

# The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs: **STAGE 2 TOOLKIT**



**Last Updated: FEBRUARY 2013**

# About this Toolkit

This Stage 2 Toolkit is an interactive document that provides users with resources and information about Stage 2 of the EHR Incentive Programs and 2014 Clinical Quality Measure requirements. The toolkit includes materials for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs).

## Table of Contents

The table of contents is interactive and includes bookmarks. Users can click on a resource to be directed to that section of the PDF. By clicking on the title of the resource, users can return to the table of contents.



# EHR Incentive Programs Stage 2 Toolkit

## The Basics

- [Stage 2 Overview Tipsheet](#) – provides an overview of the major provisions included in the Stage 2 rule
- [Stage 1 Changes Tipsheet](#) – focuses on the changes that were made to Stage 1 of meaningful use in the Stage 2 rule
- [2014 Clinical Quality Measures Tipsheet](#) – provides information on the next phase of Clinical Quality Measures (CQMs) and how to report them to meet meaningful use in 2014 and beyond
- [Stage 2 FAQs](#) – provides answers to questions about the Stage 2 rule and how it affects hospitals and EPs
- [2014 eCQM Resources](#) – lists all of the 2014 CQM webpages and resources

## Resources for Eligible Professionals (EPs)

### Stage 2 Details

- [Stage 2 Meaningful Use Specification Sheet Table of Contents for Eligible Professionals](#) – lists all the core and menu objectives for EPs, with direct links to each individual measure specification sheet (requires internet access to view spec sheets)
- [Stage 1 vs. Stage 2 Comparison Table for Eligible Professionals](#) – compares core and menu measures from Stage 1 with measures for Stage 2 of meaningful use for EPs
- [Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals](#) – provides an overview of the payment adjustment and hardship exceptions included in the Stage 2 rule for EPs



## 2014 CQMs

- [2014 CQMs for Eligible Professionals \[PDF, 348KB\]](#) – contains the description and definition statements for the 64 CQMs for use by EPs in the EHR Incentive Programs beginning in 2014
- [Technical release notes for 2014 eCQMs for Eligible Professionals \[PDF, 131KB\]](#) – contains information about changes made to 2011 CQMs for the measures that were kept as part of the 2014 CQMs for EPs
- [Full Table of Recommended Adult Measures](#) – lists the 9 CQMs in the recommended core set for the adult population
- [Full Table of Recommended Pediatric Measures](#) – lists the 9 CQMs in the recommended core set for the pediatric population

## Resources for Eligible Hospitals & Critical Access Hospitals (CAHs)

### Stage 2 Details

- [Stage 2 Meaningful Use Specification Sheet Table of Contents for Eligible Hospitals and CAHs](#) – lists all the core and menu objectives for eligible hospitals and CAHs, with direct links to each individual measure specification sheet (requires internet access to view spec sheets)
- [Stage 1 vs. Stage 2 Comparison Table for Eligible Hospitals and CAHs](#) – compares core and menu measures from Stage 1 with measures for Stage 2 of meaningful use for eligible hospitals and CAHs
- [Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Hospitals and CAHs](#) – provides an overview of the payment adjustment and hardship exceptions included in the Stage 2 rule for eligible hospitals and CAHs

## 2014 CQMs

- [2014 CQMs for Eligible Hospitals \[PDF, 377KB\]](#) – provides the description and definition statements for the 64 CQMs for use by eligible hospitals in the EHR Incentive Programs beginning in 2014
- [Technical Release Note 2014 eCQMs for Eligible Hospitals \[PDF, 362KB\]](#) – contains information about changes made to 2011 CQMs for the measures that were kept as part of the 2014 CQMs for eligible hospitals



# Stage 2 Overview Tipsheet

## THE BASICS



# Stage 2 Overview Tipsheet

Last Updated: August, 2012

## Overview

CMS recently published a final rule that specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

If you have not participated in the Medicare or Medicaid EHR Incentive Programs previously, or if you have never achieved meaningful use under the Stage 1 criteria, please visit the CMS EHR Incentive Programs website ([www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)) for more information about how to take part in the program.

## Stage 2 Timeline

In the Stage 1 meaningful use regulations, CMS had established a timeline that required providers to progress to Stage 2 criteria after two program years under the Stage 1 criteria. This original timeline would have required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013.

However, we have delayed the onset of Stage 2 criteria. The earliest that the Stage 2 criteria will be effective is in fiscal year 2014 for eligible hospitals and CAHs or calendar year 2014 for EPs. The table below illustrates the progression of meaningful use stages from when a Medicare provider begins participation in the program.

| 1 <sup>st</sup> Year | Stage of Meaningful Use |      |      |      |      |      |      |      |      |      |      |
|----------------------|-------------------------|------|------|------|------|------|------|------|------|------|------|
|                      | 2011                    | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
| 2011                 | 1                       | 1    | 1    | 2    | 2    | 3    | 3    | TBD  | TBD  | TBD  | TBD  |
| 2012                 |                         | 1    | 1    | 2    | 2    | 3    | 3    | TBD  | TBD  | TBD  | TBD  |
| 2013                 |                         |      | 1    | 1    | 2    | 2    | 3    | 3    | TBD  | TBD  | TBD  |
| 2014                 |                         |      |      | 1    | 1    | 2    | 2    | 3    | 3    | TBD  | TBD  |
| 2015                 |                         |      |      |      | 1    | 1    | 2    | 2    | 3    | 3    | TBD  |
| 2016                 |                         |      |      |      |      | 1    | 1    | 2    | 2    | 3    | 3    |
| 2017                 |                         |      |      |      |      |      | 1    | 1    | 2    | 2    | 3    |

Note that providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in



2014. All other providers would meet two years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year.

In the first year of participation, providers must demonstrate meaningful use for a 90-day EHR reporting period; in subsequent years, providers will demonstrate meaningful use for a full year EHR reporting period (an entire fiscal year for hospitals or an entire calendar year for EPs) except in 2014, which is described below. Providers who participate in the Medicaid EHR Incentive Programs are not required to demonstrate meaningful use in consecutive years as described by the table above, but their progression through the stages of meaningful use would follow the same overall structure of two years meeting the criteria of each stage, with the first year of meaningful use participation consisting of a 90-day EHR reporting period.

### **For 2014 only**

All providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period.

- For Medicare providers, this 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs, such as the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR).
- For Medicaid providers only eligible to receive Medicaid EHR incentives, the 3-month reporting period is not fixed, where providers do not have the same alignment needs.

CMS is permitting this one-time three-month reporting period in 2014 only so that all providers who must upgrade to 2014 Certified EHR Technology will have adequate time to implement their new Certified EHR systems.

## **Core and Menu Objectives**

Stage 1 established a core and menu structure for objectives that providers had to achieve in order to demonstrate meaningful use. Core objectives are objectives that all providers must meet. There are also a predetermined number of menu objectives that providers must select from a list and meet in order to demonstrate meaningful use.

For many of the core and menu objectives, exclusions were provided that would allow providers to achieve meaningful use without having to meet those objectives that were outside of their normal scope of clinical practice. Under the Stage 1 criteria, EPs had to meet 15 core objectives and 5 menu objectives that they selected from a total list of 10. Eligible hospitals and CAHs had to meet 14 core objectives and 5 menu objectives that they selected from a total list of 10.

Stage 2 retains this core and menu structure for meaningful use objectives. Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that providers must meet for the objective has been raised. We expect that providers who reach Stage 2 in the EHR Incentive Programs will be able to demonstrate meaningful use of their Certified EHR Technology for an even larger portion of their patient populations.



Some new objectives were also introduced for Stage 2, and most of these were introduced as menu objectives for Stage 2. As with the previous stage, many of the Stage 2 objectives have exclusions that allow providers to achieve meaningful use without having to meet objectives outside their normal scope of clinical practice.

To demonstrate meaningful use under Stage 2 criteria—

- **EPs must meet 17 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 20 core objectives.**
- **Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.**

The end of this tipsheet contains a complete list of the Stage 2 core and menu objectives for both EPs and eligible hospitals and CAHs. Providers can also download a table of the Stage 2 core and menu objectives and measures by clicking on the links below:

- [Stage 1 vs. Stage 2 Comparison Table for Eligible Professionals](#)
- [Stage 1 vs. Stage 2 Comparison Table for Eligible Hospitals and CAHs](#)

## New Objectives & New Measures

Though most of the new objectives introduced for Stage 2 are menu objectives, EPs and eligible hospitals each have a new core objective that they must achieve. CMS believes that both of these objectives will have a positive impact on patient care and safety and are therefore requiring all providers to meet the objectives in Stage 2.

### New Stage 2 Core Objectives:

Use secure electronic messaging to communicate with patients on relevant health information **(for EPs only)**

Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **(for Eligible Hospitals/CAHs only)**



Stage 2 also replaces the previous Stage 1 objectives to provide electronic copies of health information or discharge instructions and provide timely access to health information with objectives that allow patients to access their health information online.

**Stage 2 Patient Access Objectives:**

Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP **(for EPs only)**

Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital **(for Eligible Hospitals/CAHs only)**

In addition, the Stage 2 criteria place an emphasis on health information exchange between providers to improve care coordination for patients. One of the core objectives for both EPs and eligible hospitals and CAHs requires providers who transition or refer a patient to another setting of care or provider of care to provide a summary of care record for more than 50% of those transitions of care and referrals.

Additionally, there are new requirements for the electronic exchange of summary of care documents:

- For more than 10% of transitions and referrals, EPs, eligible hospitals, and CAHs that transition or refer their patient to another setting of care or provider of care must provide a summary of care record electronically.
- The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period.



There are also new Stage 2 menu objectives for EPs, eligible hospitals, and CAHs:

Record electronic notes in patient records

Imaging results accessible through CEHRT

Record patient family health history

Identify and report cancer cases to a State cancer registry **(for EPs only)**

Identify and report specific cases to a specialized registry (other than a cancer registry) **(for EPs only)**

Generate and transmit permissible discharge prescriptions electronically (eRx) **(new for eligible hospitals and CAHs only)**

Provide structured electronic lab results to ambulatory providers **(for eligible hospitals and CAHs only)**

Finally, there are new Stage 2 measures for several objectives that require patients to use health information technology in order for providers to achieve meaningful use. CMS believes that EPs, eligible hospitals, and CAHs are in the best position to encourage the use of health IT by patients to further their own health care.

Under the Stage 2 core objectives to provide patients the ability to view online, download and transmit their health information, more than 5 percent of patients seen by the EP or admitted to an inpatient (Place of Service 21) or emergency department (Place of Service 23) of an eligible hospital or CAH view, download, or transmit to a third party their health information.

Under the Stage 2 core objective to use secure electronic messaging to communicate with patients on relevant health information, a secure message must be sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients seen by an EP during the EHR reporting period.



# Stage 1 Changes Tipsheet

# THE BASICS



# Stage 1 Changes Tipsheet

Last Updated: August, 2012

## Overview

CMS recently announced some changes to the Stage 1 meaningful use objectives, measures, and exclusions for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). Some of these changes will take effect as early as October 1, 2012, for eligible hospitals and CAHs, or January 1, 2013, for EPs. Other Stage 1 changes will not take effect until the 2014 fiscal or calendar year and will be optional in 2013. The table at the end of this publication summarizes the changes to the Stage 1 meaningful use objectives.

## Exclusions for Menu Objectives

Beginning in 2014, EPs, eligible hospitals, and CAHs will no longer be permitted to count an exclusion toward the minimum of 5 menu objectives on which they must report if there are other menu objectives which they can select. In other words, a provider cannot select a menu objective and claim an exclusion for it if there are other menu objectives they can meet.

EPs, eligible hospitals, and CAHs will not be penalized for selecting a menu objective and claiming the exclusion if they would also qualify for the exclusions for all the remaining menu objectives. For example, EPs who must select to test the capability to submit data to either an immunization registry or a syndromic surveillance database as one of their menu objectives can select the menu objective for submitting data to an immunization registry and claim the exclusion if they would also be able to claim the exclusion for submitting data to a syndromic surveillance database. They would not be penalized for claiming this exclusion.

## Computerized Provider Order Entry (CPOE)

Beginning in 2013, CMS is adding an optional alternate measure to the objective for computerized provider order entry (CPOE). The current measure for CPOE is based on the number of unique patients with a medication in their medication list that was entered using CPOE. The new, alternate measure is based on the total number of medication orders created during the EHR reporting period. An EP, eligible hospital, or CAH may select either measure for this objective in Stage 1 in order to achieve meaningful use. (Note that this alternative measure will be required for all providers in Stage 2.)

**Alternate Measure:** More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

## Electronic Prescribing

Beginning in 2013, CMS is adding an additional exclusion to the objective for electronic prescribing for providers who are not within a 10 mile radius of a pharmacy that accepts electronic prescriptions.



**New Additional Exclusion:** Any EP who: does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

## Record and Chart Changes in Vital Signs

CMS is changing the measure of the objective for recording and charting changes in vital signs for EPs, eligible hospitals, and CAHs. The current measure specifies that vital signs must be recorded for more than 50 percent of all unique patients **ages 2 and over**. The new measure amends that age limit to recording blood pressure for patients **ages 3 and over** and height and weight for patients of **all ages**.

The exclusions for this objective for EPs are also changing. The current exclusions only allow an EP to claim the exclusion if all three vital signs (height, weight, blood pressure) are not relevant to their scope of practice or if the EP sees no patients 2 years or older. However, under the new Stage 1 changes, an EP can claim an exclusion if the EP sees no patients 3 years or older (the EP would not have to record blood pressure), if all three vital signs are not relevant to their scope of practice (the EP would not record any vital signs), if height and weight are not relevant to their scope of practice (the EP would still record blood pressure), or if blood pressure is not relevant to their scope of practice (the EP would still record height and weight).

This new measure and these new exclusions are optional in 2013 but will be required in 2014 and beyond.

**New Measure:** More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.

**New Exclusion:** Any EP who

1. Sees no patients 3 years or older is excluded from recording blood pressure;
2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;
3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or
4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.



## Electronic Exchange of Key Clinical Information

Beginning in 2013, the objective for electronic exchange of key clinical information will no longer be required for Stage 1 for EPs, eligible hospitals, and CAHs. Providers faced numerous challenges in understanding the requirements for this objective, so we are moving instead to a more robust requirement for electronic health information exchange as a part of the Stage 2 objective for providing a summary of care record following a transition of care or referral.

## Report Clinical Quality Measures

Beginning in 2013, there will no longer be a separate objective for reporting ambulatory or hospital clinical quality measures as a part of meaningful use. It is important to note, however, that EPs, eligible hospitals, and CAHs will still be required to report on clinical quality measures in order to achieve meaningful use. CMS is simply removing the standalone objective that requires providers to attest that they plan to report on clinical quality measures because it is redundant.

## Electronic Copy of and Electronic Access to Health Information

In order to better align Stage 1 objectives with the new 2014 capabilities of Certified EHR Technology, CMS is replacing several Stage 1 objectives for providing electronic copies of and electronic access to health information with objectives to provide patients the ability to view, download, or transmit their health information or hospital admission information online. The capability to provide patients online access to this information will be a part of Certified EHR Technology beginning in 2014, therefore the new Stage 1 objectives will be required beginning in 2014.

The following current Stage 1 objectives will be replaced beginning in 2014:

- EPs/Hospital Stage 1 Core Objective: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.
- Hospital Stage 1 Core Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.
- EP Stage 1 Menu Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.



### New Objectives and Measures

**New EP Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.**

**New EP Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.**

**New Hospital Objective: Provide patients the ability to view online, download and transmit information about a hospital admission.**

**New Hospital Measure: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.**

## Public Health Reporting Objectives

Beginning in 2013, all of the Stage 1 public health objectives (submitting data to an immunization registry, submitting data to a syndromic surveillance database, or submitting reportable lab results to a public health agency) will require that providers perform at least one test of their Certified EHR Technology's capability to send data to public health agencies, except where prohibited. The intent of this modification is to encourage all EPs, eligible hospitals, and CAHs to submit public health data, even when not required by State/local law. Therefore, if providers are authorized to submit the data, they should do so even if it is not required by either law or practice. If the test of submission is successful, provider should institute regular reporting with the entity with whom the successful test was conducted.

| Stage 1 Objective                                                                                                                                                                 | Changes to Objective                                                                                                                                                                                                                                                               | Effective Year (CY/FY)   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines | Change: Addition of an alternative measure<br><br>More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE | 2013 - Onward (Optional) |
| Generate and transmit permissible prescriptions electronically (eRx)                                                                                                              | Change: Addition of an additional exclusion<br><br>Any EP who: does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.     | 2013 – Onward (Required) |



| Stage 1 Objective                                                                                                                                                                                                       | Changes to Objective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Effective Year (CY/FY)                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| Record and chart changes in vital signs                                                                                                                                                                                 | <p>Change: Age Limitations on Growth Charts and Blood Pressure</p> <p>More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data</p>                                                                                                                                                                                                                                                                         | <p>2013 Only (Optional)</p> <p>2014 – Onward (Required)</p> |
| Public Health Objectives:                                                                                                                                                                                               | Change: Addition of "except where prohibited" to the objective regulation text for the public health objectives under § 495.6                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2013 – Onward (Required)                                    |
| Record and chart changes in vital signs                                                                                                                                                                                 | <p>Change: Changing the age and splitting the EP exclusion</p> <p>Any EP who</p> <p>(1) Sees no patients 3 years or older is excluded from recording blood pressure;</p> <p>(2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;</p> <p>(3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or</p> <p>(4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.</p> | <p>2013 Only (Optional)</p> <p>2014 – Onward (Required)</p> |
| Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically | Change: Objective is no longer required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 2013 – Onward (Required)                                    |



| Stage 1 Objective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Changes to Objective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Effective Year (CY/FY)   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| Report ambulatory/hospital clinical quality measures to CMS or the States                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 2013 – Onward (Required) |
| <p>EP and Hospital Objectives: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.</p> <p>EP Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4business days of the information being available to the EP.</p> <p>Hospital Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.</p> | <p>Change: Replace these four objectives with the Stage 2 objective and one of the two Stage 2 measures.</p> <p>EP Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.</p> <p>EP Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.</p> <p>Hospital Objective: Provide patients the ability to view online, download and transmit information about a hospital admission.</p> <p>Hospital Measure: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.</p> | 2014 – Onward (Required) |



# 2014 Clinical Quality Measures Tipsheet **THE BASICS**



# 2014 Clinical Quality Measures Tipsheet

Last Updated: August, 2012

## Criteria for Reporting Clinical Quality Measures

### 1. Medicare EHR Incentive Program

Beginning in 2014, the reporting of clinical quality measures (CQMs) will change for all providers. EHR technology that has been certified to the 2014 standards and capabilities will contain new CQM criteria, and eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) will report using the new 2014 criteria regardless of whether they are participating in Stage 1 or Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Although clinical quality measure (CQM) reporting has been removed as a core objective for both EPs and eligible hospitals and CAHs, all providers are required to report on CQMs in order to demonstrate meaningful use.

#### 2013

- Eligible Professionals (EPs), will continue to report from the 44 measures finalized for Stage 1 in the same schema laid out for Stage 1
  - 3 core/alternate core
  - 3 additional measures for EPs
- Eligible hospitals and CAHs will continue to report the 15 measures finalized for Stage 1
- Beginning in 2012 and continuing in 2013, there are two reporting methods available for reporting the Stage 1 measures:
  - Attestation (<https://ehrincentives.cms.gov/>)
  - eReporting Pilots:
    - [Physician Quality Reporting System EHR Incentive Program Pilot for EPs](#)
    - [eReporting Pilot for eligible hospitals and CAHs](#)

#### 2014 and Beyond

- EPs must report on 9 of the 64 approved CQMs
  - Recommended core CQMs – encouraged but not required
    - 9 CQMs for the adult population
    - 9 CQMs for the pediatric population
    - NQF 0018 strongly encouraged since controlling blood pressure is high priority goal in many national health initiatives, including the Million Hearts campaign
  - Selected CQMs must cover at least 3 of the National Quality Strategy domains (See “Measure Selection Process” below.)
- Eligible Hospitals and CAHs must report on 16 of the 29 approved CQMs
  - Selected CQMs must cover at least 3 of the National Quality Strategy domains (See “Measure Selection Process” below.)
- Beginning in 2014, all Medicare-eligible providers beyond their first year of demonstrating meaningful use must electronically report their CQM data to CMS. (Medicaid EPs and hospitals that are eligible only for the Medicaid EHR Incentive Program will electronically report their CQM data to their state.) See “Reporting Options for EPs” and “Reporting Options for Eligible Hospitals and CAHs” below for more information.



## Measure Selection Process

CMS selected the recommended core set of CQMs for EPs based on analysis of several factors:

- Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries
- Conditions that represent national public health priorities
- Conditions that are common to health disparities
- Conditions that disproportionately drive healthcare costs and could improve with better quality measurement
- Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement
- Measures that include patient and/or caregiver engagement

In addition, CMS selected all CQMs to align with the Department of Health and Human Services' National Quality Strategy priorities for health care quality improvement. These domains include:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

When selecting their CQMs to report, EPs, eligible hospitals, and CAHs must select CQMs that cover at least three of these six domains. A complete list of 2014 CQMs and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website ([www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)) in the future. CMS will also post the recommended core set of CQMs for EPs.

## Reporting and submission periods for EPs, Eligible Hospitals, and CAHs in their first year of Meaningful Use submitting CQMs via attestation beginning with CY/FY 2014

| Provider Type         | Reporting Period for First Year of Meaningful Use (Stage 1) | Submission Period for First Year of Meaningful Use (Stage 1)*                                                                       |
|-----------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| EP                    | 90 consecutive days                                         | Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year. |
| Eligible Hospital/CAH | 90 consecutive days                                         | Anytime immediately following the end of the 90-day reporting period, but no later than November 30 of the following fiscal year.   |

*\*For purposes of avoiding a payment adjustment, Medicare EPs and eligible hospitals that are in their first year of demonstrating meaningful use in the year immediately preceding a payment adjustment year must submit their CQM data no later than October 1 (EPs) or July 1 (eligible hospitals) of such preceding year.*



## Reporting and submission periods for EPs, Eligible Hospitals, and CAHs beyond their first year of Meaningful Use submitting CQMs electronically beginning with CY/FY 2014

For 2014 only, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period. Medicare providers can either report their CQMs for the entire year or select an optional three-month reporting period for CQMs that is identical to their three-month reporting period for meaningful use.

