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FAQ Answers

Are growth charts required for view, download and transmit for EPs?

Growth charting is an optional capability for certification to support the vital signs measure and was not included as a capability required for certification to the view, download and transmit to a 3rd party certification criterion. We encourage all EPs who have EHR technology with this capability to generate growth charts to make them available for patients (or their authorized representative) to view online. However, because this capability is not required for certification, we do not require EPs who have the capability to generate growth charts to also make them available for online viewing (or downloading or transmitting) to meet this measure.
Date Updated: 11/28/2012   Date Archived: 1/11/16
Old ID #7707

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients?

For the hospital meaningful use objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to an inpatient department (POS 21) and all patients admitted to an emergency department (POS 23). If the eligible hospital elects to use the alternate method for calculating emergency department patients, as detailed in FAQ #10126 (https://questions.cms.gov/faq.php?id=5005&faqId=2843), the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures.

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Under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, who is responsible for demonstrating meaningful use of certified EHR technology, the provider or the vendor?

To receive an EHR incentive payment, the provider (eligible professional (EP), eligible hospital or critical access hospital (CAH)) is responsible for demonstrating meaningful use of certified EHR technology under both the Medicare and Medicaid EHR incentive programs.

What is meaningful use, and how does it apply to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs), critical access hospitals, and eligible hospitals that successfully demonstrate are meaningful use of certified EHR technology.

The Recovery Act specifies three main components of meaningful use:

The use of a certified EHR in a meaningful manner (e.g.: e-Prescribing); The use of certified EHR technology for electronic exchange of health information to improve quality of health care; The use of certified EHR technology to submit clinical quality and other measures.

In the final rule Medicare and Medicaid EHR Incentive Program, CMS has defined stage one of meaningful use.

To view the final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10084

The meaningful use standards for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program require interoperability, is there guidance regarding who will pay for ensuring connectivity between physician practices and hospitals?

The Office of the National Coordinator for Health Information Technology (ONC) has awarded funds to 56 states, eligible territories, and qualified State Designated Entities (SDEs) under the Health Information Exchange Cooperative Agreement

Program to help fund efforts to rapidly build capacity for exchanging health information across the health care system both within and between states. These exchanges will play a critical role in facilitating the exchange capacity of doctors and hospitals to help them meet interoperability requirements which will be part of meaningful use. More information on ONC's Health Information Exchange grantees is available at: http://healthit.hhs.gov/.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10085
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Old ID #2795

If a provider purchases a Complete Electronic Health Record (EHR) but opts to use alternate certified EHR modules for certain Meaningful Use functionality, will that provider qualify as a Meaningful User under the Medicare and Medicaid EHR Incentive Programs?

To successfully demonstrate meaningful use a provider must do three things:

1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;

2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and

3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

If a provider can meet all of these requirements, that provider may qualify for an incentive payment under the Medicare and Medicaid EHR Incentive Programs.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10135
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Old ID #2853

One of the menu set Meaningful Use objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs requires eligible professionals (EPs), eligible hospitals and Critical Access Hospitals (CAHs) to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test

in order to count a structured lab result in the numerator for the measure of this objective?

The only requirement to meet the measure of this objective is that more than 40 percent of all clinical lab tests results ordered during the EHR reporting are incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective in the Medicare and Medicaid EHR Incentive Programs.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10136
Date Updated: 3/27/2012   Archived Date: 1/11/2016
Old ID# 2855

For eligible hospitals and critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Record (EHR) 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 EHR Incentive 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.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit: http://www.cms.gov/EHRIncentivePrograms.

Keywords: FAQ10146
Date Updated: 3/27/2012   Archived Date: 1/11/16
Old ID #2873

When providing the clinical summary as part of an office visit to meet the measure "Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits" (§ 495.6(j)(11)(ii)), can a provider determine whether to include information that was not changed or addressed during the visit?

Yes. Most of the elements listed in the regulation have text associated with them that are meant to provide additional context such as "for or of the office visit," "current," "pending," "during the visit," "if applicable to the visit," "recent" and

"future." Some elements listed do not have these qualifiers because we believed the context was implicit.

Those elements are: clinical instructions, laboratory test results, referrals to other providers, demographic information, smoking status and care plan field(s), including goals and instructions. All of these elements only have to be included if changed due to the visit in question.

