INCENTIVE PROGRAM

2013

Participation Year

S.C. Medicaid EHR Incentive Program State Level Repository User Guide for Eligible Professionals

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SOUTH CAROLINA Healthy Connections MEDICAID

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Table of Contents

Eligible Professional Eligibility Requirements for SC Medicaid EHR Incentive Program 1
Registration with the CMS Registration & Attestation System.....4
Overview of Attesting to the S.C. Medicaid EHR Incentive Program 6
Logging into the SLR.....7
Screen Navigation, Error Messages, and Helpful Links.....8
SLR "Home" Screen 10
CMS Registration/SC Medicaid Data Screen 13
Provider Eligibility Details Screen 16
Provider Eligibility Details - 'Needy Individual' Patient Volume Additional Screen.....21
Provider Locations Screen 23
EHR Details Screen 25
Adopt, Implement, or Upgrade? Or Meaningful Use? 29
Document Upload Screen 30
Attestation Screen 32
Review and Payment 34
Additional Resources 36
Attestations to Meaningful Use of Certified EHR Technology.....37
Meaningful Use Questionnaire Screen 38
Requirements for Meaningful Use Measures for EPs.....40
Meaningful Use Measure Menu Screen, Navigation, and Threshold Warnings 41
Meaningful Use Core Measures.....43
Meaningful Use Core Objective 1 – CPOE For Medication Orders 43
Meaningful Use Core Objective 2 – Drug Interaction Checks 44
Meaningful Use Core Objective 3 – Maintain Problem List 45
Meaningful Use Core Objective 4 – e-Prescribing 46
Meaningful Use Core Objective 5 – Active Medication List 47
Meaningful Use Core Objective 6 – Medication Allergy List 48
Meaningful Use Core Objective 7 – Record Demographics 49
Meaningful Use Core Objective 8 – Record Vital Signs.....50
Meaningful Use Core Objective 9 – Record Smoking Status 51
Meaningful Use Core Objective 10 – Clinical Decision Support Rule 52
Meaningful Use Core Objective 11 – Electronic Copy of Health Information 53
Meaningful Use Core Objective 12 – Clinical Summaries 54
Meaningful Use Core Objective 13 – Protect Electronic Health Information 55
Meaningful Use Menu Measures Screens 56
Meaningful Use Menu Measures Selections Screens & Navigation 56
Meaningful Use Menu Objective Screen – Immunization Registries Data Submission (Public Health) 58

Meaningful Use Menu Objective Screen – Syndromic Surveillance Data Submission (Public Health) 59
Meaningful Use Menu Objective Screen – Drug Formulary Checks 60
Meaningful Use Menu Objective Screen – Clinical Lab Test Results 61
Meaningful Use Menu Objective Screen – Patient Lists 62
Meaningful Use Menu Objective Screen – Patient Reminders 63
Meaningful Use Menu Objective Screen – Patient Electronic Access 64
Meaningful Use Menu Objective Screen – Patient-Specific Education Resources 65
Meaningful Use Menu Objective Screen – Medication Reconciliation 66
Meaningful Use Menu Objective Screen – Transition of Care Summary 67
Core Clinical Quality Measure Screens 68
Core Clinical Quality Measure 1 Screen: Hypertension: Blood Pressure Measurement (NQF 0013) 68
Core Clinical Quality Measure 2 Screen: Tobacco Use Assessment (NQF 0028) 69
Core Clinical Quality Measure 3 Screen: Adult Weight Screening and Follow-Up (NQF 0421) 70
Alternate Core Clinical Quality Measure Screens 71
Alternate Core Clinical Quality Measures (CCQM) Selection Screen 71
Alternate Core Clinical Quality Measure 1 Screen – Weight Assessment and Counseling for Children & Adolescents (NQF 0024) 72
Alternate Core Quality Measure 2 Screen – Influenza Immunization for Patients > 50 Years Old (NQF 0041) 73
Alternate Core Clinical Quality Measure 3 Screen- Childhood Immunization Status (NQF 0038) 74
Additional Clinical Quality Measure Screens 75
Additional Clinical Quality Measures Selection Screen 75
Additional Clinical Quality Measure 1 Screen – Initiation and Engagement of Alcohol and other Drug Dependence Treatment (a) Initiation, (b) Engagement (NQF 0004) 78
Additional Clinical Quality Measure 2 Screen – Prenatal Care: Screening for HIV (NQF 0012) 79
Additional Clinical Quality Measure 3 Screen – Prenatal Care: Anti-D Immune Globulin (NQF 0014) 80
Additional Clinical Quality Measure 4 Screen – Controlling High Blood Pressure (NQF 0018) 81
Additional Clinical Quality Measure 5 Screen – Cervical Cancer Screening (NQF 0032) 82
Additional Clinical Quality Measure 6 Screen – Chlamydia Screening for Women (NQF 0033) 83
Additional Clinical Quality Measure 7 Screen – Use of Appropriate Medications for Asthma (NQF 0036) 84

Additional Clinical Quality Measure 8 Screen – Low Back Pain: Use of Imaging Studies (NQF 0052) 85
Additional Clinical Quality Measure 9 Screen – Ischemic Vascular Disease: Complete Lipid Panel and LFL Control (NQF 0075) 86
Additional Clinical Quality Measure 10 Screen – Diabetes: HbA1c Control (<8%) (NQF 0575) 87
Additional Clinical Quality Measure 11 Screen – Diabetes: HbA1c Poor Control (NQF 0059) 88
Additional Clinical Quality Measure 12 Screen – Prostate Cancer: Avoidance of Bone Scan for Staging Low Risk Prostate Cancer Patients (NQF 0389) 89
Additional Clinical Quality Measure 13 Screen – Pneumonia Vaccination Status for Older Adults (NQF 0043) 90
Additional Clinical Quality Measure 14 Screen – Breast Cancer Screening (NQF 0031) 91
Additional Clinical Quality Measure 15 Screen – Colorectal Cancer Screening (NQF 0034).. 92
Additional Clinical Quality Measure 16 Screen – Smoking and Tobacco Use Cessation (NQF 0027) 93
Additional Clinical Quality Measure 17 Screen – Diabetes: Eye Exam (NQF 0055) 94
Additional Clinical Quality Measure 18 Screen – Diabetes: Urine Screening (NQF 0062) 95
Additional Clinical Quality Measure 19 Screen – Primary Open Angle Glaucoma: Optic Nerve Evaluation (NQF 0086) 96
Additional Clinical Quality Measure 20 Screen – Diabetes: Foot Exam (NQF 0056) 97
Additional Clinical Quality Measure 21 Screen – Diabetic Retinopathy Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (NQF 0088) 98
Additional Clinical Quality Measure 22 Screen – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (NQF 0089) 99
Additional Clinical Quality Measure 23 Screen – Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol (NQF 0074).. 100
Additional Clinical Quality Measure 24 Screen – Diabetes: LDL Management and Control (NQF 0064) 101
Additional Clinical Quality Measure 25 Screen – Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation (NQF 0084) 102
Additional Clinical Quality Measure 26 Screen – Ischemic Vascular Blood Pressure Management (NQF 0073) 103

Additional Clinical Quality Measure 27 Screen – Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic (NQF 0068) 104
Additional Clinical Quality Measure 28 Screen – Diabetes: Blood Pressure Management (NQF 0061) 105
Additional Clinical Quality Measure 29 Screen – Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (NQF 0081).. 106
Additional Clinical Quality Measure 30 Screen – Asthma Pharmacologic Therapy (NQF 0047).....107
Additional Clinical Quality Measure 31 Screen – Coronary Artery Disease: Oral Antiplatelet Therapy Prescribed for Patients with CAD (NQF 0067).....108
Additional Clinical Quality Measure 32 Screen – Asthma Assessment (NQF 0001) 109
Additional Clinical Quality Measure 33 Screen – Appropriate Testing for Children with Pharyngitis (NQF 0002).....110
Additional Clinical Quality Measure 34 Screen – Coronary Artery Disease: Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (NQF 0070) 111
Additional Clinical Quality Measure 35 Screen – Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (NQF 0387).....112
Additional Clinical Quality Measure 36 Screen – Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients (NQF 0385).. 113
Additional Clinical Quality Measure 37 Screen – Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (NQF 0083) 114
Additional Clinical Quality Measure 38 Screen – Anti-depressant Medication Management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment (NQF 0105) 115
Meaningful Use Summary of Measures Selection Screen 116
Meaningful Use Core Measures Summary 117
Meaningful Use Menu Measures Summary 118
Clinical Quality Measures Summary 119
Measure Editing Prior to Attestation 120
Change Control Record 122

Disclaimer

The pages that follow in this State Level Repository Guide for Eligible Professionals are intended to provide information to assist with completion of an Eligible Professional attestation to the S.C. Medicaid EHR Incentive Program; **however, it is important to note that this SLR Guide is not, nor is it intended to be, the full source of information about the requirements of the Medicaid EHR Incentive Program. It is the responsibility of the provider who is attesting to the S.C. Medicaid EHR Incentive Program to be acquainted with the requirements of the Medicare and Medicaid EHR Incentive Programs Final Rule and the State Medicaid HIT Plan (SMHP).**

Eligible Professional Eligibility Requirements for SC Medicaid EHR Incentive Program

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Record (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade (AIU) to certified EHR technology and use it in a meaningful manner.

The Medicare and Medicaid Programs: Electronic Health Record Incentive Program – Stage 2 Final Rule included clarifying language that maintains CMS' policy that to qualify for an AIU payment, a provider must adopt, implement, or upgrade to certified EHR technology that would allow that provider to qualify as a meaningful user. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR technology and has identified entities that may certify systems. More information about this process is available at http://www.healthit.hhs.gov .

