Small-Practice Providers and Clinical Quality Measures
Webinar Question-and-Answer List

The Centers for Medicare & Medicaid Services (CMS) hosted a webinar, titled "The CMS EHR Incentive Programs: Small-Practice Providers and Clinical Quality Measures," in October 2011 to help small practice providers successfully record clinical quality measures (CQMs) and attest to meaningful use for the Medicare EHR Incentive Program. Before and after the event, CMS subject matter experts collected questions from webinar participants. Below are the questions that were received and their corresponding answers. It may also be helpful for providers and office managers to review the CQM quick guide, which may be helpful to have on hand to reference CQM information.

Not all questions are included in this Q&A. In addition, some questions and answers have been edited for grammar and spelling corrections.

Clinical Quality Measure Questions

Please note: Many questions from the webinar focused on general CQM information, such as the CQM requirements for eligible professionals (EPs) and eligible hospitals. To answer these general questions, please review the following information:

Eligible hospitals must report on all 15 CQMs.

Eligible professionals must report a total of six (6) CQMs

– CQM Core Requirement: three (3) core or alternate core CQMs

– CQM Additional Requirement: three (3) from a list of 38 additional CQMs

After reporting the core measures, or if applicable one or more alternate core measures, any of the additional 38 CQMs may be reported. We understand at this time that there may not be clinical quality measures applicable to all practice specialties. Consequently, the EP should select 3 of the 38 CQMs to report. It is preferable they select CQMs that have values other than zero for the denominator. If their certified EHR reports all zeros for all of the clinical quality measures then they should still report 3 of the additional measures in addition to the core measures/alternate core measures. The objective for reporting clinical quality measures is met by reporting the measure results as displayed by their certified EHR technology, and therefore zeros are acceptable values for the denominators of the measures.

It is acceptable to report zero in the numerator or denominator for one or more measures, as long as that is the value displayed and calculated by your certified EHR.

1. **Q: Are the only requirements for CQMs to fill them out for attestation or are there percentage requirements that we have to attain?**

   A: At this time there is no performance threshold for reporting the CQMs.

2. **Q: Can you verify that the total CQMs attested to can possibly be 6, 7, 8, or 9?**

   A: Depending on the number of core measures with zero values for the denominator the total number of CQMs attested to could be 6, 7, 8, or 9.

3. **Q: CQM- Hypertension: Requires two visits in a reporting period; does it require two blood pressures also? CQM- Weight for Children and Adolescents: What are the acceptable codes for 2-11 year olds? I do not see them listed on your website.**

   A: No, it requires 2 encounters to be included in the denominator population but only requires one BP be recorded. We need more information to answer your second question. Please contact the help desk at 1-888-734-6433 to provide more specific information regarding your second question.

4. **Q: We are currently in the reporting period. How do we know if we completed attestation correctly? Currently, after we extract our monthly data we are doing the attestation worksheet on the website, but it does not have anything regarding CQMs. Why?**

   A: CQM results are generated directly from your EHR so no calculation is necessary.

5. **Q: Where do we find information on exactly what is expected for the CQMs?**

   A: The clinical quality measure specifications contain information on exclusions for each measure.

6. **Q: For NQF 0421, "Adult Weight Screening and Follow-Up," if the practice gives (and notates that they gave) a relevant educational brochure to the patient, is that sufficient to add the patient to the Numerator, or will they need an actual follow-up visit plan?**

   A: The codes that reflect the concepts expressed in each measure are included in the specifications. Therefore, the certified system will recognize those codes and this is not something that the EP needs to determine.

7. **Q: How are the CQM measures for the EHR incentive programs and the PQRS related?**

   A: The answer depends on the program year you are referring to. In the 2011 program year, the CQM measures may be the same, but the electronic specifications and program requirements differ. Therefore you should adhere to the program requirements for the program you are participating.

