eligible patient volume threshold calculation. Encounters for patients assigned to a patient panel that occurred during the reporting period should be recorded as encounters, whereas patients who did not have an encounter during the 90-day eligibility reporting period, but where assigned within the previous 24 months as allowed below, may be counted on the panel.

The formula for determining eligible patient volume using patient panel assignments is:

\[
\frac{[\text{Total Medicaid patients assigned to the EP during the 90-day eligibility period with at least one encounter in the 24 months preceding the start of the 90-day period}] - \text{PLUS-} \ [\text{Unduplicated Medicaid encounters in that same 90-day period}]}{[\text{Total patients assigned to the EP during the 90-day eligibility period with at least one encounter in the 24 months preceding the start of the 90-day period}] - \text{PLUS-} [\text{All unduplicated encounters in that same 90-day period}]} \]

In this calculation "unduplicated" simply means that an EP may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel) but these may not be counted in more than one place in the equation.

**Special criteria for FQHCs and RHCs calculating encounter data**

An EP registering using individual encounter data may use the special criteria detailed below to determine his or her eligible patient volume if both of the following criteria are met:

1. The EP wishes to register as an individual as opposed to using the group proxy option.
2. The EP “practices predominantly” at an FQHC and/or RHC. (An EP practices predominantly at an FQHC and/or RHC when over 50% of his or her total patient encounters occur at an FQHC and/or RHC during a sixth month period within the 12 months preceding the date of EP registration/attestation or within the previous calendar year (January 1st through December 31st)).
If both criteria are met, when calculating encounters at an FQHC and/or RHC, the EP may include the following “needy individual encounters” toward their 30 percent Medicaid encounter volume:

- MIChild
- Sliding fee scale
- Charity care

An EP registering individually may include encounter data from other sites of his or her practice if they choose; however, EPs must exclude individual encounters from locations that have already applied for the Medicaid EHR Incentive Program using the proxy option (to avoid counting encounters twice). If the EP is a general practitioner, unduplicated patient panel encounters may be added to the numerator.

FQHCs and RHCs providing eligibility data for all their EPs using the group proxy option may take advantage of reporting needy individual encounters, but not panel-assigned patients.

**Needy individual encounters**

For purposes of calculating needy individual eligible patient volume, a needy patient encounter means services rendered to an individual on any one day where:

- Medicaid and/or Children's Health Insurance Program (CHIP, known as MIChild in Michigan, or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service;
- Medicaid or CHIP, or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act, paid all or part of the individual’s premiums, co-payments, or cost-sharing;
- The services were furnished at no cost (charity); or
- The services were paid for at a reduced cost based on a sliding scale determined by the individual’s ability to pay.

Note: Medical services provided as charity, are provided as charity on the date of service. A patient, who is billed for services rendered and does not pay, and is later written off, does not count as charity.

**Eligible patient volume using needy individual encounters**

The formula for calculating eligible patient volume using needy individual encounters includes total needy individual encounters (including Medicaid) as numerator and total patient encounters as denominator.

\[
\text{Needy individual encounters} \quad \frac{\text{Needy individual encounters}}{\text{Total patient encounters}}
\]

Encounters must fall within the 90-day eligibility period.
What is meaningful use (MU)?

Three MU stages

In order to receive and continue to receive incentive payments, EPs must achieve and maintain a set of meaningful use (MU) measures as defined by CMS. MU employs a three stage approach, with each stage building on the preceding stage.

- Stage 1 - 2011: Data capture and sharing
- Stage 2 - 2014: Expand upon the Stage 1 criteria to encourage the use of health information technology and exchange for continuous quality improvement
- Stage 3 - 2016: Expand on Stage 2 with a focus on promoting improved outcomes in quality, safety, and efficiency

Stage 1 is currently defined. These requirements are explained further in the CMS final rule (http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf) and outlined in this document.

Stage 2 has also been released. Documents outlining Stage 2 can be reviewed at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Certified electronic health record technology (CEHRT)

In order to qualify for the Medicaid EHR Incentive Program, EPs must use certified EHR technology (CEHRT). CEHRT must meet or surpass minimum government requirements for security, privacy, and interoperability and allow the purchaser to meet MU measures based on the Stage they are in. A CEHRT can be a stand-alone EHR, or a series of modules put together to attain MU functionality and certification.
Starting in 2014, all Medicaid EHR Incentive Program participants will have to adopt certified EHR technology that meets the Office of the National Coordinator for Health IT (ONC) Standards & Certification Criteria 2014 Final Rule regardless of stage.

Product certification is processed through the ONC and must be listed on the Certified HIT Product List (CHPL) maintained by ONC. All certified products appear on this list. Only the product version(s) included on the CHPL are certified.

The list can be found at [http://onc-chpl.force.com/ehrcert](http://onc-chpl.force.com/ehrcert). Note: this link is subject to change but the CHPL will always be available from the ONC’s main page at [http://healthit.hhs.gov](http://healthit.hhs.gov).

The CHPL will also assign a CMS EHR Certification ID. This is the ID required when registering for the EHR incentive programs. This number represents the product, or products that will allow for MU requirements to be met. See the CHPL guide at: [http://www.michiganhealthit.org/docs/UsingCHPL.pdf](http://www.michiganhealthit.org/docs/UsingCHPL.pdf)

**Adoption, Implementation, Upgrading (AIU) – Program year one**

A Medicaid EP does not have to meet MU criteria in his or her first year of participation. Instead, all first year EPs are required to attest to adopting, implementing, or upgrading (AIU) to a CEHRT. MU criteria must be met in all subsequent participation years. The 2014 Stage 2 Final Rule clarifies that providers may not receive an AIU payment if their CEHRT does not allow them to meet MU, however this does not mean EPs attesting under AIU in 2013, have to have a Certified 2014 EHR prior to 2014.

Timing the acquisition of a Certified 2014 EHR will be left to the EP.

**AIU defined:**

- Adoption – acquired certified EHR technology (e.g., evidence of purchasing or securing access to certified EHR technology)
- Implementation – began using EHR (e.g., staff training, data entry of patient demographic information on EHR)
- Upgrading – expanded EHR (e.g., upgraded to certified EHR technology or added new functionality to meet MU)

**MU reporting period**

The MU reporting period is a continuous period during which the EP successfully demonstrates meeting MU objectives. It should not be confused with the eligibility reporting period. The breakdown of each year’s reporting period is as follows:

- An EP entering his or her first year in the program must attest under AIU and do not have to meet MU requirements.
- The subsequent year would then be the first MU *reporting period* and is a consecutive 90-day period in that same calendar year. MU must be met prior to receiving the second payment.
For all subsequent payment years, the reporting period is the full calendar year necessitating reporting and attestation in the subsequent calendar year. 2014 will be the exception as a result of Stage 2, requiring all EPs to report only three months of MU data (not 90 days).

Note: Program years do not have to be consecutive; EPs can skip years (Medicare payment adjustments for failing to meet MU will still apply).

For example, let’s say an EP registers under AIU in 2011 and receives his or her first-year incentive payment. To receive the second-year payment for 2012, the EP would have to wait at least 90 days after January 1, 2012 in order to demonstrate MU for 90 days within 2012 (a requirement for the second-year payment) before attesting. To receive the third-year payment (nominally, the 2013 payment), the EP would have to demonstrate MU for the entire year (all 12 months in 2013) and then attest in early 2014. To receive the fourth-year payment (nominally, the 2014 payment), the EP would have to demonstrate MU for three months in 2014 with a 2014 compliant CEHRT. For 2015, MU reporting will again require data for the whole year if the EP is in his or her third year or more of program participation.

Percent of encounters required in CEHRT- Program year 2 and beyond
In participation year 2-6, after AIU in year 1, EPs must have 50% or more of their combined patient encounters during the MU reporting period at locations equipped with CEHRT. Hospital encounters (POS 21 & 23) are excluded, as MU requirements in these locations will be reported by the hospital. An EP who does not conduct 50% of his or her patient encounters in any one practice/location would have to meet the 50% threshold through a combination of practices/locations.

What are the meaningful use (MU) objectives/measures?

MU objectives/measures
Originally, EPs in Stage 1 MU would attest to a total of 20 MU objectives; 15 core objectives that were required and the remaining 5 chosen from a list of 10 menu objectives. For the most part, this remains true for 2013; however some changes and options have been introduced for 2013. These changes are briefly described in the parenthesized sections added to the original measures below. A “Stage 1 Changes Tipsheet,” has been attached at the back of this guide outlining in more depth these changes. More extensive changes will be made to Stage 1 in 2014, coinciding with the application of Stage 2.

Core Objectives

1. Use CPOE for drug orders (2013-optinal alternative measure available)
2. Check drug-drug/drug-allergy interaction
3. Maintain current and active diagnoses
4. E-prescribe (eRx)
5. Maintain active medication list
6. Maintain active allergy list
7. Record patient demographics
8. Record vital signs (2013-optional addition of alternative age limitations available, and a new exclusion)
9. Record smoking status
10. Report clinical quality measures (2013-onward, removed as a core objective, and is instead considered a
    stand-alone MU requirement)
11. Implement one Clinical Decision Support rule
12. Provide electronic health information to patients
13. Provide clinical summaries
15. Protect patient data privacy and security

Menu Objectives

1. Implement drug formulary checks
2. Incorporate clinical lab test results
3. Generate patient lists by condition
4. Send care reminders to patients
5. Provide patient with timely access to electronic health information
6. Identify patient-specific education resources
7. Perform medication reconciliation between care settings
8. Generate summary of care for transferred patients
9. Submit immunization data to registries (2013-language “except where prohibited” added)
10. Submit epidemiology data to public health (2013-language “except where prohibited” added)

Note: One of the menu measures selected must be one of the two public health measures (#9 or #10). MU measures are outlined in detail at the back of this document. For information on how to connect to the public health systems for meeting MU, visit:

Clinical Quality Measures
EPs must also report on a total of the six clinical quality measures (CQMs): three required core measures (substituting alternate core measures where necessary) and three additional menu measures (selected from a set of 38 clinical quality measures). In 2011 and 2012 CQMs were considered a Core Objective (#10); however in 2013 it is considered a stand-alone MU requirement, outside the core and menu measures. In addition to reporting CQMs through attestation, EPs will have the option to report a limited sub-set of CQMs through the Physician Quality Reporting System (PQRS). More information is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AlternativeReportingMechanisms.html
What special considerations exist for reporting MU data?

When reporting MU data, EPs must collect and combine data from all practice locations utilizing CEHRT. MU reporting is concerned with CEHRT equipped sites only. This excludes hospital data (POS 21 & 23) as hospitals will report this information for their own EHR incentive. So when MU core requirement 6 says, “More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no medication allergies) recorded as structured data,” it means all unique patients in locations having CEHRT (excluding POS 21 & 23).

CMS has a parallel Medicare EHR Incentive program requiring reporting of MU data in the first year of participation (not having AIU). While Medicare and Medicaid EHR incentive programs have differing eligibility requirements, each program’s MU requirements are identical. Clarifications that CMS has made for Medicare EPs can similarly be applied to the Medicaid EHR Incentive Program. These CMS clarifications are considered below.

What do the numerators and denominators mean in measures that are required to demonstrate MU for the Medicaid EHR Incentive Program?

There are 15 measures for EPs that require the collection of data to calculate a percentage, which is the basis for determining if an MU objective was met according to a minimum threshold for that objective.

Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: one where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using certified EHR technology (within a given CEHRT location); and a second group where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using CEHRT.

This grouping is designed to reduce the burden on providers. Table 3 in the Medicare and Medicaid EHR Incentive program’s final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation, and is included at the very back of this document.

How should an EP that sees patients in multiple practice locations equipped with CEHRT calculate numerators and denominators for MU objectives and measures?

EPs should look at the measure of each MU objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the detailed MU measure outlines included in the last half of this document.

