



What You Need to Know about the Clinical Quality Measures

Webinar Question-and-Answer List

August 30, 2011

The Centers for Medicare & Medicaid Services (CMS) hosted a webinar, titled “The CMS EHR Incentive Programs: What You Need to Know about the Clinical Quality Measures,” to help eligible professionals (EPs) and eligible hospitals successfully record clinical quality measures (CQMs) and attest to meaningful use for the Medicare EHR Incentive Program. During the event, CMS subject matter experts answered questions from participants via instant message chat. Below are the questions and answers from the event.

Please note: *Not all questions are included in this Q&A. In addition, some questions and answers have been edited for grammatical and spelling corrections.*

Questions for Eligible Professionals

1. Q: Is Stage 2 MU criteria available for EP's yet in Medicare?

A: Stage 2 will be proposed through rulemaking.

2. Q: With regards to Specialists, what are the expectations for reporting on discrete measures that the PCP normally documents against? For Example: plastic surgeons who don't normally document Diabetic foot exams. Keep in mind that some EHRs present such problems given that they are limited in certification on the menu set CQMs.

A: EPs should report on measures that best apply to their practice. If measures do not apply, 0s are acceptable values.

3. Q: I am still confused as to how dentists are able to report the required number of CQMs, even with the ability for exceptions. Please advise.



A: If CQMs do not apply to your practice, 0s should be reported from your EHR for attestation.

- 4. Q:** Can providers extract data from their certified EHR and enter it into a standalone, certified CQM reporting module to generate the CQM report for attestation? Also can EPs change their CQM choice (i.e. their selection of 3 measures from the set of 38) between Stage 1 Year 1 and Stage 1 Year 2 attestation?

A: Please contact ONC for certification questions. Yes, EPs can change their CQM choice between Stage 1 Year 1 and Stage 1 Year 2 attestation.

- 5. Q:** I work at a pediatric institution and many of the QM's do not relate to any of our physicians. Are we required to build out all 44 measures to show they reported a zero OR can we build out the 6 core and alternate core QM's and only three non-core measures and report a zero for those 9 measures.

A: The answer to this question depends on how many measures your certified EHR contains.

- 6. Q:** What must be included in a weight "follow up plan"?

A: The specifications require that the codes that are representative of care goal/follow-up plan management or the codes that are representative of provider to provider communication dietary consultation order.

- 7. Q:** We have a provider that is joining our practice Sept. 1st. Currently she was employed by another local group. Would we be able to report for her for the last quarter of this year?

A: The last reporting period for EPs starts no later than 10/3.

- 8. Q:** Is there a timeline for when certified EHRs will have to have all 38 of the additional CQMs coded

A: Certification currently only requires that technology include a minimum of 9 CQMs for EPs. We would suggest monitoring the ONC website and regulations for any future changes in this policy.

- 9. Q:** is the EHR vendor required to provide calculations for all of the Additional CQMs?

A: EHR vendors should check the ONC website to obtain information regarding specific requirement for obtaining certification of an EHR system or module.



- 10. Q: When calculating QM do we calculate for attestation reporting 90 day period, do we view both office patients & hospital seen patients in those 90 days?**

A: EP reporting is done on an individual basis. Therefore, EPs report on patients for whom they have had an encounter during the reporting period. To note, the calculation of the numerator, denominator and exclusions, if applicable, should be done by the certified EHR.

- 11. Q: I understand that if the CQMs do not apply to our current practice, but do we need to push our EPs to modify their treatment plan and include some of the CQMs (i.e. surgeons for GI issue, should we be looking at BP management)?**

A: No. We recognize the current set of CQMs may not address all scopes of practice. Consequently, this is why we are allowing 0s to be reported in Stage 1.

- 12. Q: If an EP attests under the state Medicaid program the first year, then switches to the Medicare program the second year, do they start at Stage I with 90 days for Medicare? (Vs. reporting for the full year)?**

A: First, you cannot attest in the Medicaid Program in the first year. It is adopt, implement and upgrade. The next year is the first year of demonstrating Meaningful Use so the reporting period would be 90 days.

- 13. Q: Our organization prepared for MU Attestation in June and our system was certified for 9 measures. We are reporting on 9 for our medical group. We found out in July that the system is now certified for 44 CQMs. Do we need to run a report on 9 or on 44?**

A: It depends which reporting period you are attesting to. You should report on the number of measures that were available for the reporting period used for attestation.

- 14. Q: For the Hypertension measure NQF 0013 that requires 2 visits per calendar year, as a specialist practice, what if the PCP manages the Hypertension and the patient is seen frequently by them. We must actually see the patient and record our own BP results or can we obtain the PCP taken result to meet the measure? We must actually see the patient and actually bill and E&M code to have the recorded BP actually count? It can't be taken by staff that cannot bill an E&M. Is this correct?**

A: The EP reporting must have had an encounter with the patient. He/she can report the BP measurement recorded in the EHR. However, they must be reporting the patient because they had this encounter.



15. Q: If we delay attesting to meaningful use in 2011, will we still be eligible for the \$44,000 payment over the 5 year period?

A: If you begin in 2012, you are still eligible for payment over 5 years.

16. Q: Please clarify - you can report zero's on all 6 measures but then need to report an additional 3 alternate measure. Can you report 9 zeros then?

A: You may report 9 zeros if those are the results calculated by your certified EHR technology and you have no other measures in your certified EHR that would report values other than 0.

17. Q: Are specialty practice like dermatology and plastic surgery able to opt out of the program?

A: Anyone can opt out no matter their specialty. However, in 2015 the payment adjustment or penalty may apply to eligible professionals that have decided not to participate.

18. Q: If I am a plastic surgeon who maintains a problem list of all of my patients' problems, say Diabetes, my CQM report will count this patient in the denominator for the Diabetes CQMs even though it is not a condition for which I'm treating the patient. In this case, should I be reporting the denominator that appears on the EHR generated report or zero since I'm not treating the patient for the condition?

A: Yes, you should attest to what is generated by your certified EHR. If you have a patient that is being reported as having diabetes, it is included in the denominator.

19. Q: Does a procedure need to be done "In-house" to "count" for a CQM? For instance, must a mammogram be conducted at the physician's office to be counted for a CQM? Or is simply the Order sufficient? I have seen considerable confusion here. Thank you.

A: The record of the mammogram must be documented in your certified EHR (that relates to the codes identified in the specifications). However, an EP must have had an encounter with the patient during the reporting period in order to report on the patient at all.

20. Q: Does same CQM applicable for Medicaid and Medicare? Does any provider can submit CQM for first year even if it belongs to Medicaid?

A: Medicare and Medicaid share the same CQM measure set.



- 21. Q: If a practice is documenting that a pt has received a flu vaccination in a protocol but this practice does not actually administer the flu vaccination, can we use this as one of our measures? the same would be for mammogram, we want to track but we do not order**

A: Yes to both, provided the EP has had an encounter with the patient during the reporting period and the vaccination is documented in their certified EHR.

- 22. Q: I am planning on reporting the last 90 days however I have not signed up for the attestation. What is the cutoff date to sign up for attestation for this year?**

A: Attestation must be complete within 2 months after the close of the calendar year for EPs.

- 23. Q: What happens when CMS audits an EP for Meaningful Use Attestation? Will CMS review the EHR data that make up the values attested or will CMS simply verify that the numbers attested to were from a report generated by the EHR? If the latter, will a copy of the report used to attest suffice or will the EP have to re-generate the report from the EHR as part of the audit process?**

A: Audit/Appeals guidance will be issued soon.

- 24. Q: If an EP has both Medicare and Medicaid patient populations, can they attest to each but separately? Or are they required to pick one or the other and then change once?**

A: An EP can participate in either the Medicare or Medicaid EHR Incentive Program, not both. Only Eligible hospitals may be dually eligible.

- 25. Q: If the certified EHR can provide data on more than 9 CQMs are we required to report on as many CQMs as the certified EHR can display?**

A: You are only required to report on 6-9 measures (depending on Os). You should select the measures that best apply to your scope of practice.

- 26. Q: Re physician joining a new group in September, if a physician has already registered, reassigned payment to a previous group, and would qualify for less than max based on previous services, can the new group receive the incentive due for services performed the rest of the year?**

A: Has he/she already attested? If not, he/she can modify his registration and choose the new practice. If he/she has already attested, he/she may not attest again for the first year.



27. **Q: I registered via CMS' registration portal to show Meaningful Use this year, however my state has not launched its Medicaid-based program yet, and I unknowingly selected the "Medicare" option when I registered. Is there any consequence if I do not show Meaningful Use this year, (because I'm waiting for my state's Medicaid program)? If/when my state program launches, and I change my Registration to indicate I want to participate via Medicaid, does that count as my one-time "Switch" between programs, (if I have not yet shown MU)?**

A: No.

28. **Q: In cases where a pediatrician sees a few 18 year old patients (qualifying those patients for the denominator of NQF0421 Adult Weight Screen and Follow Up), it is preventing them from reporting on more applicable/relevant pediatric quality measures from the alt-core list (namely NQF0038 Child Immunization Status). Should this be of concern for a pediatrician? Or is the bottom line essentially: "For Stage 1, whatever numerators/denominators are calculated by the EHR -simply report those, regardless of perceived merit, legitimacy, etc." Thank you.**

A: Performance is not being evaluated for CQMs in Stage 1 of MU. We will consider this dilemma in future rulemaking. But you would report your 3 core and 3 additional and would only report the alternate core if one of the core measures was 0.

29. **Q: I am working with a General Surgeon who is only able to identify 3 clinical quality measures that he will be able report a denominator for, does reporting 0 for the other clinical quality measures allow us to successfully attest?**

A: 0s are acceptable values for CQMs if that is what is calculated by your certified EHR. However, there are other requirements for successfully meeting MU.

30. **Q: Do the HITSP specifications for the clinical quality metrics include exclusions in the count of rejected cases? My second question is if an EP uses a certified EHR paid for by someone other than the EP will the EP be eligible to apply for MU incentives?**

A: The exclusions are outlined in the electronic specifications. For the second question, the answer would be yes.

31. **Q: To be more specific with the question I just posed for pediatric institutions, for EP's, we have 38 non-core CQM's and 6 core and alternate core. Is it alright to build out the 6 core and alternate core CQM's and only 3 of the remaining 38 CQM's even if all are zeros?**

A: You must report on the CQM results as calculated by your certified EHR. If you EHR has 38 additional CQMs, then you must ascertain that they are in fact all 0 and could not do this unless



they were coded. For additional information on certification requirements for EHRs please go to the Office of the National Coordinator website.

32. Q: I would like to know where I can get more clarification on some of the core measures we have to meet.

A: The specifications are posted on the CMS website. You must report on the 3 core measures. If any of those core measures are 0s, alternate core measures should be reported.