For Medicare providers, this 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs, such as the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR). CMS is permitting this one-time three-month reporting period in 2014 only so that all providers who must upgrade to 2014 Certified EHR Technology will have adequate time to implement their new Certified EHR systems.

In subsequent years, the reporting period for clinical quality measures would be the entire calendar year (for EPs) or fiscal year (for eligible hospitals and CAHs).

| Provider Type         | Optional Reporting Period in 2014*                                                                                             | Reporting Period for Subsequent Years of Meaningful Use (Stage 1 and Subsequent Stages) | Submission Period for Subsequent Years of Meaningful Use (Stage 1 and Subsequent Stages) |
|-----------------------|--------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
| EP                    | <b>Calendar year quarter:</b><br>January 1 – March 31<br>April 1 – June 30<br>July 1 – September 30<br>October 1 – December 31 | <b>1 calendar year</b><br>(January 1 - December 31)                                     | <b>2 months following the end of the reporting period</b><br>(January 1 - February 28)   |
| Eligible Hospital/CAH | <b>Fiscal year quarter:</b><br>October 1 – December 31<br>January 1 – March 31<br>April 1 – June 30<br>July 1 – September 30   | <b>1 fiscal year</b><br>(October 1 - September 30)                                      | <b>2 months following the end of the reporting period</b><br>(October 1 - November 30)   |

*\*NOTE: The optional quarter reporting periods have the same submission period as a full year reporting period for electronic submission.*



## Reporting Options for EPs

| Category                                                                                  | Data Level | Payer Level   | Submission Type | Reporting Schema                                                                                    |
|-------------------------------------------------------------------------------------------|------------|---------------|-----------------|-----------------------------------------------------------------------------------------------------|
| <b>EPs in First Year of Demonstrating Meaningful Use*</b>                                 | Aggregate  | All payer     | Attestation     | Submit 9 CQMs (includes adult and pediatric recommended core CQMs), covering at least 3 NQS domains |
| <b>EPs Beyond the First Year of Demonstrating Meaningful Use</b>                          |            |               |                 |                                                                                                     |
| <b>Option 1</b>                                                                           | Aggregate  | All payer     | Electronic      | Submit 9 CQMs (includes adult and pediatric recommended core CQMs), covering at least 3 NQS domains |
| <b>Option 2</b>                                                                           | Patient    | Medicare Only | Electronic      | Satisfy requirements of PQRS reporting options using CEHRT                                          |
| <b>Group Reporting (only EPs Beyond the First Year of Demonstrating Meaningful Use)**</b> |            |               |                 |                                                                                                     |
| EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)                           | Patient    | Medicare Only | Electronic      | Satisfy requirements of Medicare Shared Savings Program of Pioneer ACOs using CEHRT                 |
| EPs satisfactorily reporting via PQRS group reporting options                             | Patient    | Medicare Only | Electronic      | Satisfy requirements of PQRS group reporting options using CEHRT                                    |

*\*Attestation is required for EPs in their first year of demonstrating meaningful use because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

*\*\*Groups with EPs in their first year of demonstrating meaningful use can report as a group, however individual EPs who are in their first year must attest to their CQM results by October 1 to avoid a payment adjustment.*



## Reporting Options for Eligible Hospitals and Critical Access Hospitals

| Category                                                                             | Data Level | Payer Level        | Submission Type | Reporting Schema                                                                                                                          |
|--------------------------------------------------------------------------------------|------------|--------------------|-----------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Eligible Hospitals in First Year of Demonstrating Meaningful Use*</b>             | Aggregate  | All payer          | Attestation     | Submit 16 CQMs, covering at least 3 NQS domains                                                                                           |
| <b>Eligible Hospitals/CAHs Beyond the First Year of Demonstrating Meaningful Use</b> |            |                    |                 |                                                                                                                                           |
| <b>Option 1</b>                                                                      | Aggregate  | All payer          | Electronic      | Submit 16 CQMs, covering at least 3 NQS domains                                                                                           |
| <b>Option 2</b>                                                                      | Patient    | Sample - all payer | Electronic      | Submit 16 CQMs, covering at least 3 NQS domains<br>➤ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot |

*\*Attestation is required for eligible hospitals in their first year of demonstrating meaningful use because it is the only reporting method that would allow them to meet the submission deadline of July 1 to avoid a payment adjustment.*

## 2. Medicaid EHR Incentive Program

### 2013 and Beyond

- EPs, eligible hospitals, and CAHs participating only in a Medicaid EHR Incentive Program will submit their CQM data directly to their State.
- Each State is responsible for sharing the details on the process for electronic reporting with its provider community.
- Subject to CMS's prior approval, the process and the timeline are within the States' purview.



# Stage 2 FAQs

# THE BASICS



## **Table of Contents**

- I. General Questions about Stage 2**
- II. Questions about Stage 2 Meaningful Use Measures & Objectives**
- III. Questions about changes to the Medicare EHR Incentive Program from Stage 2**
- IV. Questions about changes to the Medicaid EHR Incentive Program from Stage 2**

## I. General Questions about Stage 2

### 1) For the Medicare and Medicaid EHR Incentive Programs, what changes were made to Stage 1 objectives and policies in the August 23, 2012 Final Rule?

The August 23, 2012, final rule includes some changes to the Stage 1 meaningful use objectives, measures, and exclusions for eligible professionals, eligible hospitals, and critical access hospitals. Some of these changes will take effect as early as October 1, 2012, for eligible hospitals and critical access hospitals, or January 1, 2013, for eligible professionals. Other Stage 1 changes will not take effect until the 2014 fiscal or calendar year, and will be optional in 2013.

Please see the full FAQ online to see a chart of the changes to specific objectives, measures and policies: <https://questions.cms.gov/faq.php?id=5005&faqId=7527>

**Date Updated:** 8/23/2012

**New ID #7527**

### 2) What is Stage 2 for the Medicare and Medicaid EHR Incentive Programs?

In August 2012, CMS published a final rule that specifies the Stage 2 meaningful use criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs and avoid payment adjustments.

Stage 2 retains the core and menu structure for meaningful use objectives. Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that providers must meet for the objective has been raised.

New objectives are also introduced for Stage 2, and most of these are introduced as menu objectives. As with the previous stage, many of the Stage 2 objectives have exclusions that allow providers to achieve meaningful use without having to meet objectives outside of their normal scope of clinical practice.

To demonstrate meaningful use under Stage 2 criteria—

- Eligible professionals must meet 17 core objectives and 3 menu objectives they select from a list of 6, for a total of 20 core objectives (the same number of objectives that had to be met in Stage 1).
- Eligible hospitals and critical access hospitals must meet 16 core objectives and 3 menu objectives they select from a list of 6, for a total of 19 core objectives (the same number of objectives that had to be met in Stage 1).

Please note, providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014. All other providers would meet two years



of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year, regardless of the year in which you begin participation.

The Stage 2 final rule also includes some changes to the Stage 1 meaningful use objectives, measures, and exclusions. Some of the changes to Stage 1 will take effect as early as October 1, 2012, for eligible hospitals and critical access hospitals, or January 1, 2013, for eligible professionals. Other changes to Stage 1 will not be required until FY 2014 (for hospitals) or CY 2014 (for EPs), but will be optional in FY 2013 (for hospitals) or CY 2013 (for EPs).

**Date Updated:** 8/23/2012  
**New ID #**[7529](#)

## **II. Questions about Stage 2 Meaningful Use Measures & Objectives**

### **3) For meaningful use Stage 2's transitions of care and referrals objective, in what ways can I meet the second measure that requires more than 10% of the summary care records I provide for transitions of care and referrals to be electronically transmitted?**

An EP, eligible hospital, or CAH could use 3 distinct approaches (which could also be used in combination) to meet this measure. The first two rely solely on the use of CEHRT, while the third is slightly different.

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 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).

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, but 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 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 here.

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. As required by ONC to meet the CEHRT definition, 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 the primary Direct Project specification (the Applicability Statement for Secure Health Transport). Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "Direct" capability (natively or combined with an intermediary) would be able to count all such electronic transmissions in their numerator.

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. Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "SOAP-based" capability (natively or combined with an intermediary) would be able to count all of those transmissions in their numerator.

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.

We note that 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.

**Date Updated:** 11/5/2012  
**[New ID #7697](#)**

**4) What are the specific medical specialty codes associated with anesthesiology, radiology and pathology for the specialty-based determination for the granting of a hardship exception from the payment adjustments in the Medicare Electronic Health Record (EHR) Incentive Program?**

The included Medicare Specialty Codes are diagnostic radiology (30), nuclear medicine (36), interventional radiology (94), anesthesiology (30), and pathology (22).



We note that current practice guidelines issued by the American College of Radiology for interventional radiology (94) indicate that both face-to-face patient contact (pre and post procedure) and follow-up care (longitudinal care) are expected as part of the scope of practice, and we may need to revisit this issue in future rulemaking.

Radiation oncology, together with surgical and medical oncology, is one of the 3 primary disciplines involved in cancer treatment according to the American College of Radiology practice guidelines. Radiation oncologists are therefore specialized oncologists as opposed to specialized radiologists and are not eligible for the specialty-based exception. If a radiation oncologist believes they meet the hardship exception criteria for lack of face-to-face patient interaction and lack of need for follow-up care they may apply for that exception, as can any eligible professional regardless of specialty.

**Date Updated:** 1/2/2013  
**[New ID #7731](#)**

**5) If multiple eligible professionals 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?**

The answer is relevant to the following meaningful use measure for eligible professionals (EPs): "More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information."

If the patient was seen by the EP during the EHR reporting period, the patient would be counted in the EP's numerator for this measure if the patient (or his/her authorized representatives) views online, downloads, or transmits to a third party any of the health information from the shared portal or online PHR, regardless of whether the EP contributed the particular information that was viewed, downloaded, or transmitted by the patient. However, the EP must have contributed at least some of the information identified in the Stage 2 final rule to the shared portal or online PHR for the patient.

**Date Updated:** 1/2/2013  
**[New ID #7735](#)**

**6) To meet the third measure of the objective of providing "a summary of care record for each transition of care or referral" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, must the electronic exchange with a recipient using technology designed by a different EHR developer occur for each provider or can there be one exchange per location? What if the provider chooses instead to exchange information with the CMS test EHR?**

If a summary of care record used for an actual transition of care or referral is electronically exchanged with a recipient who has EHR technology that was



developed designed by a different EHR technology developer than the sender's EHR technology, then that exchange can be considered to have met the third measure of the objective for all providers involved in that transition of care and referral using the same Certified EHR Technology.

If the provider chooses instead to meet this third measure by exchanging with the CMS test EHR, we clarify that the use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient (e.g., "dummy data") must be used for the purposes of conducting the test. Providers that use the same EHR technology and share a network for which their organization either has operational control of or license to use can conduct one test that covers all providers in the organization. For example, if a large group of EPs with multiple physical locations use the same EHR technology and those locations are connected using a network that the group has either operational control of or license to use, then a single test would cover all EPs in that group. Similarly, if a provider uses an EHR technology that is hosted (cloud-based) on the developer's network, then a single test would allow all EPs, eligible hospitals, and CAHs using the EHR technology that is hosted (cloud-based) on the developer's network to meet the measure.

**Date Updated:** 1/2/2013  
**New ID #7729**

### **III. Questions about changes to the Medicare EHR Incentive Program from Stage 2**

#### **7) What are the payment adjustments for eligible professionals who are not participating in the Medicare EHR Incentive Program? Are there any hardship exceptions?**

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible professionals (EPs) who are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on January 1, 2015, for Medicare EPs. Medicaid EPs who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

EPs who can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.

Medicare EPs who are not meaningful users will be subject to a payment adjustment beginning on January 1, 2015.



For additional information on payment adjustments and hardship exceptions for EPs, please review the Payment Adjustments and Hardship Exceptions Tip Sheet which will be available on our website.

**Date Updated: 8/23/2012**  
**[New ID #7531](#)**

### **8) What are the payment adjustments for eligible hospitals and critical access hospitals that are not participating in the Medicare EHR Incentive Program? Are there any hardship exceptions?**

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible hospitals, and critical access hospitals (CAHs) that are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on October 1, 2014, for Medicare eligible hospitals. Payment adjustments for CAHs will be applied beginning with the fiscal year 2015 cost reporting period. Medicaid eligible hospitals that can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

Eligible hospitals and CAHs that can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.

Medicare Subsection (d) eligible hospitals that are not meaningful users will be subject to a payment adjustment beginning on October 1, 2014. Critical Access Hospitals (CAHs) that are not meaningful users will be subject to a payment adjustment for fiscal year 2015.

For additional information on payment adjustments and hardship exceptions for eligible hospitals and CAHs, please review the Payment Adjustments and Hardship Exceptions Tip Sheet for Eligible Hospitals and CAHs which will be available on our website.

**Date Updated: 8/23/2012**  
**[New ID #7533](#)**

## **IV. Questions about changes to the Medicaid EHR Incentive Program from Stage 2**



**9) The EHR Incentive Programs Stage 1 Rule stated that, in order for a Medicaid encounter to count towards the patient volume of an eligible provider, Medicaid had to either pay for all or part of the service, or pay all or part of the premium, deductible or coinsurance for that encounter. The Stage 2 Rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs) at the time of service without the requirement of Medicaid payment liability. How will this change affect patient volume calculations for Medicaid eligible providers?**

Importantly, this change affecting the Medicaid patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in. Billable services provided by an eligible provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume thresholds. Examples of Medicaid encounters under this expanded definition that could be newly eligible might include: behavioral health services, HIV/AIDS treatment, or other services that might not be billed to Medicaid/managed care for privacy reasons, but where the provider has a mechanism to verify eligibility. Also, services to a Medicaid-enrolled patient that might not have been reimbursed by Medicaid (or a Medicaid managed care organization) may now be included in the Medicaid patient volume calculation (e.g., oral health services, immunization, vaccination and women's health services, , telemedicine/telehealth, etc.).

Providers who are not currently enrolled with their state Medicaid agency who might be newly eligible for the incentive payments due to these changes should note that they are not necessarily required to fully enroll with Medicaid in order to receive the payment.

In some instances, it may now be appropriate to include services denied by Medicaid in calculating patient volume. It will be appropriate to review denial reasons. If Medicaid denied the service for timely filing or because another payer's payment exceeded the potential Medicaid payment, it would be appropriate to include that encounter in the calculation. If Medicaid denied payment for the service because the beneficiary has exceeded service limits established by the Medicaid program, it would be appropriate to include that encounter in the calculation. If Medicaid denied the service because the patient was ineligible for Medicaid at the time of service, it would not be appropriate to include that encounter in the calculation.

Further guidance regarding this change will be distributed to the states as appropriate.

**Date Updated: 8/23/2012**  
**[New ID #7535](#)**



**10) The EHR Incentive Programs Stage 2 Rule describes changes to how a state considers CHIP patients in the Medicaid patient volume total when determining provider eligibility. Patients in which CHIP programs are now appropriate to be considered in the Medicaid patient volume total?**

States that have offered CHIP as part of a Medicaid expansion under Title 19 or Title 21 can include those patients in their provider's Medicaid patient volume calculation as there is cost liability to the Medicaid program in either case (under the Stage 1 Rule, only CHIP programs created under a Medicaid expansion via Title 19 were eligible). Patients in standalone CHIP programs established under Title 21 are not to be considered part of the patient volume total (in Stage 1 or Stage 2). This change to the patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in.

**Date Updated: 8/23/2012**

**[New ID #7537](#)**

**11) Are there any changes in the EHR Incentive Programs Stage 2 Rule to the base year for the Medicaid hospital incentive payment calculation?**

Yes. Previously Medicaid eligible hospitals calculated the base year using a 12 month period ending in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. In an effort to encourage timely participation in the program, §495.310(g)(1)(i)(B) of the Stage 2 Rule was amended to allow hospitals to use the most recent continuous 12 month period for which data are available prior to the payment year. This change went into effect upon publication of the Stage 2 Rule. Only hospitals that begin participation in the program after the publication date of the Stage 2 Rule (i.e., program years 2013 and later) will be affected by this change. Hospitals that began participation in the program prior to the Stage 2 Rule will not have to adjust previous calculations.

**Date Updated: 8/23/2012**

**[New ID #7539](#)**



# 2014 eCQM Resources

# THE BASICS





## 2014 Clinical Quality Measures (CQMS) & eCQM Resources



### Web Pages

| Name                                                          | Description                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <a href="#"><u>Stage 2 EHR Incentive Program</u></a>          | This page provides information about Stage 2 of meaningful use, including a wide range of resources, tipsheets, reporting requirements, and an overview of the program timeline.                                                                                                                        |
| <a href="#"><u>Clinical Quality Measures</u></a>              | This page provides information about CQMs including how they are derived, the purposes they serve, reporting requirements for the EHR Incentive Programs, and how to access the electronic specifications (eCQMs) for electronic reporting through Certified EHR Technology.                            |
| <a href="#"><u>Clinical Quality Measures through 2013</u></a> | This page provides information about how the program will work and what the requirements are for reporting CQMs through 2013.                                                                                                                                                                           |
| <a href="#"><u>2014 Clinical Quality Measures</u></a>         | This page provides information and resources about the CQMs finalized in the Stage 2 rule which will be in effect beginning in 2014 for all practitioners regardless of what stage of meaningful use they are in. It also provides the finalized CQMs, reporting requirements, and access to the eCQMs. |
| <a href="#"><u>Recommended Core Set</u></a>                   | This page provides information about the adult and pediatric recommended core sets finalized in Stage 2 of meaningful use for 2014.                                                                                                                                                                     |
| <a href="#"><u>Electronic Specifications (eCQMs)</u></a>      | This page provides information about electronic specifications, the various formats of the eSpecification files, technical release notes, guidance for understanding eCQMs, and access to the electronic specifications and value sets.                                                                 |
| <a href="#"><u>Value Set Authority Center (VSAC)</u></a>      | This page is supported by the National Library of Medicine and contains the value sets for each of the 64 eCQMs for eligible professional for 2014 and the 29 eCQMs for eligible hospitals for 2014. A free license is required to access the value sets.                                               |



# 2014 Clinical Quality Measures (CQMs) & eCQM Resources



## Publications

| Name                                                                               | Description                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <a href="#"><u>2014 Clinical Quality Measures Tip Sheet</u></a>                    | This document provides an overview of the 2014 CQMs for use in the EHR Incentive Programs, including reporting requirements, reporting time period, submission options, and background on the measure selection process.             |
| <a href="#"><u>2014 CQMs for Eligible Professionals</u></a>                        | This table contains the description and definition statements for the 64 CQMs for use by eligible professionals in the EHR Incentive Programs beginning in 2014.                                                                     |
| <a href="#"><u>2014 CQMs for Eligible Hospitals</u></a>                            | This table contains the description and definition statements for the 64 CQMs for use by eligible hospitals and CAHs in the EHR Incentive Programs beginning in 2014.                                                                |
| <a href="#"><u>Adult Recommended Core Set</u></a>                                  | This table contains the 9 CQMs in the recommended core set for the adult population.                                                                                                                                                 |
| <a href="#"><u>Pediatric Recommended Core Set</u></a>                              | This table contains the 9 CQMs in the recommended core set for the pediatric population.                                                                                                                                             |
| <a href="#"><u>EP Technical Release Notes</u></a>                                  | This document contains information about changes made to 2011 CQMs for the measures that were kept as part of the 2014 CQMs.                                                                                                         |
| <a href="#"><u>EH Technical Release Notes</u></a>                                  | This document contains information about changes made to 2011 CQMs for the measures that were kept as part of the 2014 CQMs.                                                                                                         |
| <a href="#"><u>eSpecifications for 2014 eCQMs for Eligible Professionals</u></a>   | This .zip file contains the electronic specifications in a machine readable (xml) and human readable (html) format for the 2014 eCQMs for eligible professionals. To obtain the related value sets please visit the VSAC.            |
| <a href="#"><u>eSpecifications Navigator 2014 eCQMs for Eligible Hospitals</u></a> | The eSpec Navigator provides access to the electronic specifications in a machine readable (xml) and human readable (html) format for the 2014 eCQMs for eligible hospitals. To obtain the related value sets please visit the VSAC. |
| <a href="#"><u>Guide to Reading EP and Hospital eCQMs</u></a>                      | This document contains helpful information about understanding and implementing eCQMs for the EHR Incentive Program.                                                                                                                 |

**Stage 2 Meaningful Use  
Specification Sheet Table of  
Contents for Eligible  
Professionals**

**RESOURCES FOR  
ELIGIBLE  
PROFESSIONALS**



# Stage 2

## Eligible Professional (EP)

### Meaningful Use Core and Menu Measures

#### Table of Contents

Date issued: October, 2012

| Eligible Professional Core Objectives |                                                                                                                                                                                                                                                                            |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (1)                                   | Use <a href="#">computerized provider order entry (CPOE)</a> for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.           |
| (2)                                   | Generate and transmit permissible <a href="#">prescriptions electronically (eRx)</a> .                                                                                                                                                                                     |
| (3)                                   | Record the following <a href="#">demographics</a> : preferred language, sex, race, ethnicity, date of birth.                                                                                                                                                               |
| (4)                                   | Record and chart changes in the following <a href="#">vital signs</a> : height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI. |
| (5)                                   | Record <a href="#">smoking status</a> for patients 13 years old or older.                                                                                                                                                                                                  |
| (6)                                   | Use <a href="#">clinical decision support</a> to improve performance on high-priority health conditions.                                                                                                                                                                   |
| (7)                                   | <a href="#">Provide patients the ability to view online, download and transmit</a> their health information within four business days of the information being available to the EP.                                                                                        |
| (8)                                   | Provide <a href="#">clinical summaries</a> for patients for each office visit.                                                                                                                                                                                             |
| (9)                                   | <a href="#">Protect electronic health information</a> created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.                                                                                              |
| (10)                                  | Incorporate <a href="#">clinical lab-test results</a> into Certified EHR Technology as structured data.                                                                                                                                                                    |
| (11)                                  | <a href="#">Generate lists of patients</a> by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.                                                                                                                         |
| (12)                                  | Use clinically relevant information to identify patients who should receive <a href="#">reminders for preventive/follow-up care</a> and send these patients the reminders, per patient preference.                                                                         |
| (13)                                  | Use clinically relevant information from Certified EHR Technology to identify <a href="#">patient-specific education resources</a> and provide those resources to the patient.                                                                                             |
| (14)                                  | The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform <a href="#">medication reconciliation</a> .                                                                                             |
| (15)                                  | The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a <a href="#">summary care record for each transition of care</a> or referral.                                      |
| (16)                                  | Capability to submit <a href="#">electronic data to immunization registries</a> or immunization information systems except where prohibited, and in accordance with applicable law and practice.                                                                           |
| (17)                                  | Use <a href="#">secure electronic messaging</a> to communicate with patients on relevant health information.                                                                                                                                                               |



## Eligible Professional Menu Objectives

|     |                                                                                                                                                                                                         |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (1) | Capability to submit <a href="#">electronic syndromic surveillance data</a> to public health agencies except where prohibited, and in accordance with applicable law and practice.                      |
| (2) | Record <a href="#">electronic notes</a> in patient records.                                                                                                                                             |
| (3) | <a href="#">Imaging results</a> consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.                                                      |
| (4) | Record patient <a href="#">family health history</a> as structured data.                                                                                                                                |
| (5) | Capability to <a href="#">identify and report cancer cases</a> to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.                 |
| (6) | Capability to <a href="#">identify and report specific cases</a> to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. |

View or download all of the EP [Stage 2 Core and Menu Objectives](#) for Stage 2.