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will result in better healthcare, better health, and reduced costs.

The CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at http://www.cms.gov/EHRIncentivePrograms/. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

Eligible Professional Types

There are 5 types of providers who are considered Eligible Professionals (EPs) for the Medicaid EHR Incentive Program:

1. Physician*

2. Dentist

3. Nurse Practitioner

4. Certified Nurse Midwife

5. Physician Assistant (PA) practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA:

    a. The PA is the primary provider in a clinic (e.g., a clinic with a part-time physician and full-time PA); or

    b. The PA is a clinical or medical director at a clinical site of practice; or

    c. The PA is the owner of an RHC.

*In South Carolina, this includes MDs, DOs, and Optometrists.

Conditions that Exclude a Provider from Participating

1. If the EP has any state or federal exclusions that would prevent the EP from receiving federal funding, the EP is not eligible to participate in the S.C. Medicaid EHR Incentive Program.

2. If the EP is a hospital-based provider, the EP is not eligible to participate in the S.C. Medicaid EHR Incentive Program. For purposes of this Program, a hospital-based provider is defined as a provider who furnishes 90% or more of their services in the following two places of service codes for HIPAA standard transactions: 21 – Inpatient Hospital, or 23 – Emergency Room.

For purposes of the S.C. Medicaid EHR Incentive Program, SCDHHS will make the determination about whether or not an EP is hospital-based by analyzing the EP's Medicaid paid claims data; or, in the case of EPs who deliver care via Medicaid managed care programs, by analyzing encounter data. Where there is not claims data specific to the provider (for example, as in the case where the provider may bill under a supervising provider) SCDHHS will request additional information from the provider to make the determination. For purposes of making this determination, SCDHHS will analyze data from the calendar year that precedes the participation year. The statutory definition of hospital-based EP provides that to be considered a hospital-based EP, the EP must provide ‘‘substantially all’’ of his or her covered professional services in a hospital setting.

Additional Program Participation Requirements
Once an EP meets the basic eligibility requirements for the S.C. Medicaid EHR Incentive Program, there are program participation requirements to meet in order to qualify for an incentive payment.

An EP must:

- Meet applicable patient volume threshold. (This is discussed further in Patient Volume.)

AND

- Adopt, implement, or upgrade to certified Electronic Health Record (EHR) technology, or demonstrate meaningful use of the certified EHR technology, in the provider's first program year. After the first program year, the provider must successfully demonstrate meaningful use for all other program years.

Incentive Payments
The payment year for an EP is based on the calendar year. EPs may receive Medicaid EHR incentive payments over 6 payment years up to a maximum of $63,750. Medicaid EHR incentive payments do not need to be consecutive until 2016. No EP may initiate the program after 2016, and no EP will receive a payment after the 2021 Participation Year.

- Payment Year 1: $21,250 ($14,167 for Pediatricians qualifying with reduced Medicaid volume)

- Payment Years 2-6: $8,500 per year ($5,667 for Pediatricians qualifying with reduced Medicaid volume)

The South Carolina Department of Health and Human Services' State Medicaid Health Information Technology Plan (SMHP) is available at www.scdhhs.gov/hit to provide detailed information about the S.C. Medicaid EHR Incentive Program.

Registration with the CMS Registration & Attestation System

EPs who wish to participate in either the Medicare or Medicaid EHR Incentive Program must first register with the Centers for Medicare and Medicaid Services (CMS) Registration and Attestation System. The last year an EP may begin participation is the 2016 Participation Year. The last year the EP may participate is the 2021 Participation Year.

Users working on behalf of an EP for registration and attestation must have a CMS Identity and Access Management System (I&A) Web user account (User ID/Password), and be associated to the provider's NPI. In absence of a CMS I&A account, an individual may not act as a surrogate user on behalf of the EP. To establish an I&A account, visit the CMS Registration and Attestation System. For assistance, please call the CMS EHR Information Center: (888) 734-6433.

Medicaid EPs use the CMS Web site to:

- Provide basic demographic information
- Select the state incentive program in which they will participate
- If applicable, switch their participation between the Medicaid and Medicare EHR Incentive Programs; or between state Medicaid EHR Incentive Programs.
    - EPs are allowed a one-time switch between the Medicaid and the Medicare EHR Incentive Programs once an incentive has been paid. The switch must occur before the 2015 Participation Year.
    - EPs may switch multiple times between state Medicaid EHR Incentive Programs.

EPs must provide the name, NPI, business address, phone number, and tax payer ID number (TIN) of the entity receiving the payment (i.e., the "Payee"). An EP may choose to receive the incentive, or may reassign it to a clinic or group with which he or she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive is required when registering with the CMS Registration and Attestation System. Upon successful completion of registration at the CMS level, the provider will receive an email confirmation from CMS that includes the provider's individual **CMS Registration ID**.

The CMS system will transmit basic registration data to the S.C. Medicaid State Level Repository (SLR) of a provider's choice to attest to the S.C. Medicaid EHR Incentive Program. SCDHHS will check the provider's eligibility to participate in the program and will respond to CMS to either accept the registration, or to notify CMS that the provider has been found ineligible to participate. The CMS system will send an email to the EP of the registration acceptance or of the finding of ineligibility; SCDHHS will also email the EP of the next steps to begin the attestation process.

The CMS EHR Information Center is available to assist with provider inquiries: 1-888-734-6433, 6:30 a.m. until 5:30 p.m. (Eastern Time), Monday through Friday, except federal holidays.

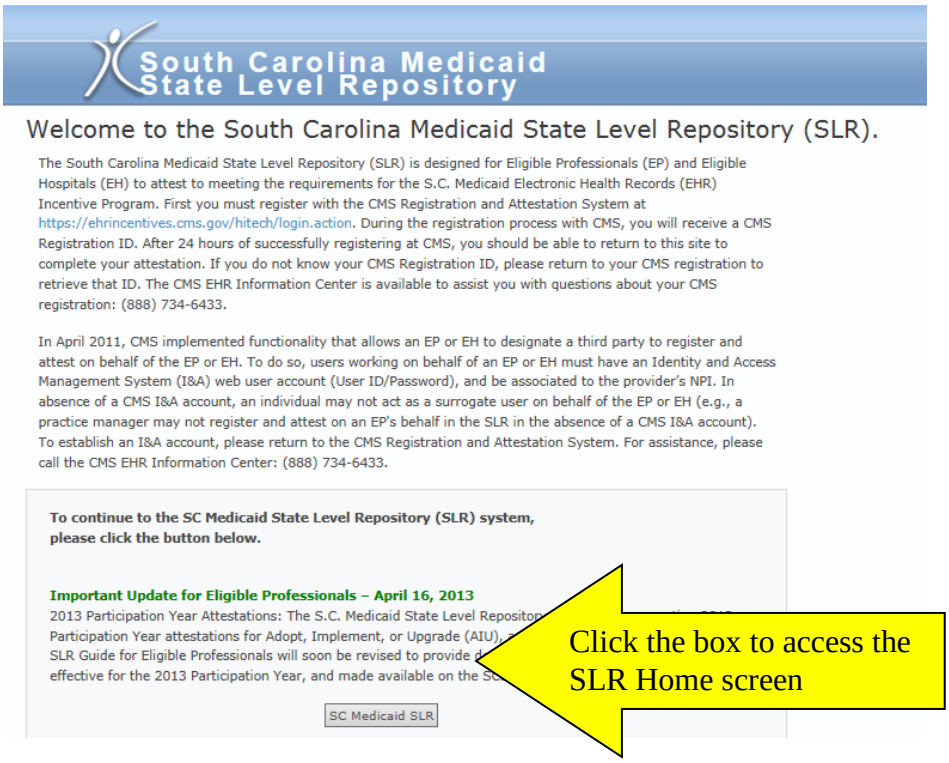
Providers must revisit the CMS Registration and Attestation System to make any changes to their registration information and/or choices, such as changing the program from which they wish to receive their incentive payment, or their Payee information. After the initial registration, the provider does not need to return to the CMS Registration and Attestation System unless information provided in that system needs to be updated.

The S.C. Medicaid EHR Incentive Program is administered by S.C.'s Medicaid agency, the South Carolina Department Health & Human Services (SCDHHS), Division of Health Information Technology (HIT). Within 24-48 hours of successfully registering at CMS, the EP may access the S.C. Medicaid State Level Repository (SLR) to complete the attestation. The SLR is available at www.scdhhs.gov/slr.

To login, the EP must provide his or her NPI and CMS Registration ID (that was generated after successfully registering with the CMS Registration and Attestation System). If the CMS Registration ID is not known, the EP must return to his or her CMS registration to retrieve that ID. The CMS EHR Information Center is available to assist with questions about the CMS registration: (888) 734-6433.

During attestation, the EP will first have the opportunity to review basic registration information provided at the CMS Registration and Attestation System (displayed in the SLR's "CMS Registration/SC Medicaid Data" screen). Then, the EP will progress through attestation screens to enter data to attest to meeting requirements of AIU (option for only the first program year) or MU (all other program years). Attestations of meaningful use require that providers attest to meeting measures for the meaningful use Core and Menu objectives, and enter information pertaining to selected Clinical Quality Measures that has been generated by the certified EHR technology.

A final Attestation screen will provide the EP the opportunity to review a summary of his or her attestation data, and will require the EP (or the EP's authorized designee) to agree to an attestation statement prior to submitting the attestation for review by the SCDHHS.



SLR Log In Screen

To access the SLR EP attestation, enter the EP's NPI and the EP's CMS Registration ID; then select Submit.

