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**Office of Medical Assistance Programs
Electronic Health Record (EHR)
Incentive Program**

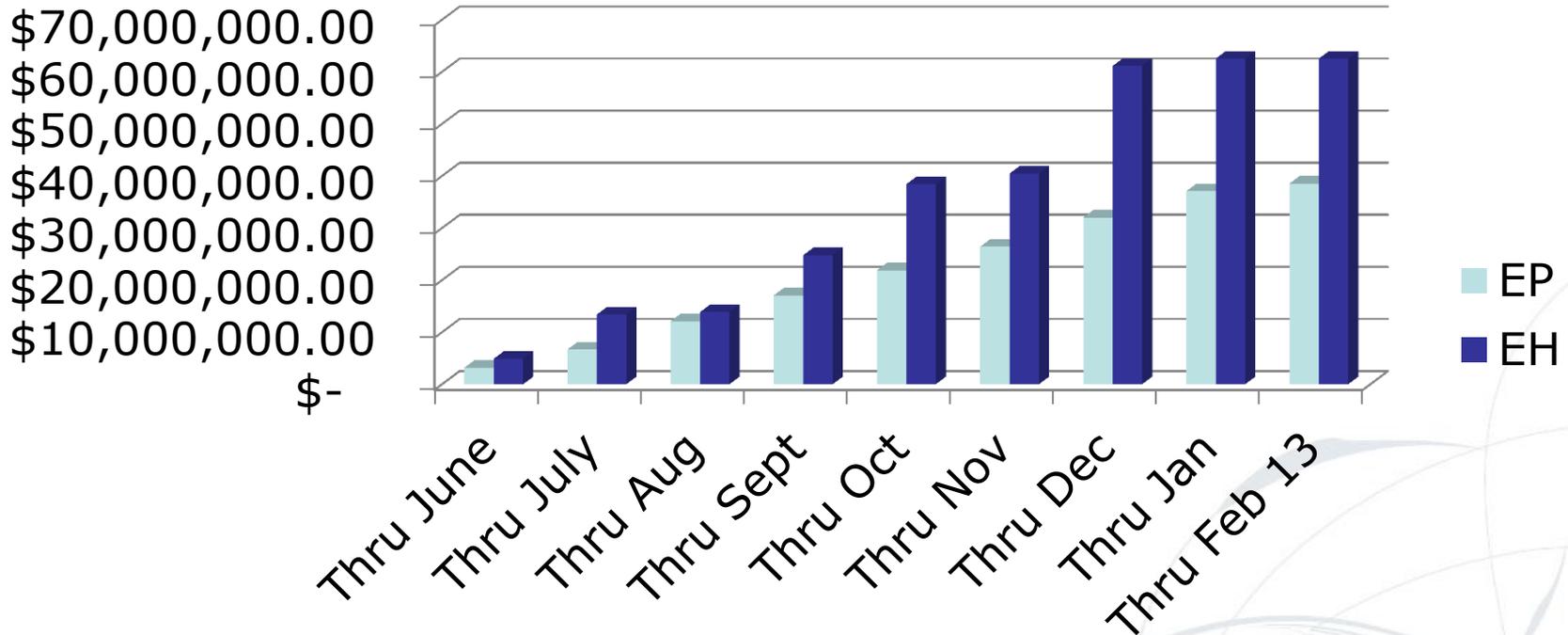
**Meaningful Use Q&A Webinar
February 22, 2012**