For example, the laboratory test results included in a clinical summary only need to be those ordered or reviewed during the visit and do not need to be laboratory test results from prior visits or other providers. Similarly, referrals are referrals made as a result of the visit and care plans are those pertaining to the visit. Smoking status and demographics are those updated at the visit.

A provider is free to include any information that was not updated at the visit just as they are free to include any information not listed in the regulation. In order for an EHR to be certified, it must include the ability for the provider to customize the data included in the clinical summary.

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Old ID #8237

When creating a clinical summary as part of an office visit to meet the measure "Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits" (§ 495.6(j)(11)(ii)), do all of the information elements specified by CMS for a clinical summary need to be individually listed?

No. The Stage 2 final rule did not include any requirements on the design of the clinical summary. For example, the information about future appointments, provider referrals, scheduled tests, and clinical instructions could be included in a section of the summary called "Next steps." If all of these information elements were empty, then "next steps" could just be "none" and all the information elements that feed this section would be covered.

If the summary is provided on letterhead that includes the office location and the provider name, that information does not have to be repeated in the text of the summary.

This design flexibility extends to all information elements of the clinical summary. Rather than listing procedures, tests, and immunizations separately, these could be collapsed under one heading and if no information feeds into that heading then "none" in that heading would cover all of those information elements. If some information does appear under that heading there does not need to be an accompanying indication that the other information elements are not applicable to that visit.

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If an Eligible Professional (EP) or hospital attesting to meaningful use (MU) in the Electronic Health Records (EHR) Incentive Program submits a successful test to the immunization registry in year 1 of Stage 1 and engages with the immunization registry in year 2, but does not achieve ongoing submission of data to the immunization registry during their reporting period in year 1 or year 2, should they attest to the measure or the exclusion?

The Stage 1 MU measure requires the EP or hospital to perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries, and follow-up submission if that test is successful. An EP or hospital that can demonstrate engagement with the immunization registry during year 2 would attest to meeting the measure even if that engagement was not in the form of another test. This engagement could be communication with the immunization registry showing that another test is not beneficial, work towards follow-up submission or an update showing that additional action by the provider towards follow-up submission is not beneficial for year 2. It is not acceptable to use the test from year 1 to meet the measure for year 2. The provider needs to show evidence of action taken during year 2 that demonstrates both that another test is not beneficial in moving towards follow-up submission and that follow-up submission is not possible in year 2. This principle applies to all of the public health objectives.

For the meaningful use Stage 2's transitions of care and referrals objective, in what ways can the second measure be met that requires more than 10% of the summary care records provided for transitions of care and referrals to be electronically transmitted in the Electronic Health Records (EHR) Incentive programs?

An EP, eligible hospital, or critical access hospital (CAH) could use three approaches) to meet this measure.
For the first two approaches, this measure can only be met if the EP, eligible hospital, or CAH uses the capabilities and standards included as part of its Certified EHR Technology (CEHRT) to electronically transmit summary care records for transitions of care and referrals (specifically those capabilities certified to the certification criterion adopted by the Office of the National Coordinator (ONC) at 45 CFR 170.314(b)(2) "transitions of care – create and transmit transition of care/referral summaries," which specifies standards for data content and transport).

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For the third approach, the EP, eligible hospital, or CAH must use its CEHRT to create a summary care record for transitions of care and referrals. However, instead of using a transport standard specified in ONC's certification criterion at 45 CFR 170.314(b)(2) (included as part of its CEHRT) to electronically transmit the summary care record, the EP, eligible hospital, or CAH may use a Nationwide Health Information Network (NwHIN) Exchange participant to facilitate the electronic transmission to the recipient. The NwHIN Exchange is now known as "eHealth Exchange" and a list of participants can be found at http://www.healthewayinc.org/index.php/exchange/participants.

The following are more detailed explanations of each permitted approach. We also emphasize that regardless of the way an EP, eligible hospital, or CAH chooses to transmit the summary of care record, such a transmission will only count in the numerator if it is received by the provider to whom the sending provider is referring or transferring the patient.