33. Q: Just to confirm...a Medicaid EP or hospital need not provide any numbers at all during the first year - but only attest that they have installed ONC certified EHR technology

A: Yes. No meaningful use attestation is required in their first participation year for the Medicaid EHR incentive. They must attest that they have adopted, implemented, or upgraded certified EHR technology.

34. Q: Are CQMs calculated at the patient level such that 2 or more providers who share in the care of the same patient on the same certified EHR system can count/report a given measure regardless of who actually performed the measure action (i.e. dilated eye exam)?

A: An EP must have an encounter with the patient to report during the reporting period. In the measure you are discussing, there must be a record of the eye exam in the EHR in addition to meeting the denominator criteria of diagnosis and encounters. Each measure specifies the specific number and type of encounter required.

35. Q: We are a podiatry practice. There really is not a whole lot of measures we can meet are there?

A: We would agree. 0s are acceptable values assuming this is what is calculated by your certified EHR.

36. Q: Does it matter if the quality measure is clinically relevant to the EP? For example, is it acceptable to report on a Diabetic measure for providers who don't specifically treat diabetic issues such as an Allergist?

A: You should report on the measures in your certified EHR that best apply to your scope of practice. You must still report the core/alt core and additional measures regardless of the anticipated values of 0. If none of measures apply to your practice you must still attest to the data from your certified EHR for the 3 core, 3 alternate core and 3 additional measures.



- 37. Q: Please clarify the \$24,000.00 threshold of Medicare allowed billings as it relates to the incentive payment.**

A: You must have 24,000 in allowed Part B claims to meet the threshold to be considered for the full incentive payment of \$18,000.

- 38. Q: Because we're using ICD codes for problem lists, does that mean they have to be entered by a physician or NP?**

A: This would depend on your current clinical guidelines and state and local laws.

- 39. Q: If your first 90 day reporting period is January 1 2012 - March 31, 2012 when can you report the 2nd period for a full year? For all of 2012? Or for all of 2013?**

A: The measurement period for the first year is any continuous 90 day period. This must be reported for EPs within 2 months after the close of the calendar year (no later than). The next measurement period for year 2 is an entire year and again must be reported no later than 2 months after the close of the calendar year.

- 40. Q: What can we do for providers who know their dashboard won't be ready by the time they want to attest?**

A: We suggest you discuss this with your vendor.

- 41. Q: You said something about potentially reporting 9 measures (3 core, 3 alt-core & 3 menu), all with zero denominators. Isn't it true that for the 38 menu measures, that you can be excluded from reporting those if ALL 38 denominators were zero, but if any are not, you need to use up to 3 measures that do have numbers for reporting?**

A: You must report on 3 out of 38 additional CQMs regardless of the core/alternate core measures reported. You should report on additional measures from your certified EHR most applicable to your practice. If you have measures that can be reported, i.e. there are values for the denominator, then those should be reported.

- 42. Q: What are the required CQMs that an EP (doctors office) report on? What if they are not applicable to our practice?**

A: 0s are acceptable values if that is what your certified EHR calculates. The CQMs are listed on the CMS website and in the EHR Incentive Program Final Rule. A zero listed as the denominator for a measure implies that no patients were seen by the EP during that reporting period that met the denominator inclusion criteria.



43. Q: Does the penalty for not participating in an EMR for an EP begin in 2012 or 2015?

A: 2015.

44. Q: Can an EP authorize an individual to register and attest on his/her behalf?

A: Yes.

45. Q: How would an EP report CQMs or MU attestation if they were to change from one certified EHR to another in the middle of a reporting year?

A: You are attesting to what is generated out of your certified EHR. If you have 2, you will need to combine the results for the reporting period.

46. Q: On the NQF 0013 that required 2 visits per year for BP checks, if my patient is seen annually, will they be included in the denominator?

A: The denominator for this measure requires 2 encounters within the reporting period. The reporting period for the first year of participation is a continuous 90 day period.

47. Q: We are a physician group with physicians that are dedicated to covering our patients at non-affiliated hospital. Less than 90% of their work is billed as inpatient. To ensure these physicians obtain their meaningful use incentive payment, do they report as EP's under our organization?

A: Please see the specific information on hospital based on the CMS website. Assuming you do not meet the criteria for hospital based, you would report as an EP.

48. Q: For exclusions, do the providers enter 0s in the num/denom boxes or in the exclusion box?

A: There is an exclusion box in the attestation module when the measure allows for exclusions.

49. Q: Can providers extract data from their certified EHR and enter it into a standalone, certified CQM reporting module to generate the CQM report for attestation?

A: Yes.



50. **Q: If an EP performs 60% of his outpatient clinical activity at Location A documenting in Certified EHR X and performs 40% of his outpatient clinical activity at Location B documenting in Certified EHR Y, does the EP need to include data from both practice locations (A and B) when reporting numerators and denominators? For the quality measures, does this mean that Certified EHR X will need to accept foreign data from Certified EHR Y (or vice versa) in order for the EP to submit his quality measure data. Because greater than 50% of the EPs clinical activity is at Location A, could the EP instead include data only from Location A?**

A: Yes.

51. **Q: Can you confirm that an EP could select different quality measures for each reporting period? In other words, an EP does not have to report on the same quality measures for each reporting period (given the EP follows the rules of reporting on 3 core/alternate core and an additional 3 menu).**

A: Yes, an EP who is in their first year of participation could report on different measures for a 90 day continuous reporting period. Should they not meet MU they could select another continuous 90 reporting period within the same calendar program year and report on different quality measures provided they have still reported on the three core, and alternate core as needed and then select 3 additional core measures. The reporting period for the first year of participation is any continuous 90 day period within the calendar year.

52. **Q: If Physician B performs 80% of his clinical activity at location X documenting on a certified EMR and 20% of his clinical activity at location Y documenting on paper, would the EP have to include the unique patients seen at location Y in the denominators of those objectives in which the denominator is calculated by: "...of unique patients regardless of whether the patient's records are maintained using certified EHR technology?"**

A: No. EPs who see patients in multiple practice locations are required to see at least 50% of their patients in locations equipped with certified EHR technology. Provided they meet this 50% requirement, they can limit their denominator to patients seen only in practice locations equipped with certified EHR technology..

53. **Q: For all measures that require at least 2 visits, can we assume (even when not specified) that this means 2 visits with the same EP, the one who will be submitting/attesting to these CQMs? Next question: Is the depression measure, 0105, written exactly as intended? The logic behind the number of days required prior to diagnosis, etc., is very difficult to decode. Wondering whether any clarifications have been published or could be published.**

A: When the specification requires 2 visits, it typically means two encounters with the provider who is reporting the data and is seeing the patient. Because each clinical quality measure can be different it is best to read the specifications for each measure should a visit with another



provider be required. We understand this may be a difficult measure to code. Please contact Mary Bramin at NCQA at bramin@ncqa.org for assistance.

54. Q: EHRs are certified for different quality measures and may be certified for only 9 measures. What do I do if I don't want to use any of the quality measures that my EHR is certified for?

A: Typically, when selecting a certified system the provider should select one that meets the needs of his/her practice and scope of care. In program year 1 of MU the requirement is to submit 3 core and if any of those measures result in 0 for the denominator, then also report on 1-3 alternate core measures. If all 6 of these measures produce 0 denominators and that is the output from your certified EHR that is acceptable. You still need to report 3 additional measures, and if all 3 additional measures also report 0 denominators, that is also acceptable provided this is the data reported from the certified EHR. In stage 1 of MU, CMS is not looking at performance for meeting the CQM objective.

55. Q: I need more information on the 38 additional CQM; where can I find this info?

A: All of the measure specifications and additional implementation guidelines are listed on the CMS website:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage. We suggest you read all of these documents as well as the other documents listed on the CMS EHR Incentive Program main webpage.

56. Q: Our dental providers use both our certified EHR and Dentrix (which is not certified). Dentrix is used to record dental exam information. Are dentists in this example eligible to participate?

A: To be eligible to participate you must be using a certified EHR. Please go to the Office of the National Coordinator website for more information on certification requirements.

57. Q: For the maximum incentive payment amount to be received in year 1 (\$18K), I understand the total allowable charges need to be \$24k. Are the charges ONLY ones that go straight to Medicare Part B vs. Advantage plans?

A: Only Medicare Part B Allowable Charges.



58. **Q: Can we change the selection of the Quality Measures for 2012? I.e. if we select three for 2011 and then decide on others for 2012, can we change our selection at the beginning of 2012?**

A: Yes. But the CQMS reported must still follow the requirements of reporting the 3 core, and if any have zero denominators, 1-3 alternate core. The 3 additional CQMs reported may be different

59. **Q: My EHR is certified in 9 CQM's, do I only report on the 9 or can I report on others as long as I can report it from our analytics?**

A: Refer to FAQ 10649

60. **Q: Would you develop clinical measures for dentists? Do dentists have to comply with the 15 core measures?**

A: We try to select measures that are applicable to most specialties. We look at the gaps in available measures and take this into consideration when developing new measures. Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded. The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology.

61. **Q: Please repeat the answer to the question about 0 denominators for clinical quality measures. If you have 0 denominator in the 3 core, 3 menu measures, how many more measures must you submit to attest that you do not qualify to report clinical quality measures? If you have a denominator, but the performance percentage is 0%, do you still qualify as reporting the clinical quality measures?**

A: Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures.



- 62. Q: If an EP has 3 CQM's in the menu set of 38 that have zero denominators can s/he report those 3 menu measures or does s/he have to continue to report measures until they find 3 that have data in the denominator?**

A: You must report on measures for which you have data (i.e., that apply to your scope of practice).

- 63. Q: Slide 32 states that an EP needs to report 6 measures. However, this is misleading. It can be a total of nine measures, if the core and alt core measures are not applicable, and have a zero denominator reported. CMS should correct this slide to reflect the fact that many EPs will need to report on additional three measures from Table 6 in the Final Rule. Reporting the core and alt core measures only, with zeros in the denominator will not suffice.**

A: Thank you for your feedback.

- 64. Q: There are a lot of questions regarding the 90 day reporting period and the word "continuous" in CMS's description. My understanding is that the days that count to add to the 90 days would be days patients were actually treated. In other words, if a doctor treats patients Monday thru Friday, they would have 5 days per week of reporting and it would take a total of 18 weeks to meet the 90 day requirement. Is this correct?**

A: A "continuous" 90-day reporting period includes all calendar days within that 90-day period not those days that are considered business days or just days in which patients were treated.

- 65. Q: Please elaborate on how exemption based on scope of practice is determined. For example, would the dermatologist simply attest that measuring blood pressure is not within their scope of practice?**

A: Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures.