Program Update – Incentive Payments



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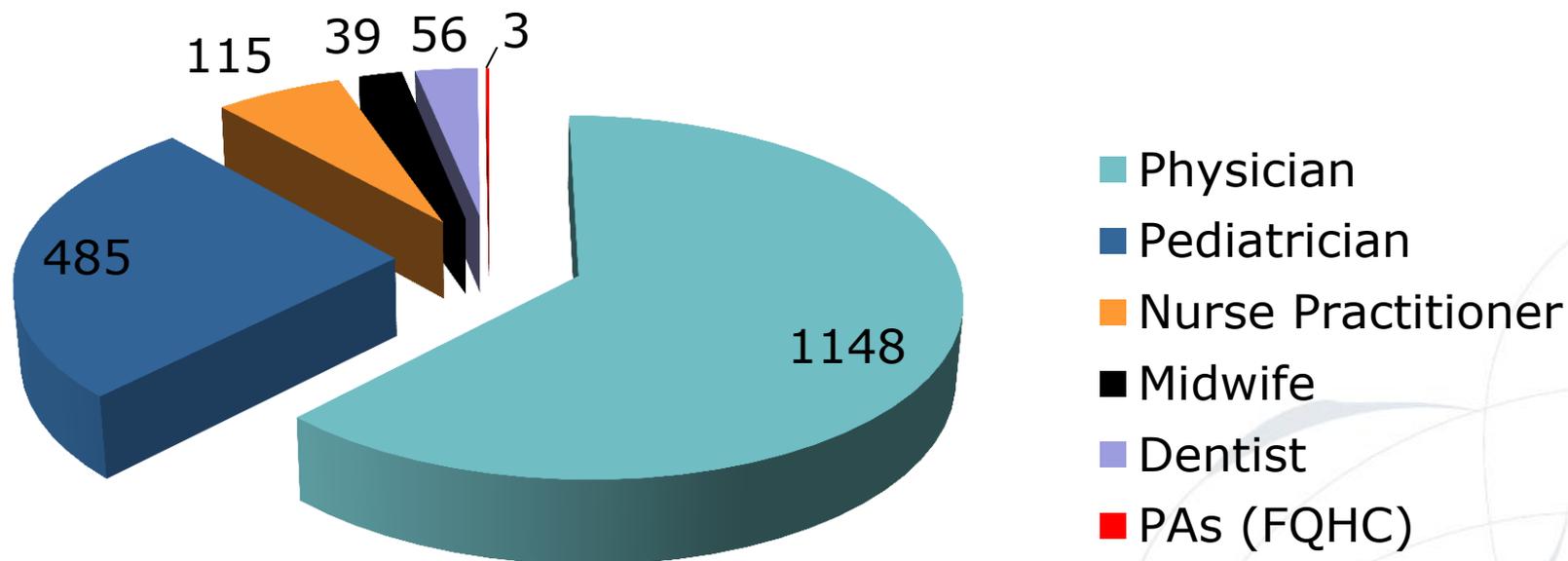
Payments – February 13, 2012



EP payment total: \$38,519,204.00
EH payment total: \$62,524,144.86
Grand total: \$101,043,348.86



Approved Provider Summary



Meaningful Use Screens



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MAPIR

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Wednesday 7/6/2012 4:14:53 PM EST

NPI 1234567890 TIN 123456789

CCN N/A



*Application (Select to Continue)	Status	Payment Year	Program Year	Payment Amount	Available Actions
<input type="radio"/>	Completed	1	2011	\$ 21,250.00	Select the "Continue" button to view this application.
<input type="radio"/>	Not Started	2	2012	Unknown	Select the "Continue" button to begin this application.
<input type="radio"/>	<i>Future</i>	<i>3</i>	<i>Future</i>	<i>Unknown</i>	<i>None at this time</i>
<input type="radio"/>	<i>Future</i>	<i>4</i>	<i>Future</i>	<i>Unknown</i>	<i>None at this time</i>
<input type="radio"/>	<i>Future</i>	<i>5</i>	<i>Future</i>	<i>Unknown</i>	<i>None at this time</i>
<input type="radio"/>	<i>Future</i>	<i>6</i>	<i>Future</i>	<i>Unknown</i>	<i>None at this time</i>

Continue

Meaningful Use Resources



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Visit: <http://www.cms.gov/apps/ehr/meaningful-use-calculator.aspx>



The Meaningful Use Attestation Calculator

Meeting the Requirements for Meaningful Use

This online tool allows providers to test whether or not they would successfully demonstrate meaningful use for the EHR Incentive Programs. Visit the Medicare and Medicaid EHR Incentive Program website for more detailed information about the program, including who is eligible to participate.