8. **Q: How can the following measure be met: Report ambulatory clinical quality measures to CMS? And how do you attest to this measure?**

A: Please go to the following link on the CMS website to learn more about reporting CQMs. If you require additional assistance contact the help desk at 1-888-734-6433.

9. **Q: How do CQMs, EHRs, and meaningful use tie together? If and when effective dates for meaningful use and the others are required to be in place within clinics or practices.**

   A: CQMs are one of the core meaningful use objectives. Please refer to the CMS website page on CQMs for more information on the CMS EHR Incentive Program.

10. **Q: If a certified EHR program calculates the CQM incorrectly (for example, by including patients in the denominator that should not be included), should we report the number calculated by the EHR program or should we report the correct number?**

    A: The EP should report the results as displayed from their certified EHR technology but we also suggest the EP contact their EHR vendor to ensure their EHR functions correctly in the future.

11. **Q: Is it required to use your qualified system's method to report CQMs?**

    A: You must use certified EHR technology to report CQMs for the CMS EHR Incentive Program.

12. **Q: Is reporting on the pneumo vaccine or the flu immunization greater than 50 years a quality measure?**

    A: Please see the list of 44 clinical quality measures on the CMS webpage.

13. **Q: Is there any minimum number of CQM office visits that have to be reported upon such as hypertension? What if you have 100 hypertension cases that have that DX, but not every visit are you TX that DX, do you have to take BP on visits you are not managing the CQM DX?**

    A: We need more specific information from you to answer this question. We also suggest you provide the Clinical Quality Measure number you are referring to. Please contact the CMS EHR Incentive Program help desk at 888-734-6433 to provide more information regarding your question

14. **Q: Please provide more information on vitals and who is exempt from taking them.**

    A: Please contact the CMS EHR Incentive Program help desk at 888-734-6433 to provide more information regarding your question.

15. **Q: Do providers have to validate the numerators and denominators shown in the certified EHR technology? Or just report them as sufficient? Our EHR lists only 22 of the 44 CQMs. Must we choose only from the 22 listed to find six to report?**

A: The provider must use a certified EHR. The reporting for CQMs must reflect the output of the certified EHR. If your certified EHR only contains a subset of the 38 measures, you must still report three additional measures. Therefore, you must report three of the 38 additional quality measures.

16. **Q: Our system lets us view MR reports on how we're doing on the other 25 meaningful use measures we'll be reporting, but we have no idea if we're meeting the CQMs yet. It was explained by our group's Project Manager that it has to be done "for us" through a special portal.**

    A: We suggest you direct this question to your vendor.

17. **Q: Please address the mismatch between the CQM timeframe and the EHR reporting period. Prime example is the influenza measure for September to February. What if an EP's reporting period is March thru May? Does the EP report a zero numerator?**

    A: The reporting period for the EHR Incentive program using a certified EHR is any continuous 90-day period during the first payment year. Please note that although the measure specifications assume a full calendar year you should only calculate the denominator and numerator from the first day of the 90 day reporting period to the last day of the 90 day reporting period. It is acceptable to report zero in the numerator or denominator, for 1 or more measures, as long as that is the value displayed & calculated by your certified EHR. Therefore for the CQM mentioned above zero denominators and zero numerators are acceptable provided that is what is displayed by your certified EHR.

18. **Q: If a faulty CQM report generated by the vendor product contains known inaccurate data and there is later an audit, what would be required of us?**

    A: Please review the October 18 CMS News Update: "What Does Attestation for the EHR Incentive Programs Entail?"

19. **Q: Do the denominators and numerators need to be calculated by the EHR software and sent to CMS by the same software? Or can the data be extracted from the EHR database, calculated, and sent by another system?**

    A: Currently through the Registration and Attestation Module, there are no data that is "sent" to CMS. Instead, Eligible Professionals, Eligible Hospitals, and CAHs (or their approved designee) manually enter fields for each measure they are reporting, to include Numerator, Denominator and Exclusions.