66. **Q: As a specialty practice many of the CQMs are not relevant to our scope of practice. However, we are a large group practice and have several subspecialties that must be considered. So our strategy should be to run calculations for all measures and see what we get for denominators. Then chose which to report. Some doctors may have fewer than 9 measures with >0 denominator values. We'd still need to attest to the fact that all other measures had a denominator value of 0 correct?**

A: Reporting is achieved on an individual basis. Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the states may be zero if these are the results as displayed by the certified EHR technology for that physician. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures.

67. **Q: For the additional set, if a provider has values other than 0 in the denominator, should the EP report those over a measures with a 0 denominator, even if the other measure is 0/150 for example (0 numerator)?**

A: Yes. The provider should report on those measures for which he/she has data, even if it is only in the denominator.

68. **Q: Please elaborate on how exemption based on scope of practice is determined. For example, would the dermatologist simply attest that measuring blood pressure is not within their scope of practice?**

A: Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures.

69. **Q: As a specialty practice many of the CQMs are not relevant to our scope of practice. However, we are a large group practice and have several subspecialties that must be considered. So our strategy should be to run calculations for all measures and see what we get for denominators. Then chose which to report. Some doctors may have fewer than 9 measures with >0 denominator values. We'd still need to attest to the fact that all other measures had a denominator value of 0 correct?**

A: Reporting is achieved on an individual basis. Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by



the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the states may be zero if these are the results as displayed by the certified EHR technology for that physician. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures.

70. Q: Are there different CQM for medical specialists i.e. orthopedic surgery?

A: You must report on the core/alternate core measures and select 3 of 38 for reporting on the additional measures.

71. Q: We have a specialist who meets the requirements for the 3 core measurements but we cannot find any additional measurements for an infectious disease specialty. Do we attest the additional 3 with a 0 as the denominator and 0 as the numerator and do we respond yes to exclusion?

A: 0s are acceptable values if that is what has been generated by your certified EHR technology.

72. Q: Can an EP attest outside of the exact dates mentioned in your slides, for example, from Feb 1 through Jan 31 as their reporting year?

A: An EP attests in the first calendar year to any continuous 90-day period. The last day that an attestation can be reported for EPs is 2 months after the close of the calendar year.

73. Q: Can an EP Core CQM be replaced at will with an Alternate Core CQM? If we'd rather implement the process to calculate one of the Alternate Cores instead of one of the Core, is that allowed?

A: It is only allowed if the value of 1 or more of the core measures is 0.

74. Q: Does the EP have to attest himself, or can a staff member do it for him?

A: If you are registered to be working on behalf of the EP, then yes. See instructions in the Registration and Attestation System for this activity.



75. Q: We are a dermatology office. For CQM measure that requires us to collect patient's weight, blood pressure and counseling if appropriate - the denominators for all these measures are any patients coming in for office visit. SO in this case, the majority for our patient base is indeed coming in for office visit, and hence we "qualify" for denominators, there will be 0 denominator value. Therefore, we are required to report on the numerator. Our problem is that measuring weight, blood pressure and counseling of such are not part of our practice scope or patient care - since we are dermatologists only. Is there any way we can get an exclusion on these measures? By the way, these are core measures.

A: Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures. You are still required to report the CQM objective; there are no exclusions from reporting CQMs.

76. Q: If one of the core measures does not apply, does it matter which alternate one you choose? Do you have to go through all 3 alternate cores if you get a 0?

A: You may select any of the 3 alternate core measures. You must report on all 3 alternate core measures if the value of those measures is 0.

77. Q: I would like to confirm - to qualify for the MU criteria around Clinical Quality Measures, the EP does not have to have submitted quality measures to CMS, they simply have to manually input the (3&3) measures during on-line attestation. Is this correct?

A: Correct, unless the value of 1 or more of the core measures is 0 in which case they would be reporting 6-9 CQMs in the attestation module.

78. Q: Once the first attestation is completed, in Texas, when should the provider expect to receive the initial payment?

A: 4-6 weeks after program requirements are met.

79. Q: If the CQMs do not apply to our current practice, do we need to push our EPs to modify their treatment plan and include some of the CQMs (i.e. surgeons for GI issue, should we be looking at BP management)?

A: CMS does not advise clinical practice. We suggest you direct this question to EPs in your practice.



- 80. Q: For the Hypertension measure NQF 0013 that requires 2 visits per calendar year, as a specialist practice, what if the PCP manages the Hypertension and the patient is seen frequently by them. We must actually see the patient and record our own BP results or can we obtain the PCP taken result to meet the measure? We must actually see the patient and actually bill and E&M code to have the recorded BP actually count? It can't be taken by staff that cannot bill an E&M. Is this correct?**

A: The EP reporting the measure must have had an encounter with the patient as specified. He/she can report the BP recorded in the EHR. However, they must be reporting the patient because they had this encounter.

- 81. Q: We are updating our new system on 9/15 in order to be able to report for EHR. So In order to obtain payment for 2011 we must submit for a 90 day period in 2011. So we must start to report no later than 10/1/2011 correct? If we do not we will miss out on a payment for 2011 correct?**

A: An EP must start the reporting period for 2011 by 10/3. Payment is based on a successful attestation of meeting MU and all program requirements.

- 82. Q: If I only have denominators for 2 additional CQMs, how do I attest? Do I need to attest that the other 36 have 0 denominators?**

A: Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology. If the value of all CQMs is 0, you will be reporting that for 9 measures (3 core/alt core) and 3 additional measures.

- 83. Q: Where can I find the definition of the smoking status in the Core measures?**

A: <http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>

- 84. Q: We have a shared charting environment. This means that our family doctors and our specialist use the same electronic chart. Therefore, the specialist may have a patient with a diagnosis of hypertension and be on an antihypertensive which is documented in the EMR. However, the specialist does not prescribe or manage the antihypertensive.**

A: The EP reporting must have had an encounter with the patient during the reporting period. He/she can report the BP recorded in the EHR. However, they must be reporting the patient because they had this encounter.



85. Q: How often do the vitals need to be recorded for a patient, specialists may not see patients as often as PCP?

A: Which measure are you referring to? For example, for the hypertension measure, the EP reporting must have had an encounter with the patient. He/she can report the BP recorded in the EHR. However, they must be reporting the patient because they had this encounter.

86. Q: We are a dermatology practice and it doesn't appear that any CQM's, Core Measures or alternate measures apply. Can we report zeros for all of them?

A: If that is the value generated by your certified EHR technology.

87. Q: We have a multi-specialty practice sharing an EHR. If the primary care physician documents some of the information, will the specialist be able to report on that as well - ex. ENT specialists may not typically measure height and weight, or document an asthma assessment. However, the PCP would document that information on the same patient that the ENT specialist would see.

A: The EP reporting must have had an encounter with the patient. For example, he/she can report the BP recorded in the EHR. However, they must be reporting the patient because they had this encounter.

88. Q: Essentially an EP could have report 0 for all 6 measures if none apply; as long as it is reported from the EHR?

A: If no CQMs apply to an EPs practice a total of 9 CQMs (core/alt core/additional) would be reported.

89. Q: Are the 3 alternate Core measures defined?

A: Refer to the specifications associated with the measures in CMS-0033.

90. Q: Can you attest a reporting period from 1/1/2012-03/31/2012 and still be eligible for the entire \$44,000?

A: Yes. A provider can receive the full \$44,000 if they successfully attest in 2012 and over the next four successive years.



91. Q: If all core and alt-core CQMs have a zero denominator how many non-core CQMs must an EP report? Previous information indicated that an EP should submit 6 non-core CQMs in this situation.

A: You must report 3 out of 38 additional measures regardless of the core/alternate core measures reported.

92. Q: On the list of 38 measures, if there are none that apply to our specialties, do we just select 3 at random to report on - even if there is nothing to report?

A: Insofar as a measure does not apply to patients treated by the EP, this will be reflected in the calculation of the clinical quality measure either by the patient not being included in the denominator for the measure or the patient being excluded...The value for any or all of those fields (related to CQMs), as reported to CMS or the States may be zero if these are the results as displayed by the certified EHR technology. So for reporting purposes, if all 38 additional measures display a value of 0 for the denominator (from your certified EHR technology), you may select any 3 additional measures, report 0 and attest that the remaining were also 0s.

93. Q: For EPs is it necessary to check values for all possible menu measures to ascertain if there are any with denominators other than zero, or is it sufficient to check for the specific measures for which the certified technology was tested?

A: Refer to FAQ 10648

94. Q: If a certified EHR makes errors in calculating CQMs, who is responsible: the EHR vendor or the EP?

A: Any concerns about the performance of certified EHR technology should be addressed with your vendor and ONC.



95. Q: CMS FAQ ID 10649 (published 05/23/2011) has led some providers to believe they can build their own CQM reports for measures that were not included in their certified technology, or, if the measure is present to report from their certified technology, believe they can tweak the reports. Please advise. Some vendors' certified products do not provide reports with exclusions for the CQMs. Should providers attest to 0s in the exclusions? If this is unacceptable, are EPs required to pay the vendor for adjusting their reports? In CMS FAQ Answer ID 10144 (Published 09/22/2010), it states the EP "may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other menu-set measures calculated by the certified EHR technology have a value of zero in the denominator. A zero report in the menu-set is not sufficient without such accompanying attestation." Where and when during attestation must providers provide this supporting documentation?

A: The attestation statement occurs before submission.

96. Q: So as a specialist we may only have num/den for say 2 CQMs but as long as we list the others as 0 - we will still pass attestation?

A: Yes, assuming you meet all of the other objectives for attestation.

97. Q: We have a provider who started August 1. Can we still attest for him this year? We don't know if his previous practice attested before he left or not.

A: As long as he meets the program requirements, has a 90-day reporting period and has not previously successfully attested.

98. Q: If none of the additional quality measures are applicable for a provider can they attest 0 for any 3 of the 44 or do they need to select measures that are closely related to their specialty?

A: 0 for any 3 if none apply.

99. Q: For EPs, they are only required to attest to 6 QMs, correct? Typically the 3 core measures and 3 other selections. We're wondering why so many questions are referring to 9 measures?

A: If 1 or more of your core measures has a value of 0, you must report alternate core measures. Depending on how many have 0, you may report on 3-6 core/alternate core measures to meet that part of the requirement. Thus, if you reported all three core and all three had zeros, then you must report all three alternate core. You are still required to report three additional measures and for this scenario the total number of measures equals 9.



- 100. Q: Can you please clarify a previous Q&A in regards to measures like 0034 colorectal cancer screening which look outside of the reporting period to include patients in the denominator (in this example an output visit thin the past 2 years)? This seems contrary to some of the measure specifications. Previous Q&A- Question: when calculating QM do we calculate for attestation reporting 90 day period, do we view both office patients & hospital seen patients in those 90 days? Answer: EP reporting is done on an individual basis. Therefore, EPs report on patients for whom they have had an encounter during the reporting period.**

A: The reporting period for the EHR Incentive program using a certified EHR is any continuous 90 day period during the first payment year. Please note that although most measure specifications assume a full calendar year you should only calculate the denominator and numerator from the first day of the 90 day reporting period to the last day of the 90 day reporting period.