For objectives that require a simple count of actions (e.g., the number of permissible prescriptions written for the objective of “Generate and transmit permissible prescriptions electronically (eRx)”), EPs must add the numerators and denominators calculated by each CEHRT in order to arrive at an accurate total for the numerator and denominator of the measure.
For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics", "Record vital signs", etc.), EPs may also add the numerators and denominators calculated by each CEHRT in order to arrive at an accurate total for the numerator and denominator of the measure. Previously, CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, CMS now permits simple addition for all meaningful use objectives.

Patients seen at CEHRT locations who, for whatever reason, have records maintained outside of the CEHRT will need to be added to denominators whenever applicable in order to provide accurate numbers.

**What about MU measures requiring a yes or no answer? How should they be approached when dealing with multiple CEHRT locations?**

MU measures requiring yes or no answers should be answered with all CEHRT locations (excluding POS 21 & 23) taken into account. For example, in order to answer “yes” to “Enable drug formulary checks?” an EP must be able to answer yes for all CEHRT locations. All CEHRT locations should have drug formulary checks enabled.

**How do I register for the Michigan Medicaid EHR Incentive Program?**

An EP must register with the CMS registration and attestation system (RAS) at the federal level to start his or her registration process. Once registered at the federal level, an EP will be invited to complete his or her registration at the state level.

**Federal level registration**

To register with the CMS RAS, all EPs must have a National Provider Identifier (NPI). The CMS RAS is available at [https://ehrincentives.cms.gov/hitech/login.action](https://ehrincentives.cms.gov/hitech/login.action).

To access the CMS RAS, an EP will need a username and password. An EP may use the same user ID and password used for the National Plan and Provider Enumeration System (NPPES). If an EP does not have an active user ID and password for NPPES, he or she can request them via CMS Identity & Access Management, available at [http://www.cms.gov/](http://www.cms.gov/). When requesting, an EP will need a type 1 NPI, Taxpayer Identification Number (TIN), and address from IRS Form CP-575. A copy of IRS Form CP-575 will need to be mailed as directed.

**What information will an EP need when registering with CMS?**

EPs must provide basic information at the CMS RAS.

- Individual (type 1) National Provider Identifier (NPI)
- Payee Tax Identification Number (if you are reassigning your benefits)
• Payee National Provider Identifier (NPI) (if you are reassigning your benefits)
• Demographic information including state and the program (Medicare or Medicaid), in which you are participating

Additional items prior to state level registration
An EP is not required provide his or her CMS EHR certification number when registering with the CMS RAS. However, it is strongly recommended that EPs do so since it will speed up the registration process at the state level.

An invitation letter for state level registration will go to the address provided in the CMS RAS. The invitation letter will contain the CMS registration number which will be required for access to state level registration.

Any changes to the information in the CMS RAS must be made by the EP in the CMS RAS. Once changes have been made at the CMS RAS, it is important that the EP submit these changes so the state level registration can be properly updated. Failure to submit changes will cause a delay in receiving an incentive payment.

A guide to registering in the CMS RAS is available at: http://www.michiganhealthit.org/ehr/registration.aspx

State level registration
An EP must complete his or her registration at the state level after the CMS RAS. The EP will receive a letter inviting him or her to complete the registration process in the Community Health Automated Medical Processing System (CHAMPS). EPs receive a 90-day window from the point of completing federal registration to initiate state level registration. EPs not registered in CHAMPS, or who are providing services through managed care entities, must be individually registered as a Medicaid provider in good standing in CHAMPS to be eligible to receive an EHR incentive. Information entered at the CMS RAS must match the information provided in CHAMPS.

• Currently a Medicaid-Enrolled Provider - Once Medicaid receives a valid EP request from the CMS RAS, Medicaid will send a welcome letter to the EP with instructions for logging into the CHAMPS EHR module to register for the EHR incentive payment. Once the EP submits registration information, Medicaid staff will start the review/validation process.

• Not Currently a Medicaid-Enrolled Provider - Once Medicaid receives a valid EP request from the CMS RAS, Medicaid will send a welcome letter to the EP with instructions for enrolling in CHAMPS. Note that this enrollment is for EHR incentive purposes only. To access the CHAMPS system for enrollment, the EP must follow the directions on the website at http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-145006--.00.html#Accessing_the_CHAMPS_System. The toll free number for help enrolling in CHAMPS is (800) 292-2550. Once approved, the EP will receive a letter with instructions on completing the EHR portion of the enrollment.
An EP will have to register and attest in the CHAMPS EHR module every year he or she wishes to participate. This will ensure EPs meet eligibility requirements and report on MU. EPs will also be required to complete an annual survey that will address general EHR issues.

Note: EPs are not required to return to the CMS RAS unless there is an update to any demographic or payment information (i.e. address, e-mail address, payee tax ID).

What information will you need when you register at the state level?
In addition to the items submitted to the CMS RAS, EPs must to provide several items at the state level. These items include:

- EP 90-day eligibility reporting period
- Type of provider, with additional items for Physician Assistants
- The following encounter types:
  - Any encounters in the hospital inpatient or emergency room setting broken down by Medicaid and total encounters in each setting
  - If using the Eligible Patient Volume by Practice/Organization Proxy option, encounters broken down by Medicaid and total encounters and the NPI of the organization whose encounters are being used as a proxy
  - Any encounters in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) broken down by Medicaid, MIChild, charity care, sliding fee scale and total patient encounters in the FQHC and/or RHC setting
  - Any Medicaid managed care primary care patient panel encounters that are included, broken down by Medicaid patients assigned to PCP panel, unduplicated Medicaid patient encounters (i.e., fee for service encounters), total patients assigned to PCP panel (including any other payers) and total unduplicated patient encounters (OPTIONAL)
  - All other encounters in any other setting broken down by Medicaid and total encounters

- EHR stage information; adopt, implement, upgrade or meaningful use
- CMS EHR Certification ID, available from EHR vendor (if not provided at federal level). Note: the CMS EHR Certification ID is case sensitive and should be entered in all upper case
- Contact e-mail (if not provided at federal level)

Detailed instructions on the state level registration are available at:
After all this work how much are the incentive payments?

The goal of all this effort, in addition to improving safety, quality and efficiency is to receive a payment incentive! Each EP can receive a maximum total incentive of $63,750 over a six year period. The first year’s maximum amount is $21,250 and years two through six are capped at $8,500 per year.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<tbody>
<tr>
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<td>2015</td>
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<td>$21,250</td>
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<tr>
<td>2016</td>
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<td><strong>TOTAL</strong></td>
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<td>$63,750</td>
<td>$63,750</td>
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</table>

EPs may start the program as early as calendar year 2011. EPs may not start the program any later than calendar year 2016. Consecutive years are not required for participation. However, EPs starting in 2016 must participate in consecutive years in order to receive the full incentive amount. No incentive payments will be made after calendar year 2021.

The total for pediatricians who meet the 20 % patient volume but fall short of the 30 % patient volume is $14,167 in the first year and $5,667 in subsequent years. This adds up to a maximum Medicaid EHR incentive payment of $42,500 over a six-year period.
Switching Programs or Switching States

An EP is allowed to switch participation from the Medicare EHR Incentive Program to the Michigan Medicaid EHR Incentive Program one time. When an EP switches from Medicare to the Medicaid incentive in the CMS RAS, the Michigan Medicaid EHR Incentive Program will be notified of the change. An EP making a switch to Medicaid will be subject to the same EHR reporting period that he or she would have been under had he or she remained in the Medicare incentive program. So for example, a Physician participating in the Medicare incentive for program year 2012, using a 2012 90 day MU reporting period, would need to report MU data for a full year in 2013 if he or she switched to the Medicaid incentive in program year 2013.

Additionally, only one payment can be received each year regardless of which program an EP is enrolled in. So, an EP that was paid by Medicare for participation in program year 2012 would need to wait until program year 2013 to participate with Medicaid.

EPs may also switch states and still be eligible for the program. When an EP switches his or her state to Michigan in the CMS RAS, the Michigan Medicaid EHR Incentive Program will be notified of the change. When the switch is made, the EP enters the Michigan Medicaid EHR Incentive Program with the same MU status that he or she reached in their previous state. EPs may only claim one incentive payment per program year, regardless of which state the payment came from.

Back of the Guide

Included for your use at the back of this Michigan Medicaid EHR Incentive Program Guide:

- **Stage 1 Changes Tipsheet** for 2013. Use this tipsheet to modify the 2012 specification sheets referenced in the next bullet-point. Should CMS release new Stage 1 specification sheets that incorporate 2013 changes, they will be used to replace both this tipsheet and the 2012 specification sheets below in an updated release of the EP guide.
- **Stage 1 EHR Meaningful Use Specification Sheets** for Eligible Professionals (2012).
- **Table: 3**, Stage 1 Meaningful Use Objectives and Associated Measures Sorted by Method of Measure Calculation.
- **Overview of Clinical Quality Measures Reporting** in the Centers for Medicare & Medicaid Services (CMS) Final Rule on Meaningful Use (now considered a requirement separate from MU core requirements).
Overview

CMS recently announced some changes to the Stage 1 meaningful use objectives, measures, and exclusions for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). Some of these changes will take effect as early as October 1, 2012, for eligible hospitals and CAHs, or January 1, 2013, for EPs. Other Stage 1 changes will not take effect until the 2014 fiscal or calendar year and will be optional in 2013. The table at the end of this publication summarizes the changes to the Stage 1 meaningful use objectives.

Exclusions for Menu Objectives

Beginning in 2014, EPs, eligible hospitals, and CAHs will no longer be permitted to count an exclusion toward the minimum of 5 menu objectives on which they must report if there are other menu objectives which they can select. In other words, a provider cannot select a menu objective and claim an exclusion for it if there are other menu objectives they can meet.

EPs, eligible hospitals, and CAHs will not be penalized for selecting a menu objective and claiming the exclusion if they would also qualify for the exclusions for all the remaining menu objectives. For example, EPs who must select to test the capability to submit data to either an immunization registry or a syndromic surveillance database as one of their menu objectives can select the menu objective for submitting data to an immunization registry and claim the exclusion if they would also be able to claim the exclusion for submitting data to a syndromic surveillance database. They would not be penalized for claiming this exclusion.

Computerized Provider Order Entry (CPOE)

Beginning in 2013, CMS is adding an optional alternate measure to the objective for computerized provider order entry (CPOE). The current measure for CPOE is based on the number of unique patients with a medication in their medication list that was entered using CPOE. The new, alternate measure is based on the total number of medication orders created during the EHR reporting period. An EP, eligible hospital, or CAH may select either measure for this objective in Stage 1 in order to achieve meaningful use. (Note that this alternative measure will be required for all providers in Stage 2.)

Alternate Measure: More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Electronic Prescribing

Beginning in 2013, CMS is adding an additional exclusion to the objective for electronic prescribing for providers who are not within a 10 mile radius of a pharmacy that accepts electronic prescriptions.
**New Additional Exclusion:** Any EP who: does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

**Record and Chart Changes in Vital Signs**

CMS is changing the measure of the objective for recording and charting changes in vital signs for EPs, eligible hospitals, and CAHs. The current measure specifies that vital signs must be recorded for more than 50 percent of all unique patients **ages 2 and over**. The new measure amends that age limit to recording blood pressure for patients **ages 3 and over** and height and weight for patients of **all ages**.

The exclusions for this objective for EPs are also changing. The current exclusions only allow an EP to claim the exclusion if all three vital signs (height, weight, blood pressure) are not relevant to their scope of practice or if the EP sees no patients 2 years or older. However, under the new Stage 1 changes, an EP can claim an exclusion if the EP sees no patients 3 years or older (the EP would not have to record blood pressure), if all three vital signs are not relevant to their scope of practice (the EP would not record any vital signs), if height and weight are not relevant to their scope of practice (the EP would still record blood pressure), or if blood pressure is not relevant to their scope of practice (the EP would still record height and weight).