1. Use of the transport standard capability required for certification – the primary Direct Project specification (the Applicability Statement for Secure Health Transport) hereafter referred to as simply "Direct". This specification is required by ONC to meet the CEHRT definition and every EP, eligible hospital, and CAH, must have EHR technology that is capable of electronically transmitting a summary care record for transitions of care and referrals according to it. To count electronically transmitted summary care records in their numerator, EPs, eligible hospitals, or CAHs:
• Must use their CEHRT's "Direct" capability (whether provided as an integrated part of their EHR technology or combined with another service provider). If an EHR technology developer uses another service provider (for example, an Health Information Exchange organization (HIE) or Health Information Service Provider (HISP)) to achieve certification for Direct, an EP, eligible hospital, CAH can only count in their numerator electronically transmitted summary care records using that certified configuration. In other words, if an EP, eligible hospital, or CAH, sought to use a different service provider that was not certified with their EHR for Direct, that service provider would not be part of their CEHRT and, thus, any Direct transmissions using that service provider would not count toward the numerator.
• May use, if their CEHRT includes it, the "Direct + XDR/XDM for Direct Messaging" transport capability which enables EHR technology to include additional metadata and communicate with SOAP-based systems.

2. Use of the SOAP-based optional transport standard capability permitted for certification. As part of certification, ONC permits EHR technology developers to voluntarily seek certification for their EHR technology's capability to perform SOAP-based electronic transmissions. EHR technology developers who take this approach would enable their customers to also use this approach to meet the measure. To count electronically transmitted summary care records in their numerator, EPs, eligible hospitals, or CAHs:

• May use their CEHRT's "SOAP-based" capability (again if their EHR technology has been certified for it). The SOAP-based standard ONC adopted for certification is a baseline on top of which an EHR technology developer may add more advanced exchange capabilities (i.e., query). An EP, eligible hospital or CAH using an EHR technology certified to that SOAP baseline may count electronic transmissions in the numerator that utilize more advanced exchange capabilities even if those capabilities were not included when the EHR technology was certified.

3. Use of CEHRT to create a summary care record in accordance with the required standard (i.e., Consolidated CDA as specified in 45 CFR 170.314(b)(2)), and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator. EPs, eligible hospitals, and CAHs, do NOT themselves need to become an eHealth Exchange participant in order to use this option. Rather, it is sufficient and acceptable to use the exchange services of a third party organization, like a health information exchange entity, that is an eHealth Exchange participant.

For this third approach, the regulation also permits an EP, eligible hospital, or CAH to count in their numerator instances where a summary care record for transitions of care or referrals was received via electronic exchange facilitated in a manner consistent with the governance mechanism ONC establishes for the nationwide health information network. ONC has not yet established a governance mechanism for the nationwide health information network. Until ONC establishes such a governance mechanism, this specific option will not be available.

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Old ID #9064

What is the deadline for eligible professionals (EP) to submit attestations to meaningful use for 2013 in the Electronic Health Records (EHR) Incentive Programs?

For EPs participate in the EHR Incentive Programs on the calendar year, which is January 1 to December 31. The attestation deadline is two months following the end of the 2013 reporting period.In order to receive an EHR incentive payment for an EHR reporting period in 2013, Medicare EPs) need to submit their attestation by 11:59 p.m. EST on February 28, 2014. Medicare EPs will not receive an incentive payment if they submit their attestation after the deadline.
EPs participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation.

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EPs must attest to demonstrating meaningful use every year to receive an incentive and avoid a payment adjustment.

Created on 11/20/2013
Date Updated: 11/22/2013   **Archived Date: 1/11/16**
Old ID #9268

What is the deadline for eligible hospitals and critical access hospitals (CAH) to submit attestations to meaningful use for 2013 in the Electronic Health Records (EHR) Incentive Programs?

Eligible hospitals participate in the EHR Incentive Programs on the fiscal year, which is October 1 to September 30. The attestation deadline is two months following the end of the 2013 reporting period. In order to receive an EHR incentive payment for and EHR reporting period in 2013, Medicare eligible hospitals and CAHs need to submit their attestation by 11:59 p.m. EST on November 30, 2013. Medicare eligible hospitals and CAHs will not receive an incentive payment if they submit their attestation after the deadline.
Hospitals participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation.
Hospitals must attest to demonstrating meaningful use every year to receive an incentive and avoid a payment adjustment.

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Date Updated: 11/22/2013   **Archived Date: 1/11/16**
Old ID #9270

When demonstrating Stage 2 meaningful use in the Electronic Health Records (EHR) Incentive programs, would an eligible professional (EP) be required to report on the "Electronic Notes" objective even if he or she did not see patients during their reporting period?

The intent of the Stage 2 Electronic Notes menu objective is to encourage documentation that assists in communicating individual patient circumstances and coordination with previous documentation of patient observations, treatments and/or results in the electronic health record.