# Stage 1 vs. Stage 2 Comparison Table for Eligible Professionals

## RESOURCES FOR ELIGIBLE PROFESSIONALS



# Stage 1 vs. Stage 2 Comparison Table for Eligible Professionals

Last Updated: August, 2012

## CORE OBJECTIVES (17 total)

| Stage 1 Objective                                                                                                                                                                 | Stage 1 Measure                                                                                                                                             | Stage 2 Objective                                                                                                                                                                                                                               | Stage 2 Measure                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines | More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE | Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines | More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE                      |
| Implement drug-drug and drug-allergy interaction checks                                                                                                                           | The EP has enabled this functionality for the entire EHR reporting period                                                                                   | <b><i>No longer a separate objective for Stage 2</i></b>                                                                                                                                                                                        | <b><i>This measure is incorporated into the Stage 2 Clinical Decision Support measure</i></b>                                                                              |
| Generate and transmit permissible prescriptions electronically (eRx)                                                                                                              | More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology                              | Generate and transmit permissible prescriptions electronically (eRx)                                                                                                                                                                            | More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology |
| Record demographics <ul style="list-style-type: none"> <li>• Preferred language</li> <li>• Gender</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Date of birth</li> </ul>        | More than 50% of all unique patients seen by the EP have demographics recorded as structured data                                                           | Record the following demographics <ul style="list-style-type: none"> <li>• Preferred language</li> <li>• Gender</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Date of birth</li> </ul>                                                        | More than 80% of all unique patients seen by the EP have demographics recorded as structured data                                                                          |
| Maintain an up-to-date problem list of current                                                                                                                                    | More than 80% of all unique patients seen                                                                                                                   | <b><i>No longer a separate objective for Stage 2</i></b>                                                                                                                                                                                        | <b><i>This measure is incorporated into the Stage</i></b>                                                                                                                  |



|                                                                                                                                                                                                                                                                       |                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                             |
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| and active diagnoses                                                                                                                                                                                                                                                  | by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data                                                              |                                                                                                                                                                                                                                                                                        | <b><i>2 measure of Summary of Care Document at Transitions of Care and Referrals</i></b>                                                                                    |
| Maintain active medication list                                                                                                                                                                                                                                       | More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data | <b><i>No longer a separate objective for Stage 2</i></b>                                                                                                                                                                                                                               | <b><i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i></b>                                        |
| Maintain active medication allergy list                                                                                                                                                                                                                               | More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data          | <b><i>No longer a separate objective for Stage 2</i></b>                                                                                                                                                                                                                               | <b><i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i></b>                                        |
| Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts for children 2-20 years, including BMI</li> </ul> | For more than 50% of all unique patients age 2 and over seen by the EP, blood pressure, height and weight are recorded as structured data                                              | Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure (age 3 and over)</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts for patients 0-20 years, including BMI</li> </ul> | More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data |
| Record smoking status for patients 13 years old or older                                                                                                                                                                                                              | More than 50% of all unique patients 13 years old or older seen by the EP have smoking status                                                                                          | Record smoking status for patients 13 years old or older                                                                                                                                                                                                                               | More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data                                                   |

|                                                                                                                                                                              |                                                                                                                                           |                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                            |
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|                                                                                                                                                                              | recorded as structured data                                                                                                               |                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule                            | Implement one clinical decision support rule                                                                                              | Use clinical decision support to improve performance on high-priority health conditions                                                                            | <ol style="list-style-type: none"> <li>1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period.</li> <li>2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period</li> </ol>         |
| Report clinical quality measures (CQMs) to CMS or the States                                                                                                                 | Provide aggregate numerator, denominator, and exclusions through attestation or through the PQRS Electronic Reporting Pilot               | <b>No longer a separate objective for Stage 2, but providers must still submit CQMs to CMS or the States in order to achieve meaningful use</b>                    | <b>Starting in 2014, all CQMs will be submitted electronically to CMS</b>                                                                                                                                                                                                                                                                                                                                                  |
| Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request | More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days | Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP | <ol style="list-style-type: none"> <li>i. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information</li> <li>ii. More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized</li> </ol> |



|                                                                                                                                                                                                                     |                                                                                                                                                                                                      |                                                                                                                                                               |                                                                                                                                                                                                                                                                                                          |
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|                                                                                                                                                                                                                     |                                                                                                                                                                                                      |                                                                                                                                                               | representatives) view, download, or transmit to a third party their health information                                                                                                                                                                                                                   |
| Provide clinical summaries for patients for each office visit                                                                                                                                                       | Clinical summaries provided to patients for more than 50% of all office visits within 3 business days                                                                                                | Provide clinical summaries for patients for each office visit                                                                                                 | Clinical summaries provided to patients within one business day for more than 50% of office visits                                                                                                                                                                                                       |
| Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically | Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information                                                                               | <b><i>This objective is eliminated from Stage 1 in 2013 and is no longer an objective for Stage 2</i></b>                                                     | <b><i>This measure is eliminated from Stage 1 in 2013 and is no longer a measure for Stage 2</i></b>                                                                                                                                                                                                     |
| Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities                                                        | Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process | Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities. | Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process |
| Implement drug-formulary checks                                                                                                                                                                                     | The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period                                                         | <b><i>No longer a separate objective for Stage 2</i></b>                                                                                                      | <b><i>This measure is incorporated into the e-Prescribing measure for Stage 2</i></b>                                                                                                                                                                                                                    |



|                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                            |                                                                                                                                   |                                                                                                                                                                                                                                       |
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| Incorporate clinical lab-test results into certified EHR technology as structured data                                                                                                                                          | More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data                                                      | Incorporate clinical lab-test results into Certified EHR Technology as structured data                                            | More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data |
| Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach                                                                                                | Generate at least one report listing patients of the EP with a specific condition                                                                                                                                                                                                          | Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach | Generate at least one report listing patients of the EP with a specific condition                                                                                                                                                     |
| Send reminders to patients per patient preference for preventive/ follow up care                                                                                                                                                | More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period                                                                                                                                         | Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care               | Use EHR to identify and provide reminders for preventive/follow-up care for more than 10% of patients with two or more office visits in the last 2 years                                                                              |
| Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP | More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information | <b><i>This objective is eliminated from Stage 1 in 2014 and is no longer an objective for Stage 2</i></b>                         | <b><i>This measure is eliminated from Stage 1 in 2014 and is no longer a measure for Stage 2</i></b>                                                                                                                                  |



|                                                                                                                                                                                                                       |                                                                                                                                                                                        |                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate                                                                               | More than 10% of all unique patients seen by the EP are provided patient-specific education resources                                                                                  | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate                                                                               | Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation                                                          | The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP                                        | The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation                                                          | The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals | The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | <ol style="list-style-type: none"> <li>1. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals</li> <li>2. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or is validated through an</li> </ol> |

|                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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|                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                             | <p>ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals</p> <p>3. The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period</p> |
| <p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice</p> | <p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)</p> | <p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice</p> | <p>Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period</p>                                                                                                                                                                                                                                                                                                                          |
| <p><b>NEW</b></p>                                                                                                                                                                                           | <p><b>NEW</b></p>                                                                                                                                                                                                                                                                                                                   | <p>Use secure electronic messaging to</p>                                                                                                                                                                   | <p>A secure message was sent using the electronic</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



|  |  |                                                          |                                                                                                                        |
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|  |  | communicate with patients on relevant health information | messaging function of Certified EHR Technology by more than 5% of unique patients seen during the EHR reporting period |
|--|--|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|



## MENU OBJECTIVES (EPs must select 3 of 6 menu objectives)

| Stage 1 Objective                                                                                                                                                                      | Stage 1 Measure                                                                                                                                                                                                                                                                                                                                                             | Stage 2 Objective                                                                                                                                                                      | Stage 2 Measure                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically) | Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice | Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period                                          |
| <b>NEW</b>                                                                                                                                                                             | <b>NEW</b>                                                                                                                                                                                                                                                                                                                                                                  | Record electronic notes in patient records                                                                                                                                             | Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients                                                                                         |
| <b>NEW</b>                                                                                                                                                                             | <b>NEW</b>                                                                                                                                                                                                                                                                                                                                                                  | Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT                                                      | More than 10% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology       |
| <b>NEW</b>                                                                                                                                                                             | <b>NEW</b>                                                                                                                                                                                                                                                                                                                                                                  | Record patient family health history as structured data                                                                                                                                | More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been |



|            |            |                                                                                                                                                                                        |                                                                                                                                                        |
|------------|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
|            |            |                                                                                                                                                                                        | reviewed                                                                                                                                               |
| <b>NEW</b> | <b>NEW</b> | Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice                                 | Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period        |
| <b>NEW</b> | <b>NEW</b> | Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice | Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period |



**Payment Adjustment & Hardship  
Exceptions Tipsheet for  
Eligible Professions**  
**RESOURCES FOR  
ELIGIBLE  
PROFESSIONALS**



# Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals

Last Updated: August, 2012

## Overview

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible professionals (EPs) who are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on January 1, 2015, for Medicare EPs. Medicaid EPs who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

EPs who can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.

## Payment Adjustments for Medicare EPs

Medicare EPs who are not meaningful users will be subject to a payment adjustment beginning on January 1, 2015.

This payment adjustment will be applied to the Medicare physician fee schedule (PFS) amount for covered professional services furnished by the EP during the year (including the fee schedule amount for purposes of determining a payment based on the fee schedule amount). The payment adjustment is 1% per year and is cumulative for every year that an EP is not a meaningful user. Depending on the total number of Medicare EPs who are meaningful users under the EHR Incentive Programs after 2018, the maximum cumulative payment adjustment can reach as high as 5%. The table below illustrates the potential application of payment adjustments to covered professional services for a Medicare EP who is not a meaningful user beginning in 2014.

| % ADJUSTMENT ASSUMING LESS THAN 75 PERCENT OF EPs ARE MEANINGFUL USERS |      |      |      |      |      |       |
|------------------------------------------------------------------------|------|------|------|------|------|-------|
|                                                                        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020+ |
| EP is not subject to the payment adjustment for the e Rx in 2014       | 99%  | 98%  | 97%  | 96%  | 95%  | 95%   |
| EP is subject to the payment adjustment for the e Rx in 2014           | 98%  | 98%  | 97%  | 96%  | 95%  | 95%   |



| % ADJUSTMENT ASSUMING MORE THAN 75 PERCENT OF EPs ARE MEANINGFUL USERS |      |      |      |      |      |       |
|------------------------------------------------------------------------|------|------|------|------|------|-------|
|                                                                        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020+ |
| EP is not subject to the payment adjustment for the e Rx in 2014       | 99%  | 98%  | 97%  | 97%  | 97%  | 97%   |
| EP is subject to the payment adjustment for the e Rx in 2014           | 98%  | 98%  | 97%  | 97%  | 97%  | 97%   |

Because payment adjustments are mandated to begin on the first day of the 2015 calendar year, CMS will apply a prospective determination for payment adjustments. Therefore Medicare EPs must demonstrate meaningful use prior to the 2015 calendar year in order to avoid the adjustments.

EPs who first demonstrated meaningful use in 2011 or 2012 must demonstrate meaningful use for a full year in 2013 to avoid payment adjustments in 2015. They must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for EPs who must demonstrate meaningful use for a full year in 2013.

|                                |      |      |      |      |      |      |
|--------------------------------|------|------|------|------|------|------|
| Payment Adjustment Year        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Full Year EHR Reporting Period | 2013 | 2014 | 2015 | 2016 | 2017 | 2019 |

EPs who first demonstrate meaningful use in 2013 must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid payment adjustments in 2015. They must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for EPs who demonstrate meaningful use for a 90-day reporting period in 2013.

|                                |      |      |      |      |      |      |
|--------------------------------|------|------|------|------|------|------|
| Payment Adjustment Year        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| 90 day EHR Reporting Period    | 2013 |      |      |      |      |      |
| Full Year EHR Reporting Period |      | 2014 | 2015 | 2016 | 2017 | 2019 |



EPs who first demonstrate meaningful use in 2014 must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, in order to avoid the payment adjustments. EPs must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for EPs who first demonstrate meaningful use in 2014.

| Payment Adjustment Year        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|--------------------------------|------|------|------|------|------|------|
| 90 day EHR Reporting Period    | 2013 |      |      |      |      |      |
| Full Year EHR Reporting Period |      | 2014 | 2015 | 2016 | 2017 | 2019 |

EPs who first demonstrate meaningful use in 2014 must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, in order to avoid the payment adjustments. EPs must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for EPs who first demonstrate meaningful use in 2014.

| Payment Adjustment Year        | 2015  | 2016 | 2017 | 2018 | 2019 | 2020 |
|--------------------------------|-------|------|------|------|------|------|
| 90 day EHR Reporting Period    | 2014* | 2014 |      |      |      |      |
| Full Year EHR Reporting Period |       |      | 2015 | 2016 | 2017 | 2019 |

\*EPs must attest to meaningful use no later than October 1, 2014.

## Hardship Exceptions for Medicare EPs

EPs may apply for hardship exceptions to avoid the payment adjustments described above. Hardship exceptions will be granted only under specific circumstances and only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use. Information on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website ([www.cms.gov/EHRIncentiveProgram](http://www.cms.gov/EHRIncentiveProgram)) in the future.

EPs can apply for hardship exceptions in the following categories:

- **Infrastructure** — EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).



- **New EPs** — Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments. Thus EPs who begin practice in calendar year 2015 would receive an exception to the penalties in 2015 and 2016, but would have to begin demonstrating meaningful use in calendar year 2016 to avoid payment adjustments in 2017.
- **Unforeseen Circumstances** — Examples may include a natural disaster or other unforeseeable barrier. We also solicited comment on a fourth category of hardship exception as follows:
- **By Specialist/Provider Type** — EPs must demonstrate that they meet all three of the following criteria:
  1. Lack of face-to-face or telemedicine interaction with patients
  2. Lack of follow-up need with patients
  3. Lack of control over the availability of Certified EHR Technology at their practice location. (EPs who practice at multiple locations may be granted a hardship exception solely for lack of control over the availability of Certified EHR Technology)

## Frequently Asked Questions

### **Do I have to be a meaningful user each year to avoid the payment adjustments or can I avoid the payment adjustments by achieving meaningful use only once?**

You must demonstrate meaningful use every year according to the timelines detailed above in order to avoid Medicare payment adjustments. For example, an EP who demonstrates meaningful use for the first time in 2013 will avoid the payment adjustment in 2015, but will need to demonstrate meaningful use again in 2014 in order to avoid the payment adjustment in 2016.

### **If I am an EP who is eligible for both the Medicare and Medicaid EHR Incentive Programs, but I register to participate in the Medicaid EHR Incentive Program, do I still have to be a meaningful user to avoid the payment adjustments?**

Yes. If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you must demonstrate meaningful use according to the timelines detailed above to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

### **If I am an EP who is eligible for both the Medicare and Medicaid EHR Incentive Programs, will I avoid the payment adjustments during a calendar year when I receive an incentive payment for adopting, implementing, or upgrading my Certified EHR Technology?**

No. Congress mandated that an EP must be a meaningful user in order to avoid the payment adjustment; therefore receiving a Medicaid EHR incentive payment for adopting, implementing, or upgrading your Certified EHR Technology would not exempt you from the payment adjustments. You must demonstrate meaningful use according to the timelines detailed above to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.



## **How do I demonstrate meaningful use in order to avoid a payment adjustment?**

You demonstrate meaningful use by successfully attesting through either the CMS Medicare EHR Incentive Programs Attestation System (<https://ehrincentives.cms.gov/>) or through your state's attestation system.

## **If I am a hospital-based Medicare EP, am I subject to the payment adjustments?**

No. If you perform 90% or more of your covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital, then you will be determined to be hospital-based and are not eligible to receive an EHR incentive and will not be subject to the payment adjustments.

However, your hospital-based status can change from year to year. For example, an EP who is determined to be hospital-based for the 2015 program year would not be subject to the payment adjustments in 2017. But if that EP is determined not to be hospital-based for the 2016 and the 2017 program year, then he or she could be subject to the payment adjustments in 2018 if the EP does not demonstrate meaningful use. Therefore it is important to check your hospital-based status at the beginning of each year. You can check your hospital-based status by visiting the Medicare EHR Incentive Programs Registration System (<https://ehrincentives.cms.gov/>).



**2014 CQMs for Eligible  
Professionals**  
**RESOURCES FOR  
ELIGIBLE  
PROFESSIONALS**



## **ADDITIONAL INFORMATION REGARDING EP CLINICAL QUALITY MEASURES FOR 2014 EHR INCENTIVE PROGRAMS**

The table below entitled “Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals” contains additional up-to-date information for the EP clinical quality measures finalized in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule. Because measure specifications may need to be updated more frequently than our expected rulemaking cycle will allow for, this table provides updates to the specifications. Subsequent updates will be provided in a new version of this table at least 6 months prior to the beginning of the calendar year for which the measure will be required, and CMS will maintain and publish an archive of each update.

Please note the titles and descriptions for the clinical quality measures included in this table were updated by the measure stewards and therefore may not match the information provided on the NQF website. Measures that do not have an NQF number are measures that are not currently endorsed.

## CLINICAL QUALITY MEASURES FOR 2014 CMS EHR INCENTIVE PROGRAMS FOR ELIGIBLE PROFESSIONALS

| CMS eMeasure ID | NQF # | Measure Title                                                            | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                     | Numerator Statement                                                                                                                                                                                                                         | Denominator Statement                                                                                                                                                                                     | Measure Steward                          | Link to NQF website                                                                                                                                                                                                 |
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| CMS146v1        | 0002  | Appropriate Testing for Children with Pharyngitis                        | Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.                                                                                                                                                                                                                                                  | Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis                                                                                                          | Children age 2-18 years who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=370">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=370</a>                                             |
| CMS137v1        | 0004  | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported.<br>a. Percentage of patients who initiated treatment within 14 days of the diagnosis.<br>b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. | Numerator 1: Patients who initiated treatment within 14 days of the diagnosis<br><br>Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit | Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period                                | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1245">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1245</a>                                           |
| CMS165v1        | 0018  | Controlling High Blood Pressure                                          | Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.                                                                                                                                                                                                                                           | Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.                                                               | Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period                               | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1236#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1236#p=1&amp;s=n&amp;so=a</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                                     | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Numerator Statement                                                                                                                                                                                                                                                                                                               | Denominator Statement                                                                                                                                                    | Measure Steward                          | Link to NQF website                                                                                                                                                                                                 |
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| CMS156v1        | 0022  | Use of High-Risk Medications in the Elderly                                                       | <p>Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.</p> <p>a. Percentage of patients who were ordered at least one high-risk medication.</p> <p>b. Percentage of patients who were ordered at least two different high-risk medications.</p>                                                                                                                                                                                                                              | <p>Numerator 1: Patients with an order for at least one high-risk medication during the measurement period.</p> <p>Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.</p>                                                                                        | Patients 66 years and older who had a visit during the measurement period                                                                                                | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=273#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=273#p=1&amp;s=n&amp;so=a</a>   |
| CMS155v1        | 0024  | Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents | <p>Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.</p> <ul style="list-style-type: none"> <li>Percentage of patients with height, weight, and body mass index (BMI) percentile documentation</li> <li>Percentage of patients with counseling for nutrition</li> <li>Percentage of patients with counseling for physical activity</li> </ul> | <p>Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period</p> <p>Numerator 2: Patients who had counseling for nutrition during the measurement period</p> <p>Numerator 3: Patients who had counseling for physical activity during the measurement period</p> | Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1247#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1247#p=1&amp;s=n&amp;so=a</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                    | Measure Description                                                                                                                                                                                    | Numerator Statement                                                                                                                                                  | Denominator Statement                                                                          | Measure Steward                                                                                    | Link to NQF website                                                                                                                                                                                                 |
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| CMS138v1        | 0028  | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user | Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user | All patients aged 18 years and older                                                           | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=391#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=391#p=1&amp;s=n&amp;so=a</a>   |
| CMS125v1        | 0031  | Breast Cancer Screening                                                          | Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.                                                                                                                | Women with one or more mammograms during the measurement period or the year prior to the measurement period                                                          | Women 42-69 years of age with a visit during the measurement period                            | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=392#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=392#p=1&amp;s=n&amp;so=a</a>   |
| CMS124v1        | 0032  | Cervical Cancer Screening                                                        | Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.                                                                                              | Women with one or more Pap tests during the measurement period or the two years prior to the measurement period                                                      | Women 24–64 years of age with a visit during the measurement period                            | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=393#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=393#p=1&amp;s=n&amp;so=a</a>   |
| CMS153v1        | 0033  | Chlamydia Screening for Women                                                    | Percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.                                              | Women with at least one chlamydia test during the measurement period                                                                                                 | Women 16-24 years of age who are sexually active and who had a visit in the measurement period | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1253#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1253#p=1&amp;s=n&amp;so=a</a> |