20. **Q: The CQMs have specific reporting periods, as originally designated by the measure stewards that developed the measures. However, Year 1 and Year 2 of Stage 1 meaningful use have 90-day and one year reporting periods. Which should EPs report?**

    A: In your first year of participation in the EHR Incentive Program the reporting period is any consecutive 90 day period during the program year. In the second year of participation the clinical

quality measures are reported for the entire year. This is a calendar year for EPs and a federal fiscal year for EH/CAHs.

21. **Q: We included the codes for CQMs on our claims (group). Is there anything else we need to do to complete reporting requirements?**

    A: The EHR Incentive Program only includes EHR-based measures. Other CMS Program such as PQRS allow for claims-based reporting, but the requirements are different and therefore you should review the clinical quality measures requirements and the CQM specifications for the CMS EHR Incentive Program.

22. **Q: We need some help understanding what numerators and denominators mean.**

    A: The Denominator is a subset of the initial patient population – In some eMeasures the denominator may be the same as the initial patient population. Generally, the Numerator is a subset of the denominator for whom a process or outcome of care occurs. Each measure specification identifies the specific numerator and denominator criteria.

23. **Q: What should we do about EHRs that only have a few CQMs available for reporting?**

    A: If your certified EHR only contains a subset of the 38 measures, you must still report 3 additional measures. All certified EHR technology must contain a minimum of 9 clinical quality measures in the CMS EHR Incentive Program and must include the core measures.

24. **Q: What are the targets providers must meet for the CQMs?**

    A: This is a reporting requirement at this time which means you must report the values for the clinical quality measures but there is no threshold to meet for performance at this time. As long as you report the results as displayed by your certified EHR technology you have met this objective.

25. **Q: What if your EHR vendor does not have all the CQMs CCHIT certified or does not have the capability to report them for meaningful use? Can the small practices still attest for those using exclusion or provide a numerator or denominator?**

    A: The Office of the National Coordinator website explains the requirements for certifying EHR technology. At a minimum the technology had to have at least 9 clinical quality measures to be certified which include the core measures. There are no exclusions to this Meaningful Use objective. Therefore assuming you only have 9 clinical quality measures you would report the 3 core, and one or more alternate core measures if applicable, and the 3 additional measures included in your certified EHR technology.

26. **Q: What will the CQM reporting process be in Stage 2 meaningful use?**

    A: This will be identified through the rulemaking process.

27. **Q: When will CMS be ready to receive CQMs electronically?**

A: Refer to the electronic reporting pilots described in the OPPS Rule (for EHs) and the MPFS (for EPs).

28. **Q: Why does the flu CQM only measure 2010-2011 flu season and not 2011-2012?**

    A: The measure does not refer to a specific year for the flu season in the specifications. Please contact the CMS EHR Incentive Program help desk at 888-734-6433 to provide more information regarding your question.

29. **Q: Will EPs be required to electronically submit CQM data in 2012 or can we attest online as in 2011? Is this electronic submission done daily, quarterly, or at end of year? Does it automatically transmit or are we in control of when it is transmitted?**

    A: The reporting period for the second year is 1 year vs. any 90-continuous days. Attestation continues to be acceptable in 2012. For electronic reporting, refer to the electronic reporting pilots described in the OPPS Rule (for EHs) and the MPFS (for EPs).

30. **Q: Will the CQMs be adjusted to harmonize with the other CMS initiatives, such as VBP?**

    A: We are working to harmonize many of the CMS quality reporting programs where possible.

31. **Q: Will the CQMs be revised to include more measures appropriate for dentists and specialists?**

    A: Stage 2 CQMs will be proposed through rulemaking.

32. **Q: Will vendors charge offices to acquire the remaining 33 CQMs for their EHR if they have not been initially provided with their purchased certified product? (Most currently offer 9 CQM)**

    A: This depends on the vendor and the provider's relationship with him/her.

General EHR Incentive Program Questions

1. **Q: When should providers expect the CQMs for dentistry to be defined? Are there penalties for failure to continue in the EHR Incentive Program beyond the first year as a Medicaid EP?**

   A: There are no penalties associated with the Medicaid EHR incentive program.