The measure requires that electronic progress notes be created for 30 percent of an EP's unique patients who have at least one office visit during the EHR reporting period.

An EP can claim an exclusion from reporting this objective if he or she demonstrates that they had no office visits during the EHR reporting period for which they are attesting.
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Old ID #9826

How can a provider meet the "Protect Electronic Health Information" core objective in the Electronic Health Records (EHR) Incentive Programs?

Health 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

Last Updated: March 2016

Health Information Privacy and Security: A 10 Step Plan:
http://www.healthit.gov/providers-professionals/ehr-privacy-security/10-step-plan

When reporting on the Summary of Care objective in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program, how can eligible professionals and eligible hospitals meet measure 3 if they are unable to complete a test with the CMS designated test EHR (Randomizer)?

CMS is aware of difficulties related to systems issues that eligible professionals, eligible hospitals, and critical access hospitals (CAHs) are having in use of the CMS Designated Test EHRs (NIST EHR-Randomizer Application) to meet measure 3 of the Stage 2 Summary of Care objective, therefore, we will be discontinuing this option effective July 1, 2015.

Providers may still meet the Stage 2 Summary of Care objective measure #3 using the following actions:

1. Exchange a summary of care with a provider or third party who has different CEHRT (and different vendor) as the sending provider as part of the 10% threshold for measure #2, allowing the provider to meet the criteria for measure #3 without the CMS Designated Test EHR. To clarify, some providers are able to conduct cross vendor exchanges in the normal course of meeting measure #2, therefore if cross vendor exchanges occurred for measure #2, measure 3 would already be met, or

2. If providers do not exchange summary of care documents with recipients using a different CEHRT in common practice, they may retain documentation on their circumstances and attest "Yes" to meeting measure #3 if they have and are using a certified EHR which meets the standards required to send a CCDA (§ 170.202).

This exchange may be conducted outside of the EHR reporting period timeframe, but must take place no earlier than the start of the year and no later than the end of the EHR reporting year or the attestation date, whichever occurs first.

For example, an eligible professional or eligible hospital that is reporting meaningful use for a 90-day EHR reporting period may conduct this exchange outside of this 90-day period as long as it is completed no earlier than the first day of the EHR reporting year and no later than the last day of the EHR reporting year.https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do to create one.

What is the reporting period for eligible professionals (EPs) participating in the electronic health record (EHR) incentive programs?

For demonstrating meaningful use through both the Medicare and Medicaid EHR Incentive Programs, the EHR reporting period for an EP's first year is any continuous 90-day period within the calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology, which does not have a reporting period.

Date Updated: **Archived Date: 3/9/2016**
Old ID #

What is the reporting period for eligible hospitals participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

For an eligible hospital or critical access hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal fiscal year. In subsequent years (except 2014), the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year.

Date Updated: **Archived Date: 3/9/2016**
Old ID #

Can an eligible professional (EP) implement an electronic health record (EHR) system and satisfy meaningful use requirements at any time within the calendar year for the Medicare and Medicaid EHR Incentive Program?

For a Medicare EP's first payment year, the EHR reporting period is a continuous 90-day period within a calendar year, so an EP must satisfy the meaningful use requirements for 90 consecutive days within their first year of participating in the program to qualify for an EHR incentive payment. In subsequent years, the EHR reporting period for EPs will be the entire calendar year. With regard to the Medicaid EHR Incentive program, EPs must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first calendar year. If the Medicaid EP adopts, implements or upgrades in the first year of payment, and demonstrates meaningful use in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the calendar year; subsequent to that, the EHR reporting period is then the entire calendar year.

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Old ID #

Can an eligible hospital implement an electronic health record (EHR) system and satisfy meaningful use requirements at any time within the Federal fiscal year for the Medicare and Medicaid EHR Incentive Program?

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For an eligible hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal Fiscal Year, so an eligible hospital must satisfy the meaningful use requirements for 90 consecutive days within their first Federal Fiscal Year of participating in the program to qualify for an EHR incentive payment. In subsequent years, the EHR reporting period for eligible hospitals will be the entire Federal Fiscal Year. With regard to the Medicaid EHR Incentive program, eligible hospitals must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first Federal Fiscal Year. If the Medicaid eligible hospital adopts, implements or upgrades in the first year of payment, and demonstrates meaningful use in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the Federal fiscal year; subsequent to that, the EHR reporting period is then the entire Federal fiscal year.

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