This new measure and these new exclusions are optional in 2013 but will be required in 2014 and beyond.

**New Measure:** More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.

**New Exclusion:** Any EP who

1. Sees no patients 3 years or older is excluded from recording blood pressure;

2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;

3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or

4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.


**Electronic Exchange of Key Clinical Information**

Beginning in 2013, the objective for electronic exchange of key clinical information will no longer be required for Stage 1 for EPs, eligible hospitals, and CAHs. Providers faced numerous challenges in understanding the requirements for this objective, so we are moving instead to a more robust requirement for electronic health information exchange as a part of the Stage 2 objective for providing a summary of care record following a transition of care or referral.

**Report Clinical Quality Measures**

Beginning in 2013, there will no longer be a separate objective for reporting ambulatory or hospital clinical quality measures as a part of meaningful use. It is important to note, however, that EPs, eligible hospitals, and CAHs will still be required to report on clinical quality measures in order to achieve meaningful use. CMS is simply removing the standalone objective that requires providers to attest that they plan to report on clinical quality measures because it is redundant.

**Electronic Copy of and Electronic Access to Health Information**

In order to better align Stage 1 objectives with the new 2014 capabilities of Certified EHR Technology, CMS is replacing several Stage 1 objectives for providing electronic copies of and electronic access to health information with objectives to provide patients the ability to view, download, or transmit their health information or hospital admission information online. The capability to provide patients online access to this information will be a part of Certified EHR Technology beginning in 2014, therefore the new Stage 1 objectives will be required beginning in 2014.

The following current Stage 1 objectives will be replaced beginning in 2014:

- **EPs/Hospital Stage 1 Core Objective**: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.
- **Hospital Stage 1 Core Objective**: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.
- **EP Stage 1 Menu Objective**: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
New Objectives and Measures

**New EP Objective:** Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.

**New EP Measure:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.

**New Hospital Objective:** Provide patients the ability to view online, download and transmit information about a hospital admission.

**New Hospital Measure:** More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.

**Public Health Reporting Objectives**

Beginning in 2013, all of the Stage 1 public health objectives (submitting data to an immunization registry, submitting data to a syndromic surveillance database, or submitting reportable lab results to a public health agency) will require that providers perform at least one test of their Certified EHR Technology’s capability to send data to public health agencies, except where prohibited. The intent of this modification is to encourage all EPs, eligible hospitals, and CAHs to submit public health data, even when not required by State/local law. Therefore, if providers are authorized to submit the data, they should do so even if it is not required by either law or practice. If the test of submission is successful, provider should institute regular reporting with the entity with whom the successful test was conducted.

<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Changes to Objective</th>
<th>Effective Year (CY/FY)</th>
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| Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines | Change: Addition of an alternative measure  
More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital’s or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE | 2013 - Onward (Optional) |
| Generate and transmit permissible prescriptions electronically (eRx)              | Change: Addition of an additional exclusion  
Any EP who: does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his/her EHR reporting period. | 2013 – Onward (Required) |
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<tr>
<th><strong>Stage 1 Objective</strong></th>
<th><strong>Changes to Objective</strong></th>
<th><strong>Effective Year (CY/FY)</strong></th>
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</thead>
</table>
| Record and chart changes in vital signs | Change: Age Limitations on Growth Charts and Blood Pressure  
More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data | 2013 Only (Optional)  
2014 – Onward (Required) |
| Public Health Objectives: | Change: Addition of "except where prohibited" to the objective regulation text for the public health objectives under § 495.6 | 2013 – Onward (Required) |
| Record and chart changes in vital signs | Change: Changing the age and splitting the EP exclusion  
Any EP who  
(1) Sees no patients 3 years or older is excluded from recording blood pressure;  
(2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;  
(3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or  
(4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight. | 2013 Only (Optional)  
2014 – Onward (Required) |
<p>| Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically | Change: Objective is no longer required | 2013 – Onward (Required) |</p>
<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Changes to Objective</th>
<th>Effective Year (CY/FY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report ambulatory/hospital clinical quality measures to CMS or the States</td>
<td>Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective</td>
<td>2013 – Onward (Required)</td>
</tr>
<tr>
<td>EP and Hospital Objectives: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request. EP Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP. Hospital Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.</td>
<td>Change: Replace these four objectives with the Stage 2 objective and one of the two Stage 2 measures. EP Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP. EP Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information. Hospital Objective: Provide patients the ability to view online, download and transmit information about a hospital admission. Hospital Measure: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.</td>
<td>2014 – Onward (Required)</td>
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</table>
CPOE for Medication Orders

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<tr>
<th>Objective</th>
<th>Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms

Computerized Provider Order Entry (CPOE) – CPOE entails the provider’s use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
- **NUMERATOR:** The number of patients in the denominator that have at least one medication order entered using CPOE.
- **EXCLUSION:** EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage \( \frac{\text{Numerator}}{\text{Denominator}} \) must be more than 30 percent in order for an EP to meet this measure.

**Additional Information**
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- Any licensed healthcare professionals can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can enter the order per state, local and professional guidelines.
- The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aids. This necessitates that the CPOE occurs when the order first becomes part of the patient’s medical record and before any action can be taken on the order.
- Electronic transmittal of the medication order to the pharmacy, laboratory, or diagnostic imaging center is not a requirement for meeting the measure of this objective. However, a separate objective (EPCMU 04) addresses the electronic transmittal of prescriptions and is a requirement for EPs to meet Meaningful Use.

**Related Meaningful Use FAQs**
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- How should an EP who orders medications infrequently calculate the measure for the CPOE objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP? [New ID #3257, Old #10639](https://questions.cms.gov/)
- Who can enter medication orders in order to meet the measure for the CPOE meaningful use objective? When must these medication orders be entered? [New ID #2851, Old #10134](https://questions.cms.gov/)
- To meet the meaningful use objective for CPOE, should EPs include hospital-based observation patients whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure? [New ID #3057, Old #10462](https://questions.cms.gov/)
- Is the physician the only person who can enter information in the EHR in order to qualify for the EHR Incentive Programs? [New ID #2771, Old #10071](https://questions.cms.gov/)
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? [New ID #2813, Old #10095](https://questions.cms.gov/)
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for
meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old #10068

• If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? New ID #2883, Old #10151

• Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? New ID #3065, Old #10466

• If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? New ID #3077, Old #10475

Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(a) Computerized provider order entry</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

Related Certification FAQs
Click on the green numbers to view the answer to the FAQ.

• I’ve selected a certified Complete EHR [or certified EHR Module] from EHR technology developer XYZ. I prefer the certified CPOE EHR Module designed by EHR technology developer ABC over the CPOE capability included in EHR technology developer XYZ’s Complete EHR. Can I use duplicative or overlapping certified capabilities of different certified EHR technologies without jeopardizing my ability to meaningfully use Certified EHR Technology? 9-10-014-1
**Drug Interaction Checks**

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>Implement drug-drug and drug-allergy interaction checks.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure</strong></td>
<td>The EP has enabled this functionality for the entire EHR reporting period.</td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

**Table of Contents**

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

**Definition of Terms**

None.

**Attestation Requirements**

YES / NO

Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

**Additional Information**

None.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to
view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- Can the drug-drug and drug-allergy interaction alerts of my EHR also be used to meet the meaningful use objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs? **New ID #2783, Old ID #10077**

### Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(a) Drug-drug, drug-allergy interaction checks</td>
</tr>
<tr>
<td>(1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE).</td>
</tr>
<tr>
<td>(2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

### Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- Is an eligible professional limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? Similarly, if the EHR technology was tested and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use? **3-11-024-1**
Eligible Professional
Meaningful Use Core Measures
Measure 3 of 15
Stage 1
Date issued: November 7, 2010

Maintain Problem List

<table>
<thead>
<tr>
<th>Objective</th>
<th>Maintain an up-to-date problem list of current and active diagnoses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms

**Problem List** – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

**Unique Patient** – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

**Up-to-date** – The term “up-to-date” means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.

Attestation Requirements

**NUMERATOR / DENOMINATOR**

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
• NUMERATOR: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

**Additional Information**

• The Medicare and Medicaid EHR Incentive Programs do not specify the use of ICD-9 or SNOMED-CT® in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 or SNOMED-CT® for the entry of structured data for this measure and made this a requirement for EHR technology to be certified. Therefore, EPs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® as a basis for the entry of structured data into certified EHR technology in order to meet the measure for this objective.

• For patients with no current or active diagnoses, an entry must still be made to the problem list indicating that no problems are known.

• An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances.

• The initial diagnosis can be recorded in lay terms and later converted to standard structured data or can be initially entered using standard structured data.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

• To meet the objective "maintain an up-to-date problem list of current and active diagnoses" for the Medicare and Medicaid EHR Incentive Programs, are EPs, eligible hospitals, and CAHs required to use ICD-9 or SNOMED-CT®? [New ID #2881, Old ID #10150](#)

• How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"? [New ID #3307, Old ID #10664](#)

• When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? [New ID #3309, Old ID #10665](#)

• Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?
If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures?

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(c) Maintain up-to-date problem list</td>
<td>§170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>§170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version.</td>
</tr>
</tbody>
</table>

Enable a user to electronically record, modify, and retrieve a patient’s problem list for longitudinal care in accordance with:
(1) The standard specified in §170.207(a)(1); or
(2) At a minimum, the version of the standard specified in §170.207(a)(2).

For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.
**e-Prescribing (eRx)**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Generate and transmit permissible prescriptions electronically (eRx).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</td>
</tr>
</tbody>
</table>

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**Table of Contents**

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

**Definition of Terms**

**Permissible Prescriptions** – The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at [http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf](http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be permissible.

**Prescription** – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

**Attestation Requirements**

**NUMERATOR / DENOMINATOR / EXCLUSION**

- **DENOMINATOR**: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
- **NUMERATOR**: Number of prescriptions in the denominator generated and transmitted electronically.
EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the EHR reporting period.
- Although the Department of Justice recently published an Interim Final Rule that allows the electronic prescribing of controlled substances, these recent guidelines could not be incorporated into the Medicare and Medicaid EHR Incentive Programs. The determination of whether a prescription is a "permissible prescription" for purposes of this measure should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010.
- EPs cannot receive incentive payments for e-prescribing under both the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Medicare EHR Incentive Program for the same year. However, EPs can receive payments from both the MIPPA E-Prescribing Incentive Program and the Medicaid EHR Incentive Program for the same year.
- Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.
- Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the NCPDP standards. However, an EP’s EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology. For more information, refer to ONC’s FAQ at http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_22/21286.
- EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur constructively if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- If I am receiving payments under the CMS Electronic Prescribing (eRx) Incentive Program, can I also receive Medicare and Medicaid EHR incentive payments?  
  *New ID #2801, Old ID #10088*
- Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective? *New ID #2763, Old ID #10067*
- How should the numerator and denominator be calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?  
  *New ID #2939, Old ID #10284*
- Can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy? Should these transactions be included in the numerator for the measure of this objective? *New ID #2857, Old ID #10137*
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? *New ID #2813, Old ID #10095*
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? *New ID #2765, Old ID #10068*
- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? *New ID #2883, Old ID #10151*
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?  
  *New ID #3065, Old ID #10466*
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures?  
  *New ID #3077, Old ID #10475*

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Description</th>
</tr>
</thead>
</table>
| §170.304(b) Electronic prescribing | Enable a user to electronically generate and transmit prescriptions and prescription-related information in accordance with:  
(1) The standard specified in §170.205(b)(1) or §170.205(b)(2); and  
(2) The standard specified in §170.207(d). |
§170.302(n) Automated measure calculation

For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

**Standards Criteria**

| Electronic Prescribing | §170.205(b)(1) - NCPDP SCRIPT Version 8.1.  
|                       | §170.205(b)(2) - NCPDP SCRIPT Version 10.6. |

| Medications            | §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine. |

**Related Certification FAQs**

Click on the green numbers to view the answer to the FAQ.

