OBJECTIVES AND MEASURES		
FAQ Number	**Question**	**Answer**
14401	For 2016, what alternate exclusions are available for the public health reporting objective?Is there an alternate exclusion available to accommodate the changes to how the measures are counted?	We do not intend to inadvertently penalize providers for changes to their systems or reporting made necessary by the provisions of the 2015 EHR Incentive Programs Final Rule. This includes alternate exclusions for providers for certain measures in 2016 which might require the acquisition of additional technologies they did not previously have or did not previously intend to include in their activities for meaningful use (80 FR 62945).For 2016, EPs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3 and eligible hospitals or CAHs scheduled to be in Stage 1 or Stage 2 must attest to at least 3 public health measures from the Public Health Reporting Objective Measures 1-4. We will allow providers to claim an alternate exclusion for the Public Health Reporting measure(s) which might require the acquisition of additional technologies providers did not previously have or did not previously intend to include in their activities for meaningful use.We will allow Alternate Exclusions for the Public Health Reporting Objective in 2016 as follows: EPs scheduled to be in Stage 1 and Stage 2: Must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3 • May claim an Alternate Exclusion for Measure 2 and Measure 3 (Syndromic Surveillance and Specialized Registry Reporting).• An Alternate Exclusion may only be claimed for up to two measures, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22 (e)(10)(i)(C). Eligible hospitals/CAHs scheduled to be in Stage 1 and Stage 2: Must attest to at least 3 measures from the Public Health Reporting Objective Measures 1-4 • May claim an Alternate Exclusion for Measure 3 (Specialized Registry Reporting) • An Alternate Exclusion may only be claimed for one measure, then the provider must either attest to or meet the exclusion requirements for the remaining measures described in 495.22 (e)(10)(ii)(C). Created 02/25/2016
2851	Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	As mentioned in 80 FR 62798, a medical staff person who is a credentialed medical assistant or is credentialed to and performs the duties equivalent to a credentialed medical assistant may enter orders. We maintain our position that medical staff must have at least a certain level of medical training in order to execute the related CDS for a CPOE order entry. We defer to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines we have proscribed. We believe that interns who have completed their medical training and are working toward appropriate licensure would fit within this definition. We maintain our position that, in general, scribes are not included as medical staff that may enter orders for purposes of the CPOE objective. However, we note that this policy is not specific to a job title but to the appropriate medical training, knowledge, and experience. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10134 Date Updated: 05/12/2016
	For the meaningful use objective "Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"?	Syndromic surveillance uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community. For additional information about syndromic surveillance data, please visit: http://www.cdc.gov/EHRmeaningfuluse/Syndromic.html" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: 10846
7623	In perioperative settings and emergent situations, medications and diagnostic studies are sometimes initiated by the provider without a formal order, or given by someone under direct supervision of the provider immediately following a verbal order and before any record of the order is created. How should those events be counted in the CPOE measure if they are subsequently recorded using the CPOE function of Certified EHR Technology by a licensed healthcare professional or certified medical assistant?	We agree that in some situations it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
11960	To meet public health objectives in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, when does the provider need to possess, own and/or install a Certified EHR Technology (CEHRT)?	Providers must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day and in use by the providers for their entire EHR reporting period. There is other functionality, including for the public health objectives, where the CEHRT may not be fully functional at the start of the provider's EHR reporting period and that is acceptable. Completing the implementation and making it fully functional would be part of the onboarding process with the public health agency. Created on 3/4/2015
11962	For Stage 2 of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, is it acceptable for providers to register their intent with the Public Health Agency (PHA) prior to the start of their EHR reporting period?	Yes, it is acceptable for providers to register with PHA prior to their EHR reporting period to begin communications and to help plan their resources for onboarding with the PHA. If registering their intent prior to the start of the EHR reporting period, the provider would not have to have Certified Electronic Health Record Technology (CEHRT) at that point, but must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day and in use by the providers for their entire EHR reporting period. There is other functionality, including for the public health objectives, where the CEHRT may not be fully functional at the start of the provider's EHR reporting period and that is acceptable. Completing the implementation and making it fully functional would be part of the onboarding process with the PHA. Created on 03/04/2015