If an EP enters an incorrect NPI and CMS Registration ID combination 5 consecutive times for the same NPI, the SLR will display the following error message:

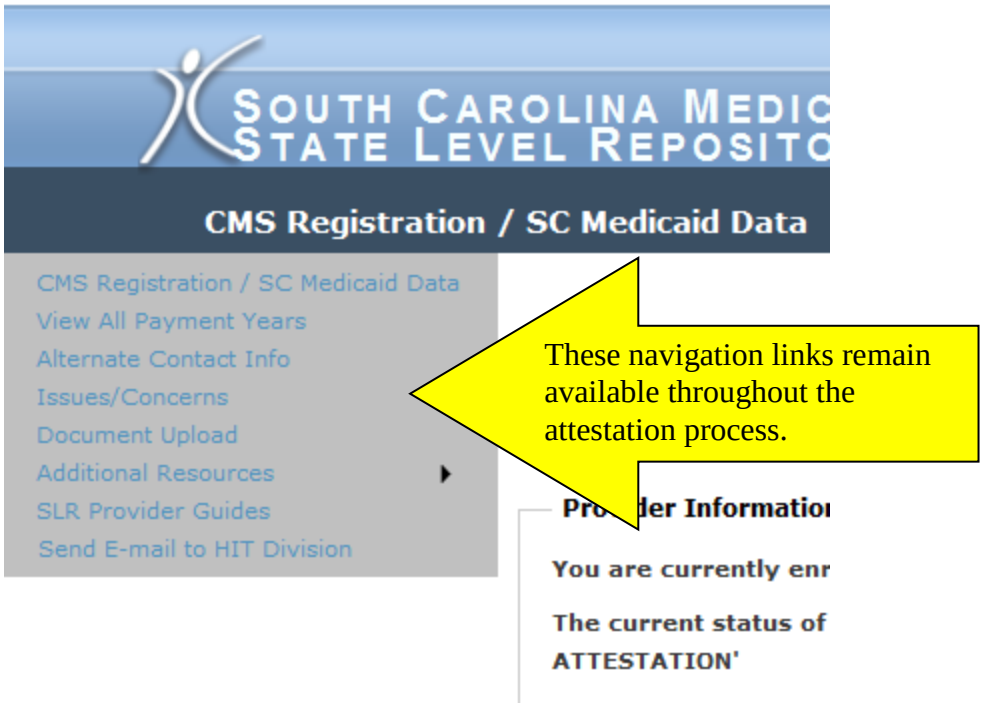
- "Your log-in screen to the SLR has been locked due to too many failed login attempts. Please contact (803) 898-2996, or email HITSC@scdhhs.gov, to request this screen be unlocked. If you do not know your CMS Registration ID, please contact the CMS EHR Information Center at (888) 734-6433."

Red Asterisks
Required fields are denoted with a red asterisk.

Error Messages
Error messages are designed to alert the EP to an issue with the attestation so that the EP may submit a complete attestation. If the screen has errors (for example, a required field has not been completed), it will display an error message when the EP attempts to save the screen. In many screens, the EP will not be able to save the information (or progress to the next attestation screen) until the error has been corrected. Some screens will allow progression to the next attestation screen even after an error message has displayed; however, when the EP attempts to complete the final Attestation screen to submit the attestation, the SLR will not allow submission unless errors have been addressed and resolved.

Save, Next, and Previous Buttons
Upon completion of any screen, select the **Save** button to save the data; then, upon logout, the SLR will retain the information. When ready to proceed to the next screen of the attestation, select the **Next** button at the bottom of the screen. (Selecting "**Next"** will also result in saving the information on the screen.) The EP may always return to a previous screen by selecting the **Previous** button at the bottom of the screen.

Left Navigation Links



- CMS Registration/SC Medicaid Data: Returns the EP to the CMS Registration/SC Medicaid Data Screen (beginning of the attestation).

- View All Payment Years: Displays a view of payments received by payment year.

- Alternate Contact Info: Allows the EP to designate alternate contacts for the SCDHHS HIT Division should there be questions related to the attestation. The Alternate Contact link is functional even if the attestation is in a submitted status.

- Issues/Concerns: Allows submission of an issue or question within the attestation to the SCDHHS HIT Division.

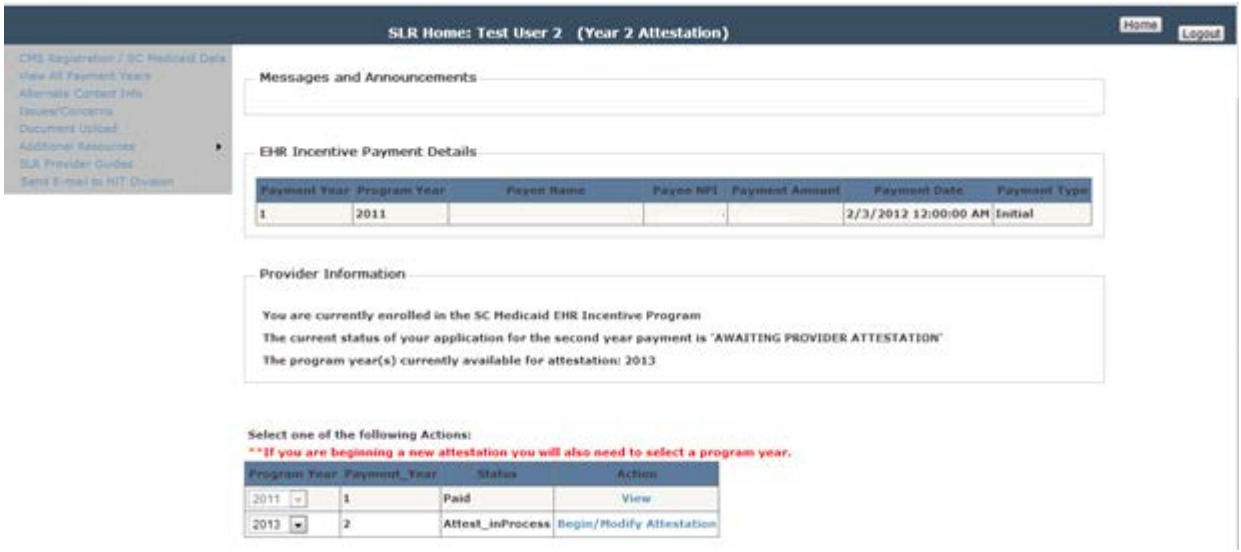
- Document Upload: Navigates the EP to a screen to browse and upload files essential to the attestation or its review by the SCDHHS.

- Additional Resources: Expands to provide links to the S.C. Medicaid HIT site, the CMS EHR site, and the ONC CHPL site.

- SLR Provider Guides: Navigates to SLR Guides specific to Eligible Professionals and to Eligible Hospitals.

- Send e-mail to HIT Division: Allows the EP to send an email to the HITSC@scdhhs.gov e-mail box.

The SLR Home screen provides a "home page" for the EP to view messages from the SCDHHS HIT Division, payment information, and current status. It also displays a grid for the EP to access a view of past Paid attestations or to begin/modify a new attestation. The name of the EP will display in the screen header.



Messages and Announcements

Information from the SCDHHS HIT Division will display. This time-limited information may be general (for example, applicable to all EPs), or may be specific to the EP.

Provider Information

In the information displayed under Provider Information, the provider's current status will display with one of the following messages:

PreCheck inProcess	SCDHHS is checking provider eligibility to participate
PreCheck_Completed	Eligibility check is complete and the provider may begin attestation
Attest_inProcess	Provider has begun the attestation, but has not yet submitted
Attest_Completed	Provider has submitted the attestation to the SLR
DHHSCheck_inProcess	SCDHHS is checking the provider attestation against requirements
DHHSCheck_Completed	SCDHHS has completed the requirements check
NLRDupCheck_inProcess	SCDHHS has sent CMS their intent to pay the incentives
NLRDupCheck_Completed	CMS has responded to SCDHHS' request
MMISPayment_inProcess	SCDHHS is processing payment
Paid	SCDHHS has disbursed the incentive
Ineligible	SCDHHS has found the provider to be ineligible for the incentives
Ineligible-CMS	CMS has found the provider to be ineligible for the incentive

EHR Incentive Payment Details
The EP may view information about all payments or adjustments in one summary table.

Program Year Selection Table
The Program Year (PY) Selection Table provides a view of past paid attestations, and also the means to begin or modify a new attestation.