- Does the certification criterion pertaining to electronic prescribing, which references certain content exchange standards (i.e., NCPDP SCRIPT 8.1 and NCPDP SCRIPT 10.6), require that a Complete EHR or EHR Module be capable of electronically exchanging information with only external recipients according to the appropriate standard or does it apply more broadly? [12-10-022-1](#)
Eligible Professional
Meaningful Use Core Measures
Measure 5 of 15
Stage 1
Date issued: November 7, 2010

Active Medication List

<table>
<thead>
<tr>
<th>Objective</th>
<th>Maintain active medication list.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms
Active Medication List – A list of medications that a given patient is currently taking.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR
- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information
- For patients with no active medications, an entry must still be made to the active medication list indicating that there are no active medications.
- An EP is not required to update this list at every contact with the patient. The EP can then use his or her clinical judgment to decide when additional updating is required.

Related Meaningful Use FAQs
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? New ID #2813, Old ID #10095
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old ID #10068
- How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"? New ID #3307, Old ID #10664
- When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? New ID #3309, Old ID #10665
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? New ID #3065, Old ID #10466
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? New ID #3077, Old ID #10475
Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(d) Maintain active medication list</td>
<td>N/A</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Enable a user to electronically record, modify, and retrieve a patient’s active medication list as well as medication history for longitudinal care.

For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.
Eligible Professional
Meaningful Use Core Measures
Measure 6 of 15
Stage 1
Date issued: November 7, 2010

<table>
<thead>
<tr>
<th>Medication Allergy List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>Measure</strong></td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
</tr>
</tbody>
</table>

**Table of Contents**
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

**Definition of Terms**

**Active Medication Allergy List** – A list of medications to which a given patient has known allergies.

**Allergy** – An exaggerated immune response or reaction to substances that are generally not harmful.

**Unique Patient** – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

**Attestation Requirements**

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
• NUMERATOR: Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

The resulting percentage \((\text{Numerator} ÷ \text{Denominator})\) must be more than 80 percent in order for an EP to meet this measure.

**Additional Information**

• For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies.

• An EP is not required to update this list at every contact with the patient. The measure ensures that the EP has not ignored having a medication allergy list for patients seen during the EHR reporting period and that at least one piece of information on medication allergies is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances at hand.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

• What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? [New ID #2813, Old ID #10095](#)

• For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? [New ID #2765, Old ID #10068](#)

• How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"? [New ID #3307, Old ID #10664](#)

• When a patient is only seen by a member of the EP’s clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? [New ID #3309, Old ID #10665](#)

• Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? [New ID #3065, Old ID #10466](#)

• If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? [New ID #3077, Old ID #10475](#)
Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(e) Maintain active medication allergy list</td>
<td>N/A</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Enable a user to electronically record, modify, and retrieve a patient’s active medication allergy list as well as medication allergy history for longitudinal care.

For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.
Eligible Professional
Meaningful Use Core Measures
Measure 7 of 15
Stage 1
Date issued: November 7, 2010

Record Demographics

| Objective | Record all of the following demographics:  
|           | (A) Preferred language  
|           | (B) Gender  
|           | (C) Race  
|           | (D) Ethnicity  
|           | (E) Date of birth |

| Measure | More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data. |

| Exclusion | No exclusion. |

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms

Preferred Language – The language by which the patient prefers to communicate.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
• NUMERATOR: Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information
• Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr).
• If a patient declines to provide all or part of the demographic information, or if capturing a patient’s ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. In regards to patients who do not know their ethnicity, EPs should treat these patients the same way as patients who decline to provide race or ethnicity—identify in the patient record that the patient declined to provide this information.
• EPs are not required to communicate with the patient in his or her preferred language in order to meet the measure of this objective.

Related Meaningful Use FAQs
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

• What documentation is required when recording the preliminary cause of death in the event of mortality? New ID #2909, Old ID #10165
• What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? New ID #2813, Old ID #10095
• For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old ID #10068
• How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"? New ID #3307, Old ID #10664
• When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? New ID #3309, Old ID #10665
• Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?
**Certification and Standards Criteria**
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(c) Record demographics</td>
<td>Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth. Enable race and ethnicity to be recorded in accordance with the standard specified at §170.207(f).</td>
</tr>
<tr>
<td>Automated measure calculation</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Vital Signs</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Objective</strong></td>
<td></td>
</tr>
<tr>
<td>Record and chart changes in the following vital signs:</td>
<td></td>
</tr>
<tr>
<td>(A) Height</td>
<td></td>
</tr>
<tr>
<td>(B) Weight</td>
<td></td>
</tr>
<tr>
<td>(C) Blood pressure</td>
<td></td>
</tr>
<tr>
<td>(D) Calculate and display body mass index (BMI)</td>
<td></td>
</tr>
<tr>
<td>(E) Plot and display growth charts for children 2-20 years, including BMI</td>
<td></td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td></td>
</tr>
<tr>
<td>For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td></td>
</tr>
<tr>
<td>Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.</td>
<td></td>
</tr>
</tbody>
</table>

**Table of Contents**

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

**Definition of Terms**

**Unique Patient** – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

**Attestation Requirements**

**NUMERATOR / DENOMINATOR / EXCLUSION**

- DENOMINATOR: Number of unique patients age 2 or over seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.
• EXCLUSION: An EP who sees no patients 2 years or older would be excluded from this requirement. Additionally, an EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information
• The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
• The only information required to be inputted by the provider is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.
• Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient’s individual circumstances as to whether height, weight, and blood pressure need to be updated.
• Height, weight, and blood pressure can get into the patient’s medical record as structured data in a number of ways. Some examples include entry by the EP, entry by someone on the EP’s staff, transfer of the information electronically or otherwise from another provider or entered directly by the patient through a portal or other means.

Related Meaningful Use FAQs
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

• Can an EP claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three? New ID #3217, Old ID #10593
• In recording height as part of the objective "Recording vital signs" for EPs, eligible hospitals, and CAHs, how should providers account for patients who are too sick or otherwise cannot be measured safely? New ID #2891, Old ID #10156
• If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? New ID #2883, Old ID #10151
• What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? New ID #2813, Old ID #10095
• For EPs who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old ID #10068
How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?

New ID #3307, Old ID #10664

When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?

New ID #3309, Old ID #10665

Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?

New ID #3065, Old ID #10466

If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures?

New ID #3077, Old ID #10475

### Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Description</th>
</tr>
</thead>
</table>
| §170.302(f) Record and chart vital signs | (1) Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, height, weight, and blood pressure.  
(2) Calculate body mass index. Automatically calculate and display body mass index (BMI) based on a patient’s height and weight.  
(3) Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients 2–20 years old. |
| §170.302(n) Automated measure calculation | For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure. |

| Standards Criteria | N/A |
Eligible Professional
Meaningful Use Core Measures
Measure 9 of 15
Stage 1
Date issued: November 7, 2010

Record Smoking Status

<table>
<thead>
<tr>
<th>Objective</th>
<th>Record smoking status for patients 13 years old or older.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Any EP who sees no patients 13 years or older.</td>
</tr>
</tbody>
</table>

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator with smoking status recorded as structured data.
- EXCLUSION: An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.
The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

**Additional Information**

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- This is a check of the medical record for patients 13 years old or older. If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? [New ID #2883, Old ID #10151](#)
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? [New ID #2813, Old ID #10095](#)
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? [New ID #2765, Old ID #10068](#)
- How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"? [New ID #3307, Old ID #10664](#)
- When a patient is only seen by a member of the EP’s clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? [New ID #3309, Old ID #10665](#)
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? [New ID #3065, Old ID #10466](#)
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? [New ID #3077, Old ID #10475](#)
## Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(g) Smoking status</td>
<td>Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
</tbody>
</table>

| Standards Criteria | N/A |
Eligible Professional
Meaningful Use Core Measures
Measure 10 of 15
Stage 1
Date issued: November 7, 2010

Clinical Quality Measures (CQMs)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Report ambulatory clinical quality measures to CMS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms
None

Attestation Requirements
YES / NO

Eligible professionals (EPs) must attest YES to reporting to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS to meet the measure.

Additional Information
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- Attesting to the measure of this objective indicates that the EP will submit complete ambulatory clinical quality measure information as required during the attestation process. During attestation, EPs will also attest to the numerators, denominators, and exclusions for individual ambulatory clinical quality measures.
For requirements and electronic specifications related to individual ambulatory clinical quality measures, EPs should refer to:  

Related Meaningful Use FAQs
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- One of the measures for the core set of CQMs for EPs is not applicable for my patient population. Am I excluded from reporting that measure? New ID #2865, Old ID #10142
- Can I use the electronic specifications for CQMs to satisfy both the PQRS and the EHR Incentive Programs? New ID #2867, Old ID #10143
- I am an EP for whom none of the core, alternate core, or additional CQMs adopted for the EHR Incentive Programs apply. Am I exempt from reporting on all CQMs? New ID #2869, Old ID #10144
- If the denominators for all three of the core CQMs are zero, do I have to report on the additional CQMs for EPs? New ID #2871, Old ID #10145
- My practice does not typically collect information on any of the core, alternate core, and additional CQMs listed in the Final Rule on the EHR Incentive Programs. Do I need to report on CQMs for which I do not have any data? New ID #2773, Old ID #10072
- Can EPs use CQMs from the alternate core set to meet the requirement of reporting three additional measures? New ID #2779, Old ID #10075
- If a provider feeds data from certified EHR technology to a data warehouse, can the provider report on meaningful use objectives and clinical quality measures from the data warehouse? New ID #2885, Old ID #10153
- If the certified EHR technology possessed by an EP generates zero denominators for all CQMs in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating? New ID #3275, Old ID #10648
- If certified EHR technology possessed by an EP includes the ability to calculate CQMs from the additional set that are not indicated by the EHR developer or on the CHPL as tested and certified by an ONC-ATCB, can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation? New ID #3277, Old ID #10649
- Who do I contact to suggest adding/deleting a code on a CQM or to suggest other CQM improvements? New ID #3675, Old ID #10884
- Will the clinical quality measure results be calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program (Formerly known as Reporting Hospital Quality Data for Annual Payment Update program)? New ID #2873, Old ID #10146
- To what attestation statements must an EP agree in order to submit an attestation, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare EHR Incentive Program? New ID #3209, Old ID #10589
If data is captured using certified EHR technology, can an eligible professional use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs? New ID #3063, Old ID #10465

**Certification and Standards Criteria**

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(j) Calculate and submit clinical quality measures</td>
</tr>
<tr>
<td>(1) Calculate.</td>
</tr>
<tr>
<td>(i) Electronically calculate all of the core clinical measures specified by CMS for eligible professionals.</td>
</tr>
<tr>
<td>(ii) Electronically calculate, at a minimum, three clinical quality measures specified by CMS for eligible professionals, in addition to those clinical quality measures specified in paragraph (1)(i).</td>
</tr>
<tr>
<td>(2) Submission. Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(f).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality reporting</td>
</tr>
</tbody>
</table>

**Related Certification FAQs**

Click on the green numbers to view the answer to the FAQ.