11964	To meet public health objectives in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, must providers register their intent to submit data for Stage 2 of Meaningful Use during each year of participation to meet the measure?	No. Providers only need to register once, with the Public Health Agency (PHA) or other body to whom the provider will be submitting data, to indicate their intent to initiate ongoing submission of data to meet a public health objective. If in subsequent years of participation, providers have not progressed into testing and validation or ongoing submission (i.e. production) status, the documentation of the initial registration of intent may be used for attestation. PHAs may periodically ask providers to verify or update the information from the initial registration. PHAs use the information collected to manage communication and prioritization of their onboarding processes. Created 03/04/2015
11978	For the Stage 2 objectives of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs that require submission of electronic data to Public Health Agencies (PHA), can a provider meet the objective even though they may not have successfully submitted data to the PHA for their entire EHR reporting period? Created 03/04/2015	Eligible professionals (EP) and hospitals may satisfy these objectives if they meet one of the four criteria for ongoing submission: 1. Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period. 2. Registration with the PHA or other body to whom the information is being submitted or intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved. 3.Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission. 4. Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation. Providers that meet the last two of these criteria would not have achieved ongoing submission during their EHR reporting period. In addition, providers that meet the second criteria may not have ongoing submission for their entire EHR reporting period. In order to meet the objective, providers who have been invited by the PHA to begin the onboarding process must participate in that process. Providers who fail to participate in the onboarding process as demonstrated by failure to respond to the PHA written requests for action within 30 days on two separate occasions during their EHR reporting period would not meet the objective. Created 03/04/2015
11982	If an eligible professional (EP) or hospital meets an exclusion for a public health objective, does the EP or hospital need to have CEHRT that meets the certification criteria related to that public health objective?	If the EP or hospital qualifies for and attests to an exclusion for a public health measure, they would not need to have CEHRT that meets the certification criteria related to that public health objective. For example, if an EP does not give any immunizations during their EHR reporting period, they would not need to have CEHRT that meets the certification criteria related to the immunization reporting objective in order to attest to the exclusion. However, if the EP or hospital qualifies for an exclusion, but elects to try to meet objective, they would need to have and use CEHRT that meets the certification criteria for the objective. Created on 3/5/2015
11984	If an eligible professional (EP) in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs is part of a group practice that has achieved ongoing submission to a public health agency (PHA), but the EP himself/herself did not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry during their EHR reporting period, can he/she attest to meeting the measure since they are part of the group practice that is submitting data to the registry?	If a provider does not administer immunizations, they should not attest to the measure; they must claim the exclusion. If a provider does administer immunizations, but did not have any for a particular EHR reporting period, they are not required to claim the exclusion as long as they have done any necessary registration and testing and are reporting when they do have the data to report. Created on 3/5/2015 Updated on 9/30/2015
2939	For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?	We define a permissible prescription as all drugs meeting the definition of prescription not listed as a controlled substance in Schedules II–V http://www.deadiversion.usdoj.gov/schedules/index.html". Although the Drug Enforcement Administration's (DEA) interim final rule on electronic prescriptions for controlled substances (75 FR 16236) removed the Federal prohibition to electronic prescribing of controlled substances, some challenges remain including more restrictive state law and widespread availability of products both for providers and pharmacies that include the functionalities required by the DEA's regulations. We continue to exclude over the counter (OTC) medicines from the definition of a prescription (77 FR 53989). We continue to allow providers the option to include or exclude controlled substances in the denominator where such medications can be electronically prescribed. These prescriptions may be included in the definition of ''permissible prescriptions'' at the providers discretion where allowable by law (80 FR 62801). The denominator for this objective is "Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed" for EPs" and "''Number of permissible new, changed, or refill prescriptions written for drugs requiring a prescription in order to be dispensed for patients discharged during the EHR reporting period'' for eligible hospitals and CAHs. The revised definition of permissible prescriptions allows providers the option of including or excluding prescriptions for controlled substances where the electronic prescription of controlled substances is permissible under state and federal law. Prescriptions from internal pharmacies and drugs dispensed on site may be excluded from the denominator. The numerator for this objective is a query of a drug formulary for EPs, eligible hospitals and CAHs. The provider may still count a patient in the numerator where no formulary exists to conduct a query and limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required.The provider would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10284 Updated 5/12/2016