Get Started!

Select Your Provider Type:

Eligible
Hospitals >
and Critical Access Hospitals

Eligible
Professionals >

CMS MU Calculator

Meaningful Use – Resources



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<http://www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf>



Electronic Health Record (EHR) Incentive Program FAQs

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- **Patrick Hamilton**, Health Insurance Specialist/
Rural Health Coordinator from CMS
- **Anita Somplasky, RN**, the PA REACH
Executive Director
- **Matt McGeorge**, OMAP HIT Coordinator,
PA Department of Public Welfare

General Incentive Program Questions



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Q1. Do providers register only once for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, or must they register every year?

A1. Providers are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have either adopted, implemented or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds. Providers will register using the Medicare and Medicaid EHR Incentive Program Registration & Attestation System, a web-based system. Providers who select the Medicaid EHR Incentive Program will demonstrate their eligibility and attest via their State Medicaid Agency's system. If any basic registration information changes, the provider will need to update their information in the Medicare and Medicaid EHR Incentive Program Registration & Attestation System.



Q2. What constitutes a Medicaid encounter?

A2. For Eligible Professionals: Services rendered on any one day to an individual where Medical Assistance paid for part or all of the service or their premiums, co-payments and/or cost-sharing.

For Hospitals: Services rendered to an individual per inpatient discharges where Medical Assistance paid for part or all of the service or their premiums, co-payments and/or cost-sharing.

Services rendered to an individual in an emergency department on any one day where Medical Assistance paid for part or all of the service; or their premiums, co-payments and/or cost-sharing.

General Incentive Program Questions



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Q3. How do you determine if a physician is hospital-based?

A3. Eligible Professionals (such as Orthopedic Surgeons) who furnish 90 percent or more of their covered professional services in a hospital setting (place of service code 21 or 23) in the year preceding the payment year would be considered hospital-based and not eligible for the program.

General Incentive Program Questions



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Q4. Will EPs be able to attest using group volume information? Can you explain the group volume calculation?

A4. EPs must attest to volume each year they participate and will have the option to use group volume to do so. Even if an EP uses group volume to reach the required volume threshold they need to attest to MU using their individual calculations for the MU measures.



Q5. What is meaningful use, and how does it apply to the Medicaid Electronic Health Record (EHR) Incentive Program?

A5. Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs), critical access hospitals, and eligible hospitals that successfully demonstrate meaningful use of certified EHR technology.

The Recovery Act specifies three main components of meaningful use:

- The use of a certified EHR in a meaningful manner (e.g.: e-Prescribing);
- The use of certified EHR technology for electronic exchange of health Information to improve quality of health care;
- The use of certified EHR technology to submit clinical quality and other measures.

General Meaningful Use Questions



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Q6. If I am attesting for the first time this year, is it for 90 days or a full year?

A6. Eligible Professionals by rule are allowed to receive their first payment for AIU regardless what calendar year it is. The second year of participation would be attesting to 90 days of Meaningful Use. The 3rd and subsequent years would be attesting to 365 days of Meaningful Use.

General Meaningful Use Questions



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Q7. When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

A7. Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit.

General Meaningful Use Questions



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Q8. Is the physician the only person who can enter information in the electronic health record (EHR) in order to qualify for the Medicare and Medicaid EHR Incentive Programs?

A8. No. The Final Rule for the Medicare and Medicaid EHR incentive programs, specifies that in order to meet the meaningful use objective for computerized provider order entry (CPOE) for medication orders, any licensed healthcare professional can enter orders into the medical record per state, local, and professional guidelines. The remaining meaningful use objectives do not specify any requirement for who must enter information.



Q9. Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice?