- 101. Q: If a physician tells the patient that they are due for their annual mammogram and documents that they counseled the patient regarding this test, do they get credit for MU? Or are they required to have a copy of that completed mammogram report in the chart to obtain credit?**

A: The record of the mammogram must be documented in your certified EHR (that relates to the codes identified in the specifications). However, an EP must have had an encounter with the patient during the reporting period in order to report on the patient at all.

- 102. Q: Does the physician need to document their hospital patients when they return to office in their office EMR, as this is where the reports will be generated, based on EMR documentation?**

A: Please refer to your office protocols for entering in information in your EHR for patients seen on a regular basis.

- 103. Q: To help us clarify the 0's issue: Hypothetically, If an EP does not meet any core OR alternate core measures, AND could not meet any of the remaining 38 measures (even though the EHR is certified on all 44 measures), is the EP required to enter 44 0's during attestation?**

A: The EP would be required to enter 9 measures with 0 if that is the result generated from the certified EHR technology.



104. Q: For EPs, they are only required to attest to 6 QMs, correct? Typically the 3 core measures and 3 other selections. It sounds like if one of the core measures has a zero value then we must report something else. Is that the 3 alternate measures or some other measure? In that case, do the core measures need to also be reported?

A: The core measures must still be reported. If any one of the core measures is 0, alternate core measures must be selected so depending on the measure results, 6-9 measures are reported.

105. Q: I thought EP incentive was calculated as 75% of allowed charges regardless of amount - no minimum required. Is that not true? Isn't \$24,000 simply the maximum that results in the max of \$18,000 this year?

A: You have to reach \$24,000 in Part B allowable claims in order to receive the \$18,000.

106. Q: Our EHR is certified for all 38 measures...are we still only required to report on 3 core and 3 alternate CQM?

A: You also need to report 3 additional measures from the 38 menu measures. Therefore, 3 core, and if one or more core results with zero denominators, report up to 3 alternate core AND 3 additional measures.

107. Q: Does the measurement period for year 2 need to be within the calendar year (i.e., January - December) or can it be abnormal (i.e., April - March)?

A: For EPs, it is Jan-Dec.--full calendar year.

108. Q: PA and NP are not eligible for the Medicare incentive, but do they still have to meet the criteria if they practice in an office with other EPs?

A: They do not have to meet meaningful use; although their activities such as recording vital signs, conducting medication reconciliation and other activities can assist other eligible professionals in meeting meaningful use.

109. Q: I have heard that in order to attest you must provide an electronic or paper copy of the patient's exam directly to the patient, even if they don't ask for it. Is this correct and if so why?

A: You have to proactively offer then a clinical summary following an office visit. If the patient declines the offer you do not have to produce the clinical summary, although you must offer again at the next office visit. It is on the EP to offer the summary not on the patient to request it.



110. Q: We are Plastic surgeons, some of our pt visits are completely cosmetic and therefore paid by pt and never billed to ins, do we exclude these from the denominator? Ex. Cosmetic face lift, or botox injections

A: No all patients are included in meaningful use regardless of payer.

111. Q: Is it possible to give a copy of the visit note to the patient instead of sending it electronically in order to satisfy the rule?

A: Yes the provider can utilize either a paper option or an electronic copy as their preferred method. They only need to provide the alternative if requested by the patient.

112. Q: Will Stage 2 MU criteria (Medicare) be available by Jan 1, 2012? If we attested in 2011 and criteria is not set yet for Stage 2 do we continue to use same criteria as 2011 Stage 1?

A: All providers will meet MU under the Stage 1 criteria for 2011 and 2012 regardless of whether they start in 2011 or 2012.

113. Q: Are hospital based radiologists considered EPs? What about hospital based radiation therapy physicians?

A: EPs with more than 90% of their services furnished in the inpatient or emergency departments of a hospital are considered hospital based and not eligible for the Medicare or Medicaid EHR incentive programs. We encourage you to register to determine whether you are hospital based.

114. Q: Not all ONC-ATCB certified software has all 44 CQM's functional yet. How did they get certified?

A: Ambulatory certification only requires that a system be certified to the 6 core CQMs and 3 from the additional set.

115. Q: What is the expectation for attestation for EPs that practice at multiple organizations which all have certified EHRs?

A: The expectation is that they would combine their meaningful use performance from each location prior to attesting to CMS.



- 116. Q: For physicians who work exclusively in the hospital setting but do not meet the definition of "hospital-based" in the EHR program (includes many radiologists and anesthesiologists as they have a fairly high outpatient volume), must demonstrate meaningful use and report the CQM's; if the hospital has the inpatient Certified EHR, must the physicians purchase or work with the hospital to purchase an ambulatory certified EHR product in order to report?**

A: Currently there is not cross certification between the ambulatory and inpatient Certified EHR Technology for the common functionalities. The EP needs ambulatory certified EHR technology; however, as opposed to a new EHR system there is no barrier to having the same system certified for both inpatient and ambulatory for those functionalities that are in common.

- 117. Q: If a rural doctor is not identified on the HPSA site but they are practicing in an identified rural county, would they qualify for the additional 10% incentive?**

A: In order to be eligible for the HPSA bonus a provider must be predominately (50% or more of their encounters) practicing in an established health professional shortage area.

- 118. Q: Regarding the penalties for not participating, if an EP is registered for the "Medicaid MU" program and fails to meet the MU minimums will their "Medicare" payments be reduced by the penalty?**

A: The CMS NPRM will discuss the penalties. It is our current thinking that if the EP demonstrates meaningful use to either Medicaid or Medicare, they would not be subject to the Medicare penalty.

- 119. Q: If my provider is Medicaid eligible attesting this year, what 90 days may they select for next year? Would they be allowed to report October through December, 2012 and then report the entire year of 2013?**

A: Their first year of meaningful use would be CY 2012, in this example. They would attest to a 90-day EHR reporting period, so yes, Oct-Dec would be acceptable. Followed by a full year EHR reporting period in 2013, yes.

- 120. Q: We are an FQHC and we are in the selection process of a certified EHR vendor. Are licensed clinical social workers eligible to participate in the Medicaid incentive program?**

A: No, they are not. This does not prevent the practice from selecting an EHR that meets your needs. However, they are not among the list of eligible professionals dictated by the HITECH Act.



121. Q: For Medicaid where EPs require 30% for a 90-day period from the previous calendar year is it the same for the CQM measures? Do they have to capture the data from a 90-day period from the previous calendar year?

A: No. Patient volume is derived from the prior calendar year. However, the EHR reporting period must occur in the same year as the payment year. For example, for a 2012 payment, a provider could use 2011 data to support patient volume but would have to demonstrate meaningful use for 90 days within CY 2012.

122. Q: If a state has not yet defined the Medicaid criteria and does not do so until 2012, is 2012 considered "year one" so that it can be a 90 day reporting period?

A: Currently no state has requested or been approved to modify Stage 1 meaningful use. However, if they were to do so, it would have to be far enough in advance to not hinder providers' pathway from AIU to Stage 1. In any scenario, the provider's 1st year of demonstrating meaningful use is always 90 days.

123. Q: If the first year that a Medicaid provider attests is 2012, do they have to report on CQMs?

A: That depends upon the State. Most States are planning to accept attestation for clinical quality measures in 2012.

124. Q: In a group practice how will reimbursement occur? Is this a Medicaid check from the state and is it considered incentive payments versus encounter payment and is it paid to the group or the individual provider?

A: The individual clinician provides CMS with the tax ID number where they want the payment to be sent. This might be their own, or it might be for their group practice. That is up each clinician and their employer/group practice. The checks are issued by State Medicaid agencies separately from claims reimbursement but are still considered as income.

125. Q: To qualify for the Medicaid incentive the EPs Medicaid population needs to be 30%. Is this based on total number of Medicaid patients or total number of Medicaid encounters?

A: Patient volume can be defined several different ways. Please see the materials on the following website for details about how CMS and States define an encounter:

<http://www.cms.hhs.gov/EHRIncentiveprograms>



126. Q: Does meaningful use apply to those providers that see not only straight Medicaid or can the EP register under the Medicaid incentive program if they see patients with 1) Medicaid Managed Care Plans 2) Medicaid Secondary?

A: Medicaid encounters are not limited to just fee-for-service but also managed care, dual-eligible and where Medicaid is a secondary payer. Please see our website materials for more details about how CMS/States define an encounter:

<http://www.cms.hhs.gov/EHRIncentiveprograms>



Questions from Eligible Hospitals

1. **Q: For pediatric hospitals, the system build and workflow changes to capture CQMs for adult population measures which are not served can be expensive and time consuming. I understand we still have to commit to those builds just so we can report zeros?**

A: You must report CQMs using a certified EHR. Whether you need to review all 44 CQMs, will depend on how many measures your certified technology includes. Os are acceptable values if that is what is calculated by your certified EHR technology.

2. **Q: Are there any exclusions for Children's hospitals from the adult (18+ years of age) measures such as the Stroke measures?**

A: No. However, Os are acceptable values if that is what is calculated by your certified EHR technology.

3. **Q: For automated measures can we use the discharge date or must we use the admit date to calculate the numerator and denominator?**

A: Hospitals should use the dates that are identified in the electronic specifications for that measure.

4. **Q: When will CQMs for eligible hospitals align with existing CMS measures (hospital inpatient quality reporting) since many of them are the same like ED, VTE and Stroke? Can an EH use HIQR guidelines to calculate these same measures?**

A: CMS is working towards alignment with hospital inpatient quality reporting programs for appropriate CQM reporting. Hospitals should use the electronic specifications outlined in the second link on slide 39. Updates to electronic specifications will be provided on that site.

5. **Q: For ED Measures- Should we be counting patients for the specific dates range based on admission or upon discharge?**

A: Hospitals should use the patient discharge dates which fall in the measurement period for clinical quality measure reporting. You may check the electronic specification for guidance. The second link on Slide 39 also provides the electronic specification details.



6. **Q: My question is regarding the Hospital eMeasures. The HITSP Documentation definitions are different from those published by the authoring agency, such as NQF or JCAHO. Are we to follow the HITSP definitions or those of NQF or JCAHO?**

A: The electronic specifications are posted on the CMS website. Refer to the second link on Slide 39. The specifications identified in the Final Rule are considered final. CMS may provide future updates to the specifications but hospitals are not required to incorporate those updates.

7. **Q: May an eligible hospital calculate and report CQM data for the purposes of MU even though certain data elements in the numerator and denominator are missing? For instance, if the eligible hospital chooses not to pursue the med rec requirement in Stage 1 and therefore does not implement that technology, are they permitted to report on CQMs without the data elements that would have been collected from that module?**

A: All data elements outlined in the electronic specifications must be entered into the certified EHR.