3057	To meet the meaningful use objective "use computerized provider order entry (CPOE)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should eligible professionals (EPs) include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure?	If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include those patients seen in locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the "use computerized provider order entry (CPOE)" objective. For more information about the Medicare and Medicaid EHR Incentive Program, please visit "https://questions.cms.gov/localadmin/%20http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10462
8904	Can a public health agency use a Health Information Exchange (HIE) to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)?	There are a variety of methods for the exchange of public health information, and CMS does not limit or define the receiving capabilities of public health entities. Among other requirements as specified in the regulations, a provider must submit data for the public health objectives of meaningful use as follows• The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT); and• The information sent from the provider's Certified EHR Technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.If a provider intends to use an intermediary as an extension of their CEHRT to satisfy a meaningful use requirement and not simply to transport the data, the intermediary would need to be certified as an EHR Module for that purpose; When obtaining a CMS certification number from the Certified HIT Products List (CHPL), a provider would need to include the intermediary's certification number during their attestation.Created on 7/24/2013
9058	When meeting the meaningful use measure for computerized provider order entry (CPOE) in the Electronic Health Records (EHR) Incentive Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of Certified EHR Technology (CEHRT) for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants?	If a staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT and have it count towards the measure This determination must be made by the eligible provider based on individual workflow and the duties performed by the staff member in question. Whether a staff member carries the title of medical assistant or another job title, he or she must be credentialed to perform the medical assistant services by an organization other than the employing organization. Also, each provider must evaluate his or her own ordering workflow, including the use of CPOE, to ensure compliance with all applicable federal, state, and local law and professional guidelines. Created: 08/20/2013
10660	For Measure 1 of the Stage 3 Health Information Exchange objective for the Electronic Health Records (EHR) Incentive Programs, may an eligible professional (EP), eligible hospital or critical access hospital (CAH) count a transition of care or referral in its numerator for the measure if they electronically create and send a summary of care document using their CEHRT to a third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document?	If a staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT and have it count towards the measure This determination must be made by the eligible provider based on individual workflow and the duties performed by the staff member in question. Whether a staff member carries the title of medical assistant or another job title, he or she must be credentialed to perform the medical assistant services by an organization other than the employing organization. Also, each provider must evaluate his or her own ordering workflow, including the use of CPOE, to ensure compliance with all applicable federal, state, and local law and professional guidelines. Created: 08/20/2013
10754	How can a provider meet the "Protect Electronic Health Information" core objective in the Electronic Health Records (EHR) Incentive Programs?	To meet the "Protect Electronic Health Information" core objective for Stage 1, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process. In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT). These steps may be completed outside or the EHR reporting period timeframe but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period. This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional "reasonable and appropriate" steps to reduce identified risks to reasonable and appropriate levels. Please note that a security risk analysis or review needs to be conducted during each EHR reporting year for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients' protected health information. For more information about completing a security risk analysis, please see the following resources: Security Risk Assessment Tip Sheet: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf">https://www.cms.gov/Regulations-and- Health Information Privacy and Security: A 10 Step Plan: a http://www.healthit.gov/providers-professionals/ehr-privacy-security/Created 10/6/2014 Updated 11/5/2014 Archived 12/15/15
13649	For Objective 1: Protect Patient Health Information (ePHI), can the security risk analysis or review take place outside the EHR reporting period?	Yes, it is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be conducted for the certified EHR technology used during the EHR reporting period and the analysis or review must be conducted on an annual basis. In other words, the provider must conduct a unique analysis or review applicable for the EHR reporting period and the scope of the analysis or review must include the full EHR reporting period. The analysis or review for the EHR reporting period must be conducted prior to the date of attestation. Created 12/11/2015