A9. For eligible professionals (EPs) who participate in the Medicare and Medicaid EHR Incentive Programs, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 15 required core objectives. The remaining 5 objectives may be chosen from the list of 10 menu set objectives. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. However, if an exclusion is not provided, or if the EP does not meet the criteria for an existing exclusion, then the EP must meet the measure of the objective in order to successfully demonstrate meaningful use and receive an EHR incentive payment. Failure to meet the measure of an objective or to qualify for an exclusion for the objective will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.



Q10. My practice does not typically collect information on any of the core, alternate core, and additional clinical quality measures (CQMs) listed in the Final Rule on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Do I need to report on CQMs for which I do not have any data?

A10. EPs are not excluded from reporting clinical quality measures, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. For the core measures, if the EP reports a zero for the core measure denominator, then the EP must report results for up to three alternate core measures (potentially reporting on all 6 core/alternate core measures). For the menu-set measures, we expect the EP to report on measures which do not have a denominator of zero. If none of the measures in the menu set applies to the EP, then the EP must report on three of such measures, reporting a denominator of zero, and then attest that the remainder of the menu-set measures have a value of zero in the denominator.

Numerator/Denominator Questions



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Q11. If an eligible professional (EP) sees a patient in a setting that does not have certified electronic health record (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 for the Medicare and Medicaid EHR Incentive Programs?

A11. Yes, an EP may include patients seen in locations without certified EHR technology in the numerators and denominators of meaningful use measures if the patients' information is entered into certified EHR technology at another practice location. However, EPs should be aware that it is unlikely that they will be able to include such patients in the numerator for the measure of the "use computerized provider order entry (CPOE)" objective or for the e-prescribing measure. As we explain in FAQ #10134, CPOE must be entered by someone who can exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Because information for patients seen in locations without certified EHR technology will be transcribed at a later date into the certified EHR system, it is unlikely that CPOE could occur before any action is taken on the order. For the e-prescribing measure, it is unlikely that EPs will be able to electronically transmit prescriptions for patients in locations without certified EHR technology.

Numerator/Denominator Questions



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Q12. For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?

A12. EPs, eligible hospitals, and CAHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the July 28, 2010 final rule (75 FR 44314).

For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "Generate and transmit permissible prescriptions electronically (eRx)"; number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information"; etc.), EPs, eligible hospitals, and CAHs can usually add the numerators and denominators calculated by each certified EHR system 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, eligible hospitals, and CAHs may not be able to simply add the numerators and denominators calculated by each certified EHR system. The EP, eligible hospital, or CAH must include only unique patients in the numerators and denominators of each objective, and it is the responsibility of the EP, eligible hospital, or CAH to reconcile information from multiple certified EHR systems in order to ensure that each unique patient is counted only once for each objective. Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators where applicable in order to provide accurate numbers.

Numerator/Denominator Questions



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Q13. For the Medicare and Medicaid EHR Incentive Programs, how does an eligible professional (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"?

A13. All cases where the EP and the patient have an actual physical encounter with the patient in which they render any service to the patient should be included in the denominator as seen by the EP. Also a patient seen through telemedicine would still count as a patient "seen by the EP." However, in cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures. For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all meaningful use measures that include patients "seen by the EP." EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies as least some of the services they render for patients as "seen by the EP" and this policy must be consistent for the entire EHR reporting period and across meaningful use measures that involve patients "seen by the EP" -- otherwise, these EPs would not be able to satisfy meaningful use, as they would have denominators of zero for some measures.

Core Objective Questions



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Q14. What information must an eligible professional provide in order to meet the measure of the meaningful use objective for “provide a clinical summary for patients for each office visit” under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A14. In our final rule, we defined "clinical summary" as: an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, 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.

The EP must include all of the above that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of the above 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

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

Core Objective Questions



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Q15. For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP) who orders medications infrequently calculate the measure for the “computerized provider order entry (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?