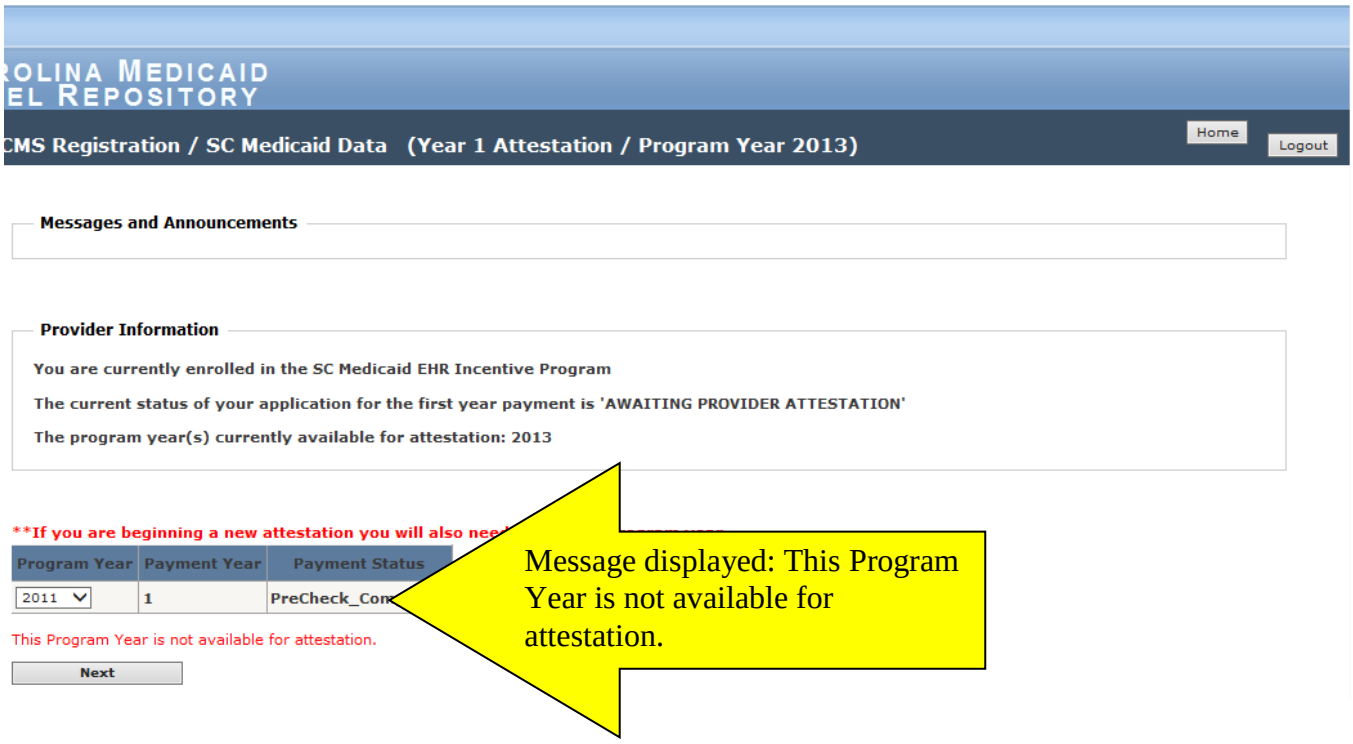
The PY Selection table will not display a Program Year (PY) for selection for attestation until the date for selection should be available.

- The EP may attest during the current participation year; or for a two-month period following the participation year (the "attestation tail period"). So, although the participation year for an EP is the calendar year (January-December), the attestation tail period extends the attestation submission period through the February that follows the participation year.

- Future attestations are not available from which to select. For example, it will not display the 2014PY until January 1, 2014.

- If the EP needs to attest for a full-year MU EHR reporting period, that PY will not display until the full-year period is complete. For example, if the EP needs to report a full-year MU EHR reporting period for 2013, the "2013PY" will not display until January 1, 2014.

- The SLR does not allow the EP to begin a PY for which the deadline to submit an initial attestation has expired. Should the EP attempt to select a PY after the attestation submission deadline, the following message will display: "This Program Year is not available for attestation." Note: Should the attestation be submitted by the PY deadline, and later be re-opened by SCDHHS for provider correction, the SLR will allow the EP to re-submit the attestation even after the PY deadline.



To view a Paid attestation, select the View link associated with the desired Program Year/Payment Year.

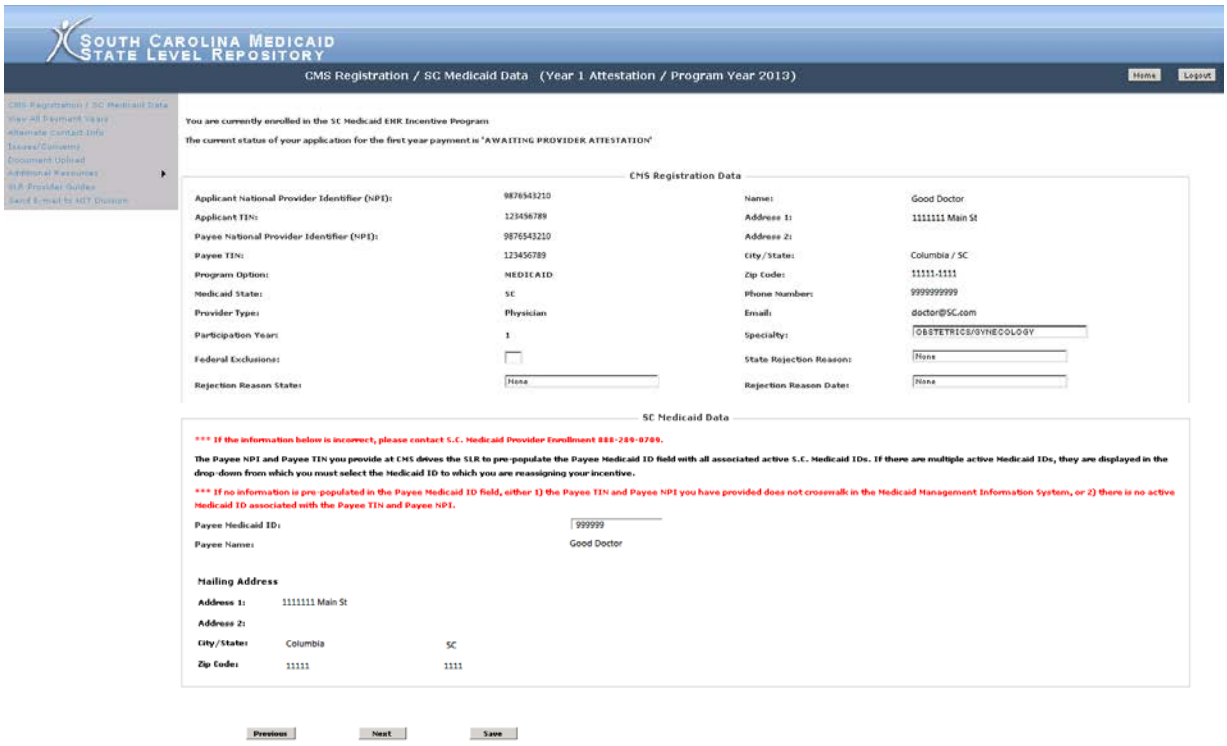
To begin or modify an attestation, select from the program year(s) currently available.

The CMS Registration/SC Medicaid Data screen allows the EP to review information sent to SCDHHS from the CMS registration, and to verify the Payee information for the incentive payments. EPs have the option of reassigning their incentive payments to their employer or an entity with which the EP has a contractual arrangement. EPs must designate their Payee NPI and Payee TIN when registering with the CMS Registration and Attestation System. **The S.C. Medicaid EHR Incentive Program requires the Payee to be actively enrolled as a S.C. Medicaid provider.** Once a payment is disbursed, the SCDHHS will notify CMS of the payment.

CMS Registration Data Review

The top portion of the CMS Registration/SC Medicaid Data screen displays information about the provider from the CMS Registration and Attestation System. Corrections to this information may only be made by the provider by returning to the CMS system to modify registration data.

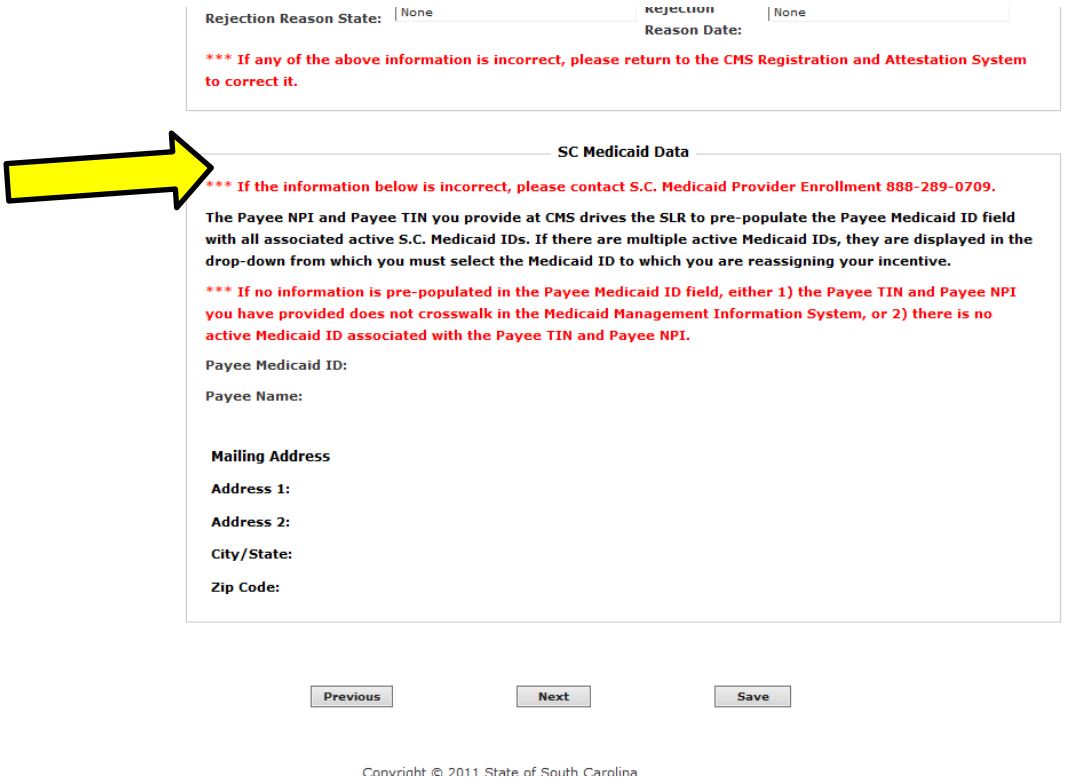
Note: Do not return to the CMS registration unless a change is needed to the CMS registration information. If the EP does return to the CMS account, the EP must be sure to re-submit the registration at the CMS Registration and Attestation System, even if no changes are made. If the registration is not re-submitted, the account status with CMS will change to **In Progress** or **Registration Started/Modified** and will remain so until it is re-submitted. If the account status shows **In Progress** or **Registration Started/Modified,** SCDHHS will not be able to exchange the transactions with CMS that are necessary to work the attestation. A status of **Pending State Validation** or **Registration Sent to State** in the CMS registration will indicate a successful submission.