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| CMS130v1        | 0034  | Colorectal Cancer Screening               | Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.                                                                         | <p>Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below:</p> <ul style="list-style-type: none"> <li>- Fecal occult blood test (FOBT) during the measurement period</li> <li>- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period</li> <li>- Colonoscopy during the measurement period or the nine years prior to the measurement period</li> </ul> | Patients 51-75 years of age with a visit during the measurement period                      | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=394#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=394#p=1&amp;s=n&amp;so=a</a> |
| CMS126v1        | 0036  | Use of Appropriate Medications for Asthma | Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. | Patients who were dispensed at least one prescription for a preferred therapy during the measurement period                                                                                                                                                                                                                                                                                                                                                                                 | Patients 5-64 years of age with persistent asthma and a visit during the measurement period | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=367#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=367#p=1&amp;s=n&amp;so=a</a> |

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| CMS117v1        | 0038  | Childhood Immunization Status                         | Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. | Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday | Children who turn 2 years of age during the measurement period and who have a visit during the measurement period | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=395#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=395#p=1&amp;s=n&amp;so=a</a>   |
| CMS147v1        | 0041  | Preventive Care and Screening: Influenza Immunization | Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization                                                                                                                                                                                                   | Patients who received an influenza immunization OR who reported receipt of an influenza immunization                                                                                                              | All patients aged 6 months and older and seen for a visit between October 1 and March 31                          | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=397#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=397#p=1&amp;s=n&amp;so=a</a>   |
| CMS127v1        | 0043  | Pneumonia Vaccination Status for Older Adults         | Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.                                                                                                                                                                                                                                                                                                       | Patients who have ever received a pneumococcal vaccination                                                                                                                                                        | Patients 65 years of age and older with a visit during the measurement period                                     | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=492#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=492#p=1&amp;s=n&amp;so=a</a>   |
| CMS166v1        | 0052  | Use of Imaging Studies for Low Back Pain              | Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.                                                                                                                                                                                                                            | Patients with an imaging study conducted on the date of the outpatient or emergency department visit or in the 28 days following the outpatient or emergency department visit                                     | Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency department visit  | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1220#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1220#p=1&amp;s=n&amp;so=a</a> |

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| CMS131v1        | 0055  | Diabetes: Eye Exam                         | Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period | <p>Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:</p> <p>A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period</p> | Patients 18-75 years of age with diabetes with a visit during the measurement period                                                                                                                  | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1223#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1223#p=1&amp;s=n&amp;so=a</a>                                                                                                                       |
| CMS123v1        | 0056  | Diabetes: Foot Exam                        | Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.                                                                                                                                                  | Patients who received a foot exam (visual inspection with either a sensory exam or pulse exam) during the measurement period                                                                                                                                                                                                                         | Patients 18-75 years of age with diabetes with a visit during the measurement period                                                                                                                  | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1224#p=1&amp;s=n&amp;so=a">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1224#p=1&amp;s=n&amp;so=a</a>                                                                                                                       |
| CMS122v1        | 0059  | Diabetes: Hemoglobin A1c Poor Control      | Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.                                                                                                                                             | Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%                                                                                                                                                                                                                                                            | Patients 18-75 years of age with diabetes with a visit during the measurement period                                                                                                                  | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1225#k=0059&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1225#k=0059&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS148v1        | 0060  | Hemoglobin A1c Test for Pediatric Patients | Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period                                                                                                                                                          | Patients with documentation of date and result for a HbA1c test during the measurement period                                                                                                                                                                                                                                                        | Patients 5 to 17 years of age with a diagnosis of diabetes and a face-to-face visit for diabetes care between the physician and the patient that predates the most recent visit by at least 12 months | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=851#k=0060&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=851#k=0060&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a>   |

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| CMS134v1        | 0062  | Diabetes: Urine Protein Screening                                         | The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.                                                                                                                                                                                                                                                                                                 | Patients with a screening for nephropathy or evidence of nephropathy during the measurement period        | Patients 18-75 years of age with diabetes with a visit during the measurement period                                                                                                                                                                                                                                                            | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1226#k=0062&amp;e=1&amp;st=&amp;sd=&amp;s=n&amp;so=a&amp;p=1&amp;mt=&amp;cs=&amp;ss=">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1226#k=0062&amp;e=1&amp;st=&amp;sd=&amp;s=n&amp;so=a&amp;p=1&amp;mt=&amp;cs=&amp;ss=</a> |
| CMS163v1        | 0064  | Diabetes: Low Density Lipoprotein (LDL) Management                        | Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.                                                                                                                                                                                                                                                                                                                  | Patients whose most recent LDL-C level performed during the measurement period is < 100 mg/dL             | Patients 18-75 years of age with diabetes with a visit during the measurement period                                                                                                                                                                                                                                                            | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1228#k=0064&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1228#k=0064&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS164v1        | 0068  | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic | Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period. | Patients who have documentation of use of aspirin or another antithrombotic during the measurement period | Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1229#k=0068&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1229#k=0068&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

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| CMS154v1        | 0069  | Appropriate Treatment for Children with Upper Respiratory Infection (URI)                                                                 | Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.                                                                                                                                                                                                                                                                                             | Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection                                                                   | Children age 3 months to 18 years who had an outpatient or emergency department (ED) visit with a diagnosis of upper respiratory infection (URI) during the measurement period                                                                                                                                                                                                 | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=369#k=0069&amp;e=1&amp;st=&amp;sd=&amp;s=n&amp;so=a&amp;p=1&amp;mt=&amp;cs=&amp;ss=">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=369#k=0069&amp;e=1&amp;st=&amp;sd=&amp;s=n&amp;so=a&amp;p=1&amp;mt=&amp;cs=&amp;ss=</a>   |
| CMS145v1        | 0070  | Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) | Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy                                                                                                                                                                                                                                                                  | Patients who were prescribed beta blocker therapy                                                                                                                                                            | All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40%                                                                                                                                                                                                          | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=377#k=0070&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=377#k=0070&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a>   |
| CMS182v1        | 0075  | Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control                                                                     | Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL). | Numerator 1: Patients with a complete lipid profile performed during the measurement period<br><br>Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL | Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period | National Committee Quality Assurance                                                               | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1232#k=0075&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1232#k=0075&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

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| CMS135v1        | 0081  | Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge | Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge | All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=383#k=0081&amp;e=1&amp;s=n&amp;so=a&amp;p=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=383#k=0081&amp;e=1&amp;s=n&amp;so=a&amp;p=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=</a> |
| CMS144v1        | 0083  | Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)                                                                        | Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge         | Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge         | All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=384#k=0083&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=384#k=0083&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS143v1        | 0086  | Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation                                                                                                       | Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months                                                                                                                                                | Patients who have an optic nerve head evaluation during one or more office visits within 12 months                                                     | All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma                      | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=436#k=0086&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=436#k=0086&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                                                    | Measure Description                                                                                                                                                                                                                                                                                                                              | Numerator Statement                                                                                                                                                                                                             | Denominator Statement                                                                                                            | Measure Steward                                                                                    | Link to NQF website                                                                                                                                                                                                                                                                                                                     |
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| CMS167v1        | 0088  | Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy | Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months                                   | Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months | All patients aged 18 years and older with a diagnosis of diabetic retinopathy                                                    | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=438#k=0088&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=438#k=0088&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS142v1        | 0089  | Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care                            | Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months | Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care                                   | All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=439#k=0089&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=439#k=0089&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS139v1        | 0101  | Falls: Screening for Future Fall Risk                                                                            | Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.                                                                                                                                                                                                                           | Patients who were screened for future fall risk at least once within the measurement period                                                                                                                                     | Patients aged 65 years and older with a visit during the measurement period                                                      | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=445#k=0101&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=445#k=0101&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                            | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                           | Numerator Statement                                                                                                                                                                                                                                                                                                                                                                                      | Denominator Statement                                                                                                                                                                                                                                                                          | Measure Steward                                                                                    | Link to NQF website                                                                                                                                                                                                                                                                                                                       |
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| CMS161v1        | 0104  | Major Depressive Disorder (MDD): Suicide Risk Assessment | Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.                                                                                                                                                                                                                                                      | Patients who had suicide risk assessment completed at each visit                                                                                                                                                                                                                                                                                                                                         | All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD                                                                                                                                                                                                          | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1238#k=0104&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1238#k=0104&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS128v1        | 0105  | Anti-depressant Medication Management                    | Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported.<br>a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).<br>b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months). | Numerator 1: Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date<br><br>Numerator 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date | Patients 18 years of age and older with a diagnosis of major depression in the 180 days (6 months) prior to the measurement period or the first 180 days (6 months) of the measurement period, who were treated with antidepressant medication, and with a visit during the measurement period | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=855#k=0105&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=855#k=0105&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a>   |

| CMS eMeasure ID | NQF # | Measure Title                                                                                           | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Numerator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                  | Measure Steward                          | Link to NQF website                                                                                                                                                                                                                                                                                                                     |
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| CMS136v1        | 0108  | ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication | <p>Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/ hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.</p> <p>a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.</p> <p>b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</p> | <p>Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSPD</p> <p>Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.</p> | <p>Denominator 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period</p> <p>Denominator 2: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSPD, and who had a visit during the measurement period.</p> | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=857#k=0108&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=857#k=0108&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

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| CMS169v1        | 0110  | Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use | Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use. | <p>Patients in the denominator with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis, and prior to or concurrent with the initiation of treatment for that diagnosis.</p> <p>(Note: the endorsed measure calls for the assessment to be performed prior to discussion of the treatment plan with the patient, but the current approach was considered more feasible in an EHR setting. The "Assessment for Alcohol or Other Drug Use" required in the numerator is meant to capture a provider's assessment of the patient's symptoms of substance use. The essence of the measure is to avoid treating the patient for unipolar depression or bipolar disorder without an assessment of their use of alcohol or other drugs.)</p> <p>The intent of the measure is that the appraisal be performed at each and every initial assessment. It is possible for there to be one or two initial assessments during the measurement period. Due to limitations in the current measurement frameworks, the numerator in the current</p> | Patients 18 years of age or older at the start of the measurement period with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and evidence of treatment for unipolar depression or bipolar disorder within 42 days of diagnosis. The existence of a 'new diagnosis' is established by the absence of diagnoses and treatments of unipolar depression or bipolar disorder during the 180 days prior to the diagnosis. | Center for Quality Assessment & Improvement in Mental Health (CQAIMH) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1241#k=0110&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1241#k=0110&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

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|                 |       |                                                                                                                            |                                                                                                                                                                                                                                                       | measure definition can be satisfied if the appraisal is performed at ANY single initial assessment. Future versions, implemented with ever improving measurement logic frameworks, should close this loophole. |                                                                                                                                                                    |                                                                                                    |                                                                                                                                                                                                                                                                                                                                         |
| CMS157v1        | 0384  | Oncology: Medical and Radiation – Pain Intensity Quantified                                                                | Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified                                                                       | Patient visits in which pain intensity is quantified                                                                                                                                                           | All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy                                    | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=621#k=0384&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=621#k=0384&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS141v1        | 0385  | Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients                                                        | Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period | Patients who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy within the 12- month reporting period                                               | All patients aged 18 through 80 years with AJCC Stage III colon cancer                                                                                             | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=628#k=0385&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=628#k=0385&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS140v1        | 0387  | Breast Cancer: Hormonal Therapy for Stage IC-III C Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer | Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period                                      | Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period                                                                                                        | All female patients aged 18 years and older with a diagnosis of stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=631#k=0387&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=631#k=0387&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

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| CMS129v1        | 0389  | Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients | Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer | Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer                     | All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=624#k=0389&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=624#k=0389&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS62v1         | 0403  | HIV/AIDS: Medical Visit                                                                          | Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.                                                                                                                                                    | Patients with at least two medical visits during the measurement year with a minimum of 90 days between each visit | All patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12 month period                                                                                                                                           | National Committee for Quality Assurance                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=580#k=0403&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=580#k=0403&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

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| CMS52v1         | 0405                       | HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis | Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis                                                                                | <p>Numerator 1: Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm<sup>3</sup></p> <p>Numerator 2: Patients who were prescribed pneumocystic jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/ mm<sup>3</sup> or a CD4 percentage below 15%</p> <p>Numerator 3: Patients who were prescribed Pneumocystic jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV</p> | <p>Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm<sup>3</sup> who had at least two visits during the measurement year, with at least 90 days in between each visit</p> <p>Denominator 2: All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm<sup>3</sup> or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit</p> <p>Denominator 3: All patients aged 6 weeks to 12 months with a diagnosis of HIV who had at least two visits during the measurement year, with at least 90 days in between each visit</p> | National Committee for Quality Assurance | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=582#k=0405&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=582#k=0405&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS77v1         | TBD (proposed as NQF 0407) | HIV/AIDS: RNA control for Patients with HIV                 | Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL. | Patients whose most recent HIV RNA level is <200 copies/mL.                                                                                                                                                                                                                                                                                                                                                                                                                                     | All patients aged 13 years and older with a diagnosis of HIV/AIDS with at least two visits during the measurement year, with at least 90 days between each visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | National Committee for Quality Assurance |                                                                                                                                                                                                                                                                                                                                         |

| CMS eMeasure ID | NQF # | Measure Title                                                                       | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                         | Numerator Statement                                                                                                                                                                                                                                                                                                                                       | Denominator Statement                                                                                                                                   | Measure Steward                                                            | Link to NQF website                                                                                                                                                                                                                                                                                                                     |
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| CMS2v1          | 0418  | Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan | Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.                                                                                                                                                                            | Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen                                                                                                                                                      | All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period. | Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=522#k=0418&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=522#k=0418&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS68v1         | 0419  | Documentation of Current Medications in the Medical Record                          | Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list <u>must</u> include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND <u>must</u> contain the medications' name, dosage, frequency and route of administration. | Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list <u>must</u> include ALL prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND <u>must</u> contain the medications' name, dosages, frequency and route of administration. | All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period               | Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=524#k=0419&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=524#k=0419&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Numerator Statement                                                                                                                                                                                                                                                                                  | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Measure Steward                                                                           | Link to NQF website                                                                                                                                                                                                                                                                                                                            |
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| CMS69v1         | 0421  | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up | <p>Percentage of patients aged 18 years and older with an encounter during the reporting period with a documented calculated BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters.</p> <p>Normal Parameters:<br/>Age 65 years and older<br/>BMI <math>\geq</math> 23 and <math>&lt;</math> 30</p> <p>Age 18-64 years BMI <math>\geq</math> 18.5 and <math>&lt;</math> 25</p> | <p>Patients with a documented calculated BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters</p> | <p>Initial Patient Population 1: All patients 65 years of age and older before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses BMI measurement, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.</p> <p>Initial Patient Population 2: All patients 18 through 64 years before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses BMI measurement, the</p> | <p>Quality Insights of Pennsylvania/<br/>Centers for Medicare &amp; Medicaid Services</p> | <p><a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=526#k=0421&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=526#k=0421&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a></p> |

| CMS<br>eMeasure ID | NQF # | Measure Title                                                                                                                       | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Numerator Statement                                                                                                                                                                                                                                                                                   | Denominator<br>Statement                                                                                                                                                                                                                                                                                                          | Measure Steward                                                                                                           | Link to NQF website                                                                                                                                                                                                                                                                                                                     |
|--------------------|-------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CMS132v1           | 0564  | Cataracts:<br>Complications<br>within 30 Days<br>Following<br>Cataract Surgery<br>Requiring<br>Additional<br>Surgical<br>Procedures | Percentage of patients<br>aged 18 years and older<br>with a diagnosis of<br>uncomplicated cataract<br>who had cataract surgery<br>and had any of a<br>specified list of surgical<br>procedures in the 30<br>days following cataract<br>surgery which would<br>indicate the occurrence<br>of any of the following<br>major complications:<br>retained nuclear<br>fragments,<br>endophthalmitis,<br>dislocated or wrong<br>power IOL, retinal<br>detachment, or wound<br>dehiscence. | Patients who had one or<br>more specified operative<br>procedures for any of the<br>following major<br>complications within 30<br>days following cataract<br>surgery: retained nuclear<br>fragments, endophthalmitis,<br>dislocated or wrong power<br>IOL, retinal detachment, or<br>wound dehiscence | the patient is in an<br>urgent or emergent<br>medical situation where<br>time is of the essence<br>and to delay treatment<br>would jeopardize the<br>patient's health status,<br>or there is any other<br>reason documented in<br>the medical record by<br>the provider explaining<br>why BMI measurement<br>was not appropriate. | American Medical<br>Association-<br>convened<br>Physician<br>Consortium for<br>Performance<br>Improvement ®<br>(AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=898#k=0564&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=898#k=0564&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                      | Measure Description                                                                                                                                                                                                                                                                                                                | Numerator Statement                                                                                                                    | Denominator Statement                                                                                                                                  | Measure Steward                                                                                    | Link to NQF website                                                                                                                                                                                                                                                                                                                       |
|-----------------|-------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CMS133v1        | 0565  | Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery | Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery. | Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery | All patients aged 18 years and older who had cataract surgery                                                                                          | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=899#k=0565&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=899#k=0565&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a>   |
| CMS158v1        | 0608  | Pregnant women that had HBsAg testing                                              | This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.                                                                                                                                                                                                                                  | Patients who were tested for Hepatitis B surface antigen (HBsAg) during pregnancy within 280 days prior to delivery.                   | All female patients aged 12 and older who had a full term delivery during the measurement period.                                                      | OptumInsight                                                                                       | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1018#k=0608&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1018#k=0608&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS159v1        | 0710  | Depression Remission at Twelve Months                                              | 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. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.      | Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.          | Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter. | MN Community Measurement                                                                           | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=55#k=0710&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=55#k=0710&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a>     |

| CMS eMeasure ID | NQF # | Measure Title                                                           | Measure Description                                                                                                                                                                                                                                                                         | Numerator Statement                                                                                      | Denominator Statement                                                                                                                 | Measure Steward                                                                          | Link to NQF website                                                                                                                                                                                                                                                                                                                       |
|-----------------|-------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CMS160v1        | 0712  | Depression Utilization of the PHQ-9 Tool                                | Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.                                                                                         | Adult patients who have a PHQ-9 tool administered at least once during the four-month period.            | Adult patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during each four month period | MN Community Measurement                                                                 | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=56#k=0712&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=56#k=0712&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a>     |
| CMS75v1         | TBD   | Children who have dental decay or cavities                              | Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.                                                                                                                                                                                | Children who had cavities or decayed teeth.                                                              | Children, age 0-20 years, with a visit during the measurement period.                                                                 | Maternal and Child Health Bureau, Health Resources & Services Administration             |                                                                                                                                                                                                                                                                                                                                           |
| CMS177v1        | 1365  | Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment | Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.                                                                                                                                  | Patient visits with an assessment for suicide risk                                                       | All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder                           | American Medical Association-Physician Consortium for Performance Improvement (AMA-PCPI) | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1365#k=1365&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1365#k=1365&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |
| CMS82v1         | 1401  | Maternal depression screening                                           | The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life. | Children with documentation of maternal screening or treatment for postpartum depression for the mother. | Children with a visit who turned 6 months of age in the measurement period.                                                           | National Committee for Quality Assurance                                                 | <a href="http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1401#k=1401&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1">http://www.qualityforum.org/MeasureDetails.aspx?actid=0&amp;SubmissionId=1401#k=1401&amp;e=1&amp;st=&amp;sd=&amp;mt=&amp;cs=&amp;ss=&amp;s=n&amp;so=a&amp;p=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                                       | Measure Description                                                                                                                | Numerator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Measure Steward                                                            | Link to NQF website |
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| CMS74v1         | TBD   | Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists     | Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.                 | Children who receive a fluoride varnish application                                                                                                                                                                                                                                                                                                                                                                                                                            | Children, age 0-20 years, with a visit during the measurement period.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | University of Minnesota                                                    |                     |
| CMS61v1         | TBD   | Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed | Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed. | <p>Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period</p> <p>Numerator 2: (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period</p> <p>Numerator 3: (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period</p> | <p>Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent</p> <p>Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who have Multiple Risk Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men &gt;= 45; women &gt;= 55)</p> <p>Denominator 3: (Low Risk) All patients aged 20 through 79 years who have risk factors 0 or 1 of the following risk factors: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or</p> | Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services |                     |

| CMS<br>eMeasure ID | NQF # | Measure Title                                                                                                              | Measure Description                                                                                                                                                                            | Numerator Statement                                                                                                                                                                                                                                                              | Denominator<br>Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Measure Steward                                                                        | Link to NQF website |
|--------------------|-------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------|
|                    |       |                                                                                                                            |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                  | <p>Age (men &gt;= 45;<br/>women &gt;= 55)</p> <p>**For Denominator 2<br/>and Denominator 3,<br/>HDL-C &gt; or equal to 60<br/>mg/dL subtracts 1 risk<br/>from the above (This is<br/>a negative risk factor.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        |                     |
| CMS64v1            | TBD   | Preventive Care<br>and Screening:<br>Risk-Stratified<br>Cholesterol –<br>Fasting Low<br>Density<br>Lipoprotein (LDL-<br>C) | Percentage of patients<br>aged 20 through 79<br>years who had a fasting<br>LDL-C test performed<br>and whose risk-stratified<br>fasting LDL-C is at or<br>below the recommended<br>LDL-C goal. | <p>Numerator 1: Patients<br/>whose most recent fasting<br/>LDL-C test is &lt;100 mg/dL</p> <p>Numerator 2: Patients<br/>whose most recent fasting<br/>LDL-C test is &lt;130 mg/dL</p> <p>Numerator 3: Patients<br/>whose most recent fasting<br/>LDL-C test is &lt;160 mg/dL</p> | <p>Denominator 1: (High<br/>Risk) All patients aged<br/>20 through 79 years<br/>who had a fasting LDL-<br/>C or a calculated LDL-<br/>C test performed during<br/>the measurement<br/>period and have CHD<br/>or CHD Risk Equivalent<br/>OR</p> <p>Have Multiple Risk<br/>Factors (2+) of the<br/>following: Cigarette<br/>Smoking,<br/>Hypertension, Low<br/>High Density<br/>Lipoprotein (HDL-C)**,<br/>Family History of<br/>Premature CHD, or<br/>Age (men &gt;= 45;<br/>women &gt;= 55) AND a<br/>10-year Framingham<br/>risk &gt;20%</p> <p>Denominator 2:<br/>(Moderate Risk) All<br/>patients aged 20<br/>through 79 years who<br/>had a fasting LDL-C or<br/>a calculated LDL-C test<br/>performed during the<br/>measurement period<br/>and have Multiple Risk</p> | Quality Insights of<br>Pennsylvania/<br>Centers for<br>Medicare &<br>Medicaid Services |                     |