A15. The CPOE measure is structured to minimize reporting burden. However, if all of the following conditions are met it can also create a unique situation that could prevent an EP from successfully demonstrating meaningful use. An EP who:

- 1) prescribes more than 100 medications during the EHR reporting period;
- 2) maintains medication lists that include medications that they did not order; and
- 3) orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period.

In these circumstances, an EP may be both unable to meet this measure and unable to qualify for the exclusion. In the unique situation where all three criteria listed above apply, an EPs may limit their denominator to only those patients for whom the EP has previously ordered medication, if they so choose. EPs who do not meet the three criteria listed above must still base their calculation on the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period regardless of who ordered the medication or medications in the patient’s medication list.

Core Objective Questions



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Q16. For the meaningful use objective of "capability to exchange key clinical information" in the Medicare and Medicaid EHR Incentive Programs, what forms of electronic transmission can be used to meet the measure of the objective?

A16. For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology. There are many acceptable transmission methods for conducting a test of the electronic exchange of key clinical information with providers of care and patient authorized entities (see FAQ 10270 (http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/))

To meet the measure of this objective a provider must:

- (1) Use certified EHR technology to generate a continuity of care document (CCD)/continuity of care record (CCR), and
- (2) Electronically transmit the CCD/CCR.

To complete step 2, an eligible professional, eligible hospital, or critical access hospital may use any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.) regardless of whether it was included by an EHR technology developer as part of the certified EHR technology in the eligible professional's, eligible hospital's, or critical access hospital's possession. Please note that the use of USB, CD-ROM, or other physical media or electronic fax would not meet the measure of this objective

Core Objective Questions



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Q17. For the meaningful use objective to “record and chart changes in vital signs” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can an eligible professional (EP) claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three?

A17. An exclusion for this objective is provided only for EPs who either see no patients 2 years or older, or who believe that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. If an EP believes that one or two of these vital signs are relevant to their scope of practice, then they must record all three vital signs in order to meet the measure of this objective and successfully demonstrate meaningful use.

Menu Objective Questions



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Q18. To meet the meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?

A18. In the patient-specific education resources objective, 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.

Menu Objective Questions



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Q19. What lab tests should be included in the denominator of the measure for the “incorporate clinical lab-test results” objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A19. For the “incorporate clinical lab-test results” objective, the denominator consists of the number of lab tests ordered during the EHR reporting period by the eligible professional (or authorized providers of the eligible hospital or critical access hospital (CAH) for patients admitted to an eligible hospital’s or CAH’s inpatient or emergency department (POS 21 and 23)) whose results are expressed in a positive or negative affirmation or as a number. Providers may limit the denominator to only those lab tests that were ordered during the EHR reporting period and for which results were received during the same EHR reporting period.



Q20. How should eligible professionals (EPs) select menu objectives for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?

A20. EPs are required to report on a total of 5 meaningful use objectives from the menu set. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.

We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. For example, we hope that EPs will report on 5 measures, if there are 5 measures that are relevant to their scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives. Please note that EPs must have complete certified EHR technology (or a complete set of certified EHR modules) capable of supporting all of the core and menu set objectives, including any objectives for which the EP can claim an exclusion and menu set objectives the EP does not select.



Q21. Can you discuss the public health options available in Pennsylvania?

A21. EPs and EHs must be able to submit to public health registries according to the standards set by CMS.

The Pennsylvania Statewide Immunization Information System (PA SIIS) is able to accept transmissions in the manner specified by CMS to meet the MU requirement. EPs and EHs should consult with their EHR vendor to determine their status with PA SIIS.

The Pennsylvania Electronic Lab Reporting system is able to accept transmissions in the manner specified by CMS to meet the MU requirement. EHs should consult with their EHR vendor.

Additional information about syndromic surveillance will be available in the near future.