- How many clinical quality measures must EHR technology be capable of calculating in order to get certified? 9-10-012-1
- I plan to use a “data warehouse” to calculate and submit meaningful use clinical quality measures. Does my data warehouse need to be certified for me to be able to use it to achieve meaningful use? 9-10-013-2
Clinical Decision Support Rule

<table>
<thead>
<tr>
<th>Objective</th>
<th>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Implement one clinical decision support rule.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms

**Clinical Decision Support** – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.

Additional Information

- CMS will not issue additional guidance on the selection of appropriate clinical decision support rules for Stage 1 Meaningful Use. This determination is best left to the EP taking into account their workflow, patient population, and quality improvement efforts.
- Drug-drug and drug-allergy interaction alerts cannot be used to meet the meaningful use objective for implementing one clinical decision support rule. EPs must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks.
Related Meaningful Use FAQs
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- Can the drug-drug and drug-allergy interaction alerts of my EHR also be used to meet the meaningful use objective for implementing one clinical decision support rule?
  
  New ID #2783, Old ID #10077

Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(e) Cl. decision support</td>
</tr>
<tr>
<td>(1) Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in: problem list; medication list; demographics; and laboratory test results.</td>
</tr>
<tr>
<td>(2) Notifications. Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

Related Certification FAQs
Click on the green numbers to view the answer to the FAQ.

- Is an EP limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? Similarly, if the EHR technology was tested and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use? [3-11-024-1](#)
Electronic Copy of Health Information

<table>
<thead>
<tr>
<th>Objective</th>
<th>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms

**Business Days** – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

**Diagnostic Test Results** – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- **DENOMINATOR**: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.
- **NUMERATOR**: Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
- **EXCLUSION**: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this
requirement. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- When responding to patient requests for information, the EP should accommodate patient requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524, Access of individuals to protected health information. HIPAA contains requirements for providing patients copies of their health information.
- Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, this would include the elements listed in the ONC final rule at 45 CFR 170.304(f) for EPs and 45 CFR 170.306(d) for eligible hospitals and CAHs as required for EHR technology to become certified.
- An EP may withhold information from the electronic copy of a patient’s health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.
- An EP should provide a patient with all of the health information they have available electronically, subject to withholding as described in the HIPAA Privacy Rule, as specified at in 45 CFR 164.524.
- Form and format should be human readable and comply with the HIPAA Privacy Rule, as specified at 45 CFR 164.524(c). The media could be any electronic form such as patient portal, PHR, CD, USB fob, etc. EPs are expected to make reasonable accommodations for patient preference as outlined in 45 CFR 164.522(b).
- The charging of fees for this information is governed by the HIPAA Privacy Rule at 45 CFR 164.524(c)(4) (which only permits HIPAA covered entities to charge an individual a reasonable, cost-based fee for a copy of the individual’s health information).
- If provision of the copy involves the mailing of physical electronic media, then it would need to be mailed by at least the third business day following the request of the patient or their agents.
- Third-Party Requests: Only specific third-party requests for information are included in the denominator. Providing the copy to a family member or patient’s authorized representative consistent with federal and state law may substitute for a disclosure of the information to the patient and count in the numerator. A request from the same would count in the denominator. All other third-party requests are not included in the numerator or the denominator.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)
To meet the meaningful use objective “provide patients with an electronic copy of their health information,” how should the numerator and denominator be calculated for patients who see multiple EPs in the same practice (e.g., in a multi-specialty group practice)?

**New ID #2935, Old ID #10269**

What information must an EP, eligible hospital or CAH provide in order to meet the measure of the meaningful use objective for “provide patients with an electronic copy of their health information”? **New ID #3305, Old ID #10663**

What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? **New ID #2813, Old ID #10095**

For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? **New ID #2765, Old ID #10068**

If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? **New ID #2883, Old ID #10151**

Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? **New ID #3065, Old ID #10466**

If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? **New ID #3077, Old ID #10475**

---

**Certification and Standards Criteria**

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>§170.304(f)</strong> Electronic copy of health information</td>
</tr>
<tr>
<td>Enable a user to create an electronic copy of a patient’s clinical information, including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in:</td>
</tr>
<tr>
<td>(1) Human readable format; and</td>
</tr>
<tr>
<td>(2) On electronic media or through some other electronic means in accordance with:</td>
</tr>
<tr>
<td>(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and</td>
</tr>
<tr>
<td>(ii) For the following data elements the applicable standard must be used:</td>
</tr>
<tr>
<td>(A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);</td>
</tr>
<tr>
<td>(B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and</td>
</tr>
<tr>
<td>(C) Medications. The standard specified in §170.207(d).</td>
</tr>
</tbody>
</table>
For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

### Standards Criteria

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
</tbody>
</table>

#### Patient summary record
- §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.

#### Problems
- §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.
- §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version.

#### Laboratory test results
- §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

#### Medication
- §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

### Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- The “electronic copy of health information” certification criteria (45 CFR 170.304(f) and 45 CFR 170.306(d)) each require that Certified EHR Technology “enable a user to create an electronic copy of a patient’s clinical information... in: (1) Human readable format; and (2) On electronic media or through some other electronic means....” Is there more than one way to demonstrate compliance with these certification criteria? [9-10-019-1]
Eligible Professional
Meaningful Use Core Measures
Measure 13 of 15
Stage 1
Date issued: April 18, 2011

Clinical Summaries

<table>
<thead>
<tr>
<th>Objective</th>
<th>Provide clinical summaries for patients for each office visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Any EP who has no office visits during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms
Clinical Summary – An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Attestation Requirements
NUMERATOR / DENOMINATOR / EXCLUSION
DENOMINATOR: Number of office visits by the EP during the EHR reporting period.
NUMERATOR: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.

EXCLUSION: EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- The provision of the clinical summary is limited to the information contained within certified EHR technology.
- The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request.
- If an EP believes that substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information from the clinical summary.
- Providers should not charge patients a fee to provide this information.
- When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for “provide clinical summaries for patients after each office visit.
- The EP must include all of the items listed under “Clinical Summary” in the above “Definition of Terms” section that can be populated into the clinical summary by certified EHR technology. If the EP’s certified EHR technology cannot populate all of these fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):
  - Problem List
  - Diagnostic Test Results
  - Medication List
  - Medication Allergy List

Related Meaningful Use FAQs
To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- What information must an EP provide in order to meet the measure of the meaningful use objective for “provide a clinical summary for patients for each office visit”?

[Image]
What do the numerators and denominators mean in measures that are required to demonstrate meaningful use?  

For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?  

If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective?  

Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?  

If an EP sees a patient in a setting that does not have certified electronic EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures?  

If a patient visit spans several days and the patient is seen by EPs during that time period, does each EP need to provide a separate clinical summary or can the provision of a single clinical summary at the end of the visit meet the meaningful use objective for "provide clinical summaries for patients after each office visit" for the EHR Incentive Programs?  

Certification and Standards Criteria  
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>§170.304(h) Clinical summaries</th>
</tr>
</thead>
</table>
| Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list. If the clinical summary is provided electronically it must be:  
(1) Provided in human readable format; and  
(2) Provided on electronic media or through some other electronic means in accordance with:  
(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and  
(ii) For the following data elements the applicable standard must be used:  
(A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);  
(B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and |
For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

### Standards Criteria

<table>
<thead>
<tr>
<th>Standards Criteria</th>
<th>Details</th>
</tr>
</thead>
</table>
§170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369. |
| **Problems**                   | §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.  
§170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. |
| **Laboratory test results**    | §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. |
| **Medication**                 | §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine. |
Eligible Professional
Meaningful Use Core Measures
Measure 14 of 15
Stage 1
Last Updated: March 9, 2012

Electronic Exchange of Clinical Information

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure</strong></td>
<td>Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.</td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms

**Diagnostic Test Results** – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

**Different Legal Entities** – A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.

**Distinct Certified EHR Technology** – Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.

**Exchange** – Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR
technologies. The exchange of information requires that the eligible professional must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

**Patient Authorized Entities** – Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.

**Attestation Requirements**

YES / NO

Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information prior to the end of the EHR reporting period to meet this measure.

**Additional Information**

- The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy this objective.

- The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.

- When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible.

- EPs can use their clinical judgment to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.304(i), and is generally outlined in this objective as: problem list, medication list, medication allergies, and diagnostic test results. An EP’s determination of key clinical information could include some or all of this information, as well as information not included here.

- An EP should test their ability to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.304(i). If the EP continues to exchange information beyond the initial test, then the provider may decide what information should be exchanged on a case-by-case basis.

- EPs must test their ability to electronically exchange key clinical information at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test. If multiple EPs are using the
same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.

- An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure of this objective.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- For the meaningful use objective of "capability to exchange key clinical information," does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective?  [New ID #3255, Old ID #10638](https://questions.cms.gov/)
- For the meaningful use objective of "capability to exchange key clinical information," what forms of electronic transmission can be used to meet the measure of the objective?  [New ID #3359, Old ID #10691](https://questions.cms.gov/)
- To meet the meaningful use objective “capability to exchange key clinical information,” can different providers of care (e.g., physicians, hospitals, etc.) share EHR technology and successfully meet this objective?  [New ID #5985, Old ID #10270](https://questions.cms.gov/)
- For meaningful use objectives that require a provider to test the transfer of data, can the EP, eligible hospital, or CAH conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives?  [New ID #3817, Old ID #10978](https://questions.cms.gov/)
- For meaningful use objectives that require a provider to test the transfer of data, if multiple EPs are using the same certified EHR technology across several physical locations, can a single test serve to meet the measures of these objectives?  [New ID #3819, Old ID #10979](https://questions.cms.gov/)

**Certification and Standards Criteria**

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(i)</td>
</tr>
</tbody>
</table>

(1) **Electronically receive and display.** Electronically receive and display a patient’s summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, and medication allergy list in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.
(2) *Electronically transmit.* Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in accordance with:

(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and

(ii) For the following data elements the applicable standard must be used:

(A) *Problems.* The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);

(B) *Laboratory test results.* At a minimum, the version of the standard specified in §170.207(c); and

(C) *Medications.* The standard specified in §170.207(d).

### Standards Criteria

| Problems               | §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. |
|                        | §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. |
| Laboratory test results | §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. |
| Medication             | §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine. |

### Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- I’ve identified that I am using two different EHR technologies to meet a single certification criterion (my document management system receives and displays summary records (45 CFR 306(f)(1)) and my EHR technology from EHR technology developer XYZ transmits summary records (45 CFR 306(f)(2)). Do both EHR technologies need to be certified? 9-10-011-1
- Could an interface that transmits lab results in HL7 message format between a hospital laboratory system and a physician’s EHR (presuming that the transmissions were occurring between two different legal entities) satisfy the certification criteria related to the exchange of key clinical information in 45 CFR 170.304(i) and 45 CFR 170.306(f)? 12-10-023-1
Eligible Professional
Meaningful Use Core Measures
Measure 15 of 15
Stage 1
Date issued: November 7, 2010

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms
**Appropriate Technical Capabilities** – A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified HER technology or outside systems and programs that support the privacy and security of certified EHR technology.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

Additional Information
- EPs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to
that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.

- A security update would be required if any security deficiencies were identified during the risk analysis. A security update could be updated software for certified EHR technology to be implemented as soon as available, changes in workflow processes or storage methods, or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.

Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(o) Access control</td>
</tr>
<tr>
<td>§170.302(p) Emergency access</td>
</tr>
<tr>
<td>§170.302(q) Automatic log-off</td>
</tr>
<tr>
<td>§170.302(r) Audit log</td>
</tr>
<tr>
<td>§170.302(s) Integrity</td>
</tr>
<tr>
<td>§170.302(t) Authentication</td>
</tr>
<tr>
<td>§170.302(u) General</td>
</tr>
</tbody>
</table>
encryption algorithm would pose a significant security risk for Certified EHR Technology.

§170.302(v) Encryption when exchanging electronic health information
Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in §170.210(a)(2).

§170.302(w) Optional. Accounting of disclosures
Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in §170.210(d).