2. **Q: What vendors would be able to help with collecting and reporting the CQMs? Why do the calculations have to be done in the certified EHR? We collect the data in our certified EHR, but currently extract the data into a non-certified data base for calculation.**

   A: Vendors and certified systems can be found on ONC's CHPL website. Questions regarding functionalities required for certified EHRs should be directed to ONC**.**

3. **Q: Please provide examples of clinical decisions that practices can report on and what type of reminders to patients are acceptable.**

   A: Clinical decision support interventions come in many forms and all are acceptable. Some common examples are alerts the indicate that a certain test has already been performed recently, alerts that blood sugar levels have been trending negatively for a patient, or any other clinical alert. Reminders to patients again are a wide spectrum and we don't seek to limit the provider's choice. Some examples are reminders about changes in medications and upcoming preventive services.

4. **Q: Do you have any suggestions on facilitating the ability to test report immunization?**

   A: Get in touch with our registry or public health agency directly. Working through vendors and others can sometimes lead to incorrect information and unrealistic expectations.

5. **Q: What are the proper steps to enroll?**

   A: Registration for the EHR Incentive Programs is an online process that can be accessed at www.cms.gov/EHRincentiveprograms.

6. **Q: What is the required start date for registering and to start submitting to qualify in 2012?**

   A: In order to receive an incentive for 2012, an EP must start their EHR reporting period by October 1, 2012 and register and attest by the end of February 2013. A hospital must start their EHR reporting period by July 1, 2012 and register and attest by the end of November 2012.

7. **Q: I already registered but I didn't receive an e-mail.**

   A: There is not an email confirmation with the registration process. The last screen is the confirmation.

8. **Q: What do we do if a practice has two locations when registering as a group?**

   A: You don't register as a group. Individual eligible professional are registered. The EP can choose which business address and tax payer identity to use in registration. When attesting to meaningful use you will add the data from all locations equipped with certified EHR technology.

9. **Q: Do nursing homes qualify for any EHR Incentive Programs?**

   A: EPs may assign their payments to a nursing home and a nursing home equipped with certified EHR technology would be included in the meaningful use of EPs who see patients there, but nursing homes are not independently eligible.

10. **Q: Do we have to register each individual provider through CMS prior to registering and attesting?**

    A: Yes.

11. **Q: When is the last date to register? How do you know when to turn in the information that is needed to get paid?**

    A: Two months after the close of the year in which you are seeking the incentive payment.

12. **Q: Once you attest, when can you expect to receive your incentive payment, and if you do very few prescriptions are you required to e-prescribe?**

    A: It takes four to eight weeks after Attestation to process the payments. If you have less than 100 prescriptions in the EHR reporting period you meet exclusion criteria for e-Rx.

13. **Q: One of our three physicians is registered. I have had problems registering the other two. Why does it have to be so cumbersome for an administrator, director, etc. to register physicians?**

    A: The EHR incentive programs use the log-in and information from other systems that support Medicare billing and the NPI. If you have errors in those systems, those need to be corrected first.

14. **Q: When will Idaho be ready?**

    A: CMS is currently reviewing their Health IT documents. Idaho is planning to launch in September 2012.

15. **Q: When will we know the criteria for year two of the EHR Incentive Programs?**

    A: Nearly all providers will use Stage 1 for both of their first two years. Stage 2 of meaningful use for year three is scheduled to be published early this year.

16. **Q: We are a pediatric specialty practice, we see about 15-20 Medicare patients per year. Since our cost to implement EHR will be greater than the incentives we would receive, is it mandatory to implement?**

    A: It is not mandatory to implement.

17. **Q: With the Medicaid EHR Incentive Program, Is it true that you can register this year, next year attest for a 90 day period, and the next year attest for the entire year?**

    A: Yes, the 1st year is to Adopt, Implement, or Upgrade with no reporting period. The 2nd year the provider must demonstrate Meaningful Use for 90 days, and the 3rd year the provider must demonstrate Meaningful Use for 365 days. (This also assumes you meet all eligibility criteria.)