Review the information the State has received from the EP's registration at the CMS Registration & Attestation System.

S.C. Medicaid Data Review

The State Level Repository (SLR) system searches a download of provider data from the S.C. Medicaid Management Information System (MMIS) to display the Medicaid Provider ID(s) associated with the Payee NPI and Payee TIN provided by the EP during the CMS registration. Only actively enrolled Medicaid ID will display.



- Where there is only one active Medicaid ID associated with the Payee info, that Medicaid ID will display in the field for Payee Medicaid ID; the Mailing Address for the Payee will display also. (Note: Any changes noted for the Mailing Address must be made by the provider by contacting the S.C. Medicaid Provider Service Center: 888-289-0709.)

- Where there are multiple active Medicaid IDs associated with the Payee info, the Payee Medicaid ID field will display **Search**. Clicking **Search** will display the active Medicaid IDs; select the one to which the incentive payment will be made. Once the selection is made, the Mailing Address will display also. (Note: Any changes noted for the Mailing Address must be made by the provider by contacting the S.C. Medicaid Provider Service Center: 888-289-0709.) If the EP does not select a Payee Medicaid ID, the SLR will display an error message: **This is a required field. Please select the Payee Medicaid ID from the list.**

- If no information is displayed in the Payee Medicaid ID field, either the Payee TIN/Payee NPI is not associated in the MMIS with an active S.C. Medicaid ID, or there is an issue with the SLR search of the MMIS data. Please contact the SCDHHS HIT Division at 803-898-2996, or by email at HITSC@scdhhs.gov, for assistance.

After reviewing information on the CMS Registration/S.C. Medicaid Data Screen, select the **Save** button to save your work; or, to proceed to the next screen, select the **Next** button.

Note: Communications from the SCDHHS HIT Division related to the provider attestation will be emailed to the email address associated with the CMS registration. Please ensure that this information is kept current.

Provider Eligibility Details Screen

EPs must enter two categories of data to complete the Provider Eligibility Details screen: Patient Volume data, and EHR Details. Patient volume reflects encounters from any representative continuous 90-day period from the calendar year preceding the participation year; or, as an additional option beginning with the 2013 Participation Year, from any representative continuous 90-day period from the 12-month period prior to attestation submission. The table below identifies **3 decision points** for determining the patient volume calculation methodology.

I. Medicaid Encounters? Or Needy Individual Encounters?	II. Individual EP's Data? Or Group/Clinic Data?	III. Encounter Methodology? Or Panel Methodology?
Medicaid Patient Volume: An EP must have a minimum **30%** patient volume attributable to Medicaid patients. *Pediatricians with reduced Medicaid patient volume may qualify for a reduced incentive with a minimum 20% patient volume. A Medicaid encounter includes **services rendered to an individual on any one day** where the individual was enrolled in Medicaid at the time of service. **OR** **"Needy Individual" Patient Volume:** An EP who **practices predominantly** in an FQHC or RHC may meet a minimum **30%** patient volume attributable to needy individuals. **Practicing predominantly**: More than 50% of the EP's encounters over 6 months in the calendar year prior to the PY occurred at FQHC or RHC. A Needy Individual encounter means **services rendered to an individual on any one day** where the individual was enrolled in Medicaid at the time of service; or the services were furnished at no cost, and calculated consistent with S495.310; or the services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.	An EP may qualify based on patient volume calculated on the individual EP's patient encounters; **OR** Clinics and group practices may calculate the clinic/group practice Medicaid patient volume (or Needy Individual patient volume, as applicable), and its EPs may attest to the volume as a proxy for their own. For purposes of the S.C. Medicaid EHR Incentive Program, a group/clinic is defined as **a group of healthcare practitioners organized as one legal entity under one Tax Identification Number (TIN)**. There are conditions for group/clinic proxy: (1)The clinic or practice's patient volume is appropriate as a patient volume calculation for the EP; (2) There is an auditable data source to support the clinic or practice's patient volume determination; (3) The clinic or practice and EPs decide to use one methodology in each year, and (4) The group or clinic uses the entire group or clinic's patient volume and does not limit it in any way. If an EP works inside and outside of the clinic or practice, the group/clinic proxy patient volume calculation includes only those encounters associated with the clinic or group practice. (The EP's outside encounters are not included.) In order for an EP to utilize group patient volume as a proxy, it must be appropriate as a patient volume methodology calculation for the EP; i.e., the EP must be able and available to see Medicaid patients.	The S.C. Medicaid EHR Incentive Program offers the EP two options from which to choose to calculate patient volume: (1) The **Encounter** methodology Total Medicaid patient encounters in any representative continuous 90-day period *in the preceding year ---------- *100 Total patient encounters in that same 90-day period **OR** (2) The **Panel** methodology: Note: An EP must not count an assigned patient who was also an encounter more than once. [Total Medicaid patients assigned to the provider in any representative continuous 90-day period *in the preceding calendar year with at least one encounter in the 24 months preceding the start of the 90-day period] + [Unduplicated Medicaid encounters in that same 90-day period] ---------- *100 [Total patients assigned to the provider in the same 90-day period with at least one encounter in the 24 months preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period] *or, the EP may opt to select the 90-day patient volume period from the 12-month period that precedes attestation submission.

The EP will provide information in these fields on the Provider Eligibility Details Screen:

Patient Volume

Enter data into the following fields, as applicable:

- **Line 1: Please indicate if you are using a clinic or group's patient volume as a proxy for your own.**
  For purposes of the S.C. Medicaid EHR Incentive Program, a group/clinic is defined as "A group of healthcare practitioners organized as one legal entity under one TIN." All encounters for that TIN (even across multiple sites) must be used in the calculation of the group/clinic patient volume. If the EP is using group patient volume as a proxy for the EP's own, answer Yes to Line 1 and also complete 2.A. and 2.B. If the answer is No to Line 1, Line 2.A and 2.B are not required (they do not allow data entry).

- **Line 2.A. If using clinic/group patient volume, indicate the TIN of the one legal entity.**

- **Line 2.B. So that the TIN may be verified, the EP is asked to indicate one NPI that is associated with the TIN.**
  If the NPI that is entered is not a valid NPI for the TIN, an error message will display as an alert that the TIN entered is not correct. ("The NPI and TIN does not match in MMIS. Please verify your info.")

- **Line 3. (If attesting to Needy Individual patient volume) Do you practice predominantly in an FQHC or RHC?**
  In order to base an attestation on Needy Individual patient encounters, the EP must individually meet the requirement of practicing predominantly in an FQHC or RHC. "Practices predominantly" is based on the EP's activity over 6 months in the most recent calendar year (e.g., 2012 for a 2013PY attestation). If attesting to Medicaid patient volume, and not Needy Individual patient volume, do not check the box for Line 3.

- **Line 4. Select the option that indicates the time period from which the 90-day patient volume period is derived:**
  Select one of the options that displays in the drop-down: prior calendar year; or, 12 months prior to attestation.

- **Line 5: Enter the starting date of the 90-day period used to calculate patient volume percentage.**
  Patient volume reflects encounters from any continuous 90-day period in the preceding calendar year; or, from any continuous 90-day period from the 12 months prior to attestation. If the starting date entered does not allow for a full 90-day period in the time period selected from the drop-down on Line 4, an error message will display.

- **Line 6. Medicaid (or Needy Individual, as applicable) patient encounters during this period.**

- **Line 7. Total patient encounters during this period.**

  If the EP confuses data entry for the patient volume, and enters the Medicaid encounters in the total encounters field, and vice versa, an error message will display.

- **Line 8. (If using the Panel Methodology) Total number of Medicaid (or Needy Individual) patients assigned to your panel with whom you did not have an encounter in the 90-day patient volume period but you did have an encounter in the 24 months prior. (If n/a, enter "0").**

  If the EP has not used the Panel methodology to calculate patient volume, please enter a "0" in line 8. For more information on Panel methodology, please see the Final Rule, or the SCDHHS State Medicaid HIT Plan.

- **Line 9. (If using the Panel Methodology) Total number of patients assigned to your panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior. (If n/a, enter "0").**

  If the EP has not used the Panel methodology to calculate patient volume, please enter a "0" in line 9. For more information on Panel methodology, please see the Final Rule, or the SCDHHS State Medicaid HIT Plan.

Enter data into fields 1-9; then, select the Calculate button.

Line 10 will display the Medicaid or Needy Individual patient volume percentage calculated from the attestation.

<u>EHR Details</u>

- **Line 11: Indicate the status of your EHR: Adopt, Implement, Upgrade (option only for first Program Year); Meaningful Use (all other Program Years)**

Upon completion of the Provider Eligibility Details Screen, select the **Save** button to save the data. The SLR will retain the information on the page.

To proceed to the next screen of the attestation, please select the **Next** button. To return to the previous screen, please select the **Previous** button.

SOUTH CAROLINA MEDICAID
STATE LEVEL REPOSITORY

Provider Eligibility Details (Year 1 Attestation / Program Year 2013)

Home | Logout

CMS Registration / SC Medicaid Data
View All Payment Years
Alternate Contact Info
Issues/Concern
Document Upl
Additional Reso

All * fields are required fields.

Only select the checkbox for Line 3 if attesting to Needy Individual patient volume.