### Standards Criteria

| Record actions related to electronic health information | §170.210(b) - The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which actions(s) occurred and by whom must also be recorded. |
| Verification that electronic health information has not been altered in transit | §170.210(c) - A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm (SHA-1) as specified by the National Institute of Standards and Technology (NIST) in FIPS PUB 180-3 (October, 2008) must be used to verify that electronic health information has not been altered. |
| Record treatment, payment, and health care operations disclosures | §170.210(a)(2) - Any encrypted and integrity protected link. |
| Record treatment, payment, and health care operations disclosures | §170.210(d) - The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations, as these terms are defined at 45 CFR 164.501. |

### Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- If an EHR Module addresses multiple certification criteria (thus providing multiple capabilities), does it need to be tested and certified to the applicable privacy and security certification criteria as a whole or for each capability? [9-10-008-1](#)
# Eligible Professional Meaningful Use Menu Set Measures

## Measure 1 of 10

### Stage 1

Date issued: November 7, 2010

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### Drug Formulary Checks

<table>
<thead>
<tr>
<th>Objective</th>
<th>Implement drug formulary checks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</td>
</tr>
</tbody>
</table>

---

### Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

---

### Definition of Terms

None

---

### Attestation Requirements

YES / NO / EXCLUSION

Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.

An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.

---

### Additional Information

- At a minimum an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.
### Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? [New ID #2883, Old ID #10151](https://questions.cms.gov/)
- How should EPs select menu objectives? [New ID #2903, Old ID #10162](https://questions.cms.gov/)

### Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(b) Drug-formulary checks</td>
<td>N/A</td>
</tr>
<tr>
<td>Enable a user to electronically check if drugs are in a formulary or preferred drug list.</td>
<td></td>
</tr>
</tbody>
</table>
Eligible Professional
Meaningful Use
Menu Set Measures
Measure 2 of 10
Stage 1
Date issued: November 7, 2010

Clinical Lab Test Results

<table>
<thead>
<tr>
<th>Objective</th>
<th>Incorporate clinical lab test results into EHR as structured data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms
None

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- **DENOMINATOR**: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
- **NUMERATOR**: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
- **EXCLUSION**: If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.
The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

**Additional Information**

- The provider is permitted, but not required, to limit the measure of this objective to labs ordered for those patients whose records are maintained using certified EHR technology.
- Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
- Lab results are not limited to any specific type of laboratory or to any specific type of lab test.
- The Medicare and Medicaid EHR Incentive Programs do not specify the use of code set standards in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory, for the entry of structured data for this measure and made this a requirement for EHR technology to be certified.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- What lab tests should be included in the denominator of the measure for the "incorporate clinical lab-test results" objective? **New ID #3263, Old ID #10642**
- One of the menu set meaningful use objectives requires EPs, eligible hospitals and CAHs to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test in order to count a structured lab result in the numerator for the measure of this objective? **New ID #2855, Old ID #10136**
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? **New ID #2813, Old ID #10095**
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? **New ID #2765, Old ID #10068**
- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? **New ID #2883, Old ID #10151**
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? **New ID #3065, Old ID #10466**
If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? **New ID #3077, Old ID #10475**

- How should EPs select menu objectives? **New ID #2903, Old ID #10162**
- How should a provider attest if the numerator displayed by their certified EHR is larger than the denominator? **New ID #3823, Old ID #10981**

## Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(h) Incorporate laboratory test results</td>
<td>(1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format.</td>
</tr>
<tr>
<td></td>
<td>(2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).</td>
</tr>
<tr>
<td></td>
<td>(3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
<th>N/A</th>
</tr>
</thead>
</table>
Patient Lists

<table>
<thead>
<tr>
<th>Table of Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of Terms</td>
</tr>
<tr>
<td>Attestation Requirements</td>
</tr>
<tr>
<td>Additional Information</td>
</tr>
<tr>
<td>Related Meaningful Use FAQs</td>
</tr>
<tr>
<td>Certification and Standards Criteria</td>
</tr>
<tr>
<td>Related Certification FAQs</td>
</tr>
</tbody>
</table>

Definition of Terms

Specific Conditions -- Those conditions listed in the active patient problem list.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Additional Information

- This objective does not dictate the report(s) which must be generated. An EP is best positioned to determine which reports are most useful to their care efforts.
- The report generated could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP.
- The report generated is required to include only patients whose records are maintained using certified EHR technology.
**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

How should EPs select menu objectives? **New ID #2903, Old ID #10162**

**Certification and Standards Criteria**

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(i) Generate patient lists</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Enable a user to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in:

1. Problem list;
2. Medication list;
3. Demographics; and
4. Laboratory test results.

**Related Certification FAQs**

Click on the green numbers to view the answer to the FAQ.

- I’m in the process of implementing EHR technology developer XYZ’s certified Complete EHR [or certified EHR Module] “E-HealthSystem2010.”
  - **Scenario 1:** Can I reconfigure E-HealthSystem2010 without compromising the certified status of my implementation of E-HealthSystem2010?
  - **Scenario 2:** EHR technology developer XYZ communicated to my organization that they relied upon a 3rd party software program “PatientInfoTracker 2.0” for the purposes of demonstrating compliance with the “generate patient lists” certification criterion specified at 45 CFR 170.302(i) in achieving E-HealthSystem2010’s certification. I have already implemented, use, and would like to continue using “SuperListGenerator 7.0.” I have determined that I can reconfigure SuperListGenerator 7.0 to work with E-HealthSystem2010. Can I use SuperListGenerator 7.0 in lieu of PatientInfoTracker 2.0 without compromising the certified status of my implementation of E-HealthSystem2010? [9-10-016-1](#)
• Is an EP limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? Similarly, if the EHR technology was tested and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use? 3-11-024-1
Patient Reminders

<table>
<thead>
<tr>
<th>Objective</th>
<th>Send reminders to patients per patient preference for preventive/follow-up care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms

None

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients 65 years old or older or 5 years older or younger.
- NUMERATOR: Number of patients in the denominator who were sent the appropriate reminder.
- EXCLUSION: If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 20 percent in order for an EP to meet this measure.
Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- EPs meet the aspect of “per patient preference” of this objective if they are accommodating reasonable requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), which is the guidance established for accommodating patient requests.
- EP has the discretion to determine the frequency, means of transmission, and form of the reminder limited only by the requirements the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), and any other applicable federal, state or local regulations that apply to them.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? [New ID #2813, Old ID #10095](#)
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? [New ID #2765, Old ID #10068](#)
- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? [New ID #2883, Old ID #10151](#)
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? [New ID #3065, Old ID #10466](#)
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? [New ID #3077, Old ID #10475](#)
- How should EPs select menu objectives? [New ID #2903, Old ID #10162](#)

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(d) Patient</td>
<td>Enable a user to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data</td>
</tr>
</tbody>
</table>
reminders

<table>
<thead>
<tr>
<th>elements included in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Problem list;</td>
</tr>
<tr>
<td>(2) Medication list;</td>
</tr>
<tr>
<td>(3) Medication allergy list;</td>
</tr>
<tr>
<td>(4) Demographics; and</td>
</tr>
<tr>
<td>(5) Laboratory test results.</td>
</tr>
</tbody>
</table>

§170.302(n) Automated measure calculation

For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

### Standards Criteria

| N/A |

### Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- Is an EP limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? Similarly, if the EHR technology was tested and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use? [3-11-024-1](#)
Patient Electronic Access

**Objective**
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

**Measure**
At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information.

**Exclusion**
Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.

**Table of Contents**
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

**Definition of Terms**

**Business Days** – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

**Unique Patient** – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

**Attestation Requirements**

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
• NUMERATOR: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.

• EXCLUSION: If an EP neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period, they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be at least 10 percent in order for an EP to meet this measure.

Additional Information

• Online electronic access through either a patient portal or personal health record (PHR) will satisfy the measure of this objective.

• An EP may decide that electronic access to a portal or PHR is not the best forum to communicate results. Within the confines of laws governing patient access to their medical records, we would defer to EP’s judgment as to whether to hold information back in anticipation of an actual encounter between the provider and the patient.

• Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, certified EHR technology makes available lab test results, problem list, medication list, and medication allergy list.

• An EP may withhold information from the electronic copy of a patient’s health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.

• The objective and measure focus on the availability of access and the timeliness of data, not utilization. The EP is not responsible for ensuring that 10 percent request access or have the means to access, only that 10 percent of all unique patients seen by the EP could access the information if they so desired.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

• How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?
  New ID #3307, Old ID #10664

• When a patient is only seen by a member of the EP’s clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator?
  New ID #3309, Old ID #10665
What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? New ID #2813, Old ID #10095

For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old ID #10068

If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? New ID #2883, Old ID #10151

Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? New ID #3065, Old ID #10466

If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? New ID #3077, Old ID #10475

How should EPs select menu objectives? New ID #2903, Old ID #10162

Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(g) Timely access</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
**Patient-specific Education Resources**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>

**Table of Contents**

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

**Definition of Terms**

**Patient-Specific Education Resources** – Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

**Unique Patient** – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

**Attestation Requirements**

**NUMERATOR / DENOMINATOR**

- **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR:** Number of patients in the denominator who are provided patient-specific education resources.
The resulting percentage (Numerator ÷ Denominator) must be more than 10 percent in order for an EP to meet this measure.

**Additional Information**

- Certified EHR technology is certified to use either the patient’s problem list, medication list, or laboratory test results to identify the patient-specific educational resources. These or additional elements can be used in the identification of educational resources that are specific to the patients needs.
- Education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- To meet the meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient," does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?  
  New ID #2907, Old ID #10164
- How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?  
  New ID #3307, Old ID #10664
- When a patient is only seen by a member of the EP’s clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? 10665
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? New ID #2813, Old ID #10095
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old ID #10068
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?  
  New ID #3065, Old ID #10466
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures?  
  New ID #3077, Old ID #10475
Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(m) Patient-specific education resources</td>
<td>N/A</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>Enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient’s: problem list; medication list; and laboratory test results; as well as provide such resources to the patient.</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
</tbody>
</table>

New ID #2903, Old ID #10162
Medication Reconciliation

<table>
<thead>
<tr>
<th>Objective</th>
<th>The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>An EP who was not the recipient of any transitions of care during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms

Medication Reconciliation -- The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Relevant Encounter – An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.)

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION
DENOMINATOR: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

NUMERATOR: Number of transitions of care in the denominator where medication reconciliation was performed.

EXCLUSION: If an EP was not on the receiving end of any transition of care during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? New ID #2813, Old ID #10095
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? New ID #2765, Old ID #10068
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? New ID #3065, Old ID #10466
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? New ID #3077, Old ID #10475
- How should EPs select menu objectives? New ID #2903, Old ID #10162
Certification and Standards Criteria
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

**Certification Criteria**

<table>
<thead>
<tr>
<th><strong>Certification Criteria</strong></th>
<th><strong>Standards Criteria</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.302(j) Medication reconciliation</td>
<td>Enable a user to electronically compare two or more medication lists.</td>
</tr>
<tr>
<td>§170.302(n) Automated measure calculation</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
</tbody>
</table>

**Standards Criteria**

| Standards Criteria | N/A |
Eligible Professional
Meaningful Use
Menu Set Measures
Measure 8 of 10
Stage 1
Date issued: November 7, 2010

Transition of Care Summary

Objective
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Measure
The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

Exclusion
An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

Table of Contents
- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms
Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
- EXCLUSION: If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.
The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

**Additional Information**

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- The transferring party must provide the summary care record to the receiving party.
- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so.
- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care.