| CMS<br>eMeasure ID | NQF # | Measure Title | Measure Description | Numerator Statement | Denominator<br>Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Measure Steward | Link to NQF website |
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|                    |       |               |                     |                     | <p>Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men &gt;= 45; women &gt;= 55) and AND 10-year Framingham risk &lt;=20% Denominator 3: (Low Risk) All patients aged 20 through 79 years who have had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 of the following risk factors: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men &gt;= 45; women &gt;= 55)</p> <p>**HDL-C &gt; or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor)</p> |                 |                     |

| CMS eMeasure ID | NQF # | Measure Title                                           | Measure Description                                                                                                                                                                       | Numerator Statement                                                                                                                                                                                                                                                                | Denominator Statement                                                                                                                                                                                                                                                                  | Measure Steward                                                                                    | Link to NQF website |
|-----------------|-------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------|
| CMS149v1        | TBD   | Dementia: Cognitive Assessment                          | Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period. | Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period                                                                                                                                                          | All patients, regardless of age, with a diagnosis of dementia.                                                                                                                                                                                                                         | American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI) |                     |
| CMS65v1         | TBD   | Hypertension: Improvement in blood pressure             | Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.                                              | Patients whose follow-up blood pressure is at least 10 mmHg less than their baseline blood pressure or is adequately controlled.<br><br>If a follow-up blood pressure reading is not recorded during the measurement year, the patient's blood pressure is assumed "not improved." | All patients aged 18-85 years of age, who had at least one outpatient visit in the first six months of the measurement year, who have a diagnosis of hypertension documented during that outpatient visit, and who have uncontrolled baseline blood pressure at the time of that visit | Centers for Medicare & Medicaid Services                                                           |                     |
| CMS50v1         | TBD   | Closing the referral loop: receipt of specialist report | Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.                          | Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.                                                                                                                                         | Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.                                                                                                                                       | Centers for Medicare & Medicaid Services                                                           |                     |
| CMS66v1         | TBD   | Functional status assessment for knee replacement       | Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.          | Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10 Global Health; PROMIS-29, KOOS) not more than 180 days prior to the primary TKA procedure, and at least 60 days and not more than 180 days after TKA procedure                  | Adults, aged 18 and older, with a primary total knee arthroplasty (TKA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after TKA procedure.                                                            | Centers for Medicare & Medicaid Services                                                           |                     |

| CMS eMeasure ID | NQF # | Measure Title                                               | Measure Description                                                                                                                                                             | Numerator Statement                                                                                                                                                                                                                                                              | Denominator Statement                                                                                                                                                                                                    | Measure Steward                          | Link to NQF website |
|-----------------|-------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------|
| CMS56v1         | TBD   | Functional status assessment for hip replacement            | Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments. | Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10-Global Health, PROMIS-29, HOOS) not more than 180 days prior to the primary THA procedure, and at least 60 days and not more than 180 days after THA procedure.               | Adults aged 18 and older with a primary total hip arthroplasty (THA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after THA procedure. | Centers for Medicare & Medicaid Services |                     |
| CMS90v1         | TBD   | Functional status assessment for complex chronic conditions | Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments                            | Patients with patient reported functional status assessment results (e.g., VR-12; VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR at least two weeks before or during the initial encounter and the follow-up encounter during the measurement year. | Adults aged 65 years and older who had two outpatient encounters during the measurement year and an active diagnosis of heart failure.                                                                                   | Centers for Medicare & Medicaid Services |                     |

| CMS eMeasure ID | NQF # | Measure Title                                                                             | Measure Description                                                                                                                                                                                                                                        | Numerator Statement                                                                                                                                                      | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Measure Steward                                                            | Link to NQF website |
|-----------------|-------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------|
| CMS179v1        | TBD   | ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range                         | Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period. | Average percentage of time that patients in the measure population have INR results within the therapeutic range (i.e., TTR)                                             | Initial Patient Population statement: Patients aged 18 and older with atrial fibrillation without valvular heart disease who had been on chronic warfarin therapy for at least 180 days before the start of and during the measurement period. Patient should have at least one outpatient visit during the measurement period<br><br>Equals All in Initial Patient Population with sufficient international normalized ratio (INR) results to calculate a warfarin time in therapeutic range (TTR) | National Committee for Quality Assurance                                   |                     |
| CMS22v1         | TBD   | Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented | Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated                     | Patients who were screened for high blood pressure AND a recommended follow-up plan is documented as indicated if the blood pressure is pre-hypertensive or hypertensive | Percentage of patients aged 18 years and older before the start of the measurement period                                                                                                                                                                                                                                                                                                                                                                                                           | Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services |                     |

# **Technical Release Notes for 2014 eCQMs for Eligible Professionals**

## **RESOURCES FOR ELIGIBLE PROFESSIONALS**



**Clinical Quality Measures for CMS's 2014  
EHR Incentive Program for Eligible  
Professionals: Release Notes**

10/1/2012

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**CLINICAL QUALITY MEASURES FOR CMS'S 2014 EHR INCENTIVE PROGRAM  
FOR ELIGIBLE PROFESSIONALS  
RELEASE NOTES**

In August 2012, the Centers for Medicare & Medicaid Services (CMS) finalized the clinical quality measures (CQMs) for the 2014 Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Professionals, also known as Meaningful Use Stage 2 (MU2) for Eligible Professionals.<sup>1</sup> This list of CQMs for MU2 includes measures retained from Meaningful Use Stage 1 (MU1) for use in MU2. All retained MU1 measures have been updated based on advances in technology and tools for eMeasure development, comments from stakeholders, changes initiated by measure developers, and CMS's standards as defined in the agency's Measures Management System Blueprint, Version 8 (Blueprint).<sup>2</sup>

CMS recognizes the importance of providing support, training, and information to MU stakeholders, particularly as the EHR Incentive Programs transition to MU2. The purpose of this document is to inform eligible providers and the vendor community about updated program requirements related to the CQMs. This update includes information about global changes incorporated across all measures as well as specific changes to the measures retained in MU2. Global changes are listed first and include structural modifications; updates to value sets; and data elements and standards revised in accordance with the Blueprint. Specific changes to measures include changes to measure components, such as initial patient populations,

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<sup>1</sup> CMS. "Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2." 2012. Available at [\[http://www.ofr.gov/\(X\(1\)S\(uzclbwrx5fwqm2w2mipkysrh\)\)/OFRUpload/OFRData/2012-21050\\_PI.pdf\]](http://www.ofr.gov/(X(1)S(uzclbwrx5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf). Accessed August 28, 2012.

<sup>2</sup> CMS. "CMS Measure Management System Blueprint, Version 8." Available at [\[http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html\]](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html). Accessed August 28, 2012.

denominators, numerators, exclusions, and exceptions, as well as logic changes that affect how data elements interrelate during the measurement period.

This document is intended for readers who are familiar with eMeasure components and the current standards for constructing an eMeasure. For more information on eMeasures, please visit the CMS website (<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/QMGuideForReadingEHR.pdf>) and download the *Guide for Reading the EHR Incentive Program EP Measures*.

### **Global Edits**

- Introduced a new measure-identification scheme that combines the eMeasure identifier, National Quality Forum (NQF) number (if applicable), and eMeasure version number.
- Updated the rationale, clinical recommendation statements, and references to include the latest clinical guidance related to the measures.
- Provided additional guidance to help implementers interpret the calculation requirements for the measures.
- Updated the eMeasure header to reflect Blueprint requirements (such as using the initial patient population to define the denominator and including stratification variables in the header) and modified other fields, such as population criteria, to reflect these changes.
- Changed the standardization of the measurement period from “year” to “period.”
- Updated the measure logic to reflect the changes to the Quality Data Model (QDM), to reflect consistent use of relative timing across measures (including age calculation), occurrence, and denominator exclusions.
- Assigned data elements based on version 2.1.1.1 of the QDM<sup>3</sup> to each clinical concept, adding attributes as needed to precisely define QDM elements.
- For measures using the QDM of “Medication, Active,” added the AND / AND NOT construct to compensate for varying interpretations of the relative timing “during.” The “Medication, Active” period can start at any time but cannot end before “Occurrence A of Encounter, Performed.”

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<sup>3</sup> For more on the Quality Data Model, visit the NQF website at [http://www.qualityforum.org/Projects/h/QDS\\_Model/QDS\\_Version\\_2.1.aspx](http://www.qualityforum.org/Projects/h/QDS_Model/QDS_Version_2.1.aspx).

- Incorporated supplemental data elements (race, ethnicity, sex, and payer) as required by the Blueprint.
- Reorganized and retitled the encounter value sets to standardize them across developers. Also incorporated encounter value sets using SNOMED-CT to align with the Health Information Technology Standards Committee's (HITSC's) vocabulary recommendations for the QDM data type "Encounter."
- Updated existing value sets and added new value sets to align with the transitional and final vocabularies, based on the HITSC recommendations and required by the Blueprint.
- Fully specified ICD-9-CM and ICD-10-CM codes and, as applicable, ensured consistency with the 2012 Physician Quality Reporting Program (PQRS) measures.
- Provided grouping object identifiers for each data element.

#### **NQF 0002: Appropriate Testing for Children with Pharyngitis**

- Clarified the initial patient population to only include the review the first episode of tonsillitis or pharyngitis per patient.
- Included only ordered medications as a criteria for the initial patient population.
- Modified the denominator exclusions to only include active antibiotic medications
- Added the restriction that antibiotic medication in the denominator exclusions must be active 30 days before the diagnosis because the encounter is linked to the diagnosis through the initial patient population criteria.
- Required the laboratory test to have a result present to ensure that the test has been completed.
- Updated the numerator criteria to require the laboratory test for Streptococcus to occur within three days of the episode.

#### **NQF 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

- Updated the measure title for consistency with the measure titles used in other programs, such as the PQRS.
- Updated the measure description to define "adolescent and adult patients" as patients age 13 or older.
- Modified the structure of the measure so that it is a single measure with reporting stratified by age group.
- Changed the time window for the first diagnosis of alcohol or drug dependency in the initial patient population to the first 11 months of the measurement period.

- Updated the specifications to require use of diagnosis criteria to determine if the patient has the condition, and to require use of encounter criteria to identify the beginning of the episode by requiring the diagnosis to start during the encounter.
- Removed acute and nonacute inpatient encounters for numerator 1.
- Clarified that, to be compliant for numerator 2, the patient must meet the criteria for both numerator 1 and 2.

#### **NQF 0018: Controlling High Blood Pressure**

- Clarified that the diagnosis of hypertension could occur any time between the first part of the measurement period to before the measurement period.
- Changed the age range from age 17–84 to age 18–85.
- Clarified that the denominator exclusion of pregnancy had to be in the measurement period.
- Clarified that the systolic and diastolic blood pressure reading must come from the most recent visit.

#### **NQF 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**

- Modified the structure of the measure so it is a single measure with reporting stratified by age groups.
- Changed the age criteria of the initial patient population from patients age 2–17 to age 3–17.
- Clarified that the eligible encounter in the initial patient population should be with a primary care physician or obstetrician/gynecologist.
- Changed the denominator exclusion to only include a diagnosis of pregnancy.
- Added the patient’s height and weight to numerator criteria, in addition to body mass index.

#### **NQF 0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

- Combined the measure pair a and b into one measure, and updated the title to reflect this modification.
- Expanded the definition of “eligible encounters” in the initial patient population.
- Combined the numerator criteria from the previously paired measures.
- Updated the QDM data type for “Procedure, Performed: Tobacco Use Cessation Counseling to “Intervention, Performed: Tobacco Use Cessation Counseling.”

- Added denominator exceptions for medical reasons.

### **NQF 0031: Breast Cancer Screening**

- Added “female” sex criteria to the initial patient population.
- Changed the age criteria of the initial patient population from age 41–68 to age 42–69.
- Changed the eligible time period for an encounter in the initial patient population from two years to during the one-year measurement period.
- Clarified that because we are only looking for complete mastectomies, a patient that had two unilateral mastectomies should be excluded.
- Changed the numerator criterion from “performed” to requiring a “result” to be present.

### **NQF 0032: Cervical Cancer Screening**

- Added “female” sex criteria to the initial patient population.
- Changed the eligible time period for an encounter in the initial patient population from three years to during the one-year measurement period.
- Changed the age criteria of the initial patient population from age 23–63 to age 24–63.

### **NQF 0033: Chlamydia Screening for Women**

- Modified the structure of the measure so it is a single measure with reporting stratified by age group.
- Changed the age criteria of the initial patient population from age 15–24 to age 16–24.
- Added “female” sex criteria to the initial patient population.
- Updated the categories of events that identify women as sexually active.
- Removed active and dispensed medications and performed procedures from the list of exclusions, requiring only that the procedure or medication be ordered.

### **NQF 0034: Colorectal Cancer Screening**

- Changed the eligible time period for an encounter in the initial patient population from two years to during the one-year measurement period.
- Changed the age criteria of the initial patient population from age 50–74 to age 51–75.
- Added an exclusion for malignant neoplasm of the colon.

### **NQF 0036: Use of Appropriate Medications for Asthma**

- Changed the age criteria of the initial patient population from age 5–50 to age 5–64.
- Modified the structure of the measure so it is a single measure with reporting stratified by age groups.
- Clarified the eligible time window for a diagnosis of persistent asthma to any time before or during the measurement period, with a requirement of only one encounter.
- Modified the criteria for the initial patient population to require a diagnosis of asthma (medication alone will not suffice).
- Removed active and dispensed medications from the list of numerator criteria, requiring only that the medication be ordered.

### **NQF 0038: Childhood Immunization Status**

- Modified the measure to report only one combined rate; separate rates for each vaccine or a combination of vaccines will no longer be calculated.
- Clarified that the encounter criteria for the initial patient population does not need to be with a primary care or OB/GYN provider.
- Expanded the numerator criteria to include both medication administered and the procedure for administering the vaccine.
- Changed the exclusion for “medication allergy” to be defined by an anaphylactic reaction to the vaccine and allowed this reaction to count as numerator compliance for each vaccine.
- Combined the separate measles, mumps, and rubella (MMR) administered vaccines into one numerator criterion. Also updated the time window for MMR vaccine administration to occur any time before the patient’s second birthday in the numerator.
- Allowed past diagnoses of disease to count for the appropriate vaccine.
- Added a laboratory test for the hepatitis A antigen to the numerator criteria for the hepatitis A vaccine. Also updated hepatitis A medication criteria to allow only one vaccination to count for numerator compliance.
- Updated the HiB vaccine medication criteria to require three vaccinations for compliance.
- Separated two- and three-dose rotavirus vaccines to ensure the proper number of doses is administered.

### **NQF 0041: Preventive Care and Screening: Influenza Immunization**

- Updated the measure title to reflect the updated measure specifications.
- Expanded the age group to include all patients age 6 months or older in the initial patient population.
- Changed the time window of the denominator for which the encounters must occur to reflect the new time period for the flu season recommended by the Centers for Disease Control and Prevention.
- Added “peritoneal dialysis procedure” and “hemodialysis procedure” to the denominator criteria.
- Added to the numerator any communication from patient to provider regarding the previous receipt of a vaccine.

### **NQF 0043: Pneumonia Vaccination Status for Older Adults**

- Restricted the time window for an encounter in the initial patient population to only during the measurement period.
- Changed the age criteria of the initial patient population from age 64 and older to age 65 and older.
- Added pneumococcal vaccine administered and history of a pneumococcal vaccine to the numerator criteria.

### **NQF 0052: Use of Imaging Studies for Low-Back Pain**

- Rephrased the measure title.
- Changed the age criteria of the initial patient population from age 18–49 to age 18–50.
- Added the eligible age of patients (18–50) to the measure description.
- Specified that the low-back pain diagnosis must occur during an office or emergency-department visit no more than 337 days after the start of the measurement period.
- Moved the exclusion criteria for the denominator to the denominator-exclusion section, including a low-back pain diagnosis less than 180 days before occurrence A of a low-back pain diagnosis or a diagnosis of cancer, trauma, IV drug abuse, or neurologic impairment during the year before the measurement period.
- Changed the measure to calculate the number of patients with a diagnosis of low-back pain who did have an imaging study (e.g., X-ray, MRI, CT scan) within 28 days of the diagnosis; a lower rate is thus a better score for this measure.

### **NQF 0055: Eye Exam**

- Changed the age criteria of the initial patient population from age 18–74 to age 18–75.
- Removed from the denominator criteria any dispensed, ordered, or active medications indicative of diabetes.
- Updated the time window for an active diabetes diagnosis to any time before or during the measurement period.
- Modified the encounter criteria in the initial patient population, including limiting the time window to the measurement period.
- Modified the exclusion criteria for the denominator, including removing polycystic ovaries diagnosis and medications indicative of diabetes as well as restricting the time window for an active gestational-diabetes diagnosis to the measurement period.
- Limited the eye-exam procedures in the numerator to either a negative retinal exam during the year before the measurement period or a retinal or dilated eye exam during the measurement period.

### **NQF 0056: Diabetes: Foot Exam**

- Removed details about the type of diabetes (type 1 or 2) and type of foot exam (visual inspection, sensory exam with monofilament, or pulse exam) from the measure description.
- Changed the age criteria of the initial patient population from age 18–74 to age 18–75.
- Removed from the denominator criteria any dispensed, ordered, or active medications indicative of diabetes.
- Updated the time window for an active diabetes diagnosis to any time before or during the measurement period.
- Modified the encounter criteria in the initial patient population, including limiting the time window to the measurement period.
- Modified the exclusion criteria for the denominator, including removing polycystic ovaries and medications indicative of diabetes as well as restricting the time window for an active gestational-diabetes diagnosis to the measurement period.
- Modified the foot-exam criteria to include the specific components of the foot exam, including a visual exam and either a sensory or pulse exam during the measurement period.

### **NQF 0059: Diabetes: Hemoglobin A1c Poor Control**

- Changed the age criteria of the initial patient population from age 18–74 to age 18–75.
- Removed from the denominator criteria any dispensed, ordered, or active medications indicative of diabetes.
- Updated the time window for a diagnosis of active diabetes to any time before or during the measurement period.
- Modified the encounter criteria in the initial patient population, including limiting the time window to the measurement period.
- Modified the exclusion criteria for the denominator, including removing polycystic ovaries and medications indicative of diabetes as well as restricting the time window for an active gestational-diabetes diagnosis to the measurement period.
- Added the absence of an HbA1c laboratory test results during the measurement period for eligible patients as a numerator criterion.

### **NQF 0062: Diabetes: Urine Protein Screening**

- Updated the measure title to specify protein screening.
- Removed the details about the type of diabetes (type 1 or 2) from the measure description.
- Changed the age criteria of the initial patient population from age 18–74 to age 18–75.
- Removed from the denominator criteria any dispensed, ordered, or active medications indicative of diabetes.
- Updated the time window for a diagnosis of active diabetes to any time before or during the measurement period.
- Modified the encounter criteria in the initial patient population, including limiting the time window to the measurement period.
- Modified the exclusion criteria for the denominator, including removing polycystic ovaries and medications indicative of diabetes as well as restricting the time window for an active gestational-diabetes diagnosis to the measurement period.

#### **NQF 0064: Diabetes: Low-Density Lipoprotein (LDL) Management and Control**

- Removed “and Control” from the measure title.
- Specified in the measure description that LDL-C under 100 mg/dL is considered adequately controlled.
- Changed the age criteria of the initial patient population from age 18–74 to age 18–75.
- Removed from the denominator criteria any dispensed, ordered, or active medications indicative of diabetes.
- Updated the time window for an active diabetes diagnosis to any time before or during the measurement period.
- Modified the encounter criteria in the initial patient population, including limiting the time window to the measurement period.
- Modified the exclusion criteria for the denominator, including removing polycystic ovaries and medications indicative of diabetes as well as restricting the time window for an active gestational-diabetes diagnosis to the measurement period.
- Removed the screening indicator.

#### **NQF 0068: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic**

- Updated the measure description to reflect the change in the look-back period and active-medication requirement.
- Changed the age criteria of the initial patient population from age 17 and older to age 18 and older.
- Changed the “percutaneous transluminal cardiac angioplasty” category to the broader category of “percutaneous coronary interventions” for the initial patient population.
- Changed the eligible time period for diagnoses and procedures for the initial patient population from 2 to 12 months before the measurement period to the year before the measurement period.
- Removed the requirement from the initial patient population that the diagnosis and procedures of interest needed to occur during an encounter.
- Limited the numerator criteria to “medication active” (not ordered or dispensed), and required that the medication be active at some time during the measurement period.

**NQF 0070: Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left-Ventricular Systolic Dysfunction (LVEF) < 40%**

- Revised the measure title and description to reflect the most up-to-date information from the measure developer/steward.
- Divided the calculation of the measure into two rates to reflect the two distinct denominator populations. It is expected that the implementer will report each population score separately and a total score.
- Expanded the definition of eligible encounter in initial patient populations 1 and 2.
- Added a denominator population; denominator 1 includes patients with a prior (resolved) myocardial infarction, and denominator 2 includes patients with LVEF < 40%.
- Clarified the recommended type of beta-blocker therapy for each denominator population in the guidance statement and logic, in accordance with updated clinical recommendations.
- Added to the denominator exceptions additional methods of capturing allergies and intolerances, based on HITSC recommendations

**NQF 0075: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control**

- Changed the measure title from “LDL” to “LDL-C.”
- Specified in the measure description that LDL-C under 100 mg/dL is considered adequately controlled.
- Changed the age criteria of the initial patient population from age 17 and older to age 18 and older.
- Changed “percutaneous transluminal cardiac angioplasty” to the broader category of “percutaneous coronary interventions” for the initial patient population.
- Changed the eligible time period for diagnoses and procedures for the initial patient population from 2 to 12 months before the measurement period to the year before the measurement period.
- Removed the requirement from the initial patient population that the diagnosis and procedures of interest needed to occur during an encounter.
- Included a requirement in the numerator 1 criteria that a complete lipid-panel test result is present or all the separate components of a complete lipid panel must be performed and have a result.
- Changed numerator 2 criteria to include only a LDL-C lab test result < 100 mg/dL; removed the other components needed to calculate the LDL-C for high triglycerides.