Clinical Quality Measure Questions



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Q22. Can eligible professionals (EPs) use clinical quality measures from the alternate core set to meet the requirement of reporting three additional measures for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A22. No, if EPs report data on all three clinical quality measures from the core set, they would not report on any from the alternate core set. The three additional clinical quality measures must come from Table 6 of the final rule (75 FR 44398-44408), excluding those clinical quality measures included in either the core set or the alternate core set.

Clinical Quality Measure Questions



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Q23. Can I use the electronic specifications for clinical quality measures to satisfy both the Physician Quality Reporting System (PQRS) and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A23. No. Each program has specific specifications for reporting. In the future CMS expects to harmonize specifications between PQRS (formerly known as the Physician Quality Reporting Initiative, or PQRI) and the Medicare and Medicaid EHR Incentive Programs. Therefore if a provider is reporting under the PQRI EHR program, they must refer to the PQRS EHR specifications found at http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp. Providers are required to report using the specifications for clinical quality measures found at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.

Clinical Quality Measure Questions



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Q24. If the denominators for all three of the core clinical quality measures are zero, do I have to report on the additional clinical quality measures for eligible professionals (EPs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A24. If the denominator value for all three of the core clinical quality measures is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core clinical quality measures. If the denominator values for all three of the alternate core clinical quality measures is also '0,' an EP still needs to report on 3 additional clinical quality measures. Zero is an acceptable denominator provided that this value was produced by certified EHR technology. Please see question number 10144 for a discussion of zero denominator reporting in the menu set.



Q25. Does everything have to be working and calculating correctly for the full 90 days to be able to attest for MU this year?

A25. Yes, it needs to be calculating correctly during the entire EHR reporting period.



Q26. If a provider purchases a certified Complete Electronic Health Record (EHR) or has a combination of certified EHR Modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?

A26. No, the provider would not be able to successfully demonstrate meaningful use. To successfully demonstrate meaningful use, a provider must do three things:

1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and
3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.



Q27. If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs?

A27. By definition, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals and eligible hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the core and menu set meaningful use objectives.

Eligible professionals and eligible hospitals will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Eligible professionals and eligible hospitals will fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use.

Please note that eligible professionals and eligible hospitals cannot use a non-certified system to calculate the numerators, denominators, and exclusion information for clinical quality measures. Numerator, denominator, and exclusion information for clinical quality measures must be reported directly from certified EHR technology. For additional clarification about this, please refer to the following FAQ from the Office of the National Coordinator of Health Information Technology: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775.



Q28. If a provider feeds data from certified electronic health record (EHR) technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse?

A28. To be a meaningful EHR user a provider must do three things:

1. Have complete certified EHR technology for all meaningful use objectives either through a complete EHR or a combination of modules; and
2. Meet 20 measures (19 for eligible hospitals and CAHs), including all of the core and five (5) menu-set measures associated with the objectives (unless excluded). Core measures include reporting clinical quality measures.
3. Use the capabilities and standards of certified EHR technology in meeting the measure of each objective.

If the conditions above are met and data is transferred from the certified EHR technology to a data warehouse, the provider can use information from the data warehouse to report on Meaningful Use objectives and clinical quality measures. However, in order to report calculated clinical quality measures, the data warehouse may need to be certified.

The Office of the National Coordinator of Health Information Technology has addressed the issue of certification of a data warehouse in the following Frequently Asked Question:
<http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3163&PageID=20775>.



Q29. The Eligible Professional just started their meaningful use reporting period. The EP questioned if it is allowed to switch from one certified Electronic Health Records software system to another within the 90 day reporting period.

A29. Yes, as long as certified EHR technology is used for the entire reporting period. The eligible professional (EP) or eligible hospital should enter the certified EHR technology from both systems into the CHPL to generate a CMS EHR Certification ID for their attestation. The EP or eligible hospital would need to report on the numerators and denominators from both certified EHR systems by adding them together. All EHR technology used for the purposes of demonstrating meaningful use must be certified.



• QUESTIONS

- ▀ You may type your question in the Chat box and we will respond to them as we receive them
- ▀ You may ask your question when the phone lines are opened up