8. **Q: If an eligible hospital chooses the “observation services” method for calculating ED data, are their ED CQMs also limited to this patient population? Or does the hospital need to collect data from a broader population for the purposes of meeting the CQM requirement?**

A: The definition for observation services is outlined in the electronic specifications for each ED measure. Observation patients are a stratified population on which the measure requires reporting.

9. **Q: If one or more CQM's for a hospital have a denominator of zero due to data that has not been captured in the EHR. Is zero acceptable as a denominator?**

A: Zero is an acceptable denominator value if that is the value displayed and calculated by your certified EHR.

10. **Q: When reporting the ED measures during MU attestation - I have a question regarding median times that are not a whole number. Should the hospital round the time up or round down when attesting? Some of the median times we see use precision beyond a whole number, such as 350.5 minutes for example. What should the hospital do in this case? Round down to 350 or round up to 351?**

A: The decision to round up or down is done according to each hospital practice.



- 11. Q: Hospitals are concerned about reporting the data from their EHRs, which for various reasons will likely be inaccurate data. Will CMS ever publically report the CQM data submitted to meeting meaningful use? Will CMS ever use these as baseline data for a different program, such as value-based purchasing?**

A: We are not publicly reporting the CQM data. Currently we are publicly reporting participants who have received this incentive.

- 12. Q: If a hospital's certified EHR calculate "zero" for a CQM denominator, but the hospital has other information that would suggest it should not be "zero" (such as the result from a manually abstracted measure calculation), is it OK (and required) to report the result calculated by the certified EHR?**

A: The eligible hospital or CAH is only attesting that what they put in the attestation module is identical to the output generated by certified EHR technology. CMS, through meaningful use, does not require any data validation. If an eligible hospital or CAH has concerns about the accuracy of their output they should work with their vendor and/or the Office of the National Coordinator to improve the accuracy of the individual product and/or the level of accuracy guaranteed by certification.

- 13. Q: If a hospital reports an exclusion to one of the 15 quality measures, who determines if exclusions are appropriate?**

A: The exclusion criteria are defined in the electronic specifications which are located via the second link on slide 39 of the presentation.

- 14. Q: How do M/U CQMs for a hospital compare and align with the CMS Core measures for PN, AMI, SCIP and HF?**

A: We are currently examining how to align measures in programs and seek to do so in future rulemaking where possible.

- 15. Q: Will you please give the definition of exclusions when addressing VTE and Stroke for Hospital clinical quality measures?**

A: The exclusions are listed in the electronic specifications located via the second link on slide 39 of the presentation.



- 16. Q: Many of the hospital quality measure Meaningful Use reports require that both a diagnosis AND a problem exist for defining a population. Why would a patient have to have both a diagnosis and a problem to be included? Shouldn't it be either/or if they are truly trying to look at a particular population?**

A: The measure stewards provide information on what is to be included in the reporting requirements for CQMs which is reflected in the electronic specifications located via the second link on slide 39 of the presentation.

- 17. Q: Is Joint Commission who we should ask procedural questions about the hospital CQM's? Such as: where in the EHR the data elements should be found.**

A: The Oklahoma Foundation for Medical Quality (OFMQ) is the measure steward for the ED measures. The data elements are outlined in the electronic specification.

- 18. Q: For attestation, should exceptions and exclusions both be included in the data field titled exclusions?**

A: Hospital measures contain exclusions. There are no exceptions, Both are explained in the e-measure logic.

- 19. Q: Can you describe how to use the PQRI XML to get the data for attestation for hospitals?**

A: You do not use the PQRS XML for attestation. Attestation is accomplished by manually entering CQM results into the CMS Registration and Attestation portal.

- 20. Q: We're a hospital and having a very difficult time registering at the federal level. It is giving us error messages. We have tried to get help using numbers on the CMS website but they do not work or the person transfers us to numbers that don't work or people that can't help. Please provide a number we can call for help with registration.**

A: EHR Incentive Program Help Desk - 1-888-734-6433



21. Q: The data required to create accurate CQMs, especially non-VTEs, is not necessarily captured electronically during the care process. Therefore, to generate accurate measures, EHs must go through abstractors to verify that all required information is in the EHR before calculating the results. This means thousands of records and the burden on hospitals is overwhelming. One quote for a small hospital I have seen was \$400,000. For the 90 day period. Is sampling allowed? I heard no sampling is allowed. I also heard that there is no expectation that abstractors will ensure that all required data is in the EHR. This means that there is no expectation that the results of the measures will be accurate. Will you please comment on this?

A: You are correct. Sampling is not allowed in the EHR Incentive Program at this time. CMS is requiring that you report the data generated by your certified EHR technology. Any discrepancies beyond that should be discussed with ONC and your vendor.

22. Q: Just for clarification, when discussing eligible hospitals, can the 90-day attestation period overlap between two fiscal years? (E.g. can we attest from August 1 through October 30?)

A: No, you must attest to a continuous 90 day period within the same fiscal year.

23. Q: Many hospital EHRs are still in a hybrid state. For example, documentation from a transferring provider and some physician progress notes may still be on paper. Where physician progress notes are electronic, although the notes may primarily consist of discrete data fields, there may still be information pertinent to clinical quality measures entered as free text. Finally, some information comes into the EHR as free text “blobs” from other systems (e.g., Radiology or Vascular Lab interpretations, which may include information needed to determine whether a given test was ordered specifically to diagnose VTE). If a hospital is using certified vendor software that provides capability for capturing all data elements required for a clinical quality measure, but a physician documents conflicting information in either a free text field or on paper, are we still in compliance with the requirement that we capture all data elements for the CQMs electronically? For example, a discrete field for “Reason for Not Administering Antithrombic Therapy By End of Hospital Day 2” may exist, but the physician may not use it, and instead write a free-text note OR the contraindication may be in documentation from a transferring provider. Another example is that although there may be a “Registration Time” captured in the ED that is typically the earliest arrival time, occasionally there is documentation of an earlier time captured on paper ED notes (e.g., a note regarding intubation). Are we still in compliance with reporting requirements for ED CQMs if there is a contradictory arrival time not captured in the certified EHR?

A: The scenarios provided outline ways in which hospital EHRs and paper records mismatch. Therefore, hospitals should make every attempt possible to streamline clinical and documentation processes to control these situations so that the EHR is populated with accurate



information reflective of the patient's care. However, CQMs are not calculated using any other data source than the EHR. Hospitals that become aware of conflicting documentation should take the necessary steps to correct these deficiencies.

24. Q: For the ED measures in the CQM section can you tell me again what the "exclusions" field is intended for?

A: Refer to the following document on our website for a further description of ED measure stratification:

http://www.cms.gov/QualityMeasures/downloads/EH_EDThroughputStratificationTable.pdf

25. Q: Is CMS aware of the significant errors in the hospital e-measure specifications that are currently posted to your website and embedded in the certification requirements? Will you be publishing corrected specifications?

A: The measure specifications are considered final for 2011 and 2012. We will post updated specifications related to measures proposed in the next rulemaking cycle.

26. Q: What about Stage 2 CQM requirements for hospitals? Have those been finalized yet?

A: Stage 2 requirements will be identified in the next Rule.

27. Q: For current quality measures, we use CMS certified vendor to report. With EHR, hospitals are required to report directly to the website. Does this mean that certified EHR vendors will take a role as current certified vendor of core measures?

A: Hospitals have several reporting programs. Each has its own reporting requirements at this time. Hospitals may elicit the use of a third party vendor to submit EHR Incentive Program requirements.

28. Q: Where do we find the 15 core measures for hospitals?

A: Please refer to the Core and Menu Measures Specification Sheets

[\[https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage\]](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage) located on the CMS EHR website.



- 29. Q: For the hospital CQM, is the requirement to have the original source of the data (ex DVT prophylaxis) be electronically captured or is it acceptable that the source information be obtained by chart abstraction, entered into a qualifying EHR and then that EHR does the calculation?**

A: For Stage 1 reporting to CMS, the terminologies in the electronic specifications shall be used to output measure results. It is acceptable for the data to be manually entered into the certified EHR for that certified EHR to perform the calculations.

- 30. Q: How should a CAH proceed if their certified EHR generates 0 values for their CQMs, but the hospital knows they have patients that meet the CQM denominator criteria? Essentially, if the EHR is not running their calculations correctly, should you still attest to the 0 values that are known to be inaccurate?**

A: The EP, eligible hospital or CAH is only attesting that what was entered into the attestation module is identical to the output generated by Certified EHR Technology. CMS, through meaningful use, does not require any data validation. If an EP, eligible hospital or CAH has concerns about the accuracy of their output they should work with their vendor and/or the Office of the National Coordinator to improve the accuracy of the individual product and/or the level of accuracy guaranteed by certification.

- 31. Q: I have had several problems, as of late, accessing the CMS website to try and attest for our eligible hospitals. Has volume on the website been a problem lately? If so, has this been resolved?**

A: We have had no other reports of load issues. I would suggest you contact EHR Incentive Program Help Desk - 1-888-734-6433.

- 32. Q: Are there any differences in the reporting guidelines for CAH's and RH's? Do they each have to meet all 15 CQM's that they cannot claim exclusions to?**

A: Results must be reported for all 15 CQMs.

- 33. Q: For an eligible hospital, if we do not capture all the data electronically at the time of visit (stroke and VTE data), but extract it from the paper chart and place in a database within our certified EHR after the fact and calculate the outcome with programming, will that be satisfactory for Stage I?**

A: Yes. For Stage 1 reporting to CMS, the terminologies in the electronic specifications shall be used to output measure results.



34. Q: If a hospital is already reporting VTE through another quality program, are they still required to report VTE for meaningful use? Do they need to report VTE 1 and 2 for all patients?

A: Yes at this time.

35. Q: 1) Are eligible hospitals allowed to sample? HITSP specs say that sampling is allowed but it doesn't provide any explanation for what the sampling requirements are. 2) There are many errors and ambiguities in HTISP specs. What body is responsible for resolving or fixing these issues? 3) For automated measures can we use the discharge date or must we use the admit date to calculate the numerator and denominator? 4) When will CQMs for eligible hospitals align with existing CMS measures (hospital inpatient quality reporting) since many of them are the same like ED, VTE and Stroke? Can an eligible hospital use HIQR guidelines to calculate these same measures?

A: 1) Not at this time.

2) We are working with the measure stewards to update specifications to be available for the next rulemaking period. The measures identified in CMS-0033 are considered final for 2011 and 2012.

3) Refer to the specifications for detail. For ED measures, patients should be counted based on discharge date.

4) Our goal is alignment moving forward.

36. Q: For the Quality measure for Stroke education provided to patients- what types of solutions can hospitals use for attestation purposes? Must they report this directly from their EHR (vs. using a logicare type discharge solution to document that education was provided)?

