



Meaningful Use Supporting Documentation

Eligible Professional
Program Year 2017
Modified Stage 2 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.

General Instructions

- 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](#).

▶ Objective 0- ONC Questions

Required Documentation

The Office of National Coordinator, the federal entity that certifies electronic health systems, has added several questions to the attestation process. This is new for Program Year 2017. Supporting documentation may be requested based on the answers from your attestation(s).

[Click here to review the ONC questions.](#)

Objective 1- Protect Patient Health Information

Required Documentation

- A completed 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 within the calendar year of your Meaningful Use 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.

▶ 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, an explanation of the relation to the high-priority health conditions may be requested post pay. A list of EP's names and NPI numbers for which this analysis applies should accompany the report.

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.

Objective 3 – Computerized Provider Order Entry (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 measure of the objective 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.

▶ Objective 4 – Electronic Prescribing (eRx)

Required Documentation

Dashboard or report from the EHR system supporting 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 did not have a pharmacy within the organization and there were no pharmacies accepting electronic prescriptions within 10 miles of the EP's practice location at the start of the EHR reporting period.

▶ Objective 5 - Health Information Exchange

Required Documentation

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

Documentation to Support an Exclusion

Dashboard or report generated from the EHR system supporting a denominator of less than 100.

▶ 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.

▶ 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.

▶ Objective 8 - Patient Electronic Access

Required Documentation

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

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 than 50% of the housing units in the county having 4 Mbps broadband availability as of the 1st day of the reporting period. To see if you qualify, please [click here](#).

[CMS Specification Sheet](#)

▶ Objective 9 - Secure Electronic Messaging

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

Exclusion 1: An explanation supporting there were no office visits during the EHR reporting period.

-OR-

Exclusion 2: Screenshot showing less than 50% of the housing units in the county having 4 Mbps broadband availability as of the 1st day of the EHR reporting period. To see if you qualify, please [click here](#).

▶ Objective 10 - Public Health

Modified Stage 2

- Must Pass 2 of the 3 Public Health Measures
- May attest to and meet the requirements for Measure 3 twice in order to pass this Objective
- If unable to meet 2 of the Public Health Measures, then the EP must attest to ALL 3 Public Health Measures with a combination of passing the Measure; or qualifying for the exclusion

(In MAPIR you will see the term 'Public Health Options' instead of 'Public Health Measures')

▶ Objective 10a - Public Health - Immunization

Required Documentation

Confirmation/acknowledgement from the immunization registry indicating registration of intent, completion of test 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 was capable of accepting specific standards required to meet the CEHRT definition at the start of the reporting period.

-OR-

Exclusion 3: Screenshot of the Immunization Registry's Declaration of Readiness indicating it is unable to receive immunization data.

Objective 10b - Public Health – Syndromic Surveillance

Required Documentation

Confirmation/acknowledgement from the Syndromic Surveillance registry indicating registration of intent, completion of test 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: Documentation showing no public health agency can receive electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the reporting period.

-OR-

Exclusion 3: Screenshot of the Department of Health's Declaration of Readiness indicating the syndromic surveillance registry request for data from Emergency Departments only.

Objective 10c - Public Health – Specialized Registry

Required Documentation

Confirmation/acknowledgement from the Specialized registry indicating registration of intent, completion of test 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 Specialized registry.

-OR-

Exclusion 2: Documentation showing no specialized registry can accept electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the reporting period.

-OR-

Exclusion 3: Screenshot of the Department of Health's Declaration of Readiness indicating it is unable to receive electronic registry transactions at the beginning of the EHR reporting period.

▶ 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.