**NQF 0081: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin-Receptor Blocker (ARB) Therapy for Left-Ventricular Systolic Dysfunction (LVSD)**

- Revised the measure description to reflect the most up-to-date information from the measure developer/steward.
- Removed one denominator option used to capture a patient with LVSD—“LVF ASSMT.”
- Changed all denominator options for capturing a patient with LVSD from a “starts before start of...” timing to “starts before or during...”
- Added to the denominator exception additional methods of capturing allergies and intolerances, based on HITSC recommendations.
- Refined the value sets for the denominator exception.
- Changed the QDM data type for “Patient reason for ACE inhibitor or ARB decline” value set.

**NQF 0083: Heart Failure (HF): Beta-Blocker Therapy for Left-Ventricular Systolic Dysfunction (LVSD)**

- Revised the measure description to reflect the most up-to-date information from the measure developer/steward.
- Removed one denominator option used to capture a patient with LVSD—“LVF ASSMT.”
- Changed all denominator options for capturing a patient with LVSD from a “starts before start of...” timing to “starts before or during...”
- Refined the value sets for the denominator exception.

**NQF 0086: Primary Open-Angle Glaucoma (POAG): Optic-Nerve Evaluation**

- Revised the measure description to reflect the most up-to-date information from the measure developer/steward.
- Expanded the “optic-nerve head evaluation” to capture its two components: cup-to-disc ratio and optic-disc exam for structural abnormalities.

**NQF 0088: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**

- Revised the measure logic of the numerator based on the updated QDM for type and category of the numerator criteria.

### **NQF 0089: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**

- Updated the denominator criteria from performing a macular or fundus exam to identifying the results of the diagnostic study.
- Further defined the results of the macular exam in the numerator by separating the findings into “present” or “absent.”

### **NQF 0105: Antidepressant Medication Management**

- Shortened the measure title.
- Updated the measure description to specify the two calculated rates.
- Changed the age criteria of the initial patient population from patients age 18 and older 245 days into the measurement period to age 18 and older at the start of the measurement period.
- Changed the eligible time period for a diagnosis of major depression in the initial patient population. The original time period was less than 245 days before the measurement period starts to no more than 245 days before the measurement period ends. The revised time period is less than 180 days before the measurement period starts to no more than 180 days after the measurement period ends.
- Removed the criterion that the depression diagnosis must occur during an encounter.
- Limited the criteria for the initial patient population to “antidepressant medication active” (not ordered or dispensed).
- Removed a denominator criterion that another diagnosis of depression not occur sooner than 120 days before the diagnosis of depression for the episode of interest.
- Added a denominator exclusion that another antidepressant medication not be active less than 90 days before the antidepressant medication of interest.
- Changed the numerator criteria for numerator 1 and 2 to focus on the cumulative amount of medication dispensed.

### **NQF 0385: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients**

- Revised the measure title and description to reflect the most up-to-date information from the measure developer/steward.
- Added “AJCC” to the measure title.
- Revised the measure description to include an upper limit of 80 years of age. Also revised the initial patient population to include all patients age 18 through 80 with colon cancer.

- Removed an inactive diagnosis of colon cancer (history of colon cancer) from the criteria for the initial patient population, as the measure is limited to patients with a first-recorded diagnosis of colon cancer during the 12-month reporting period (that is, during an eligible encounter between the patient and provider).
- Excluded patients whose clinical-staging procedure started before the active diagnosis of colon cancer.
- Excluded patients whose diagnosis of colon cancer was more than two years before the measurement end date.
- Specified that the patient’s clinical-staging procedure resulting in “colon distant metastasis status MO” started before the eligible encounter.
- Specified the tumor sizes and lymph-node statuses following the clinical-staging procedure that are eligible for inclusion in the denominator.
- Specified the timing of ordering or administering chemotherapy eligible for inclusion in the numerator.
- Alternate methods of capturing allergies and intolerances added to denominator exceptions to align with HITSC recommendations.

**NQF 0387: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR)-Positive Breast Cancer**

- Revised the measure title by deleting the term “oncology” to reflect the most up-to-date information from the measure developer/steward.
- Specified that an active diagnosis of breast cancer took place less than five years before the patient-provider encounter for the initial patient population.
- Removed an inactive diagnosis of breast cancer (history of breast cancer) from the criteria for the initial patient population, as the measure is limited to patients with a first-recorded diagnosis of breast cancer within the past five years.
- Excluded patients whose clinical-staging procedure started before the active diagnosis of breast cancer.
- Specified that the patient’s clinical-staging procedure resulting in “breast distant metastasis status MO” started before the eligible encounter.
- Removed the breast cancer Stage IC-IIIC procedure from the denominator criteria and added the clinical-staging procedure.
- Specified the tumor sizes and lymph-node statuses following the clinical-staging procedure that are eligible for inclusion in the denominator.
- Specified the eligible timing of the ordering and dispensing of tamoxifen or aromatase inhibitor therapy for numerator inclusion.

- Revised the denominator exceptions to capture clinical-trial participants and removed adverse medication events to align with HITSC recommendations.

**NQF 0389: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients**

- Corrected prostate-specific criterion for antigen test results from  $\leq 10$  mg/dL to  $\leq 10$  ng/mL.
- Removed “Procedure result: AJCC cancer stage low-risk recurrence prostate cancer” from denominator criteria.
- Added performance of a “clinical staging procedure” with result of prostate cancer primary tumor size T1c or T2a to denominator criteria.
- Added “Diagnostic Study, Order: Bone Scan (Source: ‘Other provider’)” to list of denominator exceptions (note: MU1 denominator exclusions are now considered denominator exceptions in MU2).

**NQF 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**

- Updated the description and numerator to include timing guidance for follow-up of “BMI outside of normal parameters” to include “in the past six months or during the current visit.”
- Added definitions for Body Mass Index (BMI), Calculated BMI, and Follow-Up Plan.
- Revised Denominator Exclusion by deleting “terminal illness” and system reasons for not calculating BMI, added “patients receiving palliative care,” and moved patient and medical reason for not calculating BMI to Denominator Exceptions.
- Clarified patient reason for not calculating BMI to include “The patient refuses BMI measurement.”
- Clarified medical or other reason for not calculating BMI to include “If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate” OR “If the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.”
- Added Care Goal and Communication follow-up to applicable above and below normal BMI follow-up interventions.
- Added BMI interventions for “Above Normal Follow-up,” “Above Normal Referrals,” “Above Normal Medications,” “Below Normal Follow-up,” “Below Normal Referrals,” and “Below Normal Medications.”

**Full Table of Recommended  
Adult Measures**  
**RESOURCES FOR  
ELIGIBLE  
PROFESSIONALS**





## 2014 Clinical Quality Measures (CQMs) Adult Recommended Core Measures



Please note, in Stage 2 of meaningful use, the core set requirement has been removed. Instead, the Centers for Medicare & Medicaid Services (CMS) proposed a recommended core which includes measures aligned with high priority health care improvement goals. If one or more of these measures are not relevant for your organization, please utilize other measures from the approved 2014 CQM set to meet the reporting requirement.

| CMS eMeasure ID & CQM Number                | CQM Title & Description                                                                                                                                                                                                                                                                                                                                                                                      | Measure Steward & Contact Information                                                                                             | Other Quality Measure Programs that use the Same CQM                                                                       | Domain                             |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| <b>CMS165v1</b><br><br><b>NQF 0018</b>      | <b>Controlling High Blood Pressure</b><br><br>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.                                                                                                                                                                                  | <b>National Committee for Quality Assurance (NCQA):</b><br><a href="http://www.ncqa.org">www.ncqa.org</a>                         | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ ACO</li> <li>▪ Group Reporting PQRS</li> <li>▪ UDS</li> </ul> | Clinical Process/<br>Effectiveness |
| <b>NEW: CMS156v1</b><br><br><b>NQF 0022</b> | <b>Use of High-Risk Medications in the Elderly</b><br><br>Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. <ol style="list-style-type: none"> <li>a. Percentage of patients who were ordered at least one high-risk medication.</li> <li>b. Percentage of patients who were ordered at least two different high-risk medications.</li> </ol> | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a>                                                                    | PQRS                                                                                                                       | Patient Safety                     |
| <b>CMS138v1</b><br><br><b>NQF 0028</b>      | <b>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</b><br><br>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.                                                                                                       | <b>AMA Physician Consortium for Performance Improvement (AMA-PCPI):</b><br><a href="mailto:cpe@ama-assn.org">cpe@ama-assn.org</a> | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ ACO</li> <li>▪ Group Reporting PQRS</li> <li>▪ UDS</li> </ul> | Population/<br>Public Health       |



2014 Clinical Quality Measures (CQMs)  
Adult Recommended Core Measures



| CMS eMeasure ID & CQM Number               | CQM Title & Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Measure Steward & Contact Information                                                                                                                                                                                                                                                    | Other Quality Measure Programs that use the Same CQM                                                        | Domain                                |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------|
| <b>CMS166v1</b><br><br><b>NQF 0052</b>     | <b>Use of Imaging Studies for Low Back Pain</b><br><br>Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.                                                                                                                                                                                                                                                                      | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a>                                                                                                                                                                                                                           |                                                                                                             | Efficient Use of Healthcare Resources |
| <b>NEW: CMS2v1</b><br><br><b>NQF 0418</b>  | <b>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</b><br><br>Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.                                                                                                                                     | <b>CMS:</b><br>1-888-734-6433, or<br><a href="http://questions.cms.hhs.gov/app/ask/p/21,26,1139">http://questions.cms.hhs.gov/app/ask/p/21,26,1139</a><br><br><b>Quality Insights of Pennsylvania (QIP):</b><br><a href="http://www.usqualitymeasures.org">www.usqualitymeasures.org</a> | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ ACO</li> <li>▪ Group Reporting PQRS</li> </ul> | Population/<br>Public Health          |
| <b>NEW: CMS68v1</b><br><br><b>NQF 0419</b> | <b>Documentation of Current Medications in the Medical Record</b><br><br>Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration. | <b>CMS:</b><br>1-888-734-6433, or<br><a href="http://questions.cms.hhs.gov/app/ask/p/21,26,1139">http://questions.cms.hhs.gov/app/ask/p/21,26,1139</a><br><br><b>QIP:</b><br><a href="http://www.usqualitymeasures.org">www.usqualitymeasures.org</a>                                    | <ul style="list-style-type: none"> <li>▪ PQRS</li> <li>▪ EHR PQRS</li> </ul>                                | Patient Safety                        |



## 2014 Clinical Quality Measures (CQMs) Adult Recommended Core Measures



| CMS eMeasure ID & CQM Number             | CQM Title & Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Measure Steward & Contact Information                                                                                                                                                                                                                               | Other Quality Measure Programs that use the Same CQM                                                                       | Domain                       |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------|
| <b>CMS69v1</b><br><br><b>NQF 0421</b>    | <p><b>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</b></p> <p>Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current reporting period documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current reporting period.</p> <p>Normal Parameters:</p> <ul style="list-style-type: none"> <li>▪ Age 65 years and older BMI ≥ 23 and &lt; 30</li> <li>▪ Age 18-64 years BMI ≥ 18.5 and &lt; 25</li> </ul> | <p><b>CMS:</b><br/>1-888-734-6433,<br/>or<br/><a href="http://questions.cms.hhs.gov/app/ask/p/21,26,1139">http://questions.cms.hhs.gov/app/ask/p/21,26,1139</a></p> <p><b>QIP:</b><br/><a href="http://www.usqualitymeasures.org">www.usqualitymeasures.org</a></p> | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ ACO</li> <li>▪ Group Reporting PQRS</li> <li>▪ UDS</li> </ul> | Population/<br>Public Health |
| <p><u><b>New:</b></u> <b>CMS50v1</b></p> | <p><b>Closing the referral loop: receipt of specialist report</b></p> <p>Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.</p>                                                                                                                                                                                                                                                                                                                                                                   | <p><b>CMS:</b><br/>1-888-734-6433,<br/>or<br/><a href="http://questions.cms.hhs.gov/app/ask/p/21,26,1139">http://questions.cms.hhs.gov/app/ask/p/21,26,1139</a></p>                                                                                                 |                                                                                                                            | Care<br>Coordination         |

**Full Table of Recommendation  
Pediatric Measures  
RESOURCES FOR  
ELIGIBLE  
PROFESSIONALS**





## 2014 Clinical Quality Measures (CQMs) Pediatric Recommended Core Measures



Please note, in Stage 2 of meaningful use, the core set requirement has been removed. Instead, the Centers for Medicare & Medicaid Services (CMS) proposed a recommended core which includes measures aligned with high priority health care improvement goals. If one or more of these measures are not relevant for your organization, please utilize other measures from the approved 2014 CQM set to meet the reporting requirement.

| CMS<br>eMeasure ID &<br>CQM Number     | CQM Title & Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Measure<br>Steward &<br>Contact<br>Information                                                            | Other Quality<br>Measure<br>Programs that<br>use the Same<br>CQM                                                                                                          | Domain                                |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| <b>CMS146v1</b><br><br><b>NQF 0002</b> | <b>Appropriate Testing for Children with Pharyngitis</b><br><br>Percentage of children 2-18 years of age, who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>National Committee for Quality Assurance (NCQA):</b><br><a href="http://www.ncqa.org">www.ncqa.org</a> | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ CHIPRA</li> </ul>                                                                                            | Efficient Use of Healthcare Resources |
| <b>CMS155v1</b><br><br><b>NQF 0024</b> | <b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</b><br><br>Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. <ul style="list-style-type: none"> <li>▪ Percentage of patients with height, weight, and body mass index (BMI) percentile documentation.</li> <li>▪ Percentage of patients with counseling for nutrition.</li> <li>▪ Percentage of patients with counseling for physical activity.</li> </ul> | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a>                                            | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ UDS</li> </ul>                                                                                               | Population/<br>Public Health          |
| <b>CMS153v1</b><br><br><b>NQF 0033</b> | <b>Chlamydia Screening for Women</b><br><br>Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement period.                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a>                                            | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ CHIPRA</li> <li>▪ ACA 2701</li> <li>▪ HEDIS</li> <li>▪ State Use</li> <li>▪ NCQA-PCMH Recognition</li> </ul> | Population/<br>Public Health          |



**2014 Clinical Quality Measures (CQMs)  
Pediatric Recommended Core Measures**



| CMS eMeasure ID & CQM Number                       | CQM Title & Description                                                                                                                                                                                                                                                                                                                                                                                                                           | Measure Steward & Contact Information                          | Other Quality Measure Programs that use the Same CQM                                      | Domain                                      |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------|
| <b>CMS126v1</b><br><br><b>NQF 0036</b>             | <b>Use of Appropriate Medications for Asthma</b><br><br>Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.                                                                                                                                                                                                                      | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a> | EHR PQRS                                                                                  | Clinical Process/<br>Effectiveness          |
| <b>CMS117v1</b><br><br><b>NQF 0038</b>             | <b>Childhood Immunization Status</b><br><br>Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a> | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ UDS</li> </ul>               | Population/<br>Public Health                |
| <b><u>NEW:</u> CMS154v1</b><br><br><b>NQF 0069</b> | <b>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</b><br><br>Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.                                                                                                                                                           | <b>NCQA:</b><br><a href="http://www.ncqa.org">www.ncqa.org</a> | <ul style="list-style-type: none"> <li>▪ PQRS</li> <li>▪ NCQA-PCMH Recognition</li> </ul> | Efficient Use<br>of Healthcare<br>Resources |



2014 Clinical Quality Measures (CQMs)  
Pediatric Recommended Core Measures



| CMS<br>eMeasure ID &<br>CQM Number                   | CQM Title & Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Measure<br>Steward &<br>Contact<br>Information                                                                                                                                                                                                                                                                                            | Other Quality<br>Measure<br>Programs that<br>use the Same<br>CQM                                            | Domain                                         |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <p><b>NEW: CMS136v1</b><br/><br/><b>NQF 0108</b></p> | <p><b>ADHD: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication</b></p> <p>Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.</p> <p>a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.</p> <p>b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</p> | <p><b>NCQA:</b><br/><a href="http://www.ncqa.org">www.ncqa.org</a></p>                                                                                                                                                                                                                                                                    |                                                                                                             | <p>Clinical<br/>Process/<br/>Effectiveness</p> |
| <p><b>NEW: CMS2v1</b><br/><br/><b>NQF 0418</b></p>   | <p><b>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</b></p> <p>Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.</p>                                                                                                                                                                                                                                                                                                                                                                              | <p><b>Centers for Medicare &amp; Medicaid Services (CMS):</b><br/>1-888-734-6433, or<br/><a href="http://questions.cms.hhs.gov/ask/p/21,26,1139">http://questions.cms.hhs.gov/ask/p/21,26,1139</a></p> <p><b>Quality Insights of Pennsylvania (QIP):</b><br/><a href="http://www.usqualitymeasures.org">www.usqualitymeasures.org</a></p> | <ul style="list-style-type: none"> <li>▪ EHR PQRS</li> <li>▪ ACO</li> <li>▪ Group Reporting PQRS</li> </ul> | <p>Population/<br/>Public Health</p>           |



2014 Clinical Quality Measures (CQMs)  
Pediatric Recommended Core Measures



| CMS<br>eMeasure ID &<br>CQM Number | CQM Title & Description                                                                                                                                               | Measure<br>Steward &<br>Contact<br>Information                                                                                                                   | Other Quality<br>Measure<br>Programs that<br>use the Same<br>CQM | Domain                          |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------|
| <b>NEW: CMS75v1</b>                | <p><b>Children who have dental decay or cavities</b></p> <p>Percentage of children ages 0-20, who have had tooth decay or cavities during the measurement period.</p> | <p>Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB-HRSA):<br/><a href="http://mchb.hrsa.gov/">http://mchb.hrsa.gov/</a></p> |                                                                  | Clinical Process/ Effectiveness |

**Stage 2 Meaningful Use  
Specification Sheet Table of  
Contents for Eligible Hospitals  
and CAHs**

**RESOURCES FOR  
ELIGIBLE HOSPITALS &  
CRITICAL ACCESS  
HOSPITALS**



# Stage 2

## Eligible Hospital and Critical Access Hospital (CAH) Meaningful Use Core and Menu Objectives

### Table of Contents

Date issued: October, 2012

| Eligible Hospital Core Objectives |                                                                                                                                                                                                                                                                            |
|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (1)                               | Use <a href="#">computerized provider order entry (CPOE)</a> for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.         |
| (2)                               | Record all of the following <a href="#">demographics</a> : preferred language, sex, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.                                                         |
| (3)                               | Record and chart changes in the following <a href="#">vital signs</a> : height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI. |
| (4)                               | Record <a href="#">smoking status</a> for patients 13 years old or older.                                                                                                                                                                                                  |
| (5)                               | Use <a href="#">clinical decision support</a> to improve performance on high-priority health conditions.                                                                                                                                                                   |
| (6)                               | <a href="#">Provide patients the ability to view online, download, and transmit</a> information about a hospital admission.                                                                                                                                                |
| (7)                               | <a href="#">Protect electronic health information</a> created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.                                                                                              |
| (8)                               | Incorporate <a href="#">clinical lab test results</a> into Certified EHR Technology as structured data.                                                                                                                                                                    |
| (9)                               | <a href="#">Generate lists of patients</a> by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.                                                                                                                         |
| (10)                              | Use clinically relevant information from Certified EHR Technology to identify <a href="#">patient-specific education resources</a> and provide those resources to the patient.                                                                                             |
| (11)                              | The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform <a href="#">medication reconciliation</a> .                                                                       |
| (12)                              | The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a <a href="#">summary care record for each transition of care</a> or referral.                      |
| (13)                              | Capability to submit <a href="#">electronic data to immunization registries</a> or immunization information systems except where prohibited, and in accordance with applicable law and practice.                                                                           |
| (14)                              | Capability to submit <a href="#">electronic reportable laboratory results</a> to public health agencies, where except where prohibited, and in accordance with applicable law and practice.                                                                                |
| (15)                              | Capability to submit <a href="#">electronic syndromic surveillance data</a> to public health agencies, except where prohibited, and in accordance with applicable law and practice.                                                                                        |
| (16)                              | Automatically track medications from order to administration using assistive technologies in conjunction with an <a href="#">electronic medication administration record (eMAR)</a> .                                                                                      |



## Eligible Hospital Menu Objectives

|     |                                                                                                                                                    |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------|
| (1) | Record whether a patient 65 years old or older has an <a href="#">advance directive</a> .                                                          |
| (2) | Record <a href="#">electronic notes</a> in patient records.                                                                                        |
| (3) | <a href="#">Imaging results</a> consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT. |
| (4) | Record patient <a href="#">family health history</a> as structured data.                                                                           |
| (5) | Generate and transmit permissible discharge <a href="#">prescriptions electronically (eRx)</a> .                                                   |
| (6) | Provide structured <a href="#">electronic lab results</a> to ambulatory providers.                                                                 |

View or download all of the eligible hospital and CAH [Stage 2 Core and Menu Objectives](#) for Stage 2.