18. **Q: I would like to know about EHRs for long term care physicians.**

    A: Many long term care settings are adopting their own EHRs and many EHRs for physicians are now portable on tablets and laptops. Long term care facilities are included in meaningful use if they are equipped with Certified EHR Technology and do count in determining whether an EP is even eligible for the program with 50 percent of their encounters at facilities equipped with Certified EHR Technology. There are FAQs on both these issues on the CMS website

19. **Q: What are the software requirements necessary for qualification at the time of registration and moving forward?**

    A: There are no requirements at the time of registration. Prior to the end of the EHR reporting period, you must possess Certified EHR Technology and of course be meaningfully using it to successfully attest.

20. **Q: When do I perform attestation? Is it after I have completed the 90 day reporting period? When is it anticipated that the Medicaid incentive program will be available?**

    A: After the 90 day reporting period. The availability of the Medicaid incentive program varies by state and updates can be found on our website.

21. **Q: What is the deadline to sign up for the EHR Incentive Programs?**

    A: You must sign up for a given year within 2 months after that year ends. Otherwise you would have to sign up for the next year.

22. **Q: We are a small private practice and looking to switch to EHRs in early 2012. Will we still qualify for the incentive?**

    A: EPs can get incentives if they attest to meaningful use as late at 2014.

23. **Q: We are a very small DME supplier. Are we going to be held to the same regulations as physicians?**

    A: DME suppliers are not included in the Medicare and Medicaid EHR incentive programs.

24. **Q: What about Radiologist? How can these specialty providers receive these incentive type programs?**

    A: We include many exclusions for certain objectives that we believe make it possible for all specialty providers to meet meaningful use. A specialty may be reliant on information from other providers to a greater extent than a primary care provider. Also hospital-based providers are not eligible. These are providers with 90% or more of their services in the hospital inpatient and emergency departments. Please register to determine if you are hospital based.

25. **Q: We are located in Virginia. According to Medicaid, we are not eligible yet. Since Medicare is federal can we go ahead and attest and expect payment or do we still have to wait until next year like Medicaid.**

    A: You can attest to Medicare for meaningful use now. However, if you qualify for Medicaid there is a large first year payment in that program that you would lose out on so please consider that before making your decision.

26. **Q: We don't do immunizations; therefore, leaving us to choose syndromic surveillance. Our vendor does not have an interface for syndromic surveillance yet, but has one for immunization registry. We are ready to attest except for this. Can we attest to immunizations?**

    A: You would meet both exclusions: immunizations because you don't do them, and syndromic surveillance because you can't send them to the public health agency electronically.

27. **Q: We employ PAs and an NP, should I include them in the registration process when listing providers?**

    A: Only if they are eligible for the Medicaid incentive independently, in which case they would register independently. There is not a mechanism for registering more than one EP under one registration. In regards to meaningful use, please see our FAQs on this topic.

28. **Q: We have a total of 8 physicians. One physician moves quite a bit slower than the others and has not registered or attested because she did not meet one of the core objectives. Does she has until February 2012 to get the 2011 incentive? Will other docs get paid?**

    A: Determinations are made on an individual EP basis so one doctor would not hold up the others' payments if they have already attested. Yes, you have through February 2012 to attest for the 2011 incentive.

29. **Q: We have used EHRs since June 2011. The only patients with appointments since then are in the EHR. Some of the CQMs look for two visits in the reporting period and our reporting period is October to December, so we won't have many. Can we just use the reporting period?**

    A: Yes, you can use the reporting period.

30. **Q: We have done attestation via the web site for 2011. I was under the impression that upcoming attestations would be generated and reported directly for our EHR programs, is that going to be a reality for making the reporting process much quicker?**

    A: CMS cannot accept direct reports from EHRs currently nor do we expect to be able to in 2012.