Patient Volume:

1. Please indicate if you are using a clinic or group's patient volume as a proxy for your own (A group of healthcare practitioners organized as one legal entity under one TIN): No
2A. If yes, enter the TIN (FEIN) of the one legal entity: 0
2B. To ensure this is a valid TIN, enter an NPI associated with the entity's TIN: 0
3. (If attesting to Needy Individual patient volume) Do you practice predominantly in an FQHC or RHC? ☑
4. Select the option that indicates the time period from which the 90-day patient volume period is derived: * Prior calendar year
5. Select the starting date of the 90-day period used to calculate patient volume percentage: * 1/1/2012 (mm/dd/yy)
6. Medicaid (or Needy Individual, as applicable) patient encounters during this period: * 2289
7. Total patient encounters during this period: * 4887
8. (If using the Panel methodology) Total number of Medicaid (or Needy Individual, as applicable) patients assigned to your panel with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior: (If n/a, enter "0") * 0
9. (If using the Panel methodology) Total number of patients assigned to your panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior: (If n/a enter "0") * 0
10. Medicaid or Needy Individual patient volume percentage: 46.83% Calculate

EHR Details:

11. Indicate the status of your EHR: *
- ◉ Adopt
- ○ Implement
- ○ Upgrade
- ○ Meaningful User

Previous | Next | Save | Cancel

SOUTH CAROLINA MEDICAID
STATE LEVEL REPOSITORY

Home | Logout

Provider Eligibility Details (Year 1 Attestation / Program Year 2013)

- CMS Registration / SC Medicaid Data
- View All Payment Years
- Alternate Contact Info
- Issues/Concerns
- Document Upload
- Additional Resources
- SLR Provider Guides
- Send E-mail to HIT Division

All * fields are required fields.

Patient Volume:

1. Please indicate if you are using a clinic or group's patient volume as a proxy for your own (A group of healthcare practitioners organized as one legal entity under one TIN): [No]

2A. If yes, enter the TIN (FEIN) of the one legal entity: [0]

2B. To ensure this is a valid TIN, enter an NPI associated with the entity's TIN: [0]

3. (If attesting to Needy Individual patient volume) Do you practice predominantly in an FQHC or RHC? [☑]

4. * Select the option that indicates the time period from which the 90-day patient volume period is derived: [Prior calendar year]

5. * Select the starting date of the 90-day period used to calculate patient volume percentage: [1/1/2012] (mm/dd/yy)

6. * Medicaid (or Needy Individual, as applicable) patient encounters during this period: [2289]

7. * Total patient encounters during this period: [4887]

8. * (If using the Panel methodology) Total number of Medicaid (or Needy Individual, as applicable) patients assigned to your panel with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior: (If n/a, enter "0") [0]

9. * (If using the Panel methodology) Total number of patients assigned to your panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior: (If n/a enter "0") [0]

10. Medicaid or Needy Individual patient volume percentage: **46.83%** [Calculate]

EHR Details:

11. * Indicate the status of your EHR:
- (●) Adopt
- ( ) Implement
- ( ) Upgrade
- ( ) Meaningful User

[Previous] [Next] [Save] [Cancel]

If the EP is NOT attesting to using the Panel methodology to calculate patient volume, enter "0" in Fields 8 & 9.

Provider Eligibility Details - 'Needy Individual' Patient Volume Additional Screen (EPs attesting to Needy Individual Patient Volume)

If the EP is attesting to Needy Individual patient volume (selected the checkbox to line 3 to attest to “practicing predominantly”), the next screen that will display is the Needy Individual Patient Volume screen. In order to attest to meeting patient volume requirements based on Needy Individual patient volume, an EP must individually meet the definition of “practicing predominantly” in an FQHC or RHC. The Final Rule defines an EP who "practices predominantly" as "an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occurs at an FQHC or RHC." In other words, the six-month period used for this determination must be from the calendar year preceding the participation year.

In this screen, the EP will identify the FQHC/RHC location(s) for the attestation of practicing predominantly by completing an FQHC/RHC table. Note: If the EP has not selected the checkbox in line 3 to attest to “practicing predominantly,” and is attesting to Medicaid patient volume, this screen will not display. Instead, the next screen that will display will be the Provider Locations screen.

When the screen first displays, the FQHC/RHC table is empty awaiting attestation. Select the FQHC/RHC(s) from the options; the choices will populate the table. Once the FQHC/RHC table is complete, select **Next** to proceed to the next attestation screen.

SOUTH CAROLINA MEDICAID
STATE LEVEL REPOSITORY

Provider Eligibility Details - 'Needy Individual' Patient Volume (Year 1 Attestation)

Logout

CMS/NLR
View All Payment Years
Alternate Contact Info
Issues/Concerns
Additional Resources
SLR Provider Guides
Send E-mail to HIT Division

FQHC/RHC

On this page you will provide information about the FQHC(s)/RHC(s) at which you practice. This page allows you to search by FQH provider name. To search, enter part of the FQHC/RHC name in the field provided and click Find. Select the location(s) from the F listing. Your selection(s) will appear in the FQHC/RHC table displayed below. Delete options display at the left side of your listed c should you wish to delete one or all of your selections, click the Delete link(s).

	Provider Name	Address	City	State
		No record found.		

Filter: Provider Name | Little | Find | Reset

	Provider Name	Address		
Select	ROBESON HEALTH CARE CORP	402 NORTH PINE STREET STE	LUMBERTON	NC
Select	FRANKLIN C FETTER FAMILY H	51 NASSAU STREET	CHARLESTON	SC
Select	BEAUFORT JASPER CHS INC	721 OKATIE HIGHWAY	OKATIE	SC
Select	ALLENDALE CO RURAL HEALTH	PO BOX 990	FAIRFAX	SC
Select	HEALTH CARE PARTNERS OF SC	PO BOX 2100	CONWAY	SC
Select	PALMETTO FAMILY PRIMARY	POST OFFICE BOX 326	WINNSBORO	SC
Select	CAROLINA HEALTH CTRS INC-	535 JACKSON STREET	CALHOUN FALLS	SC
Select	CAROLINA HEALTH CTRS INC	219 GREENWOOD HWY	SALUDA	SC

Enter part of the name in the search field, and select Find. In this example, the provider is searching by "Little."

SOUTH CAROLINA MEDICAID
STATE LEVEL REPOSITORY

Provider Eligibility Details - 'Needy Individual' Patient Volume (Year 1 Attestation)

Logout

CMS/NLR
View All Payment Years
Alternate Contact Info
Issues/Concerns
Additional Resources
SLR Provider Guides
Send E-mail to HIT Division

FQHC/RHC

On this page you will provide information about the FQHC(s)/RHC(s) at which you practice. This page allows you to search by FQH provider name. To search, enter part of the FQHC/RHC name in the field provided and click Find. Select the location(s) from the F listing. Your selection(s) will appear in the FQHC/RHC table displayed below. Delete options display at the left side of your listed c should you wish to delete one or all of your selections, click the Delete link(s).

	Provider Name	Address	City	Stat
Delete	LITTLE RIVER MEDICAL CENTE	4303 LIVE OAK DR PO BOX547	LITTLE RIVER	SC
Delete	LITTLE RIVER MEDICAL CENTE	7724 NORTH KINGS HWY	MYRTLE BEACH	SC

Filter: Provider Name | Little | Find | Reset

	Provider Name	Address	City	Stat
Select	LITTLE RIVER MEDICAL CENTE	1075 MR JOE WHITE AVE 101	MYRTLE BEACH	SC
Select	LITTLE RIVER MEDICAL CENTE	3817 MAIN ST	LORIS	SC

Previous | Next

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In this example, the EP has selected two locations.
The EP may 'Delete' a choice from the table.

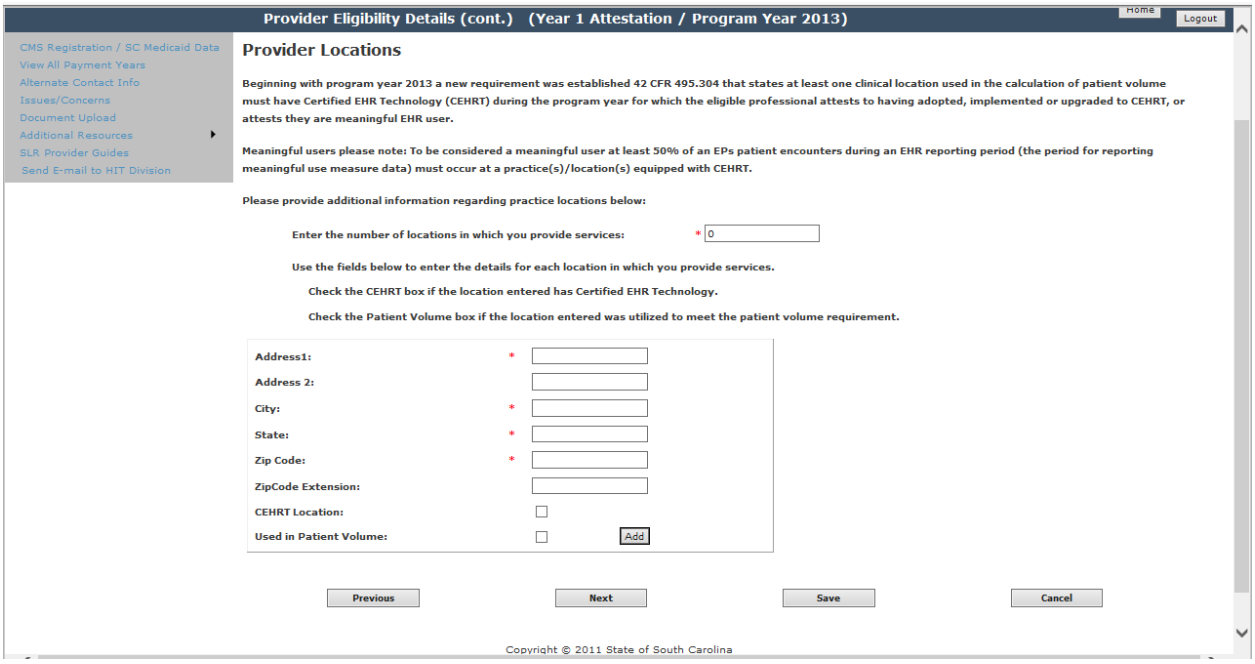
Click the Next button to save the information and proceed.