**Stage 1 vs. Stage 2 Comparison  
Table for Eligible Hospitals  
and CAHs**

**RESOURCES FOR  
ELIGIBLE HOSPITALS &  
CRITICAL ACCESS  
HOSPITALS**



# Stage 1 vs. Stage 2 Comparison Table for Eligible Hospitals and CAHs

Last Updated: August, 2012

## CORE OBJECTIVES (16 total)

| Stage 1 Objective                                                                                                                                                                                                                                                                   | Stage 1 Measure                                                                                                                                                                                                                            | Stage 2 Objective                                                                                                                                                                                                                                                                                 | Stage 2 Measure                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines                                                                                                   | More than 30% of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE | Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines                                                   | More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE |
| Implement drug-drug and drug-allergy interaction checks                                                                                                                                                                                                                             | The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period                                                                                                                                               | <b><i>No longer a separate objective for Stage 2</i></b>                                                                                                                                                                                                                                          | <b><i>This measure is incorporated into the Stage 2 Clinical Decision Support measure</i></b>                                                                                                                                                            |
| Record demographics <ul style="list-style-type: none"> <li>• Preferred language</li> <li>• Gender</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Date of birth</li> <li>• Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH</li> </ul> | More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data                                                           | Record the following demographics <ul style="list-style-type: none"> <li>• Preferred language</li> <li>• Gender</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Date of birth</li> <li>• Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH</li> </ul> | More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data                                                                         |

|                                                                     |                                                                                                                                                                                                                                                                       |                                                   |                                                                                                                                      |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Maintain an up-to-date problem list of current and active diagnoses | More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data                    | <b>No longer a separate objective for Stage 2</b> | <b><i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i></b> |
| Maintain active medication list                                     | More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data | <b>No longer a separate objective for Stage 2</b> | <b><i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i></b> |
| Maintain active medication allergy list                             | More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data          | <b>No longer a separate objective for Stage 2</b> | <b><i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i></b> |



|                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Record and chart changes in vital signs:</p> <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts for children 2-20 years, including BMI</li> </ul> | <p>More than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), blood pressure height and weight are recorded as structured data</p> | <p>Record and chart changes in vital signs:</p> <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure (age 3 and over)</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts for patients 0-20 years, including BMI</li> </ul> | <p>More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data</p>                                                                                                                                             |
| <p>Record smoking status for patients 13 years old or older</p>                                                                                                                                                                                                              | <p>More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data</p>        | <p>Record smoking status for patients 13 years old or older</p>                                                                                                                                                                                                                               | <p>More than 80% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data</p>                                                                                                                                                                                               |
| <p>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule</p>                                                                                                                     | <p>Implement one clinical decision support rule</p>                                                                                                                                                                    | <p>Use clinical decision support to improve performance on high-priority health conditions</p>                                                                                                                                                                                                | <ol style="list-style-type: none"> <li>1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period.</li> <li>2. The eligible hospital or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period</li> </ol> |

|                                                                                                                                                                              |                                                                                                                                                                                                                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Report clinical quality measures (CQMs) to CMS or the States                                                                                                                 | For 2011, provide aggregate numerator, denominator, and exclusions through attestation or electronically through the Hospital Reporting Pilot                                                                            | <b><i>No longer a separate objective for Stage 2, but providers must still submit CQMs to CMS or the States in order to achieve meaningful use</i></b> | <b><i>Starting in 2014, all CQMs will be submitted electronically to CMS.</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request | More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days | Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital          | <ul style="list-style-type: none"> <li>i. More than 50% of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period are provided timely (available to the patient within 36 hours after discharge from the hospital.) online access to their health information</li> <li>ii. More than 5% of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information</li> </ul> |

|                                                                                                                                                                                                                     |                                                                                                                                                                                                                                    |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                          |
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| Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request                                                                                                         | More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it | <b><i>This objective is eliminated from Stage 1 in 2014 and is no longer a separate objective for Stage 2</i></b>                                            | <b><i>This measure has been incorporated into the View, Download, and Transmit objective for Stage 2</i></b>                                                                                                                                                                                             |
| Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically | Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information                                                                                                             | <b><i>This objective is eliminated from Stage 1 in 2013 and is no longer an objective for Stage 2</i></b>                                                    | <b><i>This measure is eliminated from Stage 1 in 2013 and is no longer a measure for Stage 2</i></b>                                                                                                                                                                                                     |
| Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities                                                        | Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process                               | Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities | Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process |

|                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Implement drug-formulary checks                                                                                                  | The eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period                                                                                                                                                                                                     | <b>No longer a separate objective for Stage 2</b>                                                                                 | <b>This measure is incorporated into the e-Prescribing measure for Stage 2</b>                                                                                                                                                                                                                                                                                    |
| Incorporate clinical lab-test results into certified EHR technology as structured data                                           | More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data | Incorporate clinical lab-test results into Certified EHR Technology as structured data                                            | More than 55% of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data |
| Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach | Generate at least one report listing patients of the eligible hospital or CAH with a specific condition                                                                                                                                                                                                                                                             | Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach | Generate at least one report listing patients of the eligible hospital or CAH with a specific condition                                                                                                                                                                                                                                                           |



|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate                                                                                                      | More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources                                           | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate                                                                                                      | More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient and emergency departments (POS 21 and 23) are provided patient-specific education resources identified by Certified EHR Technology                                                                                                                                                                                                                                                                                         |
| The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation                                                          | The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) | The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation                                                          | The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)                                                                                                                                                                                                                                                                                         |
| The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals                  | The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | <ol style="list-style-type: none"> <li>1. The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals</li> <li>2. The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the</li> </ol> |



|  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |  |  | <p>recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or is validated through an ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals</p> <p>3. The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designed test EHR during the EHR reporting period</p> |
|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Capability to submit electronic data to immunization registries or Immunization Systems and actual submission except where prohibited and in accordance with applicable law and practice</p>                                      | <p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information have the capacity to receive the information electronically)</p>                            | <p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice</p>                          | <p>Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period</p>                                                |
| <p>Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice</p> | <p>Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)</p> | <p>Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice</p> | <p>Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice</p> |



|                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                        |                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically) | Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice | Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period                                                                            |
| <b>NEW</b>                                                                                                                                                                             | <b>NEW</b>                                                                                                                                                                                                                                                                                                                                                              | Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)                    | More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked are tracked using eMAR |



## MENU OBJECTIVES (Eligible Hospitals and CAHs must report on 3 of 6 menu objectives)

| Stage 1 Objective                                            | Stage 1 Measure                                                                                                                                                                                  | Stage 2 Objective                                                                                                                  | Stage 2 Measure                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Record advance directives for patients 65 years old or older | More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded | Record whether a patient 65 years old or older has an advance directive                                                            | More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data                                                                 |
| <b>NEW</b>                                                   | <b>NEW</b>                                                                                                                                                                                       | Record electronic notes in patient records                                                                                         | Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period                                                                                   |
| <b>NEW</b>                                                   | <b>NEW</b>                                                                                                                                                                                       | Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT. | More than 10% of all scans and tests whose result is an image ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are incorporated into or accessible through Certified EHR Technology |

|            |            |                                                                                |                                                                                                                                                                                                                                                                                                    |
|------------|------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>NEW</b> | <b>NEW</b> | Record patient family health history as structured data                        | More than 20% of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been reviewed |
| <b>NEW</b> | <b>NEW</b> | Generate and transmit permissible discharge prescriptions electronically (eRx) | More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology                                                                   |
| <b>NEW</b> | <b>NEW</b> | Provide structured electronic lab results to ambulatory providers              | Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received                                                                                                                                                         |



**Payment Adjustment & Hardship  
Exceptions Tipsheet for Eligible  
Hospitals and CAHs**

**RESOURCES FOR  
ELIGIBLE HOSPITALS &  
CRITICAL ACCESS  
HOSPITALS**



# Payment Adjustments & Hardship Exceptions TipSheet for Eligible Hospitals and CAHs

Last Updated: August, 2012

## Overview

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible hospitals, and critical access hospitals (CAHs) that are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on October 1, 2014, for Medicare eligible hospitals. Payment adjustments for CAHs will be applied beginning with the fiscal year 2015 cost reporting period. Medicaid eligible hospitals that can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

Eligible hospitals and CAHs that can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.

## Payment Adjustment for Medicare Subsection (d) Eligible Hospitals

Medicare Subsection (d) eligible hospitals that are not meaningful users will be subject to a payment adjustment beginning on October 1, 2014. This payment adjustment is applicable to the percentage increase to the Inpatient Prospective Payment System (IPPS) payment rate for those eligible hospitals that are not meaningful EHR users. These hospitals will receive a reduced update to the IPPS standardized amount. The payment adjustment is cumulative for each year that a Medicare Subsection (d) eligible hospital is not a meaningful EHR user. The table below illustrates the application of the reduced update to the IPPS standardized amount.

|            | 2015 | 2016 | 2017 | 2018 | 2019 | 2020+ |
|------------|------|------|------|------|------|-------|
| % Decrease | 25%  | 50%  | 75%  | 75%  | 75%  | 75%   |

For example if the increase to IPPS for 2015 was 2%, then an Medicare subsection (d) eligible hospital that is not a meaningful user would only receive a 1.5% increase in 2015.

Medicare Subsection (d) eligible hospitals that first demonstrated meaningful use in fiscal year 2011 or 2012 must demonstrate meaningful use for a full year in fiscal year 2013 to avoid payment adjustments in 2015. They must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for Medicare Subsection (d) eligible hospitals that must demonstrate meaningful use for a full year in 2013.



|                                       |      |      |      |      |      |      |
|---------------------------------------|------|------|------|------|------|------|
| <b>Payment Adjustment Year</b>        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| <b>Full Year EHR Reporting Period</b> | 2013 | 2014 | 2015 | 2016 | 2017 | 2019 |

Medicare Subsection (d) eligible hospitals that first demonstrate meaningful use in fiscal year 2013 must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid payment adjustments in 2015. They must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for EPs who demonstrate meaningful use for a 90-day reporting period in 2013.

|                                       |      |      |      |      |      |      |
|---------------------------------------|------|------|------|------|------|------|
| <b>Payment Adjustment Year</b>        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| <b>90 day EHR Reporting Period</b>    | 2013 |      |      |      |      |      |
| <b>Full Year EHR Reporting Period</b> |      | 2013 | 2013 | 2013 | 2013 | 2013 |

Medicare Subsection (d) eligible hospitals that first demonstrate meaningful use in fiscal year 2014 must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first 9 months of fiscal year 2014, and Medicare Subsection (d) eligible hospitals must attest to meaningful use no later than July 1, 2014, in order to avoid the payment adjustments. Medicare Subsection (d) eligible hospitals must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. The table below illustrates the timeline to avoid payment adjustments for Medicare Subsection (d) eligible hospitals that first demonstrate meaningful use in 2014.

|                                       |       |      |      |      |      |      |
|---------------------------------------|-------|------|------|------|------|------|
| <b>Payment Adjustment Year</b>        | 2015  | 2016 | 2017 | 2018 | 2019 | 2020 |
| <b>90 day EHR Reporting Period</b>    | 2014* | 2014 |      |      |      |      |
| <b>Full Year EHR Reporting Period</b> |       |      | 2015 | 2016 | 2017 | 2019 |

\* Medicare Subsection (d) eligible hospitals must attest to meaningful use no later than April 1, 2014.



## Payment Adjustment for Critical Access Hospitals

Critical Access Hospitals (CAHs) that are not meaningful users will be subject to a payment adjustment for fiscal year 2015. This payment adjustment is applicable to a CAH's Medicare reimbursement for inpatient services during the cost reporting period in which they failed to demonstrate meaningful use. If a CAH has not demonstrated meaningful use for an applicable reporting period, then for a cost reporting period that begins in FY 2015, its reimbursement would be reduced from 101 percent of its reasonable costs to 100.66 percent. For a cost reporting period beginning in FY 2016, its reimbursement would be reduced to 100.33 percent of its reasonable costs. For a cost reporting period beginning in FY 2017 and each subsequent FY, its reimbursement would be reduced to 100 percent of reasonable costs. The table below illustrates the application of the payment adjustments to CAHs that fail to demonstrate meaningful use.

|                       | 2015    | 2016    | 2017 | 2018 | 2019 | 2020+ |
|-----------------------|---------|---------|------|------|------|-------|
| % of reasonable costs | 100.66% | 100.33% | 100% | 100% | 100% | 100%  |

In order to avoid the payment adjustments, CAHs must demonstrate meaningful use within the full Federal fiscal year that is the same as the payment adjustment year. The adjustment would then apply based upon the cost reporting period that begins in the payment adjustment year (that is, fiscal year 2015 and thereafter). Thus, if a CAH is not a meaningful user for fiscal year 2015, and thereafter, then the adjustment would be applied to the CAH's reasonable costs incurred in a cost reporting period that begins in that affected fiscal year. The table below illustrates the timeline to avoid payment adjustments for CAHs that demonstrate meaningful use for the first time prior to fiscal year 2015.

| Payment Adjustment Year        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|--------------------------------|------|------|------|------|------|------|
| Full Year EHR Reporting Period | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |

The table below illustrates the timeline to avoid payment adjustments for CAHs that demonstrate meaningful use for the first time in fiscal year 2015.

| Payment Adjustment Year        | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|--------------------------------|------|------|------|------|------|------|
| 90 day EHR Reporting Period    | 2015 |      |      |      |      |      |
| Full Year EHR Reporting Period |      | 2016 | 2017 | 2018 | 2019 | 2020 |



Note: CAHs are required to submit their attestations for meaningful use by November 30th of the following fiscal year. For example, if a CAH is attesting that it was a meaningful EHR user for fiscal year 2015, the attestation must be submitted no later than November 30, 2015 in order to avoid payment adjustments.

## Hardship Exceptions for Medicare Eligible Hospitals and CAHs

Eligible hospitals and CAHs may apply for hardship exceptions to avoid the payment adjustments described above. Hardship exceptions will be granted only under specific circumstances and only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use. Information on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website ([www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)) in the future.

Medicare Subsection (d) eligible hospitals can apply for hardship exceptions in the following categories:

- **Infrastructure** — Eligible hospitals must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- **New eligible hospitals** — Eligible hospitals with new CMS Certification Numbers (CCNs) that would not have had time to become meaningful users can apply for a limited exception to payment adjustments. The hardship exception is limited to one full-year cost reporting period.
- **Unforeseen Circumstances** — Examples may include a natural disaster or other unforeseeable barrier.

Critical Access Hospitals (CAHs) can apply for hardship exceptions in the following categories:

- **Infrastructure** — CAHs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- **New CAHs** — CAHs with new CMS Certification Numbers (CCNs) that would not have had time to become meaningful users can apply for a limited exception to payment adjustments. The hardship exception is limited to one full year after the CAH accepts its first patient.
- **Unforeseen Circumstances** — Examples may include a natural disaster or other unforeseeable barrier.

## Frequently Asked Questions

**Does a hospital have to achieve meaningful use each year to avoid the payment adjustments or can it avoid the payment adjustments by achieving meaningful use only once?**

Hospitals must demonstrate meaningful use every year according to the timelines detailed above in order to avoid Medicare payment adjustments. For example, eligible hospital that demonstrates meaningful use for the first time in 2013 will avoid the payment adjustment in 2015, but will need to demonstrate meaningful use again in 2014 in order to avoid the payment adjustment in 2016. Similarly,



CAHs that demonstrate meaningful use in fiscal year 2015 will avoid the payment adjustment in 2015, but they also must demonstrate meaningful use in fiscal year 2016 to avoid the payment adjustment in 2016.

**How does a hospital demonstrate meaningful use in order to avoid a payment adjustment?**

An eligible hospital or CAH demonstrates meaningful use by successfully attesting through either the CMS Medicare EHR Incentive Programs Attestation System (<https://ehrincentives.cms.gov/>) or through its state's attestation system.



**2014 CQMs for Eligible Hospitals**  
**RESOURCES FOR**  
**ELIGIBLE HOSPITALS &**  
**CRITICAL ACCESS**  
**HOSPITALS**



CLINICAL QUALITY MEASURES FINALIZED FOR ELIGIBLE HOSPITALS AND CRITICAL ACCESS HOSPITALS  
BEGINNING WITH FY 2014

| CMS eMeasure ID | NQF # | Measure Title                                                                                                                                     | Measure Description                                                                                                                                                                       | Numerator Statement                                                                                                                                                                             | Denominator Statement                                                                                                                                                                                                   | Measure Steward                 | Link to NQF website                                                                                                                                                                                             |
|-----------------|-------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 55              | 0495  | Emergency Department (ED)-1<br>Emergency Department<br>Throughput – Median<br>time from ED arrival<br>to ED departure for<br>admitted ED patients | Median time from<br>emergency department<br>arrival to time of<br>departure from the<br>emergency room for<br>patients admitted to the<br>facility from the<br>emergency department.      | For Meaningful Use<br>Stage 2 reporting:<br>Median time (in minutes)<br>from ED arrival to ED<br>departure for patients<br>admitted to the facility<br>from the emergency<br>department.        | For Meaningful Use<br>Stage 2 reporting: All ED<br>patients admitted to the<br>facility from the ED and<br>stratified according to<br>Inpatient Admission or<br>Diagnosis of<br>Psychiatric/Mental<br>Health condition  | CMS<br>OFMQ is the<br>developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=470&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=470&amp;print=0&amp;entityTypeID=1</a> |
| 111             | 0497  | ED-2 Emergency<br>Department<br>Throughput –<br>admitted patients –<br>Admit decision time<br>to ED departure time<br>for admitted patients       | Median time (in minutes)<br>from admit decision time<br>to time of departure from<br>the emergency<br>department for<br>emergency department<br>patients admitted to<br>inpatient status. | For Meaningful Use<br>Stage 2 reporting:<br>Median time (in minutes)<br>from Decision to Admit<br>to ED departure for<br>patients admitted to the<br>facility from the<br>emergency department. | For Meaningful Use<br>Stage 2 reporting: All<br>ED patients admitted to<br>the facility from the ED<br>and stratified according<br>to Inpatient Admission or<br>Diagnosis of<br>Psychiatric/Mental<br>Health condition. | CMS<br>OFMQ is the<br>developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=472&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=472&amp;print=0&amp;entityTypeID=1</a> |
| 104             | 0435  | Stroke-2 Ischemic<br>stroke – Discharged<br>on anti-thrombotic<br>therapy.                                                                        | Ischemic stroke patients<br>prescribed antithrombotic<br>therapy at hospital<br>discharge.                                                                                                | Ischemic stroke patients<br>prescribed<br>antithrombotic therapy at<br>hospital discharge.                                                                                                      | Ischemic stroke patients.                                                                                                                                                                                               | The Joint<br>Commission         | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=672&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=672&amp;print=0&amp;entityTypeID=1</a> |
| 71              | 0436  | Stroke-3 Ischemic<br>stroke –<br>Anticoagulation<br>Therapy for Atrial<br>Fibrillation/Flutter                                                    | Ischemic stroke patients<br>with atrial fibrillation/flutter<br>who are prescribed<br>anticoagulation therapy at<br>hospital discharge.                                                   | Ischemic stroke patients<br>prescribed<br>anticoagulation therapy<br>at hospital discharge.                                                                                                     | Ischemic stroke patients<br>with documented atrial<br>fibrillation/flutter.                                                                                                                                             | The Joint<br>Commission         | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=673&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=673&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                | Measure Description                                                                                                                                                                                                       | Numerator Statement                                                                                                                                                        | Denominator Statement                                                                                                                                               | Measure Steward      | Link to NQF website                                                                                                                                                                                                 |
|-----------------|-------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 91              | 0437  | Stroke-4 Ischemic stroke – Thrombolytic Therapy                              | Acute ischemic stroke patients who arrive at this hospital within 2 hours (120 minutes) of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours (180 minutes) of time last known well. | Acute ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (less than or equal to 180 minutes) of time last known well. | Acute ischemic stroke patients whose time of arrival is within 2 hours (less than or equal to 120 minutes) of time last known well.                                 | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=674&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=674&amp;print=0&amp;entityTypeID=1</a> |
| 72              | 0438  | Stroke-5 Ischemic stroke – Antithrombotic therapy by end of hospital day two | Ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.                                                                                                                              | Ischemic stroke patients who had antithrombotic therapy administered by end of hospital day two.                                                                           | Ischemic stroke patients.                                                                                                                                           | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=675&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=675&amp;print=0&amp;entityTypeID=1</a> |
| 105             | 0439  | Stroke-6 Ischemic stroke – Discharged on Statin Medication                   | Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.  | Ischemic stroke patients prescribed statin medication at hospital discharge.                                                                                               | Ischemic stroke patients with an LDL greater than or equal to 100 mg/dL, OR LDL not measured, OR who were on a lipid-lowering medication prior to hospital arrival. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=676&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=676&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                          | Measure Description                                                                                                                                                                                                                                                                                                                            | Numerator Statement                                                                                                                                                                                                                                                                                                                                                                                                                           | Denominator Statement                                                                                                                                                                                                                                        | Measure Steward      | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 107             | 0440  | Stroke-8 Ischemic or hemorrhagic stroke – Stroke education             | Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke. | Ischemic or hemorrhagic stroke patients with documentation that they or their caregivers were given educational material addressing all of the following:<br><ol style="list-style-type: none"> <li>1. Activation of emergency medical system</li> <li>2. Need for follow-up after discharge</li> <li>3. Medications prescribed at discharge</li> <li>4. Risk factors for stroke</li> <li>5. Warning signs and symptoms of stroke.</li> </ol> | Ischemic stroke or hemorrhagic stroke patients discharged to home.                                                                                                                                                                                           | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=678&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=678&amp;print=0&amp;entityTypeID=1</a> |
| 102             | 0441  | Stroke-10 Ischemic or hemorrhagic stroke – Assessed for Rehabilitation | Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.                                                                                                                                                                                                                                                         | Ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services.                                                                                                                                                                                                                                                                                                                                                 | Patients admitted to the hospital for inpatient acute care with a principal diagnosis code for ischemic or hemorrhagic stroke with hospital stays <= 120 days during the measurement period for patients age 18 and older at the time of hospital admission. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=680&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=680&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                   | Measure Description                                                                                                                                                                                                                                                                                               | Numerator Statement                                                                                                                                                                                                                                                                                                                                       | Denominator Statement                             | Measure Steward      | Link to NQF website                                                                                                                                                                                                 |
|-----------------|-------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 108             | 0371  | Venous Thromboembolism (VTE)-1 VTE prophylaxis  | This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.                                      | <p>Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:</p> <ul style="list-style-type: none"> <li>• the day of or the day after hospital admission</li> <li>• the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission</li> </ul>                   | All patients in the initial patient population.   | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=270&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=270&amp;print=0&amp;entityTypeID=1</a> |
| 190             | 0372  | VTE-2 Intensive Care Unit (ICU) VTE prophylaxis | This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the ICU or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). | <p>Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:</p> <ul style="list-style-type: none"> <li>• the day of or the day after ICU admission (or transfer)</li> <li>• the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)</li> </ul> | Patients directly admitted or transferred to ICU. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=267&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=267&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                           | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Numerator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Denominator Statement                              | Measure Steward      | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 73              | 0373  | VTE-3 VTE Patients with Anticoagulation Overlap Therapy | <p>This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.</p> | <p>Patients who received overlap therapy (warfarin and parenteral anticoagulation):</p> <ul style="list-style-type: none"> <li>• Five or more days, with an INR greater than or equal to 2 prior to discontinuation of parenteral therapy, OR</li> <li>• Five or more days, with an INR less than 2 and discharged on overlap therapy, OR</li> <li>• Less than five days and discharged on overlap therapy, OR</li> <li>• With documentation of reason for discontinuation of overlap therapy, OR</li> <li>• With documentation of a reason for no overlap therapy</li> </ul> | Patients with confirmed VTE who received warfarin. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=271&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=271&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                                                              | Measure Description                                                                                                                                                                                                                                                                                                                                                                   | Numerator Statement                                                                                                                                                                                                                                                                                                       | Denominator Statement                                                                        | Measure Steward      | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 109             | 0374  | VTE-4 VTE Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram) | This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.                                                                                                                                                          | Patients who have their IV UFH therapy dosages AND platelet counts monitored according to defined parameters such as a nomogram or protocol.                                                                                                                                                                              | Patients with confirmed VTE receiving IV UFH therapy.                                        | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=268&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=268&amp;print=0&amp;entityTypeID=1</a> |
| 110             | 0375  | VTE-5 VTE discharge instructions                                                                                           | This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions. | Patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following:<br>1. compliance issues<br>2. dietary advice<br>3. follow-up monitoring<br>4. potential for adverse drug reactions and interactions | Patients with confirmed VTE discharged to home or court/law enforcement on warfarin therapy. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=269&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=269&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                 | Measure Description                                                                                                                                                                                                                                  | Numerator Statement                                                                    | Denominator Statement                                                                                        | Measure Steward           | Link to NQF website                                                                                                                                                                                                   |
|-----------------|-------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 114             | 0376  | VTE-6 Incidence of potentially preventable VTE                | This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date. | Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.  | Patients who developed confirmed VTE during hospitalization.                                                 | The Joint Commission      | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=272&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=272&amp;print=0&amp;entityTypeID=1</a>   |
| 100             | 0142  | AMI-2-Aspirin Prescribed at Discharge for AMI                 | AMI patients who are prescribed aspirin at hospital discharge.                                                                                                                                                                                       | Acute Myocardial Infarction patients who are prescribed aspirin at hospital discharge. | All AMI patients age 18 and older with an ICD-9-CM Principal Diagnosis Code for Acute Myocardial Infarction. | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=1145&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=1145&amp;print=0&amp;entityTypeID=1</a> |
| 113             | 0469  | PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation | Patients with elective vaginal deliveries or elective cesarean sections at $\geq 37$ and $< 39$ weeks of gestation completed.                                                                                                                        | Patients with elective deliveries.                                                     | Patients delivering newborns with $\geq 37$ and $< 39$ weeks of gestation completed.                         | The Joint Commission      | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=296&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=296&amp;print=0&amp;entityTypeID=1</a>   |