31. **Q: We have successfully finished our 2011 phase 1 EHR program and have received payment. I want to know what needs to be done to be best prepared for phase 2.**

    A: We will be publishing our proposed rule on Stage 2 shortly.

32. **Q: Are Skilled Nursing Facilities included in this group to receive incentives? I have only heard of Physician Practices and Hospitals. We are feeling left out in New York. If they are included, when is the date they may register?**

    A: They are not included independently; however, they are a setting that can be included in the meaningful use of physicians and physicians could re-assign their incentive to such a facility.

33. **Q: By what date do hospitals need to attest to receive the full incentive payments available.**

    A: Hospitals must attest in 2013 to receive the full incentive. Such an attestation must be made by November 30, 2013.

34. **Q: What happens to providers who do not get an EHR system before the deadline? Will the percent fines continue in the years to come or is the incentive for this year only?**

    A: Payment adjustments do not begin until much later. Details on the payment adjustments will be in our proposed rule coming out in early 2012.

35. **Q: Do you have to be registered with PECOS in order to register for Medicaid incentive program?**

    A: EPs do not. Hospitals do.

36. **Q: How do I know if EPs qualify for exclusions?**

    A: Each exclusion has unique criteria and the EP must evaluate themselves on those criteria.

37. **Q: Why are providers encouraged to register as soon as possible, only to have their registration access deleted if they do not have account activity within 180 days? This occurred with one of our providers.**

    A : We encourage providers to register so that they can find out if they are hospital-based and also have as much time as possible to address any issues there may be in linking the individual NPI with the Tax Payer ID.

38. **Q: How does reporting work? How do we choose the denominators and all for our practice**?

    A: Details on meaningful use can be found on the EHR website.

39. **Q: How many months of data do you need to attest?**

    A: In the first year you need 90 days, after the first year you attest the full year.

40. **Q: Exactly what is the definition of a "test" for the meaningful use Objective concerning interfacing with an Inoculation Registry?**

    A: Please see the meaningful use specification sheets located on the EHR website.

41. **Q: Please explain small practice expectations of risk analysis and HIPAA Expectations.**

    A: We cannot provide guidance on HIPAA. The meaningful use expectation is simply that the HIPAA expectations are re-evaluated in light of the adoption of Certified EHR Technology.

42. **Q: Can you provide a clear understanding of each component of meaningful use?**

    A: Each objective of meaningful use has its own specification sheet on our website.

43. **Q: Can you receive more than one incentive payment - example PQRI & e-prescribing?**

    A: You can receive the PQRI incentive and the Medicare EHR incentive. You cannot receive the e-Rx incentive and the Medicare EHR incentive. You can receive both and the Medicaid EHR Incentive.

44. **Q: For nephrologists registering for the Medicaid program - I see 50% of my patients in my private office and 50% in the outpatient dialysis unit. May I count the patients that I see in the dialysis unit towards my 30% Medicaid (e.g., ICD 585.6 CPT 90962)?**

    A: Yes, you can calculate the 30% Medicaid Patient Volume for a 90 day reporting period in the previous calendar year in any practice location.

45. **Q: For a one provider Neurology clinic (seeing adult and children) with an implemented EHR that has a projected opening date of Dec. 2011 to Jan 2012: Can I attest only after I have seen the first 30 Medicaid patients?**

    A: No, you must have seen 30% Medicaid Patient Volume for a 90 day reporting period in the previous calendar year (or 30% needy individual patient volume for a 90 day reporting period in the previous calendar year if working in an FQHC or RHC) to qualify as a Medicaid Eligible Provider (The other exception is if you are a pediatrician, then you may qualify if you had at least 20% Medicaid patient volume for a 90 day period in the previous calendar year).

46. **Q: How soon after attestation will we receive payment for the EHR Incentive Program?**

    A: 4 – 8 weeks after attestation has been completed.

47. **Q: Can a physician receive the incentive payment if the hospital pays for the EHR?**

    A: Yes.

