CLINICAL QUALITY MEASURES (CQMS)		
FAQ Number	**Question**	**Answer**
3601	Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete clinical quality measure data for the Medicare and Medicaid Promoting Interoperability Programs?	We recognize that providers are continuing to implement new workflow processes to accurately capture clinical data in their certified EHR technology, but many providers are not able to capture all data at this time. Although we encourage providers to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, CMS does not require providers to record all clinical data in their certified EHR technology at this time. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the certified EHR technology that are not identical to the values generated from other methods (such as record extraction).However, at this time CMS requires providers to report the clinical quality measure data exactly as it is generated as output from the certified EHR technology in order to successfully demonstrate meaningful use. We will continue to collaborate with our partners in the Office of the National Coordinator for Health Information Technology and with industry stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products.
3673	For the Medicare and Medicaid Promoting Interoperability Programs' clinical quality measures (CQMs) ED-1, ED-2, and Stroke-4, how should eligible hospitals and critical access hospitals (CAHs) define an Emergency Department patient since the UB-04 data set referred to in the HITSP specifications no longer provides this information?	The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department.This data element specification to be used for ED-1, ED-2, and Stroke-4 can be found at in Section 1 Data Dictionary/Alphabetical Data Dictionary (page 1-146).
3675	For the Medicare and Medicaid Promoting Interoperability Programs, who do I contact to suggest adding/deleting a code on a clinical quality measure (CQM) or to suggest other CQM improvements?	Please contact the measure steward (the entity responsible for maintaining and updating a clinical quality measure) if you have suggestions or comments for improving the measure, comments regarding the measure's scientific or medical soundness/applicability, or would like to add specific vocabulary taxonomies or codes to the measure that may be appropriate for the measure population. The measure steward for each eCQM is identified at the eCQI Resource Center at https//ecqi.healthit.gov/
3277	For the Medicare and Medicaid Promoting Interoperability Programs, if certified EHR technology possessed by an eligible professional (EP) includes the ability to calculate clinical quality measures (CQMs) from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC - Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation?	Through 2013, yes, the EP can submit results for CQMs in the additional set (Table 6 of the Stage 1 final rule) calculated by certified EHR technology, even if those CQMs were not individually tested and certified by an ONC-ATCB. We expect to revisit CQM requirements in more detail for later stages of meaningful use as well as the corresponding certification requirements. Starting in 2014, the EP must have 2014 edition Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria.
3611	For the Medicare and Medicaid Promoting Interoperability Programs, how should an eligible hospital or critical access hospital (CAH) with multiple certified EHR systems report their clinical quality measures?	To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23))
9276	Can a hospital receive credit for any of the Inpatient Quality Reporting (IQR) Program requirements by electronically submitting the Clinical Quality Measures (CQMs) for the Promoting Interoperability Program?	Yes, a hospital will be able to receive credit for the EHR Incentive Program and IQR by electronically submitting the CQMs (also referred to as eCQMs) for the EHR Incentive Program, using the IQR system (Qualitynet.org). There are 16 CQMs that are shared by the two programs, and these shared measures are organized into four measure sets, stroke (seven measures), venous thromboembolism (six measures), emergency department (two measures) and perinatal care (one measure). Hospitals choosing to report the specified measure sets electronically to meet the CQM requirements for the Medicare Promoting Interoperability Program and the IQR Program, may report one quarter of data (either January – March 2014, April – June 2014, or July – September 2014). If a provider reports measures electronically, they are not required to report the same measures by via chart abstraction or attestation. Please note that both the IQR Program and the Promoting Interoperability Program have additional requirements which must be reported IQR Program For the IQR Program, a hospital must continue to submit all 14 of the remaining IQR measure sets each quarter if it wishes to fulfill the requirements for the IQR program. The 14 measure sets include data for the following: Clinical, HCAHPS, Aggregate Population and Sample size counts, HAI, Claims, and Structural Measures. Hospitals participating in the IQR program must also sign a notice of participation, provide a security administrator and complete the Data Accuracy and Completeness Acknowledgement (DACA). For more information regarding IQR requirements and a checklist for providers, please go to the Inpatient Quality Reporting Program Tab How to participate on http://www.qualitynet.org/"www.QualityNet.org Promoting Interoperability Program Electronic submission of the 16 eCQMs will meet the CQM requirement for the Medicare Promoting Interoperability Program. Hospitals also need to attest to the core and menu objectives for meaningful use through the Medicare Promoting Interoperability Program Registration and Attestation System. Critical Access Hospitals and Eligible Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid EHR Incentive Program. For more information on program details, please visit the CMS EHR Incentive Programs page. http://www.cms.gov/ehrincentiveprograms"Created on 11/22/2013 Updated on 11/27/2013
12356	For the Medicare Promoting Interoperability Program, can I report a CQM with a zero result in the numerator and/or denominator?	While we strongly encourage providers to report CQMs which are relevant to their patient population, zero is an acceptable result provided that this value was produced by certified EHR technology.