| CMS eMeasure ID | NQF # | Measure Title                                                              | Measure Description                                                                                                                                                                                                                                    | Numerator Statement                                                                  | Denominator Statement                                                                                                                                                                                                                                                                                                                                        | Measure Steward           | Link to NQF website                                                                                                                                                                                                 |
|-----------------|-------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 60              | 0164  | AMI-7a Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival | Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less. | AMI patients whose time from hospital arrival to fibrinolysis is 30 minutes or less. | AMI patients age 18 and older with ST-elevation or LBBB on ECG who received fibrinolytic therapy with an ICD-9-CM Principal Diagnosis Code for AMI AND ST-segment elevation or LBBB on the ECG performed closest to hospital arrival AND Fibrinolytic therapy within 6 hours after hospital arrival AND Fibrinolytic therapy is primary reperfusion therapy. | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1152&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1152&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                     | Measure Description                                                                                                                                                                                                            | Numerator Statement                                                                 | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Measure Steward           | Link to NQF website                                                                                                                                                                                                 |
|-----------------|-------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 53              | 0163  | AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival | Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less. | AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less. | Principal diagnosis of AMI (International Classification of Diseases, 9th revision, Clinical Modification [ICD-9-CM] principal diagnosis code: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91); and PCI procedure ICD-9-CM principal or other procedure code for PCI: 00.66); and AMI patients age 18 and older with ST-elevation or LBBB on ECG who received primary PCI with an ICD-9-CM Principal Diagnosis Code for AMI AND PCI (ICD-9-CM Principal and Other Procedure Codes for PCI) AND ST-segment elevation or LBBB on the ECG performed closest to hospital arrival; and PCI performed within 24 hours after hospital arrival. | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1151&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1151&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                                        | Measure Description                                                                                                                               | Numerator Statement                                                                                                                                                                                                                                                                                                | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                        | Measure Steward           | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 30              | 0639  | AMI-10 Statin Prescribed at Discharge                                                                | Acute Myocardial Infarction (AMI) patients who are prescribed a statin at hospital discharge.                                                     | AMI patients who are prescribed a statin medication at hospital discharge.                                                                                                                                                                                                                                         | AMI patients.                                                                                                                                                                                                                                                                                                                                                                                                                                | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=102&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=102&amp;print=0&amp;entityTypeID=1</a>   |
| 188             | 0147  | PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients | Immunocompetent patients with CAP who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines. | Pneumonia patients who received an initial antibiotic regimen consistent with current guidelines during the first 24 hours of hospitalization. Numerator 1 (in population 1) defines appropriate antibiotics for ICU patients. Numerator 2 (in population 2) defines appropriate antibiotics for non-ICU patients. | Pneumonia patients 18 years of age and older with an ICD-9-CM Hospital Measures-Principal Diagnosis Code of pneumonia, OR ICD-9-CM Hospital Measures-Principal Diagnosis Code of septicemia or respiratory failure (acute or chronic) and also a secondary ICD-9-CM Other Diagnosis Code of pneumonia, and abnormal findings on chest x-ray or CT scan of the chest within 24 hours prior to hospital arrival or during the hospitalization. | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=1134&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standarID=1134&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                           | Measure Description                                                                                                                                                                                                                                                                                                                                                                                                                        | Numerator Statement                                                                                                                                                                                                            | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Measure Steward           | Link to NQF website                                                                                                                                                                                                 |
|-----------------|-------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 171             | 0527  | SCIP-INF-1<br>Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision | Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received Vancomycin or a Fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within 2 hours prior to surgical incision. Due to the longer infusion time required for Vancomycin or a Fluoroquinolone, it is acceptable to start these antibiotics within 2 hours prior to incision time. | Number of surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if receiving vancomycin, in Appendix C, Table 3.8, or a fluoroquinolone, in Appendix C, Table 3.10). | <p>All selected surgical patients 18 years of age and older with no evidence of prior infection with an ICD-9-CM Principal Procedure Code of selected surgeries.</p> <p>Denominator for population 1 – Coronary artery bypass graft (CABG) procedures</p> <p>Denominator for population 2 – Other cardiac surgery</p> <p>Denominator for population 3 – Hip arthroplasty</p> <p>Denominator for population 4 – Knee arthroplasty</p> <p>Denominator for population 5 – Colon surgery</p> <p>Denominator for population 6 – Abdominal hysterectomy</p> <p>Denominator for population 7 – Vaginal hysterectomy</p> <p>Denominator for population 8 – Vascular surgery</p> | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1154&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1154&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                         | Measure Description                                                                                                                       | Numerator Statement                                                                                                   | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Measure Steward           | Link to NQF website                                                                                                                                                                                                 |
|-----------------|-------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 172             | 0528  | SCIP-INF-2<br>Prophylactic Antibiotic Selection for Surgical Patients | Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure). | Number of surgical patients who received recommended prophylactic antibiotics for their specific surgical procedures. | <p>All selected surgical patients 18 years of age and older with no evidence of prior infection with an ICD-9-CM Hospital Measures-Principal Procedure Code of selected surgeries.</p> <p>Denominator for population 1 – Coronary artery bypass graft (CABG) procedures</p> <p>Denominator for population 2 – Other cardiac surgery</p> <p>Denominator for population 3 – Hip arthroplasty</p> <p>Denominator for population 4 – Knee arthroplasty</p> <p>Denominator for population 5 – Colon surgery</p> <p>Denominator for population 6 – Abdominal hysterectomy</p> <p>Denominator for population 7 – Vaginal hysterectomy</p> <p>Denominator for population 8 – Vascular surgery</p> | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1155&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1155&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                                                                                      | Measure Description                                                                                                                               | Numerator Statement                                                                                                                                   | Denominator Statement                                                                                                                                                                                                                                                                                                                                                                                                                           | Measure Steward           | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 178             | 0453  | SCIP-INF-9 Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day of surgery being day zero | Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.                 | Number of surgical patients whose urinary catheter is removed on POD 1 or POD 2 with day of surgery being day zero.                                   | All selected surgical patients 18 years of age and older with a catheter in place postoperatively with an ICD-9-CM Principal Procedure Code of selected surgeries.                                                                                                                                                                                                                                                                              | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=648&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=648&amp;print=0&amp;entityTypeID=1</a> |
| 32              | 0496  | ED-3 Median time from ED arrival to ED departure for discharged ED patients                                                        | Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department. | For Meaningful Use Stage 2 reporting: Median time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department. | For Meaningful Use Stage 2 reporting: All ED patients discharged from the ED and stratified according to Discharge Home, Diagnosis of Psychiatric/Mental Health condition, Observation status, Transferred to Another Acute Care Hospital, or other patients not discharged from the ED. Do Not Include in any of the Strata: Patients who are not an ED Patient; Patients who expire in the ED; Patients admitted to the hospital from the ED. | CMS OFMQ is the developer | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=471&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=471&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                                           | Measure Description                                                                                                                                               | Numerator Statement                                                                                                                                                                                                                                                                                                                                                                                                   | Denominator Statement                                                                                                                                   | Measure Steward      | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 26              | 0338  | Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver | An assessment that there is documentation in the medical record that a Home Management Plan of Care document was given to the pediatric asthma patient/caregiver. | Pediatric asthma inpatients with documentation that they or their caregivers were given a written HMPC document that addresses all of the following: <ol style="list-style-type: none"> <li>1. Arrangements for follow-up care</li> <li>2. Environmental control and control of other triggers</li> <li>3. Method and timing of rescue actions</li> <li>4. Use of controllers</li> <li>5. Use of relievers</li> </ol> | Pediatric asthma inpatients with an age of 2 through 17 years, length of stay less than or equal to 120 days, and discharged to home or police custody. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=348&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=348&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                 | Measure Description                                                        | Numerator Statement                                  | Denominator Statement                                                                                                                                                                                               | Measure Steward      | Link to NQF website                                                                                                                                                                                               |
|-----------------|-------|-------------------------------|----------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9               | 0480  | Exclusive Breast Milk Feeding | Exclusive breast milk feeding during the newborn's entire hospitalization. | Newborns that were fed breast milk only since birth. | Single term newborns discharged from the hospital who have no diagnosis of galactosemia, no procedure of parenteral infusion, no diagnosis of premature newborn, and length of stay less than or equal to 120 days. | The Joint Commission | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=307&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=307&amp;print=0&amp;entityTypeID=1</a> |

| CMS eMeasure ID | NQF # | Measure Title                                       | Measure Description                                                                                                                                                               | Numerator Statement                                                                                                                                                                                                         | Denominator Statement                                                                                                                                                                                                                                                                                                                                                            | Measure Steward                                | Link to NQF website                                                                                                                                                                                                   |
|-----------------|-------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 185             | 0716  | Healthy Term Newborn                                | Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or in nursery care. | The absence of conditions or procedures reflecting morbidity that happened during birth and nursery care to an otherwise normal infant.                                                                                     | The denominator is composed of singleton, term (>=37 weeks), inborn, livebirths in their birth admission. The denominator further has eliminated fetal conditions likely to be present before labor. Maternal and obstetrical conditions (e.g., hypertension, prior cesarean, malpresentation) are not excluded unless evidence of fetal effect prior to labor (e.g., IUGR/SGA). | California Maternal Quality Care Collaborative | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=171&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=171&amp;print=0&amp;entityTypeID=1</a>   |
| 31              | 1354  | EHDI-1a Hearing screening before hospital discharge | This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.                                                                | All live births during the measurement time period born at a facility and screened for hearing loss prior to discharge, or screened but still not discharged; or not screened due to medical reasons or medical exclusions. | All live births during the measurement time period born at a facility and, discharged without being screened, or screened prior to discharge, or screened but still not discharged.                                                                                                                                                                                              | Centers for Disease Control and Prevention     | <a href="http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=1354&amp;print=0&amp;entityTypeID=1">http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardsID=1354&amp;print=0&amp;entityTypeID=1</a> |

**Technical Release Note 2014  
eCQMs for Eligible Hospitals**

**RESOURCES FOR  
ELIGIBLE HOSPITALS &  
CRITICAL ACCESS  
HOSPITALS**



**Clinical Quality Measures for CMS's 2014  
EHR Incentive Program for Eligible Hospitals:  
Release Notes**

10/11/2012

**CLINICAL QUALITY MEASURES FOR CMS'S 2014 EHR INCENTIVE PROGRAM  
FOR ELIGIBLE HOSPITALS  
RELEASE NOTES**

In August 2012, the Centers for Medicare & Medicaid Services (CMS) finalized the clinical quality measures (CQMs) for the 2014 Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for Eligible Hospitals, also known as Meaningful Use Stage 2 (MU2) for Eligible Hospitals.<sup>1</sup> This list of CQMs for MU2 includes measures retained from Meaningful Use Stage 1 (MU1) for use in MU2. All retained MU1 measures have been updated based on advances in technology and tools for eMeasure development, comments from stakeholders, changes initiated by measure developers, and CMS's standards as defined in the agency's Measures Management System Blueprint, Version 8 (Blueprint).<sup>2</sup>

CMS recognizes the importance of providing support, training, and information to MU stakeholders, particularly as the EHR Incentive Programs transition to MU2. The purpose of this document is to inform eligible hospitals and the vendor community about updated program requirements related to the CQMs. This update includes information about global changes incorporated across all measures as well as specific changes to the measures retained in MU2. Global changes are listed first and include structural modifications; updates to value sets; and data elements and standards revised in accordance with the Blueprint. Specific changes to measures include changes to measure components, such as initial patient populations, denominators, numerators, exclusions, and exceptions, as well as logic changes that affect how data elements interrelate during the measurement period.

This document is intended for readers who are familiar with eMeasure components and the current standards for construction an eMeasure. For more information on eMeasures, please visit the CMS website (<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html>)

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<sup>1</sup> CMS. "Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2." 2012. Available at [ [http://www.ofr.gov/\(X\(1\)S\(uzclbwrX5fwqm2w2mipkysrh\)\)/OFRUpload/OFRData/2012-21050\\_PI.pdf](http://www.ofr.gov/(X(1)S(uzclbwrX5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf) ]. Accessed August 28, 2012.

<sup>2</sup> CMS. "CMS Measure Management System Blueprint, ." Available at [ <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html> ]. Accessed August 28, 2012. Since the completion of MU2 CQM's the latest Blueprint version is 9.0.

## Global Edits

- Introduced a new measure-identification scheme that combines the eMeasure identifier, National Quality Forum (NQF) number (if applicable), and eMeasure version number.
- Updated the rationale, clinical recommendation statements, and references to include the latest clinical guidance related to the measures.
- Provided additional guidance to help implementers interpret the calculation requirements for the measures as well as instructional and clarifying notes.
- Updated the eMeasure header to reflect Blueprint requirements (such as using the initial patient population to define the denominator and including stratification variables in the header) and modified other fields, such as population criteria, to reflect these changes.
- Changed the standardization of the measurement period from “year” to “period.”
- Updated the measure logic to reflect the changes to the Quality Data Model (QDM), to reflect consistent use of relative timing across measures (including age calculation), occurring, and denominator exclusions.
- Assigned data elements based on version 2.1.1.1 of the QDM<sup>3</sup> to each clinical concept, adding attributes as needed to precisely define QDM elements.
- For measures using the QDM of “Medication, Active,” added the AND / AND NOT construct to compensate for varying interpretations of the relative timing “during.” The “Medication, Active” period can start at any time but cannot end before “Occurrence A of Encounter, Performed.”
- Incorporated supplemental data elements (race, ethnicity, sex, and payer) as required by the Blueprint.
- Reorganized and retitled the encounter value sets to standardize them across developers. Also incorporated encounter value sets using SNOMED-CT to align with the Health Information Technology Standards Committee (HITSC) vocabulary recommendation for the QDM data type “Encounter.”
- Updated existing value sets and added new value sets to align with the transitional and final vocabularies, based on the HITSC recommendations and required by the Blueprint.
- Value sets include fully-specified ICD-9-CM and ICD-10-CM codes.
- Provided grouping object identifiers for each data element.
- Added copyright information for vocabularies.

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<sup>3</sup> For more on the Quality Data Model, visit the NQF website at <http://www.qualityforum.org/QualityDataModel.aspx>

**NQF 0495 Median time from ED arrival to ED departure for admitted ED patients**

- Added length of stay check for initial patient population of <=120 days
- Observation services no longer used for stratification
- ED visit must end within one hour of the inpatient encounter to associate the ED encounter with the inpatient encounter.

**NQF 0497 Median admit decision time to ED departure time for admitted patients**

- Added length of stay check for initial patient population of <=120 days
- Observation services no longer use for stratification
- ED visit must end within one hour of the inpatient encounter to associate the ED encounter with the inpatient encounter.

**NQF 0435 Ischemic stroke – Discharged on anti-thrombotic therapy**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Specified that a medication order for antithrombotic therapy could be present within one day prior to discharge.

**NQF 0436 Ischemic stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Created the Atrial Ablation procedure value set to only include procedures specifically done for atrial fibrillation/flutter.

**NQF 0437 Ischemic stroke – Thrombolytic Therapy**

- Revised “Last Known Well” data element to create value sets for neurologic symptoms of stroke or baseline state symptom documented within 120 minutes of ED arrival.
- ED visit must end within one hour of the inpatient encounter to associate the ED encounter with the inpatient encounter.
- Added denominator exclusion if Thrombolytic Therapy (t-PA) was administered within two days prior to inpatient encounter.
- Added denominator exclusion for risk category of National Institute of Health Stroke Scale = 0.

**NQF 0438 Ischemic stroke – Antithrombotic therapy by end of hospital day two**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added logic to denominator exclusion to identify patients with Thrombolytic Therapy (t-PA) administered during their ED encounter for ED encounters within one hour of the inpatient encounter.

#### **NQF 0439 Ischemic stroke – Discharged on Statin Medication**

- Added logic to denominator to evaluate timing of LDL-c laboratory results or Lipid-Lowering medication in relation to the ED encounter for ED encounters within one hour of the inpatient encounter.
- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Specified that a medication order for statin could be present within one day prior to discharge.
- Removed denominator exclusion for patients without evidence of atherosclerosis.

#### **NQF 0440 Ischemic or hemorrhagic stroke – Stroke education**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.

#### **NQF 0441 Ischemic or hemorrhagic stroke – Assessed for Rehabilitation**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added numerator statement to include patients transferred to a rehabilitation facility.

#### **NQF 0371 Venous Thromboembolism Prophylaxis**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added denominator exclusion for patients with palliative care (comfort measures only) orders within one day of a procedure using general or neuraxial anesthesia occurring the day of or the day after the inpatient encounter.
- VTE prophylaxis medication and VTE prophylaxis mechanical device value sets separated into individual value sets based on type of medication and device.
- Added numerator statement for patient assessment of low risk for VTE.

#### **NQF 0372 Intensive Care Unit (ICU) Venous Thromboembolism Prophylaxis**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added denominator exclusion for patients with palliative care (comfort measures only) orders within one day of a procedure using general or neuraxial anesthesia occurring the day of or the day after the ICU admission or transfer.
- VTE prophylaxis medication and VTE prophylaxis mechanical device value sets separated into individual value sets based on type of medication and device.
- Added numerator statement for patient assessment of low risk for VTE.

### **NQF 0373 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Removed denominator exclusion for patients not discharged on warfarin.
- Added denominator exclusions for the following discharge status values:
  - Discharge to Another Hospital
  - Discharge to Home for Hospice Care
  - Discharge to Health Care Facility for Hospice Care
  - Patient expired
  - Left against advice
- Added denominator statement to include patients with warfarin administration starting within one day prior to inpatient encounter.
- Clarified calculation method for determining patients who were on 5 or more days of overlap therapy.
- Added numerator statements to include patients with documented reason for no overlap or discontinuation of overlap therapy.
- Added numerator statements to check for the administration of parenteral anticoagulant during the ED encounter for ED encounters within one hour of the inpatient encounter.

### **NQF 0374 Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)**

- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- Added denominator exclusions for the following discharge status values:
  - Discharge to Another Hospital
  - Discharge to Home for Hospice Care
  - Discharge to Health Care Facility for Hospice Care
  - Patient expired
  - Left against advice
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to inpatient encounter.
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to ED encounter for ED encounters within one hour of the inpatient encounter.

### **NQF 0375 Venous Thromboembolism Discharge Instructions**

- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to inpatient encounter.
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to ED encounter for ED encounters within one hour of the inpatient encounter.
- Revised description and updated denominator statement to include patients discharged to court/law enforcement.
- Added denominator statement to include patients with warfarin administration starting within one day prior to inpatient encounter
- Added numerator statement to include patients who refused discharge instructions.

**NQF 0376 Incidence of potentially preventable Venous Thromboembolism**

- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to inpatient encounter.
- Added denominator statement to use confirmed VTE from diagnostic study performed up to two days prior to ED encounter for ED encounters within one hour of the inpatient encounter.
- Added logic to denominator exclusion to accept documentation of palliative care (comfort measures only) order during ED encounter for ED encounters within one hour of the inpatient encounter.
- VTE prophylaxis medication and VTE prophylaxis mechanical device value sets separated into individual value sets based on type of medication and device.