48. **Q: How can dental providers meet meaningful use?**

    A: Meaningful use is the same for everyone. We have included many exclusions that may apply to dentists; however, this has to evaluated by the individual provider. There is no blanket all dentists don't have to do X. We encourage you to review the specification sheets on our website.

49. **Q: I will be starting my Practice in December 2011; will the 2012 penalty apply to me?**

    A: There is no EHR payment adjustment in 2012.

50. **Q: I will be opening a private practice in the next 1-2 weeks. I do not know if the majority of patients will be Medicare or Medicaid. How do you recommend I choose a program? How many patients do I need to qualify for the incentive program, and is it too late for this year?**

    A: To qualify for an incentive payment under the Medicaid EHR Incentive Program, you must be one of the eligible professional types, you must have 30% Medicaid Patient Volume for a 90 day reporting period in the previous calendar year (in your case, while working at a different practice or location), you must have adopted, implemented, or upgraded to, or demonstrated meaningful use of certified EHR technology, and you must meet all other eligible criteria. To qualify for an incentive payment under the Medicare EHR Incentive Program, you need to attest to having demonstrated meaningful use for a 90-day period during the calendar year, as well as meet other eligibility criteria. Please visit our website to understand the differences between the Medicare and Medicaid EHR Incentive Programs. If you qualify for the Medicaid EHR Incentive Program, you could receive a higher total incentive payment ($63,750 across 6 years of program participation, versus $44,000 across 5 years of participation in the Medicare EHR Incentive Program). In terms of timing, you have until the end of February to attest to meaningful use for the Medicare 2011 EHR incentive payment.

For Medicaid, each State picks the end date, typically 60-90 days after the end of the calendar year for eligible professionals by which you would have to attest to having adopted, implemented or upgraded to certified EHR technology.

51. **Q: I would like to know why you can register as a NP for the EHR incentive and not a PA.**

    A: Eligibility was defined in the HITECH Act and would require changes by Congress.

52. **Q: If a provider is in a state that doesn't activate its Medicaid program until 2012, and the provider qualifies under AIU in 2012, will the provider have to meet Stage 2 criteria in 2013?**

    A: No, Medicaid Eligible Providers can attest to having adopted, implemented, or upgraded to certified EHR technology in 2012, in this example: their second year of participation, they attest to demonstrating meaningful use under Stage 1 for a 90-day period; and their third year, they attest to demonstrating meaningful use under Stage 1 for a 365-day period (2014 in your example).

53. **Q: If I am not using EHR yet and I work in a rural area, will I be penalized starting January 2012? Are there any exceptions and what do I need to do to avoid penalty? I hope to start implementing EHRs in early 2012.**

    A: There are no payment adjustments associated with the Medicare and Medicaid EHR incentive programs in 2012.

54. **Q: If my EHR is a complete certified EHR, can I use any electronic means to provide patients with timely access to their health records within 4 days (e.g., CD-ROM, thumb drive, patient portal) or do I have to use the specific one that my EHR tested with?**

    A: Timely electronic access is continuous access to information and so implies online solutions such as CD-ROM, thumb drive or other physical media would have to be present every time an update happens. You don't have to use the solution that the EHR tested with, however.

55. **Q: If a patient does not ask for their record, why would we still print it out to them?**

    A: You only have to actively provide office visit summaries. We believe that this is useful information for all patients not just those who happen to have the forethought to request it. Please review the specification sheet for details.

56. **Q: If the patients have Medicare as primary insurance and Medicaid as secondary, can we register for the EHR Incentive Program with Medicaid?**

    A: Yes, as long as Medicaid has some liability for the services provided to the patient then the encounter can be included to meet the 30% Medicaid patient volume requirement. If the practitioner meets all eligibility criteria (adopting, implementing or upgrading to certified EHR

technology, not being hospital-based, etc) then they can qualify for the Medicaid EHR Incentive Program.