9062	The specifications for Denominator 2 for measure CMS64v3 do not produce an accurate calculation according to the measure's intent. When will a correction to this clinical quality measure (CQM) be published?	The Medicare and Medicaid Promoting Interoperability Programs; Stage 2 final rule (77 FR 54056) states that updates to the CQM specifications may be published annually approximately 6 months prior to the beginning of the calendar year (CY) for which the data would be collected (e.g., for the EHR reporting periods in CY 2014, approximately 6 months in advance of the beginning of CY 2014). A correction for this measure will be included in the next annual update, to be published in CY 2014. Within the logic for Denominator 2, there is a missing "OR" operator in the Risk Assessment Logic between count = 3 and count = 2. This omission may result in cases incorrectly excluded from the denominator. This missing "OR" operator in Denominator 2 creates a situation where 3+ risk factors AND a High Density Lipoprotein (HDL) laboratory result of 60 mg/dL will cause the patient to not fall into Denominator 2, which is an error. The issue would only impact cases when a patient's Framingham Risk Score is not recorded in the EHR. The exact impact on the performance calculation for Denominator 2 is unknown. Since the CQM asks for either the data to calculate risk or a pre-calculated Framingham Risk Score, the result will not be miscalculated in denominator 2 if there is a Framingham score already in the EHR system. It; is highly recommended that eligible professionals (EPs) implementing this CQM record a Framingham Risk Score as outlined in the U.S. Department of Health Human Services' Third Report of the National Cholesterol Education; Program (NCEP) (2002, p. III-4 – III-5) to ensure accurate performance calculation: http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full. Created on 8/22/2013 Updated on 8/29/2013
2873	For eligible hospitals and critical access hospitals (CAHs) under the Medicare and Medicaid Promoting Interoperability Incentive Programs, will the clinical quality measure results be calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program (Formerly known as Reporting Hospital Quality Data for Annual Payment Update program)?	No. For all clinical quality measures reported for the Medicare and Medicaid Promoting Interoperability Programs, the certified EHR must report the numerator, denominator, and exclusion results. Providers will report their aggregate results for clinical quality measures during attestation to CMS or the States.
3125	Is a hospital participating in the Medicare and Medicaid Promoting Interoperability Programs required to report quality metrics on ALL patients?	The technical specifications issued by CMS for the clinical quality measures under the Medicare and Medicaid Promoting Interoperability Programs specify what data should be included in the numerator and the denominator. Clinical quality measure reporting is inclusive of all applicable patients or actions during the Electronic Health Record reporting period, with no differentiation by payer.