A: Please identify the specific measure you are questioning and contact the Information Center Helpdesk - 1-888-734-6433 with the specific information. There are multiple Stroke measures with education components and we do not know which one you are referring to.

37. Q: The reporting of the 15 CQMs for hospitals will require manual entry of denominator, numerator, and exclusions into the EHR website. Will this ever be electronically submitted from the certified EHR to CMS?

A: You must follow the specifications and requirements for each program. Please refer to the OPPS Rule for a description of the proposed pilot for 2012 electronic CQM reporting.



38. Q: You mentioned the pilot for electronic reporting of CQMs. Since the comment period ended just today, how soon will we know what the actual transmission standard will be? I am concerned since collection of data starts Oct 1 2011 for hospitals. I need to make sure my vendor is ready before I commit to a full year of measurement.

A: Additional information will be posted on the proposed pilots, should they be finalized.

39. Q: Can manually abstracted hospital data be used for calculation of meaningful use clinical quality measures?

A: For Stage 1 reporting to CMS, the terminologies in the electronic specifications shall be used to output measure results from your certified EHR technology.

40. Q: If a hospital is already reporting VTE through another quality program, are they still required to report VTE for meaningful use? Do they need to report VTE 1 and 2 for all patients?

A: 1) Yes.
2) Yes.

41. Q: What, if any, differences can be identified between Critical Access vs. Rural Hospitals (besides the PPS vs. CAH incentive calculations)?

A: All hospitals for must report on all 15 CQMs for the EHR Incentive Program.

42. Q: May an eligible hospital calculate and report CQM data for the purposes of MU even though certain data elements in the numerator and denominator are missing? For instance, if the eligible hospital chooses not to pursue the med rec requirement in Stage 1 and therefore does not implement that technology, are they permitted to report on CQMs without the data elements that would have been collected from that module?

A: You must report your output based on the specifications for the measure.

43. Q: Are hospitals to report on just the data that is in the EHR certified system used to report Clinical Quality Measures? For instance, must we manually abstract any other data into the certified system, before reporting for Stage 1?

A: You are required to report CQM results as calculated by your certified EHR technology.



44. Q: How can a hospital demonstrate that the data from a certified EHR is accurate when the certification process EXPLICITLY does NOT test for accuracy of the measure calculation and the e-specification are flawed?

A: We encourage you to work with ONC and your vendor on this issue.

45. Q: Can we use abstracted data for hospital quality reporting for meaningful use?

A: Your data output must be generated from your certified EHR technology.

46. Q: For meaningful use purposes, we understand that psychiatric services are not included in the calculations for complying with the incentive thresholds. When implementing an electronic health record, do all aspects of the applications have to be consistently applied throughout the Hospital (acute and psych)? Or can certain aspects not be implemented for psych services (only implemented for acute IP's and ER patients) and still be compliant with the incentive program guidelines?

A: Meaningful use only addresses the inpatient and emergency departments (POS 21 and 23) of a hospital.

47. Q: For hospitals, what is the definition of "up-to-date" problem list? In the definitions, it says that it is the last known diagnosis, coded in ICD-9. A patient may come in and be discharged before all tests are complete. The final coded diagnosis may be 2 or 3 weeks later. My reading is that this would not be included in the up-to date problem list until then, correct?

A: The measure for this objective only looks at whether a patient has a problem list coded in ICD-9 or SNOMED CT. There is not a time constraint on when this data becomes part of the certified EHR technology other than the natural constraint that it must be before the hospital attests to meaningful use.

48. Q: For core measure 15/15 "Protect electronic health information" what tool should be used for the analysis?

A: We do not specify a specific tool.



General Questions

- 1. Q: Can you please provide another example of reporting that has both Exclusion and Exceptions?**

A: Example--all patients who had foot exams. An exclusion may be below the knee amputation bilaterally. An exception may be that a patient refused the foot exam. To note, not all measure have exclusions and or exceptions.

- 2. Q: I'm looking for the actual numbers (as an example). How many is initial population, how many is denominator, how many are numerator, how many are exception, how many are exclusions.**

A: In the example, there was no difference between the initial patient population and the denominator so 200 patients met the initial population/denominator criteria. The physician, performed blood pressure measurement on 100 of those 200 patients and no one was excluded (the measure did not allow for exclusions). Therefore, the physician reported that 50% of the time, he took blood pressure measurements for his hypertensive patients.

- 3. Q: Is there a percent that the CQM have to meet in order to qualify for meaningful use?**

A: Not for CQMs. Hospitals must report data for all 15 CQMs (0s or values) and EPs must report on 3 core/alt core and 3 additional measures (0s or values) as reported out of the EHR.

- 4. Q: For first year reporting, may we report more than 90 days when we attest?**

A: You must report on a minimum of 90 days.

- 5. Q: When attesting, are we only using Medicare patients for those figures, or the entire patient base?**

A: The CMS Medicare EHR Incentive Program requires the EP or eligible hospital/CAH to report on all patients (regardless of payor type) from their certified EHR.

- 6. Q: During this presentation there have been multiple references to reports for CQM being "Displayed and Calculated by Certified EHR". Does this mean that we must use ONLY our EHR to generate the quality data? Will we be unable to develop our own Crystal Reports to run against our EHR's back end data?**

A: The data must be generated from a certified EHR.



7. Q: Is sampling allowed?

A: No, sampling is not allowed for any CQMs in the EHR Incentive Program.

8. Q: How do NQFs differ from CQMs?

A: NQF is the National Quality Forum, which is a consensus development body whereby CQMs are endorsed. CQMs are Clinical Quality Measures.

9. Q: Can you further explain what you mean by "all patients in the EHR Incentive Program"? To me that means the Medicare patients only if we are applying for the Medicare Incentive Payments. Also are Medicare Advantage patients included in this?

A: The CMS Medicare EHR Incentive Program requires the EP or eligible hospital/CAH to report on all patients (regardless of payer type) from their certified EHR.

10. Q: Do all "modules" that exchange data within an EMR need to be certified? Or is certification a "whole-system" validation?

A: Each module must meet at least 1 criterion for meaningful use and together form a complete certified EHR system. Please see the ONC website for specific requirements.

11. Q: How will CMS develop which sites that they will Pilot for attestation?

A: Attestation is a method by which all participants in the EHR incentive program submit CQM and MU data. Attestation is not a pilot process.

12. Q: Did I understand that even in 2012, we will have to attest online to report CQMs?

A: The current attestation method that providers use to report CQM's will be an option for reporting CQMs in 2012. In addition to attestation, the Medicare Physician Fee Schedule and the Outpatient Perspective Payment System NPRMs establish the 2012 pilot EHR reporting as an alternative to attestation.

13. Q: Is the incentive only based off of your Medicare Part B charges? Or is off of all Medicare patients seen regardless of which Medicare that they have?

A: Medicare Part B claims are used to meet the threshold for the incentive payment.



- 14. Q: Must reporting be continuous or can there be a break between the 90 day year 1 and when the 12 months of year 2 begins?**

A: Your continuous 90-day reporting period can take place anytime during the first year. For the second year, the reporting period is the entire year.

- 15. Q: There are many errors and ambiguities in HITSP specs. What body is responsible for resolving or fixing these issues?**

A: CMS is working with subject matter experts to address the issues raised with the HITSP electronic specifications. CMS will provide updates when this process is complete.

- 16. Q: I believe that in the webinar it was stated that 0's should be replaced with an optional measure value that is not 0. However, in this Q&A a question was answered stating that 0's were OK. Can you explain?**

A: You must report on measures available in your certified EHR if they apply to your population. However, if no measures apply, 0s are an acceptable value.

- 17. Q: The spreadsheet accompanying the PDF for each of the measures contains ICD-9, ICD-10, RxNorm #, etc . . . to assist developers in correctly calculating the measures. How often will those be changed and how will we be notified of those changes?**

A: The specifications identified in the Final Rule are considered final. However, we have posted updates as they have become available from measure stewards. You may use the updates however you are not required to.

- 18. Q: Can reporting only be done within one calendar year? I.e. Can you report your 90 days from November 1 through January 31?**

A: EP reporting must be within the same calendar year. . Eligible hospital reporting is within the Federal Fiscal Year (FFY), October 1-September 30. A 90 day reporting period must be within the same FFY.

- 19. Q: For the calculation of the numerator and denominator in the first year, you mentioned manual reporting, are those numbers calculated by manual auditing of the EHR?**

A: No, the certified EHR automatically produces the numerators, denominators and exclusions.



20. Q: 90 day reporting period is business days or 90 days including weekends? We don't see patients on weekends.

A: The 90 day reporting period is at least 90 continuous days, so it would not be only business days.

21. Q: Once we have initiated the registration process, how soon can we submit our quality measures?

A: You can attest to meaningful use and CQMs at the same time as long as the CQM data included in your certified EHR is for 90 continuous days

22. Q: Do we need to use certified EHR to produce numerators and denominators or can we use an existing vendor or excel to produce those numbers (based on data generated from the certified EHR).

A: Your CQM results must be generated from your certified EHR.

23. Q: Where can the best information about eMeasure and HQMF specifications be found?

A: We post some helpful guides and specifications on our CMS specification website at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage Additional information can be found on the HL7 website and the NQF website.

24. Q: Who determines if you can claim an exemption, i.e. ophthalmologists treat diabetic retinopathy, blood pressure affects this condition, are we obligated to now begin taking blood pressures? If we claim an exemption, can the government deny the attested exemption?

A: You are not exempt from CQMs. You may report 0s if that is what is calculated by your certified EHR.

25. Q: How will we know if our measures are being reported properly?

A: When completing the attestation process, you will see the results of what you have entered when you select the submission button.

26. Q: The EHR Incentive Program website says there may be future audits. What type of back-up documentation do you suggest providers keep related to the CQMs?

A: You should keep any and all information used to generate your numbers.



27. Q: Can you participate in the PQRI and EHR Incentive Programs in the same year or do you have to choose one or the other?

A: You may participate in both programs.

28. Q: For Medicaid, in the first year, we are only required to adopt the "certified" EHR, for the meaningful use. The second year we are required to report on CQM for 90 days, correct?

A: Yes.

29. Q: Will we be able to receive incentive payments for both PQRI and EHR for the same year?

A: Yes, assuming you meet the program requirements for each program.

30. Q: Is it acceptable to manually enter data from the paper record or another certified EHR into the certified EHR for CQM so that it can correctly report the information for attestation, or does the data have to flow from one EHR to the certified one without manual entry?

A: Yes, a variety of sources may be used for input into the certified EHR.

31. Q: We want to report to Medicaid this year, but the state of FL is not ready yet. Will all states be ready to report this year?

A: Florida has launched within the past month. Check your State Medicaid Website.

32. Q: Our state will not allow registration for incentives until Sept, if we attest in September to the upgrade and implementation of an EHR, when will we have to show MU?