Provider Locations Screen

Beginning with the 2013 Participation Year, a new requirement was established (42 CFR 495.304) that states at least one clinical location used in the calculation of patient volume must have certified EHR technology (CEHRT) during the program year for which the eligible professional attests to having adopted, implemented or upgraded to CEHRT, or attests they are meaningful EHR user.

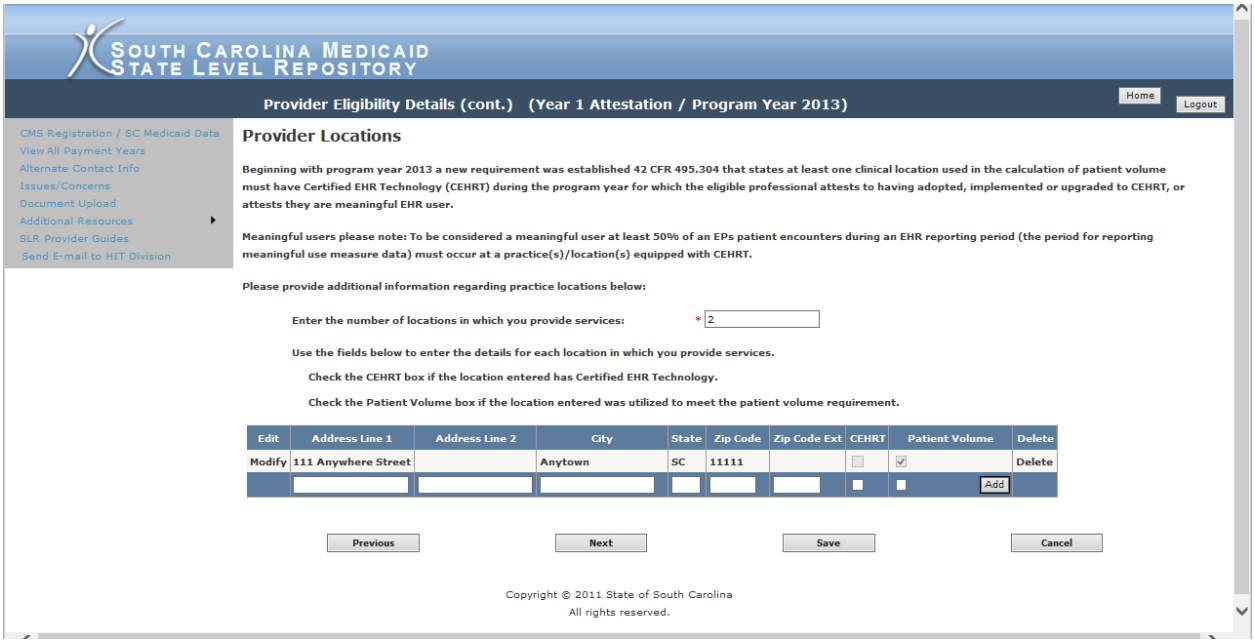
The Provider Locations screen collects information from the EP regarding all outpatient locations at which the EP renders services.

The screenshot below provides an example of how the screen will display prior to information being entered.



Once the EP enters information for the first provider location, and selects **Add**, the display will change to a more linear display. Information about additional locations must be typed into the fields under the column headings; then, select the **Add** button.

In the screenshot below, the provider has indicated 2 practice locations, and has entered data related to 1 of the 2 locations. Note that each row of the table includes a **Delete** button, and a **Modify** button, to either delete or modify the information in that row.



The EP must enter data for each practice location; for example, where the EP has indicated 2 locations, there must be 2 rows completed in the provider locations table. Should information be entered that is inconsistent (for example, only 1 description where the provider has indicated multiple locations), the SLR will display the following error message when the provider attempts to select **Next** to progress:

- "The number of locations in which you provide services must equal the number of location descriptions entered below."

Enter the number of locations at which the EP provides outpatient services; then complete the provider locations table, indicating for each location if the location was used for patient volume data, and if the location currently has certified EHR technology.

Upon completion of the Provider Locations screen, select the **Save** button to save the data. The SLR will retain the information on the page.

To proceed to the next screen of the attestation, please select the **Next** button. To return to the previous screen, please select the **Previous** button.

On this screen, the EP will enter information to provide the EP's attestation to the certified EHR technology (CEHRT). If the EP is attesting to Adopt, Implement, or Upgrade (option only for first program year), the EP will attest to the CEHRT that has been adopted, implemented, or upgraded at the time of the attestation. If the EP is attesting to Meaningful Use, the EP will attest to the CEHRT(s) that was used for the meaningful use EHR Reporting period.

When the EP returns for a second year of the Medicaid EHR Incentive Program, the information that was entered in the CMS Certification ID field and the CHPL table in the first program year will display. **Please review the information to ensure that it still reflects the correct CEHRT information and the correct CMS EHR Certification ID.** The EP may make changes as necessary to update the information.

Certified EHR Technology is technology certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to the Office of the National Coordinator (ONC). The ONC Certified Health IT Product List (CHPL) serves as the official listing of certified products: http://onc-chpl.force.com/ehrcert. This Web site is the single authority to obtain the CHPL/ONC Product Number(s) and the 15-character alphanumeric CMS EHR Certification ID for the certified EHR technology products(s). Please note: the left navigation link, "Additional Resources," will expand when clicked to display a link to the ONC CHPL Website.

Step 1: Enter the CMS Certification ID of your certified EHR Technology.

The CMS Certification ID is a 15-character alphanumeric ID. Clicking the **What Is This** link located next to the field will enable the EP to view the ONC CHPL Web site. For more information on steps to take to determine the CMS Certification ID for the certified EHR technology, click the link to ***CMS Tutorial***.

- If the EP provided the CMS Certification ID of the certified EHR technology during the registration with the CMS Registration and Attestation System (optional), or if the EP has provided this information during a previous year's attestation, this field will pre-populate that information. **If the field is pre-populated, please review the information to be sure that it still accurately reflects the certified EHR technology in place at the time of the attestation submission (for AIU attestations), or the CEHRT used during the MU EHR reporting period (for MU attestations).**

- If there is no information displayed in the CMS Certification ID field, please enter information into this field.

Step 2: Complete the Certified Health IT Product List.

Certified EHR technology must be a complete product, or combination of multiple products, that offers 100% of the criteria required by the Medicare and Medicaid EHR Incentive Programs.

Enter information into this CHPL table for the certified EHR technology product(s) by completing the fields for **Product Name** and **Version #**, **Vendor Name**, and **CHPL Product Number**. Select **Click Here to Add Product** to save the information. Information will display in the CHPL table.

Failure to select "Click Here to Add Product," will result in the following error message: **"There cannot be any empty Certified Health IT Product List field. Please complete the Certified Health IT Product table."**

For more information on how to find the CHPL Product Number, a link to a tip sheet is provided on the EHR Details screen.

Step 3: Complete the Text Box.

Note: Instructions for an AIU attestation differ than that for a MU attestation.

EHR Details Screen: Adopt, Implement, Upgrade Attestation

Enter a description of the EP's legal or financial commitment to the certified EHR technology at the time of attestation in this required text box. Include the full name **and version** of the technology, and relevant dates.

Examples are as follows:

- Adopt: "I purchased [name and version of product] on [date] and have a receipt for that purchase."
- Implement: "My practice purchased [name and version of product] on [date] and is in the process of implementation; we have retained a receipt for that purchase."
- Upgrade: "XYZ Medical Group signed its first contract with [vendor name] on [date]; we committed to an upgrade to certified EHR technology [name and version of product], as demonstrated by a legally binding contract dated [date]. The current contractual commitment is for three years ending [date]."

The EP must retain documentation for a minimum of six years that demonstrates a legal or financial commitment to the acquisition, purchase, or access to certified EHR technology prior to the incentive. This documentation would serve to differentiate between activities that may not result in AIU (for example, researching EHRs, interviewing EHR vendors, contract proposals) and an actual commitment to AIU. The documentation must show a legal or financial commitment to the adoption, implementation, or upgrade to certified EHR technology, naming

the product(s) and version(s). Such documentation may include but is not limited to: an invoice and receipt for payment; purchase agreement; license agreement; binding contract (signed by both parties). Should the documentation not specify the certified EHR technology product (product name and version), a letter from the certified EHR technology vendor that clarifies the product name and version may be retained with the documentation as a supplement; however, such information will not be regarded as sufficient for stand-alone evidence.

EHR Details Screen: Meaningful Use Attestation

The CMS EHR Certification ID and the CHPL table should reflect current information for the certified EHR technology relative to the attestation to meaningful use (the CEHRT(s) used in the EHR reporting period). If the EHR details have changed from the previous year's attestation, please provide a brief explanation of the change in the text box.

Step 4: Save Your Information

Select the **Save** button before leaving this screen.

The SLR will run a check against the ONC CHPL site to validate that the CMS Certification ID that was entered is a valid CMS Certification ID. There may be slight delay as the system runs this check. If the CMS Certification ID supplied is not valid, the following error message will display: **"Not a valid CMS certification ID."**

To continue to the next attestation screen, select the **Next** button at the bottom of the screen.

SOUTH CAROLINA MEDICAID STATE LEVEL REPOSITORY

EHR Details (Year 2 Attestation)

Logout

CMS/NLR
View All Payment Years
Alternate Contact Info
Issues/Concerns
Additional Resources
SLR Provider Guides
Send E-mail to HIT Division

All * fields are required fields.