8400	When can a hospital use the case number threshold exemption for the clinical quality measure (CQM) requirement of meaningful use?	The case number threshold exemption for hospital CQM reporting helps reduce the burden placed on hospitals that very seldom have cases that would be counted in the denominator of certain CQMs. Eligible hospitals and critical access hospitals (CAHs) with a low number of inpatient discharges per electronic health records (EHR) reporting period as defined by a CQM's denominator population, could be exempted from reporting on that CQM. The CQM case number threshold exemption for eligible hospitals and CAHs is available beginning in FY2013 for all stages of meaningful use (MU). The hospital must submit the aggregate population and sample size counts for Medicare and non-Medicare discharges for the EHR reporting period for the CQM(s) for which the hospital seeks an exemption.To meet the threshold for exemption from reporting a CQM, the following criteria must be met for the corresponding EHR reporting periods:•;1st year of demonstrating MU 90-day EHR reporting period; 5 or fewer discharges during the EHR reporting period• 2nd year or beyond of demonstrating MU;Full year EHR reporting period ;20 or fewer discharges during the EHR reporting period; In FY 2014, three-month quarter EHR reporting period with 5 or fewer discharges during the EHR reporting period;Discharges are defined by the CQM's denominator population;Applies on a CQM by CQM basis When invoking the case number threshold exemption in FY 2013:•;All 15 of the CQMs from Stage 1 final rule are required.• The number of CQMs required to report is reduced by the number of CQMs for which the hospital does not meet the case number threshold of discharges. When invoking the case number threshold exemption in FY 2014:• 16 CQMs covering at least 3 domains from a list of 29 CQMs are required.•The same process as in FY 2013 is employed, but in order to be exempted from reporting fewer than 16 CQMs, the hospital would need to qualify for the case number threshold exemption for more than 13 of the 29 CQMs.•;If the CQMs for which the hospital can meet the case number threshold of discharges do not cover at least 3 domains, the hospital would be exempt from the requirement to cover the remaining domains.To view the rules that include this policy for the Medicare and Medicaid EHR Incentive programs, please visit:•;Stage 2 Final Rule (77 FR 54080): http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf"•Interim Final Rule (77 FR 72988 – 72989): http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29607.pdf" Created on 7/1/2013

8896	When new versions of clinical quality measure (CQM) specifications are released by the Centers for Medicare and Medicaid Services (CMS), do developers of Promoting Interoperability need to seek retesting/recertification of their certified complete EHR or certified EHR module in order to keep its certification valid?	No. The minimum version required for 2014 Edition certification is the version of CQM specifications released by CMS in December 2012. EHR technology that has been issued a certification based on the December 2012 version will remain certified even when CMS releases new versions of CQM specifications. We strongly encourage EHR technology developers to update to the newest CQMs specifications as they become available since those updates include new codes, logic corrections and clarifications. We also recommend EHR technology developers consider that other CMS programs (beyond the EHR Incentive Programs) and other private sector programs generally update CQMs on an annual basis. As a result, an EHR technology developer's customers continued ability to successfully participate and report in those other programs could be impacted if the CQM data generated by the EHR technology is based on older specification versions (and no longer accepted by the other programs).Please see FAQ 8898 and 8900 for additional information pertaining to the relationship between EHR certification and the CQM specification updates. For more information on the 2014 CQM specifications, please visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html" For more information on ONC Health Information Technology (HIT) Certification, please visit: http://www.healthit.gov/policy-researchers-implementers/about-certification
8900	If Electronic Health Records (EHR) technology is not yet certified to the clinical quality measure (CQM) criteria (45 CFR 170.314(c)(1) through (3)), can the EHR technology be tested and certified to only the newest available version of the CQM specifications or must it be tested and certified to the December 2012 specifications (first or as well)?	Yes, EHR technology may be presented for testing and certification to only newest CQM specifications.We strongly encourage EHR technology developers to test and certify to the newest CQMs specifications as they become available since those updates include new codes, logic corrections and clarifications. In addition, other CMS programs (beyond the EHR Incentive Programs) and other private sector programs generally update CQMs on an annual basis. Updating EHR technology to the newest CQM version specifications enables providers to participate and report in those other programs for which they are eligible as well. Please see FAQ 8896 and 8898 for additional information pertaining to the relationship between EHR certification and the CQM specification updates. For more information on the 2014 CQM specifications, please visit: "http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html" For more information on ONC Health Information Technology (HIT) Certification, please visit: http://www.healthit.gov/.
