Meaningful Use Supporting Documentation

Eligible Professional

Program Year 2015

Modification Rule Objectives

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General Instructions

- Documentation should support all information entered in the Meaningful Use (MU) section of the MAPIR application.

- Where measures allow, use of sample data from within your "live" system is appropriate.

- For percentage-based measures, your Certified EHR product will electronically record the numerator and denominator and generate a report including the numerator, denominator and percentage.

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General Instructions

- Screenshots and other non-numerical supporting documentation should be dated.
- Documentation should be de-identified and HIPAA compliant.
- Groups may submit dashboards or reports containing individual data for multiple providers as long as the report is broken out by name or individual NPI numbers.

CMS Specification Sheets are updated frequently. The links in this document represent the documentation available at the time of publication and will be updated as new information becomes available. For the most up to date information, click here.

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Objective 1- Protect Patient Health Information

Required Documentation

A copy of the conducted or reviewed security risk analysis and corrective action plan (if negative findings are identified) that ensures that you are protecting private health information. Report should be dated or updated no earlier than the start of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period and should include evidence to support that it was generated for that provider's system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.) A single report submitted for a physician group of applying providers can be used. A list of EP's names and NPI numbers for which this analysis applies should accompany the report.
*Security Risk Assessment Tool can be found here.

Documentation to Support an Exclusion

No exclusion available for this measure.

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Objective 2 - Clinical Decision Support

Required Documentation

Measure 1 (Modified Stage 2): Screenshots of all five clinical decision support rules being implemented and what clinical quality measures (CQMs) they relate to. If choosing clinical decision support rules not related to CQMs, explain the relation to the high-priority health conditions.
Measure 1 (Alternate Measure): Screenshot of one clinical decision support rule being implemented and how it relates to CQMs. If choosing a clinical decision support rule not related to CQMs, explain the relation to high-priority health conditions.
Measure 2: Dashboard or screenshot showing when the drug-drug and drug-allergy interaction checks occurred. A single report submitted for a physician group of applying providers can be used. A list of EP's names and NPI numbers for which this analysis applies should accompany the report.

Documentation to Support Exclusion for Measure 2

Dashboard or report from the EHR system or from an external data source demonstrating fewer than 100 medication orders were written during the EHR reporting period.

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Objective 3 - CPOE

Required Documentation

Dashboard or report generated from the EHR system or from an external data source supporting each of the three numerators and denominators.

Documentation to Support an Exclusion

For each section of the measure being excluded, a dashboard or report from the EHR or from an external data source demonstrating fewer than 100 orders were written during the EHR reporting period.

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Objective 4 - ePrescribing

Required Documentation

Dashboard or report from the EHR system showing the numerator and denominator.

Documentation to Support an Exclusion

Dashboard or report from the EHR or from an external data source demonstrating fewer than 100 prescriptions were written during the EHR reporting period.

-OR-

Documentation showing the provider does not have a pharmacy within the organization and there are no pharmacies accepting electronic prescriptions within 10 miles of the EP's practice location at the start of the EHR reporting period.

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Objective 5 - Health Information Exchange

Required Documentation

Dashboard or report generated from the EHR system supporting numerator and denominator.

-AND-

Evidence of the successful electronic exchanges of summary of care documents according to standards identified in the specification sheet link below.

Documentation to Support an Exclusion

Dashboard or report generated from the EHR system supporting a denominator of less than 100.
If taking the alternate exclusion, no documentation is required.

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Objective 6 - Patient Specific Education

Required Documentation

Dashboard or report generated from the EHR system or from an external data source supporting the numerator and denominator.

Documentation to Support an Exclusion

An explanation supporting there were no office visits during the EHR reporting period.
If taking the alternate exclusion, no documentation is required.

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Objective 7 - Medication Reconciliation

Required Documentation

Dashboard or report generated from the EHR system or from an external data source supporting the numerator and denominator reported.

Documentation to Support an Exclusion

Dashboard or report from the EHR system or from an external data source showing no incoming transitions of care during the EHR reporting period. This could be a dashboard or a report generated from the EHR system showing a denominator of zero. If taking the alternate exclusion, no documentation is required.