A: You will demonstrate MU the next year.

33. Q: Once you attest, is that when your reporting period begins? Or can you attest and your reporting period dates be prior to you attestation date?

A: You attest to after you have completed your reporting period.

34. Q: If we are to report our full pt population for a CQM - we are including BCBS pts, self pays, Cigna etc correct?

A: You should report on all patients regardless of payer.



35. Q: After attesting I understand we need to keep everything used for attesting. Does that mean that all patient data used for the creation of the reports (A lot of data) needs to be saved? Or just the reports pulled from the certified system.

A: All records used to calculate measures should be saved for a period of 6 years.

36. Q: Why is the example listed as NQF not CQM?

A: Not sure we understand the question. NQF stands for National Quality Forum and it is used in the examples to denote the NQF identification number for the endorsed measure.

37. Q: I have seen some questionable decisions being made by software vendors when deciding how their EHR data will be used to calculate the CQMs, and EHR Certification testing does not include any testing of the accuracy of the CQM calculations. Do you expect such testing will be added at some point, or is automation rather than accuracy the primary goal?

A: Response provided by ONC: Over time, it is our goal to introduce additional rigor into CQM testing. We recognize, however, that the shift from manual chart abstraction to automated CQM calculation based solely on provider use of an EHR is an evolving art. As best practices emerge, we intend to highlight them, but in the interim we are carefully watching and listening to feedback about how CQMs are being implemented and calculated by EHRs.

38. Q: I know she said it's okay to have zero in the denominator, but is it okay to report the CQMs with a number in the denominator, but zero in the numerator, such as 0/50?

A: Yes, this is acceptable provided it is the data reported from the certified electronic health record.

39. Q: How do I gather my numerators?

A: Each CQM has a denominator (the population of patients for whom the measure applies) for example, percent of patient visits, for patients 18 years and older with a diagnosis of hypertension (this is the denominator) with BP recorded (this is the numerator). Thus, the certified EHR should be able to report the number of visits for patients that meet the denominator, and of those patients the number that had their BP recorded which is the numerator for this measure.



40. Q: Can a provider participate in both the Medicare and Medicaid incentive program at the same time?

A: EPs cannot. Dually eligible hospitals can. Children's hospitals and cancer centers can only participate in Medicaid.

41. Q: Do CQM change each year? If so, are the certified systems required to support these changes?

A: The CQMs will remain the same for 2011 and 2012 and are considered final with the publication of the final rule.

42. Q: I thought CMS was going to follow a calendar year, as the outpatient measures are reported throughout the calendar year and they wanted to be consistent.

A: For reporting measures, EPs follow the calendar year and eligible hospital/CAHs follow a fiscal year.

43. Q: When will the rules for Stage 2 Medicare meaningful use be presented?

A: The proposed rules for this program for Stage 2 will be published in a Notice of Public Rule Making in the Federal Register.

44. Q: Do you have to register through PECOS to comply with this electronic mandate?

A: Yes, for Medicare you cannot access the registration module without having a PECOS record.

45. Q: If we have numbers in the denominator, is it ok to have all zeroes in the numerator or should we be asking for exceptions on each of the zero numerators?

A: If you are asking specifically about clinical quality measures, then yes, it is acceptable to have 0 for the numerators and denominators for clinical quality measures provided that is the data reported by your certified EHR

46. Q: Is there a document or resource that maps alignment of the CQMs between MU and PQRS? It doesn't always appear to be a one-to-one correspondence.

A: CMS is working to align programs and we hope in the future such a document will be made available. For meaningful use Stage 1, please note the measure specifications may be different for the same measure in the two different programs.



47. Q: If you use a 90 day period early in the year for the 1st year do you have to report for the remainder of that year? Or do you wait until the next time period for eligible hospitals or EPs?

A: No, if you attested to a continuous 90-day reporting period in the first year of participation in the program, the next time you participate in the program you will report a full 12 months of data for the next payment year.

48. Q: The second to last slide showed the calendar year and fiscal year reporting periods for EPs and eligible hospitals. Do they have to stick to these exact dates? For example, if an EH wants to report from Feb 1 through January 31, is that allowed?

A: The second year of reporting is a full year. For hospitals, this is a full fiscal year, i.e., 10/1-9/30.

49. Q: Can we opt PQRS Measure and configure our rules as per the PQRS specification where PQRS/NQF cross over are there?

A: You must follow the specifications and requirements for each program. Please refer to the MPFS Rule for a description of the proposed pilot for 2012 electronic CQM reporting.

50. Q: How often will the CQM parameters be changed? How will we know when they're changed? For instance, one measure may require one of 10 medications today. A new medication comes out tomorrow that can be added. How and when will we be notified of those changes?

A: The measures and their specifications published in the final rule are considered final for 2011 and 2012.

51. Q: Do all quality measure reports have to be produced from the certified EHR?

A: Yes if they are being used for participation in this CMS program.

52. Q: What does CMS do with the CQM values submitted for attestation?

A: We do not post CQM results for the EHR Incentive Program at this time. Data is stored and used for trending and other policy-making decisions.

53. Q: Re: reporting periods: If my first 90 day reporting period is 01/01/2012 to 03/31/2012, then when can my next reporting period (1 year) be? Can it be for 01/01/2012 to 12/31/12 or do I wait for 01/01/2013 to 12/31/2013?

A: Your second year reporting period is 01/01/2013 to 12/31/2013 per your example.



54. Q: Are there any defined percentages that must be met for the CQM's or is it just that the process is being measured for this year?

A: For CQMs, you are required to report numerators, denominators, and exclusion results. There are no defined performance thresholds that must additionally be met.

55. Q: Can we opt PQRS Measure and configure our rules as per the PQRS specification where PQRS/NQF overlap?

A: You must follow the specifications and requirements for each program. Please refer to the MPFS Rule for a description of the proposed pilot for 2012 electronic CQM reporting.

56. Q: Is it expected that we abstract charts and/or validate the CQM measures as calculated by our certified system? In addition, if the certified system cannot pull all of the data necessary to respond to all of the questions under each measure, do we need a clinical abstractor to "fill in the blanks" or are you only expecting what the certified system produces for purposes of meaningful use attestation?

A: 1) Not at this time.

2) The provider should work with their vendor to assure that all discrete data fields exist in the certified EHR to capture the CQM data.

57. Q: Can you change the criteria for attestation after the first 90 day period and before the full year period?

A: We are not sure we understand this question and the provider may need to clarify what they mean by change the criteria. The program requirements cannot be changed. If he/she is asking about his/her attestation, you can change your input any time before final submission.

58. Q: If I use software that did not certify a specific CQM measure and I want to report that measure can I do so?

A: Refer to FAQ 10649

59. Q: For the additional set, if a provider has values other than 0 in the denominator, should the EP report those over a measures with a 0 denominator, even if the other measure is 0/150 for example (0 numerator)?

A: Yes. The provider should report on those measures for which he/she has data, even if it is only in the denominator.



60. Q: In Stage I meaningful use, it states that we are to send CQMs in the manner specified by CMS. How does CMS want to receive this information?

A: Attestation is the mechanism for reporting CQM results for 2011.

61. Q: If I use software that did not certify a specific CQM measure and I want to report that measure can I do so?

A: Refer to FAQ 10649.

62. Q: In Stage I meaningful use, it states that we are to send CQMs in the manner specified by CMS. How does CMS want to receive this information?

A: Attestation is the mechanism for reporting CQM results for 2011.

63. Q: There are a lot of questions regarding the 90 day reporting period and the word "continuous" in CMS's description. My understanding is that the days that count to add to the 90 days would be days patients were actually treated. In other words, if a doctor treats patients Monday thru Friday, they would have 5 days per week of reporting and it would take a total of 18 weeks to meet the 90 day requirement. Is this correct?

A: A "continuous" 90-day reporting period includes all calendar days within that 90-day period, not just those days that are considered business days or days in which patients were treated.

64. Q: When does reimbursement start?

A: Incentive payments started in may and are dependent on when you have successfully met the program requirements.

65. Q: Our system should be updated in the next month so that we are compliant, will this be too late to qualify for the incentive program?

A: The day to start a reporting period for 2011 is 10/3 for EPs. For hospitals, it was July 3rd.

66. Q: Can you utilize your State HIE to submit the CQM when this is available or does it have to be your certified EHR?

A: The source has to be the certified EHR.



67. Q: Why are CQMs not aligned with PQRS? In other words why doesn't one suffice for the other and vice a versa?

A: We suggest you review the proposed CQM pilot option in the MPFS NPRM on display.

68. Q: Where can we go to get clarification on Quality Measures to make sure we understand what exactly the measure is looking for?

A: We suggest you review the CQM specifications posted on our website:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

69. Q: The EHR system calculates the quality measures, but what about patients whose records are not in the EHR? Are we only counting patients whose records are in the EHR?

A: CQMs are generated electronically from the EHR. You are attesting to the results as reported from your certified EHR system.

70. Q: Does the 90 days for CQM reporting have to be the same 90 days as reporting for the EHR incentive program in year 1?

A: Yes.

71. Q: Do you have any information or insight into CMS's plans for requiring hospitals and EPs to electronically submit their CQM data to CMS? The final rule stated that they would look to do so in 2012 but I haven't heard if that is likely or unlikely.

A: Refer to electronic CQM reporting pilots proposed in the OPPS and the MPFS draft rules on display.

72. Q: Once you attest to the CQM's, do you have to continuously collect the data via the EHR with no breaks?

A: You must attest in the first year to a continuous 90-day period. No additional attestations are necessary for the same reporting year.

73. Q: To meet the EHR Incentive requirements for Medicare program, do we also have to report PQRS codes?

A: Not for the EHR Incentive Program.



74. Q: What are the specific requirements for NQF0070?

A: Refer to the specifications found on

http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

75. Q: Does attestation have to occur within a certain number of days once the 90 day EHR reporting period is over?

A: Attestation must be submitted within 2 months of the end of the reporting year.

76. Q: Is there anything at all that needs to be done with the CQM's that we have not selected to report on in Stage 1?

A: No.

77. Q: Can the quality measures be abstracted from multiple sources i.e. paper chart, non certified software and then entered into the certified EHR?

A: For Stage 1 reporting to CMS, the terminologies in the electronic specifications shall be used to output measure results.

78. Q: What is the difference between PQRI and CQM?

A: PQRS and the EHR Incentive Program are separate reporting programs authorized under law.

79. Q: For the code sets provided in the measures, what if you do not use a specific code, but have an internal code that can be mapped to the requested code. For example, optic nerve evaluation requires a SNOMED CT code, this is not a billable procedure. We use a 'local code' that means the same thing. Can we map the local code to the SNOMED CT code, or are we required to use the SNOMED CT code?

A: For Stage 1 reporting to CMS, the terminologies in the electronic specifications shall be used to output measure results.