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? [New ID #2813, Old ID #10095](https://questions.cms.gov/)
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? [New ID #2765, Old ID #10068](https://questions.cms.gov/)
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP’s patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? [New ID #3065, Old ID #10466](https://questions.cms.gov/)
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? [New ID #3077, Old ID #10475](https://questions.cms.gov/)
- How should EPs select menu objectives? [New ID #2903, Old ID #10162](https://questions.cms.gov/)
- Should transitions of care between EPs within the same practice who share certified EHR technology be included in the numerator or denominator of the measure? [New ID #3821, Old ID #10980](https://questions.cms.gov/)
**Certification and Standards Criteria**

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>§170.304(i)</td>
<td>Electronically receive and display. Electronically receive and display a patient’s summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.</td>
</tr>
<tr>
<td>§170.302(n)</td>
<td>For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.</td>
</tr>
<tr>
<td>§170.302(n)</td>
<td>Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list in accordance with:</td>
</tr>
<tr>
<td></td>
<td>(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and</td>
</tr>
<tr>
<td></td>
<td>(ii) For the following data elements the applicable standard must be used:</td>
</tr>
<tr>
<td></td>
<td>(A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);</td>
</tr>
<tr>
<td></td>
<td>(B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and</td>
</tr>
<tr>
<td></td>
<td>(C) Medications. The standard specified in §170.207(d).</td>
</tr>
</tbody>
</table>
### Patient summary record
- §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.

### Problems
- §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.
- §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version.

### Laboratory test results
- §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

### Medication
- §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

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## Related Certification FAQs
Click on the green numbers to view the answer to the FAQ.

- I’ve identified that I am using two different EHR technologies to meet a single certification criterion (my document management system receives and displays summary records (45 CFR 306(f)(1)) and my EHR technology from EHR technology developer XYZ transmits summary records (45 CFR 306(f)(2)). Do both EHR technologies need to be certified? [9-10-011-1](#)
- Could an interface that transmits lab results in HL7 message format between a hospital laboratory system and a physician’s EHR (presuming that the transmissions were occurring between two different legal entities) satisfy the certification criteria related to the exchange of key clinical information in 45 CFR 170.304(i) and 45 CFR 170.306(f)? [12-10-023-1](#)
Eligible Professional
Meaningful Use
Menu Set Measures
Measure 9 of 10
Stage 1
Date issued: November 7, 2010

Immunization Registries Data Submission

<table>
<thead>
<tr>
<th>Objective</th>
<th>Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).</td>
</tr>
<tr>
<td>Exclusion</td>
<td>An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.</td>
</tr>
</tbody>
</table>

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

Definition of Terms
None.

Attestation Requirements

YES / NO / EXCLUSION

- Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.
• **EXCLUSION:** If an EP does not perform immunizations during the EHR reporting period, or if there is no immunization registry that has the capacity to receive the information electronically, then the EP would be excluded from this requirement. EPs must select NO next to the appropriate exclusion(s), then click the APPLY button in order to attest to the exclusion(s).

**Additional Information**

• The test to meet the measure of this objective must involve the actual submission of information to a registry or immunization information system, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
• The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
• If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
• An unsuccessful test to submit electronic data to immunization registries or immunization information systems will be considered valid and would satisfy this objective.
• If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
• The transmission of immunization information must use the standards at 45 CFR 170.302(k).

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

• To meet the public health meaningful use objectives (submitting information to an immunization registry, reporting lab results to a public health agency, or reporting syndromic surveillance information), does a provider have to send information directly from their certified EHR technology to the appropriate receiving entity or can they use an intermediary such as an HIE or another third-party software vendor? **New ID #3461, Old ID #10764**

• If my certified EHR technology is capable of submitting batch files to an immunization registry using the standards adopted by ONC (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the meaningful use objective "submit electronic data to immunization registries"? **New ID #3369, Old ID #10713**

• If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion? **New ID #3371, Old ID #10714**
- Will the requirement that EPs and eligible hospitals choose at least one public health objective among the meaningful use measures still apply to those States that ask CMS for approval to change the definition of meaningful use? New ID #3119, Old ID #10532
- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? New ID #2883, Old ID #10151
- How should EPs select menu objectives? New ID #2903, Old ID #10162
- Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives? New ID #3605, Old ID #10841

### Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>§170.302(k)</strong> Submission to immunization registries</td>
<td><strong>Electronic submission to immunization registries</strong></td>
</tr>
</tbody>
</table>
• §170.205(e)(2) - HL7 2.5.1. Implementation specifications. HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0.  |
| (1) The standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2); and |  |
| (2) At a minimum, the version of the standard specified in §170.207(e). |  |

| Immunizations | • §170.207(e) - HL7 Standard Code Set CVX—Vaccines Administered, July 30, 2009 version. |

### Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- If my EHR technology is capable of submitting batch files to an immunization registry using the adopted standards (HL7 2.3.1 or 2.5.1 and CVX), is that sufficient for demonstrating compliance with the certification criterion specified at 45 CFR 170.302(k)? 9-10-002-1
- I use or would like to use an “interface” to submit data to a public health agency/registry. Does this interface need to be certified? 9-10-018-1
Eligible Professional  
Meaningful Use  
Menu Set Measures  
Measure 10 of 10  
Stage 1  
Date issued: November 7, 2010

<table>
<thead>
<tr>
<th>Objective</th>
<th>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).</td>
</tr>
<tr>
<td>Exclusion</td>
<td>An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.</td>
</tr>
</tbody>
</table>

**Table of Contents**

- Definition of Terms
- Attestation Requirements
- Additional Information
- Related Meaningful Use FAQs
- Certification and Standards Criteria
- Related Certification FAQs

**Definition of Terms**

**Public Health Agency** -- An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

**Attestation Requirements**

YES / NO / EXCLUSION

- Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test was successful (unless none of the public health agencies to
which the EP submits such information has the capacity to receive the information electronically) to meet this measure.

- **EXCLUSION:** If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period or if no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

**Additional Information**

- The test to meet the measure of this objective must involve the actual submission of electronic syndromic surveillance data to public health agencies, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of electronic syndromic surveillance data is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- An unsuccessful test to submit electronic syndromic surveillance data to public health agencies will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- EPs must test their ability to submit electronic syndromic surveillance data to public health agencies at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Each payment year requires its own unique test.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- The transmission of syndromic surveillance information must use the standards at 45 CFR 170.302(l).

**Related Meaningful Use FAQs**

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at [https://questions.cms.gov/](https://questions.cms.gov/) and enter the New ID # into the Search Box, clicking the “FAQ #” option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the “Text” option.)

- To meet the public health meaningful use objectives (submitting information to an immunization registry, reporting lab results to a public health agency, or reporting syndromic surveillance information), does a provider have to send information directly from their certified EHR technology to the appropriate receiving entity or can they use an intermediary such as a HIE or another third-party software vendor? [New ID #3461, Old ID #10764](#)
- If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion?
Will the requirement that EPs and eligible hospitals choose at least one public health objective among the meaningful use measures still apply to those States that ask CMS for approval to change the definition of meaningful use? New ID #3119, Old ID #10532

If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? New ID #2883, Old ID #10151

How should EPs select menu objectives? New ID #2903, Old ID #10162

Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives? New ID #3605, Old ID #10841

What is the definition of "syndromic surveillance"? New ID #3615, Old ID #10846

**Certification and Standards Criteria**
Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

<table>
<thead>
<tr>
<th>Certification Criteria</th>
<th>Standards Criteria</th>
</tr>
</thead>
</table>
| §170.302(l) Public health surveillance | • §170.205(d)(1) - HL7 2.3.1.
  • §170.205(d)(2) - HL7 2.5.1. |

Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard specified in §170.205(d)(1) or §170.205(d)(2).

**Related Certification FAQs**
Click on the green numbers to view the answer to the FAQ.

- In the Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology Final Rule published on July 28, 2010, the Secretary adopted the following implementation specifications at 45 CFR 170.205(d)(2) for the HL7 2.5.1 standard: Public Health Information Network HL7 Version 2.5 Message Structure Specification for National Condition Reporting Final Version 1.0 and Errata and Clarifications National Notification Message Structural Specification. Their adoption does not appear to either provide the appropriate or requisite implementation guidance for the adopted standard, HL7 2.5.1, or more importantly, to enable the user to “electronically record, modify, retrieve, and submit
syndrome-based public health surveillance information...,” as required by the adopted certification criterion, 45 CFR 170.302(l). Please clarify whether these implementation specifications are appropriate for the intended capability specified by the public health surveillance certification criterion at 45 CFR 170.302(l). 9-10-003-2

- I use or would like to use an “interface” to submit data to a public health agency/registry. Does this interface need to be certified? 9-10-018-1
### Table 3: Stage 1 Meaningful Use Objectives and Associated Measures Sorted by Method of Measure Calculation

<table>
<thead>
<tr>
<th>Measures with a Denominator of Unique Patients Regardless of Whether the Patient’s Records Are Maintained Using Certified EHR Technology</th>
<th>Stage 1 Objectives</th>
<th>Stage 1 Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Professionals</strong></td>
<td>Maintain an up-to-date problem list of current and active diagnoses</td>
<td>More than 80% of all unique patients seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data</td>
</tr>
<tr>
<td><strong>Eligible Hospitals and CAHs</strong></td>
<td>Maintain an up-to-date problem list of current and active diagnoses</td>
<td>More than 80% of all unique patients seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data</td>
</tr>
<tr>
<td>Maintain active medication list</td>
<td>Maintain active medication list</td>
<td>More than 80% of all unique patients seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data</td>
</tr>
<tr>
<td>Maintain active medication allergy list</td>
<td>Maintain active medication allergy list</td>
<td>More than 50% of all unique patients seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data</td>
</tr>
<tr>
<td>Record demographics</td>
<td>Record demographics</td>
<td>More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information</td>
</tr>
<tr>
<td></td>
<td>o Preferred language</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Race</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Ethnicity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Date of Birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH</td>
<td></td>
</tr>
</tbody>
</table>
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate  | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate  | More than 10% of all unique patients seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources

### Measures with a Denominator of Based on Counting Actions for Patients whose Records are Maintained Using Certified EHR Technology

<table>
<thead>
<tr>
<th>Stage 1 Objectives</th>
<th>Stage 1 Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Professionals</strong></td>
<td><strong>Eligible Hospitals and CAHs</strong></td>
</tr>
<tr>
<td>Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</td>
<td>Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</td>
</tr>
<tr>
<td>Generate and transmit permissible prescriptions electronically (eRx)</td>
<td></td>
</tr>
<tr>
<td>Record and chart changes in vital signs:</td>
<td>Record and chart changes in vital signs:</td>
</tr>
<tr>
<td>o Height</td>
<td>o Height</td>
</tr>
<tr>
<td>o Weight</td>
<td>o Weight</td>
</tr>
<tr>
<td>o Blood pressure</td>
<td>o Blood pressure</td>
</tr>
<tr>
<td>o Calculate and display BMI</td>
<td>o Calculate and display BMI</td>
</tr>
<tr>
<td>o Plot and display growth charts for children 2-20 years, including BMI</td>
<td>o Plot and display growth charts for children 2-20 years, including BMI</td>
</tr>
<tr>
<td>Record smoking status for patients 13 years old or older</td>
<td>Record smoking status for patients 13 years old or older</td>
</tr>
<tr>
<td></td>
<td>Record advance directives for patients 65 years old or older</td>
</tr>
<tr>
<td>Incorporate clinical lab-test results into certified EHR technology as structured data</td>
<td>Incorporate clinical lab-test results into certified EHR technology as structured data</td>
</tr>
<tr>
<td>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request</td>
<td>More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days</td>
</tr>
<tr>
<td>Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request</td>
<td>More than 50% of all patients who are discharged from an eligible hospital or CAH’s inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it</td>
</tr>
<tr>
<td>Provide clinical summaries for patients for each office visit</td>
<td>Clinical summaries provided to patients for more than 50% of all office visits within 3 business days</td>
</tr>
<tr>
<td>Send reminders to patients per patient preference for preventive/follow up care</td>
<td>More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period</td>
</tr>
<tr>
<td>The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation</td>
<td>The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation</td>
</tr>
<tr>
<td>The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral</td>
<td>The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral</td>
</tr>
</tbody>
</table>

**Measures Requiring Only a Yes/No Attestation**

<table>
<thead>
<tr>
<th>Stage 1 Objectives</th>
<th>Stage 1 Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Professionals</strong></td>
<td><strong>Hospitals</strong></td>
</tr>
<tr>
<td>Implement drug-drug and drug-allergy interaction checks</td>
<td>Implement drug-drug and drug-allergy interaction checks</td>
</tr>
<tr>
<td>Implement drug-formulary checks</td>
<td>Implement drug-formulary checks</td>
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<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach</td>
<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach</td>
</tr>
<tr>
<td>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule</td>
<td>Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule</td>
</tr>
<tr>
<td>Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically</td>
<td>Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically</td>
</tr>
<tr>
<td>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice</td>
<td>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice</td>
</tr>
<tr>
<td>Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice</td>
<td>Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice</td>
</tr>
<tr>
<td>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</td>
<td>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</td>
</tr>
<tr>
<td>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</td>
<td>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</td>
</tr>
</tbody>
</table>

3 For purposes of this final rule, the term “eligible hospital” for the Medicaid EHR incentive program is inclusive of Critical Access Hospitals (CAHs) as defined in this final rule.