57. **Q: If a physician is registered and attested for the EHR Incentive Program and does not meet all the criteria needed, can he then qualify for the E-Rx incentive for 2011? If so does he need to register for the E-RX incentive program?**

    A: Yes they can. They would need to do all of the requirements for the e-Rx program.

58. **Q: Where might one find information regarding EPs from a remote practice that go out to service patients in Nursing Homes and Long Term Care Centers**

    A: There are FAQs available that both discuss the determination of whether 50 percent of a provider's encounters occur at locations equipped with Certified EHR Technology and what it means for a location to be equipped with Certified EHR Technology.

59. **Q: Where do I even begin as a solo practitioner? Are there exceptions for a solo practitioner for the EHR requirements?**

    A: Meaningful use is the same for all providers. There are not special exclusions based on the fact that a practitioner is solo. We would encourage a solo practitioner to look into their Regional Extension Centers, a list of which is available at healthit.hhs.gov.

60. **Q: What is an acceptable way to electronically exchange records if there are no hospitals with an HIE to interface with? We have permissions to electronically receive records from Hospitals and we send records via computer fax, CD, or thumb drive.**

    A: The following FAQ can help answer this question: FAQ #10764

61. **Q: To clarify - the core measure that states we must give a clinical summary is specific to patients that are having an office visit with an E&M code. Patients without E&M codes should not be considered in the denominator. Is this a correct understanding?**

    A: Office visits are not limited to E&M codes.

62. **Q: Please address the concerns of specialty physicians and the recording of vital signs and use of the Problem List by specialists; i.e., dermatologists who don't do vital signs routinely; reluctance to document problems outside of specialty area.**

    A: There is an exclusion for vital signs that EP should review. The problem list measure only speaks to a minimum of one problem.

63. **Q: Is it necessary to provide the patient with a printed plan at the time of the visit to be meeting any of the requirements?**

A: There is a requirement for an office visit summary following the visit, but this can be up to three days later.

64. **Q: Is BMI required for optometry?**

    A: BMI is not an automated calculation resulting from the recording of height and weight. There are exclusion criteria for the recording of height and weight which should be evaluated by the provider.

65. **Q: Implement one clinical decision support rule: Should this rule be written or incorporated in an alert in the EMR?**

    A: This is part of the certified EHR technology.

66. **Q: For the meaningful use core objective number 3 (up-to-date problem list of cur/active diagnoses): If a practice chooses to document/update only chronic diagnoses in the problem list and the report from certified EHRs shows that they are exceeding 80%, does the practice technically meet this objective?**

    A: The measure only requires the documentation of at least one problem.

67. **Q: For the HIE measure, what qualifies as "exchange"? Would a CCD sent to another facility in an email format which is then opened suffice or do they have to be able to upload it to their EHR?**

    A: Yes that would suffice. You are testing the sending, not the receipt.

68. **Q: Explain the CMS I & A proxy process and when, how, and why it's needed. We're very confused about this.**

    A: This is a process that allows the EP to designate someone to act on their behalf in the registration and attestation module. This person would have their own unique user ID and password.

69. **Q: For meaningful use core measure number 14 (Capacity to exchanged clinician information among providers): Does granting the provider remote access to our database cover this requirement? What if neither public health measure can be met because agencies do not accept electronic submissions?**

    A: No, you must send electronically a continuity of care document or record.

70. **Q: At this time, specialties such as dermatology are, or will be, having a challenging time meeting and reporting on Measure 8 (record vital signs), because it is not relevant to the patient's dermcare. Is CMS looking at modifying this measure for specialties?**

    A: We will be considering changes to Stage 1 in our Stage 2 proposed rule to come out in early 2012.

71. **Q: Can you have information contained in your certified EHR that has been imported from another system? - e.g. If you capture ethnicity/advanced directly in your ADT system and bring them over to your EHR is that okay or do you need to enter directly into your EHR?**

    A: Yes information can come from feeder systems. ONC has an FAQ on this topic on their website healthit.hhs.gov.