3605	Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	For information and/or instructions on where to submit your public health-related data, please contact your local or state public health agencies and immunization registries. For more information on specialized registry, see FAQ #13657 and #14117 For more information about the Medicare and Medicaid EHR Incentive Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10841 Updated 5/12/2016
3257	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP) who orders medications infrequently calculate the measure for the "computerized provider order entry (CPOE)" objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?	Stage 1 providers may have this issue if they choose the alternate specification. yes;"However, these providers may simply use the total number of orders for the denominator. If they prescribe fewer than 100 medications, they may qualify for the exclusion. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10639 Updated 5/12/2016
2763	Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	The inclusion of controlled substances in the permissible prescriptions for the purposes of the eRx meaningful use objective is an option for providers, but not be required. As discussed in the Stage 3 Final Rule, many states have varying policies regarding controlled substances and may address different schedules, dosages, or types of prescriptions differently. Given these developments with states easing some of the prior restrictions on electronically prescribing controlled substances, we believe it is no longer necessary to categorically exclude controlled substances from the term "permissible prescriptions" (80 FR 62801). yes;"Therefore, for the purposes of this objective, that prescriptions for controlled substances may be included in the definition of permissible prescriptions where the electronic prescription of a specific medication or schedule of medications is permissible under state and federal law." For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10067 Updated 5/12/2016
2783	Can the drug-drug and drug-allergy interaction alerts of my electronic health record (EHR) also be used to meet the meaningful use objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs?	No. The drug-drug and drug-allergy checks and the implementation of clinical decision support interventions are separate measures. EPs and eligible hospitals must implement five clinical decision support interventions in addition to CDS drug-drug and drug-allergy interaction.For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10077 Updated 5/12/2016
2857	In order to satisfy the Meaningful Use objective for electronic prescribing (eRx) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy and include this transaction in the numerator for the measure of this objective?	The threshold for e-prescribing for an EHR reporting period in 2015 through 2017 is more than 50 percent for EPs and more than 10 percent) for eligible hospitals and CAHs. If the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to either a pharmacy or an intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Updated 6/29/16
3369	If my certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology, is that sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs?	Submitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Public Health Reporting objective measure 1, Immunization Registry reporting. However, if a provider within the group does not administer immunizations, they should not attest to meeting the measure; they must instead claim the exclusion. If a provider within the group does administer immunizations, but did not;have any for a particular EHR reporting period, they are not required to claim the exclusion as long as they have done any necessary registration and testing and are reporting when they do have the data to report. (See FAQ #11984) For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Updated 1/7/2016

7693	Does the inclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using CPOE and have them count in the numerator?	Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can enter the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.
7705	Both the Stage 1 and Stage 2 objective and measure for protecting electronic health information created or maintained by Certified EHR Technology privacy and security contain the phrase “implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.” Does this mean that all security deficiencies must be fully corrected prior to attestation?	Providers are not required to attest that a specific security update has been implemented or a specific security deficiency has been corrected by the attestation date as the timing of security updates and deficiency corrections is driven by the provider’s risk management process. The scope of that security risk analysis must include data created or maintained by the provider’s CEHRT. As long as the provider meets the requirements under 45 CFR 164.308(a)(1), including the requirement to “Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with [45 CFR]§164.306(a),” then the provider’s risk management process drives the timeline for the implementation of security updates and correction of security deficiencies, not the date a provider chooses to submit the meaningful use attestation. Providers are not attesting to having made a specific security update has been implemented or a specific security deficiency by the attestation date as the timing of security updates and deficiency corrections is driven by the provider’s risk management process. This objective and measure do not impose security requirements beyond those within the HIPAA Security Rule. yes;"