80. Q: Since some eligible hospitals (and EPs) are producing outputs of zeros during attestation, would it be possible to change the MU attestation statement on the CMS attestation screen to remove the word "accuracy" and reflect that it is to the best of attesters' ability based on the data that is captured using our certified EHR technology?

A: We will take your recommendation into future considerations. However, you are to report what is generated from your certified EHR technology. Any questions concerning that data should be discussed with ONC and your vendor.



81. Q: The BMI measure has to be reported every six months. Will it meet the reporting requirements if it is reported once within the 90-day timeframe?

A: The reporting period for the EHR Incentive Program using a certified EHR is any continuous 90 day period during the first payment year. Please note that although most measure specifications assume a full calendar year you should only calculate the denominator and numerator from the first day of the 90 day reporting period to the last day of the 90 day reporting period.

82. Q: Does the EHR merely have to generate the raw data (numerator, denominator) or must it also perform the calculation?

A: Calculated Numerations, Denominators, and Exclusion results are reported to CMS.

83. Q: Explain how to use the HITTS manual for CQMs? I was unfamiliar with this manual.

A: You should use the specifications identified in the EHR Incentive Program Final Rule CMS-0033. The specifications are also available on http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.

84. Q: If the data must be generated by the EHR but we attest manually, how does it transfer to CMS? Does it depend on the EHR program?

A: For 2011, report to CMS is accomplished via attestation only.

85. Q: Our vendor's HQM tool has not been released to all of its clients. Can we use reporting tools to extract the data from our EHR database to determine our statistics?

A: Your data must be generated from your certified EHR technology.

86. Q: If I report "0" for a measure do I need to prove that all other certified measures are a "0" as well?

A: You attest that all other results were also 0.

87. Q: If there's exclusion and exception, are these exclusion and exception numbers included in the numerator and denominator being reported?

A: You will need to look at each measure specification to see how this is handled.



88. Q: Do the CQMs also qualify for PQRI reporting?

A: The programs are separate at this time. Please see proposed CQM reporting pilot in the MPFS Rule on display.

89. Q: Are there any minimum percentages for CQMs that you do report on? For example, to qualify for the PQRS bonus you need to successfully perform the measure on 80% of patients. Do the CQMs have any minimum percentages for successful performance of the measure on patients? For example, the certified EHR software does not report a 0 for a CQM, but instead reports a numerator and denominator equal to, say, 5%. This 5% will count as successful reporting of a CQM?

A: No.

90. Q: Do the HITSP specifications for the clinical quality metrics include exclusions in the count of rejected cases?

A: Where applicable. Refer to the specifications.

91. Q: Once you attest, that is when you begin your reporting period? Or can you report for a period prior to when you attest?

A: You attest to a reporting period. That period must have occurred before you report.

92. Q: For the maximum incentive payment amount to be received in year 1 (\$18K), I understand the total allowable charges need to be \$24K. Are the charges ONLY ones that go to straight Medicare Part B vs. Advantage plans? If so - how can we find out how much we've billed as "allowable" so far for the year to see if it's better to attest for 2011 or wait for 2012 in the hope we have more Medicare patients?

A: Only Medicare Part B Allowable Charges. To find out what has been determined as allowable, we would suggest contacting your MAC.

93. Q: There is likely to be a difference between the system generated data reporting for MU CQM measures that match what we currently survey manually. Are we going to be held accountable for any differences in the numbers?

A: I would suggest you contact EHR Incentive Program Help Desk - 1-888-734-6433. You are required to report CQM results as calculated by your certified EHR technology.



94. Q: Is only chewable and enteric coated aspirin truly the only aspirin that is considered valid for the stroke measure Stroke 2?

A: Please use the Joint Commission Stroke Antithrombotic Medications Value Set Table 3-231 in the HITSP specifications.

95. Q: Any plans to address gender in the HumanReadable population logic? I laughed when I first heard the question posed to me, but after considerable thought, it leads to the questions of: "patient's reported gender?" or "patient's birth gender?" I know gender is addressed in the HumanReadable descriptions, but the logic never speaks to this.

A: CMS is making some changes to the data elements that will be included in future clinical quality measures specifications. Please check the CMS website when the measures are updated or when Stage 2 measures are posted.

96. Q: Please further explain the threshold of \$24,000; is this \$24,000 of allowed charges for the 90 day period?

A: You have to reach \$24,000 in Part B allowable claims for the year in which you attest.

97. Q: 1. I am troubled by your responses suggesting that EPs consult legal counsel before attesting that the data coming out of the certified EHR is accurate. FAQ 10589 says the following: "CMS considers information to be accurate and complete for CQMs insofar as it is identical to the output that was generated from certified EHR technology. Numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting that the information for CQMs entered into the Registration and Attestation System is identical to the information generated from certified EHR technology. CMS does not require EPs, eligible hospitals, or CAHs to provide any additional information beyond what is generated from certified EHR technology in order to satisfy the requirement for submitting CQM information." 2. How can a hospital demonstrate that the data from a certified EHR is accurate when the certification process EXPLICITLY does NOT test for accuracy of the measure calculation and the e-specification are flawed? What would such a demonstration look like?

A: The EP, eligible hospital or CAH is only attesting that what was entered into the attestation module is identical to the output generated by Certified EHR Technology. CMS, through meaningful use, does not require any data validation. If an EP, eligible hospital or CAH has concerns about the accuracy of their output they should work with their vendor and/or the Office of the National Coordinator to improve the accuracy of the individual product and/or the level of accuracy guaranteed by certification.



98. Q: Should PQRI measures be reported on all patients or just Medicare patients?

A: The EHR Incentive Program reporting requirements are for all patients, the PQRS Program reporting requirements are for Medicare only.

99. Q: Why won't CMS allow us to upload our data in databases instead of manually entering? It seems it would be a better use of resources to upload all of the data at once instead of manually entering. Any chance there will be a fix/change before attestation?

A: The method for reporting for 2011 is via attestation.

100. Q: For menu set measure #2 - incorporate clinical lab test results as structured data - all our results are structured data BUT the orders are entered on a separate system and as such our EHR cannot do the measure calculation automatically so 1) can we calculate the measure manually 2) if yes, is the denominator lab tests by procedure code or by test item?

A: Yes, you can calculate the measure manually. Any lab test with a result that is affirmative/negative or numeric would be included in the denominator.

101. Q: For the menu-set measures, it says that you only need to 5 of the 10. Does this mean that you only have to CHOOSE 5 of the 10 or that you can opt out on up to 5 of the 10 measures if you simply don't meet the requirements?

A: You choose five. Once you have met five you do not have to fulfill additional requirements regardless of whether you could or not.

102. Q: The presentation indicated that for Medicaid programs, the reporting period for the second year is 90 continuous day. Can you please verify this?

A: Yes. The first year of Medicaid is for adoption, implementation or upgrade of certified EHR technology. The second year is for meaningful use based on a 90 day EHR reporting period. Starting in the third year, meaningful use must utilize a full year reporting period.

103. Q: When do we expect the rules for future stages to be decided upon?

A: We will propose the Stage 2 meaningful use regulations in February 2012 with the final rule published in summer 2012.



104. Q: Are outpatient Radiologists who work in standalone imaging centers eligible? They should be able to exclude from many of the mandatory measures and attest 0 for CQM's?

A: They are eligible and 0 is an acceptable submission for CQMs. They should look at the exclusion criteria for each objective to determine whether they meet the criteria before excluding the objective.

105. Q: Hello, regarding meaningful use and your definition of an 'encounter' is that only a 'billable' encounter and those patients we report on for meaningful use? What about Global or NoCharge suture removals-- do we have to count those patients in the meaningful use calculations?

A: For CQMs, encounter is defined by the measure specification codes.

106. Q: Where are you publicly reporting who has received the incentive payments? I have only been able to find a list from about two months ago.

A: We are posting the names of those attesting to meaningful use on a quarterly basis. As required by the American Recovery and Reinvestment Act of 2009, CMS will post the names, business addresses, and business phone numbers of all Medicare eligible professionals (EPs) and hospitals who receive EHR incentive payments. There is no such requirement for CMS to publish information on eligible professionals and hospitals receiving Medicaid EHR incentive payments, though individual States may opt to do so.

107. Q: If we attest in 2011 will we be held to Stage 1 for the next 2 years?

A: CMS will identify and propose options of delaying Stage 2 until 2013 in the NPRM, to be released in early 2012.



- 108. Q: PQRS XML File issue: The following issue came up during ONC-ATCB certification testing of one of our Ambulatory products. Background: We based our XML content on the specifications provided here: <https://www.cms.gov/PQRS/downloads/PQRI2009RegistryXMLSpecsFinal508.pdf>. In this document, on page 6, the <eligible-instances> element is defined as "Number of eligible instances (reporting denominator) for the PQRI measure." We interpreted that to mean that we should use the value from our report's denominator. However, during the testing session, the ATCB indicated that this value should also include the count of patients who were excluded from the report as well. So our question is: which is the correct interpretation of the value that is to be reported in the <eligible-instances> element? Should it be the actual denominator count or the denominator count *plus* the exclusion count?**

A: Eligible instances are the reporting denominator count only. The exclusions are listed separately and the calculation of all is identified in the reporting rate percentage.

- 109. Q: Do certified EHRs required to produce denom, num, exclusion and exception values if they are appropriate and the certified EHR is certified for that CQM?**

A: In order to be certified, EHR technology must be able to calculate the requirements expressed by a CQM.

- 110. Q: For CAH Incentive Reimbursement why is CMS using meaningful use to modify reimbursement of the complete ONC "Certified EMR System"? CMS and the FI's are denying that certain modules of a "Certified System" are covered under the incentive reimbursement i.e., Finance, and Human Resources for example and they are part of and ONC Certified System. The issue with the modules makes no sense for several reasons; one the potentially excluded modules are in fact required for M/U i.e., HR is the portal for ALL staff for HIPAA compliance M/U rule 14 and Finance provide all CPT, HCPCS and Revenue Codes. Secondly this clearly violates the intent of the rule and the rule as written. Also hardware is being parsed out by requiring that it will only provide incentive reimbursement for the portion of the Hardware that runs the EHR. How does anybody measure that? The rule makers need to talk to the vendors on that one. This also violates the rule as written. Please explain.**

A: An EHR Module is defined at 45 CFR 170.102 as "means any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary." If the technology cannot perform a capability for which certification is required then it cannot be certified as an EHR Module and would not meet the regulatory definition of EHR Module.



111. Q: Do you know how often the ONC website updates EHR additional certifications?

A: Typically the Certified HIT Products List is updated at least once per week.

112. Q: How often does the ONC update its website? Our vendor is telling us that they are certified in almost all CQM's but when I look at the ONC site they only have 9 that are certified. Would anyone know how often it updates?

A: Typically the Certified HIT Products List is updated at least once per week.