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Objective 8 - Patient Electronic Access

Required Documentation

Measure 1: Dashboard or report generated from the EHR system or from an external data source supporting the numerator and denominator.
Measure 2: Dashboard or report generated from the EHR system showing a numerator and denominator greater then zero.

Documentation to Support an Exclusion

Exclusion 1 and 2: Explanation demonstrating the exclusion was met based on the criteria on the specification sheet. Check the criteria on the specification sheet link below.
Exclusion 2 Only: Screenshot showing less then 50% of the housing units in the county having 4 MBPs broadband availability as of the 1st day of the reporting period. Check this site to see if you qualify.

If taking the alternate exclusion, no documentation is required.

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Objective 9 - Secure Electronic Messaging

Required Documentation

Dashboard or report generated from the EHR system or from an external data source showing a numerator and denominator greater then zero.

-OR-

A screen shot demonstrating the function was enabled in the EHR system during the EHR reporting period.

Documentation to Support an Exclusion

Exclusion 1: Documentation supporting there were no office visits during the report period.

-OR-

Exclusion 2: Screenshot showing less then 50% of the housing units in the county having 4 MBPs broadband availability as of the 1st day of the EHR reporting period. Check this site to see if you qualify.

If taking the alternate exclusion, no documentation is required.

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Objective 10 - Public Health

Modified Stage 2 with Alternates

- Must Pass 1 of the 3 Public Health Options
- May claim an 'alternate' exclusion for Options 1, 2 or 3
- An 'alternate' exclusion may be claimed for up to 2 options – the provider must pass or meet the 'standard' exclusion for the third option
- If unable to meet 1 of the Public Health Options, then the EP must either take the 'alternate' exclusions or qualify for the 'standard' exclusion for ALL 3 Public Health Options in order to pass the Public Health Objective

Modified Stage 2

- Must Pass 2 of the 3 Public Health Measures
- May claim an 'alternate' exclusion for Measures 2 or 3 or both
- There is no 'alternate' exclusion available for Option 1
- May attest to and meet the requirements for Option 3 twice in order to pass this Objective
- If unable to meet 2 of the Public Health Options, then the EP must attest to ALL 3 Public Health Measures with a combination of: passing the Option; taking the 'alternate' exclusion; or qualifying for the 'standard' exclusion

CMS Specification Sheet

Option 1 – Immunizations
Option 2 – Syndromic Surveillance
Option 3 – Specialized Registry

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Objective 10a - Public Health - Immunization

Required Documentation

Confirmation/acknowledgement from the immunization registry indicating registration of intent or ongoing submission during the EHR reporting period, with provider group indicated.

Documentation to Support an Exclusion

Exclusion 1: Signed letter or email indicating no immunizations were done during the reporting period.

-OR-

Exclusion 2: Documentation showing no immunization registry or immunization information system is capable of accepting specific standards required to meet the CEHRT definition at the start of the reporting period.

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Objective 10b - Public Health – Syndromic Surveillance

Required Documentation

Confirmation/acknowledgement from the Syndromic Surveillance registry indicating registration of intent or ongoing submission during the reporting period, with provider group indicated.

Documentation to Support an Exclusion

Exclusion 1: Signed letter or email indicating no ambulatory syndromic surveillance data is collected.

-OR-

Exclusion 2: Screenshot of the Department of Health's Declaration of Readiness indicating the syndromic surveillance registry request for data from Emergency Departments only.

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Objective 10c - Public Health – Specialized Registry

Required Documentation

Confirmation/acknowledgement from the Specialized registry indicating registration of intent or ongoing submission during the reporting period, with provider group indicated.

Documentation to Support an Exclusion

Exclusion 1: Signed letter or email indicating that the EP does not diagnose or treat patients for which they would need to submit data to the Department of Health's Cancer registry.

-AND-

Exclusion 2: Signed letter or email indicating that the EP does not participate in any other Specialized Registry.

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Clinical Quality Measures

Required Documentation

Dashboard or report generated from the EHR system or from an external data source supporting the numerator, denominator, exclusions and exceptions for each measure attested to in the application.

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