12825	In calculating the meaningful use objectives requiring patient action, if a patient sends a message or accesses his/her health information made available by their eligible professional (EP), can the other EPs in the practice get credit for the patient’s action in meeting the objectives?	Yes.This transitive effect applies to the Secure Electronic Messaging objective, the 2nd measure of the Patient Electronic Access (View, Download and Transmit) objective, and the Patient Specific Education objective. If a patient sends a secure message about a clinical or health related subject to the group practice of their EP, that patient can be counted in the numerator of the Secure Electronic ;Messaging measure for any of the EPs at the group practice who use the same certified electronic health records technology (CEHRT) that saw and patient during their EHR reporting period. Similarly, if a patient views, downloads or transmits to a third party the health information that was made available online by their EP, that patient can be counted in the numerator of the 2nd Patient Electronic Access measure for any of the EPs in that group practice who use the same CEHRT and saw that patient during their EHR reporting period. If patient-specific education resources are provided electronically, it may be counted in the numerator for any provider within the group sharing the CEHRT who has contributed information to the patient’s record if that provider has the patient in their denominator for the EHR reporting period. For more information on accurately calculating the numerator for measures, please visit FAQ 8231: https://questions.cms.gov/faq.php?faqId=8231 Created 10/2/2015 Updated 11/9/2015
9204	If an eligible hospital (EH) or critical access hospital (CAH) does not have any reportable lab results during the EHR reporting period (for example, the EH or CAH outsources all lab testing to a commercial lab or does not perform any lab tests for conditions that are reportable in their jurisdiction) can they be excluded from the requirement in the Electronic Health Records (EHR) Incentive programs to submit reportable lab results to a public health agency? yes;	The EH or CAH should indicate the following exclusion when attesting yes; Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period (80 FR 62824). Updated 5/12/2016
9824	Can a hospital count a patient toward the measures of the “Patient Electronic Access” objective in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs if the patient accessed his/her information before they were discharged?	The second measure of Objective 8: Patient Electronic Access for eligible hospitals and CAHs states, "For EHR reporting period in 2016, at least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period."In 2017, the threshold increases to more than 5% of unique patients.The denominator for measure 2 includes the number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of the eligible hospital or CAH during the EHR reporting period (80 FR 62816). Patients may choose to access their information prior to leaving the hospital, where guidance and support in using the online patient portal is still available to them. To this end, the hospital may include patients found in the denominator who access their information on or before the hospital discharge date in the numerator. Patients may also access their information after the hospital discharge date, but must take place no later than the date of attestation in order to be counted in the numerator. The calculation may include actions taken before, during, or after the EHR reporting period if the period is less than one full year; however, consistent with FAQ 8231, these actions must be taken no earlier than the start of the same year as the EHR reporting period and no later than the date of attestation (80 FR 62814). For more information about actions taken outside of the EHR reporting period and numerator calculations, please see FAQ 8231. https://questions.cms.gov/faq.php?faqId=8231"Updated 5/12/2016
14117	What steps do eligible hospitals and Critical Access Hospitals need to take to meet the specialized registry objective? Is it different from EPs?	For an eligible hospital or Critical Access Hospitals (CAHs), the process is the same as for an EP. The eligible hospital or CAH should check their State* and any such organization or specialty society with which they are affiliated to determine if that entity maintains a specialized registry and for which they have made a public declaration of readiness to receive data for meaningful use no later than the first day of the provider’s EHR reporting period. However, we note that eligible hospitals or CAHs do not need to explore every specialty society with which their hospital-based specialists may be affiliated. The hospital may simply check with their State* and any such organization with which it is affiliated, and if no registries exist, they may simply exclude from the measure. For further information please see FAQ "FAQ #13657" href="http://questions.cms.gov/faq.php?faqId=13657 For eligible hospitals and CAHs: The provider may meet the specialized registry measure up to 3 times. This can be done through reporting to: Three registries maintained by a public health agency Three registries maintained by one or more specialized societies One or two registries maintained by a public health agency and two or one maintained by a specialty society Two registries maintained by a public health agency and one exclusion Two registries maintained by a specialty society and one exclusion One registry maintained by a public health agency and one registry maintained by a specialty society and one exclusions* One registry maintained by a public health agency and two exclusions* One registry maintained by a specialty society and two exclusions* *In these cases, the exclusion which overlaps a category of registries would be based on there being no additional option for reporting beyond those already selected by the eligible hospital or CAH. In 2015, providers may also simply claim an alternate exclusion for a measure as defined in FAQ https://questions.cms.gov/faq.php?faqId=12985 *If you report to an entity other than a State as your reporting jurisdiction (such as a county) you may elect to check with them.