9676	For some of the eligible professional (EP) clinical quality measures (CQMs), there are look back periods or look forward periods for which data was not available. How are these CQMs calculated for the reporting period?	CQMs that include look back periods or look forward periods may require data outside of the reporting period of a CMS quality reporting program. Look Back Period – Example CQM: An example of a CQM that includes a look back period is CMS130 (NQF 0034) Colorectal Cancer Screening. The CQM assesses performance on the percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer. If the screening occurred within the reporting period and through the EP's practice, it should be captured in the calculated performance rate. However, if the screening took place before the reporting period and/or occurred outside of the EP's practice, it is possible that the screening would be omitted from the calculated performance rate. Look Forward Period – Example CQM: An example of a CQM that includes a look forward period is CMS159 (NQF 0710) Depression Remission at Twelve Months. The CQM assesses performance on adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5 (includes newly diagnosed and existing patients with depression or dysthymia). If the assessment for remission at twelve months occurs within the reporting period and through the EP's practice, it should be captured in the calculated performance rate. However, if the assessment takes place after the reporting period and/or occurred outside of the EP's practice, it is possible that the occurrence of the remission would be omitted from the calculated performance rate. General Guidelines: We recommend that the information needed from the look back periods be requested from the patient as part of the encounter and recorded in the Electronic Health Records (EHR) technology, for example, as part of the patient's history. For EHR vendors, we recommend that EHRs include the capability of capturing the type of information needed for the look back periods as part of the encounter (e.g., in the history section of an encounter note) and then extract data from this entry for purposes of reporting CQMs with look back periods.There is no practical way to capture information for look forward periods that go into the next reporting period. In most cases, this should affect the performance rates of all EPs similarly. For CQM data reporting to CMS that may be used for a pay for performance program, the collective EP performance rates should be reflected in the benchmark for each respective CQM that contains a look forward period. Since EPs who are subject to the value-based payment modifier would be assessed, in part, based on the performance rate of the CQMs they report through the Physician Quality Reporting System (PQRS), those EPs may review the CQMs available and try to report on CQMs that are not affected by look back or look forward periods to help mitigate the issues described above for programs that have the option to select CQMs. Added on 2/6/2014
10786	Can SCIP INF-9 (CMS178v4 / NQF0453) still be used to meet the reporting requirements of the Promoting Interoperability (Meaningful Use) for Eligible Hospitals and the Hospital Inpatient Quality Reporting Program?	CMS suggests eligible hospitals participating in the Medicare and Medicaid Promoting Interoperability Programs and/or choosing the voluntary electronic reporting option under the Hospital Inpatient Quality Reporting (IQR) Program not select SCIP INF-9 (CMS 178v4/NQF 0453) as one of their electronic clinical quality measures (eCQMs) and choose another eCQM for Meaningful Use reporting and/or Hospital IQR reporting in 2015. A critical error identified in the measure (CMS 178v4/NQF 0453) renders a zero denominator. The denominator error noted in the SCIP INF-9 (CMS 178v4/NQF 0453) was identified after the 2014 Annual Update posting. If the measure is used for reporting, a zero in the denominator will count as a successful submission for that CQM for both the Medicare EHR Incentive Program and the Hospital IQR Program. Eligible hospitals and CAHs reporting CQMs using certified EHR technology are required to report on a minimum of 16 CQMs across 3 National Quality Strategy Domains. If an eligible hospital or CAH reports on a CQM generating a zero denominator, it will count toward the required 16 CQMS for the Medicare EHR Incentive Program and the Hospital IQR Program. For additional clarification on reporting zero denominators, please see the page 50323 of the FY 2015 IPPS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.Created 10/9/2014