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3. Sections 4101(a) and 4102(a)(1) of the HITECH Act: Reporting on Clinical Quality Measures Using EHRs by EPs, Eligible Hospitals, and CAHs

a. General

As discussed in the meaningful use background in section II.A.2.a. there are three elements of meaningful use. In this section, we discuss the third requirement: using certified EHR technology, the EP, eligible hospital, or CAH submits to the Secretary, in a form and manner specified by the Secretary, information for the EHR reporting period on clinical quality measures and other measures specified by the Secretary. The submission of other measures is discussed in section II.A.2.c of this final rule. The two other elements of meaningful use are discussed in section II.A.2.d.1 of this final rule.

b. Requirements for the Submission of Clinical Quality Measures by EPs, Eligible Hospitals, and CAHs

Sections 1848(o)(2)(B)(ii) and 1886(n)(3)(B)(ii) of the Act provide that the Secretary may not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

In the proposed rule, we stated that we do not anticipate that HHS will complete the necessary steps for us to have the capacity to electronically accept data on clinical quality measures from EHRs for the 2011 payment year. We believe that it is unlikely that by 2011 there will be adequate testing and demonstration of the ability to receive the required transmitted information on a widespread basis. The capacity to accept information on clinical quality measures also would depend upon the Secretary promulgating technical specifications for EHR vendors with respect to the transmission of information on clinical quality measures.

sufficiently in advance of the EHR reporting period for 2011, so that adequate time has been provided either for such specifications to be certified, or for EHR vendors to code such specifications into certified systems. Therefore, for 2011, we proposed that Medicare EPs, eligible hospitals, and CAHs use an attestation methodology to submit summary information to us on clinical quality measures as a condition of demonstrating meaningful use of certified EHR technology, rather than electronic submission.

We proposed that from the Medicaid perspective, delaying the onset of clinical quality measures electronic reporting until 2012 addresses concerns about States having the ready infrastructure to receive and store clinical quality measures data before then. More importantly, we recognized that since Medicaid providers are eligible to receive incentive payments for adopting, implementing, or upgrading certified EHR technology, Medicaid providers may not be focused on demonstrating meaningful use until 2012 or later.

We stated that we anticipate that for the 2012 payment year we will have completed the necessary steps to have the capacity to receive electronically information on clinical quality measures from EHRs, including the promulgation of technical specifications for EHR vendors to use for obtaining certification of their systems. Therefore, for the Medicare EHR incentive program beginning in CY 2012 we proposed that an EP using a certified EHR technology or beginning in FY 2012 an eligible hospital or CAH using a certified EHR technology, as appropriate for clinical quality measures, must submit information on clinical quality measures electronically, in addition to submitting the other measures described in section II.2.d.2, in order for the EP, eligible hospital, or CAH to be a meaningful EHR user, regardless of whether CY 2012 is their first or second payment year. However, if the Secretary does not have the capacity to accept the information on clinical quality measures electronically in 2012, consistent with sections 1848(o)(2)(B)(ii) and 1886(n)(3)(B)(ii) of the Act, we will continue to rely on an attestation methodology for reporting of clinical quality measures as a requirement for demonstrating meaningful use of certified EHR technology for payment year 2012. We stated in the proposed rule that should we not have the capacity to accept information on clinical quality measures electronically in 2012, we would inform the public of this fact by publishing a notice in the Federal Register and providing instructions on how this information should be submitted to us.

We also are finalizing in this final rule that States must identify for us in their State Medicaid HIT Plans how they plan to accept data from Medicaid providers who seek to demonstrate meaningful use by reporting on clinical quality measures, either via attestation or via electronic reporting, subject to our prior approval. If they initiate their program by accepting attestations for clinical quality measures, they must also describe how they will inform providers of their timeframe to accept submission of clinical quality measures electronically. We expect that States will have the capacity to accept electronic reporting of clinical quality measures by their second year implementing their Medicaid EHR incentive program.

For purposes of the requirements under sections 1848(o)(2)(A)(iii) and 1886(n)(3)(iii) of the Act, we defined “clinical quality measures” to consist of measures of processes, experience, and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care. We noted that certain statutory limitations apply only to the reporting of clinical quality measures, such as the requirement discussed in the previous paragraph prohibiting the Secretary from requiring the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, as well as other statutory requirements for clinical quality measures that are discussed below in.
### Core CQMs: Report All 3 Measures *

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0013</td>
<td>Hypertension: Blood Pressure Measurement</td>
<td>Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who has been seen for at least 2 office visits, with blood pressure (BP) recorded.</td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment b) Tobacco Cessation Intervention</td>
<td>a) Tobacco Use Assessment. Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. b) Tobacco Cessation Intervention Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.</td>
</tr>
<tr>
<td>NQF 0421</td>
<td>Adult Weight Screening and Follow-up</td>
<td>Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.</td>
</tr>
</tbody>
</table>

* If any of the 3 core measures are reported with zero values for the denominator, you are required to substitute an alternate core measure. For example if: NQF 0028 & NQF 0421 are 0; report 2 measures from the alternate core measures. All values reported in the denominator of the measure should be the values produced by the certified EHR technology.
<table>
<thead>
<tr>
<th>NQF #</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
<td>The percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.</td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status</td>
<td>Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.</td>
</tr>
<tr>
<td>NQF 0041</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old</td>
<td>Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).</td>
</tr>
</tbody>
</table>

* If you reported 0 for all 3 core measures, you must report on all 3 alternate core measures even if you will report zeroes for all 6 measures. If you reported a 0 for 2 core measures you will need to report 2 alternate core measures, likewise, if you reported 0 for 1 core measure you are required to report 1 of the 3 alternate core measures. Note: All values reported should be the values produced by the certified EHR technology.
## Additional CQMs: Report 3 Measures *

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0004</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement</td>
<td>Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.</td>
</tr>
<tr>
<td>NQF 0012</td>
<td>Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)</td>
<td>Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.</td>
</tr>
<tr>
<td>NQF 0014</td>
<td>Prenatal Care: Anti-D Immune Globulin</td>
<td>Percentage of D(Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.</td>
</tr>
<tr>
<td>NQF 0018</td>
<td>Controlling High Blood Pressure</td>
<td>The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.</td>
</tr>
<tr>
<td>NQF 0032</td>
<td>Cervical Cancer Screening</td>
<td>Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.</td>
</tr>
<tr>
<td>NQF 0033</td>
<td>Chlamydia Screening for Women</td>
<td>Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.</td>
</tr>
<tr>
<td>NQF 0036</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).</td>
</tr>
<tr>
<td>NQF 0052</td>
<td>Low Back Pain: Use of Imaging Studies</td>
<td>Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.</td>
</tr>
<tr>
<td>NQF #</td>
<td>Title</td>
<td>Description</td>
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</tr>
<tr>
<td>NQF 0075</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</td>
<td>Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C&lt;100 mg/dL.</td>
</tr>
<tr>
<td>NQF 0575</td>
<td>Diabetes: HbA1c Control (&lt;8%)</td>
<td>The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c &lt;8.0%.</td>
</tr>
<tr>
<td>NQF 0059</td>
<td>Diabetes: HbA1c Poor Control</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c &gt; 9.0%.</td>
</tr>
<tr>
<td>NQF 0389</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.</td>
</tr>
<tr>
<td>NQF 0043</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
<td>Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.</td>
</tr>
<tr>
<td>NQF 0031</td>
<td>Breast Cancer Screening</td>
<td>Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.</td>
</tr>
<tr>
<td>NQF 0034</td>
<td>Colorectal Cancer Screening</td>
<td>Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.</td>
</tr>
<tr>
<td>NQF #</td>
<td>Title</td>
<td>Description</td>
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</tr>
<tr>
<td>NQF 0027</td>
<td>Smoking and Tobacco Use Cessation, Medical assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies</td>
<td>Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.</td>
</tr>
<tr>
<td>NQF 0055</td>
<td>Diabetes: Eye Exam</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.</td>
</tr>
<tr>
<td>NQF 0062</td>
<td>Diabetes: Urine Screening</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.</td>
</tr>
<tr>
<td>NQF 0086</td>
<td>Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.</td>
</tr>
<tr>
<td>NQF 0056</td>
<td>Diabetes: Foot Exam</td>
<td>The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).</td>
</tr>
<tr>
<td>NQF 0088</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.</td>
</tr>
<tr>
<td>NQF 0089</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.</td>
</tr>
<tr>
<td>NQF #</td>
<td>Title</td>
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<tr>
<td>NQF 0074</td>
<td>Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD who was prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).</td>
</tr>
<tr>
<td>NQF 0064</td>
<td>Diabetes: LDL Management &amp; Control</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C &lt; 100 mg/dL.</td>
</tr>
<tr>
<td>NQF 0084</td>
<td>Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation</td>
<td>Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation that were prescribed warfarin therapy.</td>
</tr>
<tr>
<td>NQF 0073</td>
<td>Ischemic Vascular Disease (IVD): Blood Pressure Management</td>
<td>Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (&lt;140/90 mmHg).</td>
</tr>
<tr>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic</td>
<td>Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.</td>
</tr>
<tr>
<td>NQF 0061</td>
<td>Diabetes: Blood Pressure Management</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure &lt;140/90 mmHg.</td>
</tr>
<tr>
<td>NQF #</td>
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<tr>
<td>NQF 0081</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF &lt; 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
</tr>
<tr>
<td>NQF 0047</td>
<td>Asthma Pharmacologic Therapy</td>
<td>Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.</td>
</tr>
<tr>
<td>NQF 0067</td>
<td>Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.</td>
</tr>
<tr>
<td>NQF 0001</td>
<td>Asthma Assessment</td>
<td>Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, which were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.</td>
</tr>
<tr>
<td>NQF 0002</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>Percentage of children 2-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.</td>
</tr>
<tr>
<td>NQF 0070</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.</td>
</tr>
<tr>
<td>NQF 0387</td>
<td>Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIII Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer</td>
<td>Percentage of female patients aged 18 years and older with Stage IC through IIIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.</td>
</tr>
</tbody>
</table>
### Additional CQMs: Report 3 Measures *

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>NQF 0385</td>
<td>Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients</td>
<td>Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.</td>
</tr>
<tr>
<td>NQF 0083</td>
<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF &lt; 40%) and who were prescribed beta-blocker therapy.</td>
</tr>
<tr>
<td>NQF 0105</td>
<td>Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment</td>
<td>Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.</td>
</tr>
</tbody>
</table>

* Select any 3 measures that apply to your practice. It is acceptable to have zero for the denominator if that is the value produced by the certified EHR technology. Three additional measures are required for a total of 6-9 measures depending on the number of core and alternate core measures.