14393	Can a provider register their intent after the first 60 days of the reporting period in order to meet the measures if a registry becomes available after that date?	If a registry declares readiness at any point in the calendar year after the initial 60 days, a provider may still register their intent to report with that registry to meet the measure under Active Engagement Option 1. However, a provider who could report to that registry may still exclude for that calendar year if they had already planned to exclude based on the registry not being ready to allow for registrations of intent within the first 60 days of the reporting period.Created 02/25/2016
1959	Will the National Provider Identifier (NPI) be used as the standard identifier for E-Prescribing transactions?	The NPI will eventually be the standard identifier for e-prescribing under Part D. It already is a standard identifier that will have to be used in standard transactions after the NPI compliance date, as required under HIPAA. This means that covered entities (including Medicare, Medicaid, private insurers, clearinghouses, and other covered entities) must accept and use NPIs for covered HIPAA transactions by May 23, 2007, and May 23, 2008 for small health plans. On April 7th 2007 CMS published a second final rule that adopted additional standards for e-prescribing under Part D. In that final rule CMS adopted the individual level NPI for all e-prescribing transactions under Part D.
12821	If multiple eligible professionals or eligible hospitals contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use when the patient accesses the information on the portal or PHR?	This answer is relevant to the following meaningful use objectives: Patient Specific Education and Patient Electronic Access measure 2.If an eligible professional sees a patient during the EHR reporting period, the eligible professional may count the patient in the numerator for this measure if the patient (or an authorized representative) views online, downloads, or transmits to a third party any of the health information from the shared portal or online PHR. The same would apply for an eligible hospital or CAH if a patient is discharged during the EHR reporting period. If patient-specific education resources are provided electronically, it may be counted in the numerator for any provider within the group sharing the CEHRT who has contributed information to the patient's record if that provider has the patient in their denominator for the EHR reporting period. The respective eligible professional, eligible hospital, or CAH must have contributed at least some of the information identified in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program ;Stage;3 and Modifications to Meaningful Use in 2015 Through 2017 final rule (80 FR 62807 through 62809);to the shared portal or online PHR for the patient.& However, the respective provider need not have contributed the particular information that was viewed, downloaded, or transmitted by the patient. Although availability varies by state and geographic location, some Health Information Exchanges (HIEs) provide shared portal or PHR services. If a provider uses an HIE for these services to make information available to patients, in order to meet meaningful use requirements the provider must use an HIE that is certified as an EHR Module for that purpose. The HIE must be able to verify whether a particular provider actually contributed some of the information identified in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program -;Stage;3 and Modifications to Meaningful Use in 2015 Through 2017;final rule to the shared portal or PHR for a particular patient. If a provider elects to use the HIE for these shared portal or PHR services, the provider must include the HIE’s certification number as part of their attestation.Created 10/2/2015 Updated 11/9/2015
22349	Are Computerized Provider Order Entry (CPOE) and Clinical Decision Support (CDS) required objectives under the Medicare and Medicaid EHR Incentive Programs?	In the 2017 OPPS rule, we finalized the elimination of the CPOE and CDS objectives and associated measures for eligible hospitals and Critical Access Hospitals (CAHs). The elimination of the CPOE and CDS objectives and associated measures also applies to dual-eligible hospitals that are attesting to CMS for both the Medicare and Medicaid EHR Incentive Programs. However, the CPOE and CDS objectives and measures are still required for the Medicaid EHR Incentive Program to successfully attest to meaningful use. Please also note we did not include CPOE and CDS objectives and associated measures as part of the advancing care information performance category, thus, they are not required for reporting by MIPS eligible clinicians.