EHR Details: Enter the CMS EHR Certification ID of your certified EHR (alphanumeric ID, with letters in ALL CAPS): * 30000001SWGTEAS What is this? CMS Tutorial

Certified Health IT Product List (CHPL) *

Payment Year	Sequence Number	Product Name and Version #	Vendor Name	CHPL Product Number		
2	1	Test Product Y 2	Test Vendor Y 2	Test CHPL Product No Y 2	Edit	Delete
2	2	Test Product	Test Vendor	Test CHPL Product No	Edit	Delete

Product Name and Version # *

Vendor Name *

CHPL Product Number *

Click Here to Add Product

The CMS EHR Certification ID and the CHPL table information you provide on this screen should reflect current information for the certified EHR technology at one location at which you practice relative to your meaningful use attestation. If your EHR details have changed from last year's attestation, please modify the information above and provide a brief explanation of the change in this text box:

Upgraded practice wide to SuccessEHS version 6.0

Previous Next Save Cancel

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Meaningful Use:
Review previous information, and update information as needed. Describe the update.

SOUTH CAROLINA MEDICAID STATE LEVEL REPOSITORY

EHR Details (Year 1 Attestation)

Logout

CMS/NLR
View All Payment Years
Alternate Contact Info
Issues/Concerns
Additional Resources
SLR Provider Guides
Send E-mail to HIT Division

All * fields are required fields.

EHR Details: Enter the CMS Certification ID of your certified EHR (alphanumeric ID, with letters in ALL CAPS): * What is this? CMS Tutorial

Certified Health IT Product List (CHPL) *

Sequence Number	Product Name and Version #	Vendor Name	CHPL Product Number	
No uploaded product found.				

Product Name and Version # *

Vendor Name *

CHPL Product Number *

Click Here to Add Product

Enter the Description of your legal or financial commitment to certified EHR. Include full name and version of the technology, and relevant dates: *

Previous Next Save Cancel

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AIU:
Describe the legal or financial commitment to AIU of certified EHR technology.

Adopt, Implement, or Upgrade? Or Meaningful Use?

For an Eligible Professional attesting to **Adopt, Implement, or Upgrade**, information pertaining to the attestation process continues on the following page. (Refer to "Document Upload" page.)

For an Eligible Professional attesting to **Meaningful Use, please select this link to be directed to the Meaningful Use portion of the SLR Guide for EPs.**

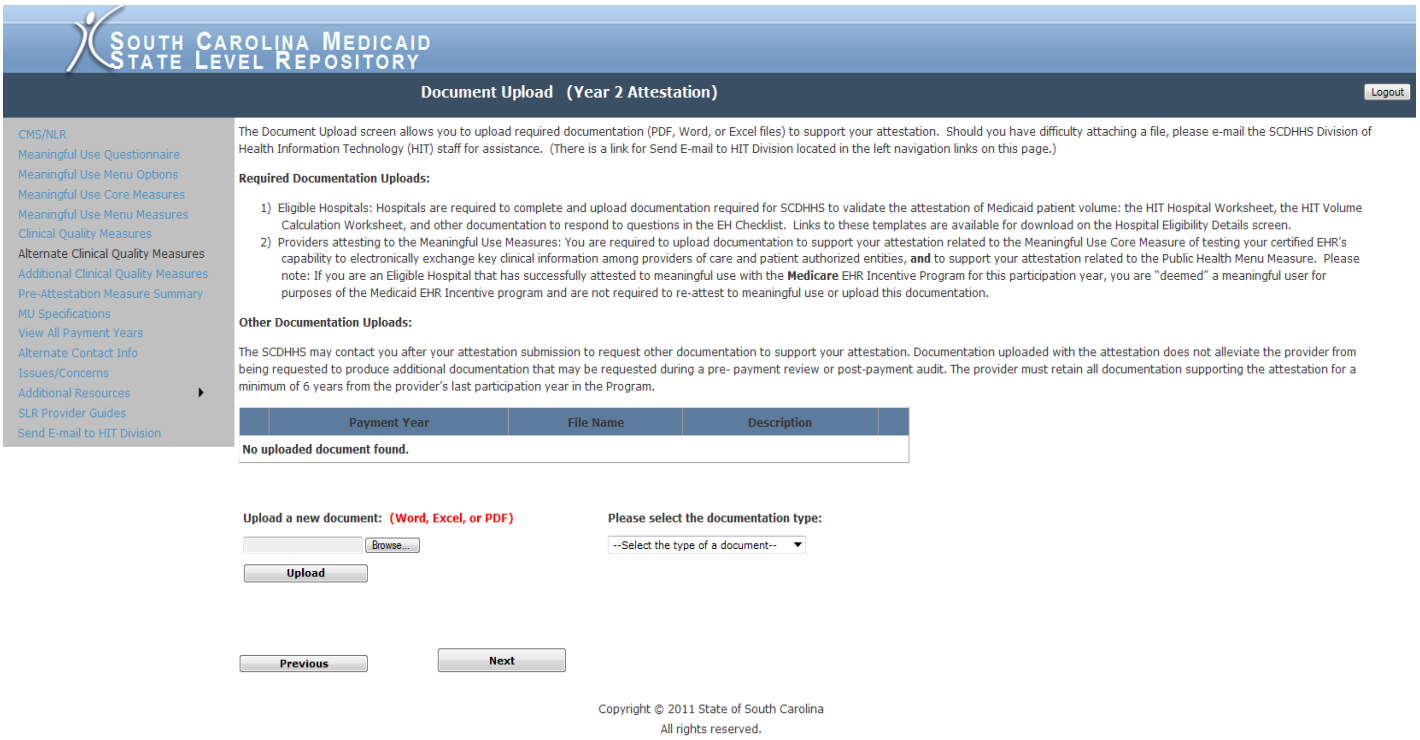
Document Upload Screen

Providers attesting to meaningful use must upload documentation to support the attestation for the selected public health menu objective(s) measures and/or exclusions. The SCDHHS Division of Health Information Technology (Division of HIT) may also contact a provider to request documentation to support or clarify an attestation. The Document Upload screen provides the means for providers to attach PDF, Word, or Excel files to the provider attestation.

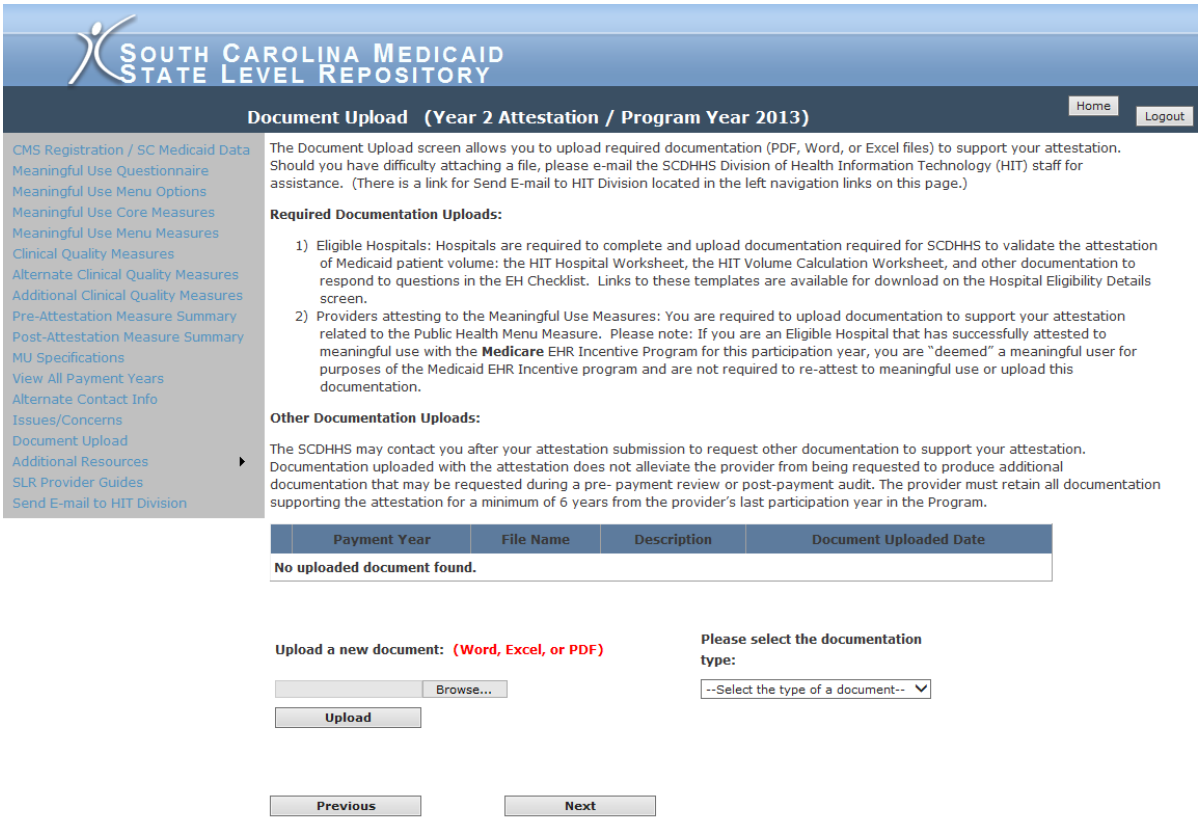
To upload a document, select the **Browse** button and locate the desired information. Then, select the **Upload** button.

If the upload is successful, the SLR will display a message:

'You have successfully uploaded: [File Name].'



The EP may review the uploaded document by selecting the **View** button. To delete the file, select the **Delete** button. Once the attestation is submitted, uploaded documents may not be deleted.



Select **Next** to proceed to the next screen.

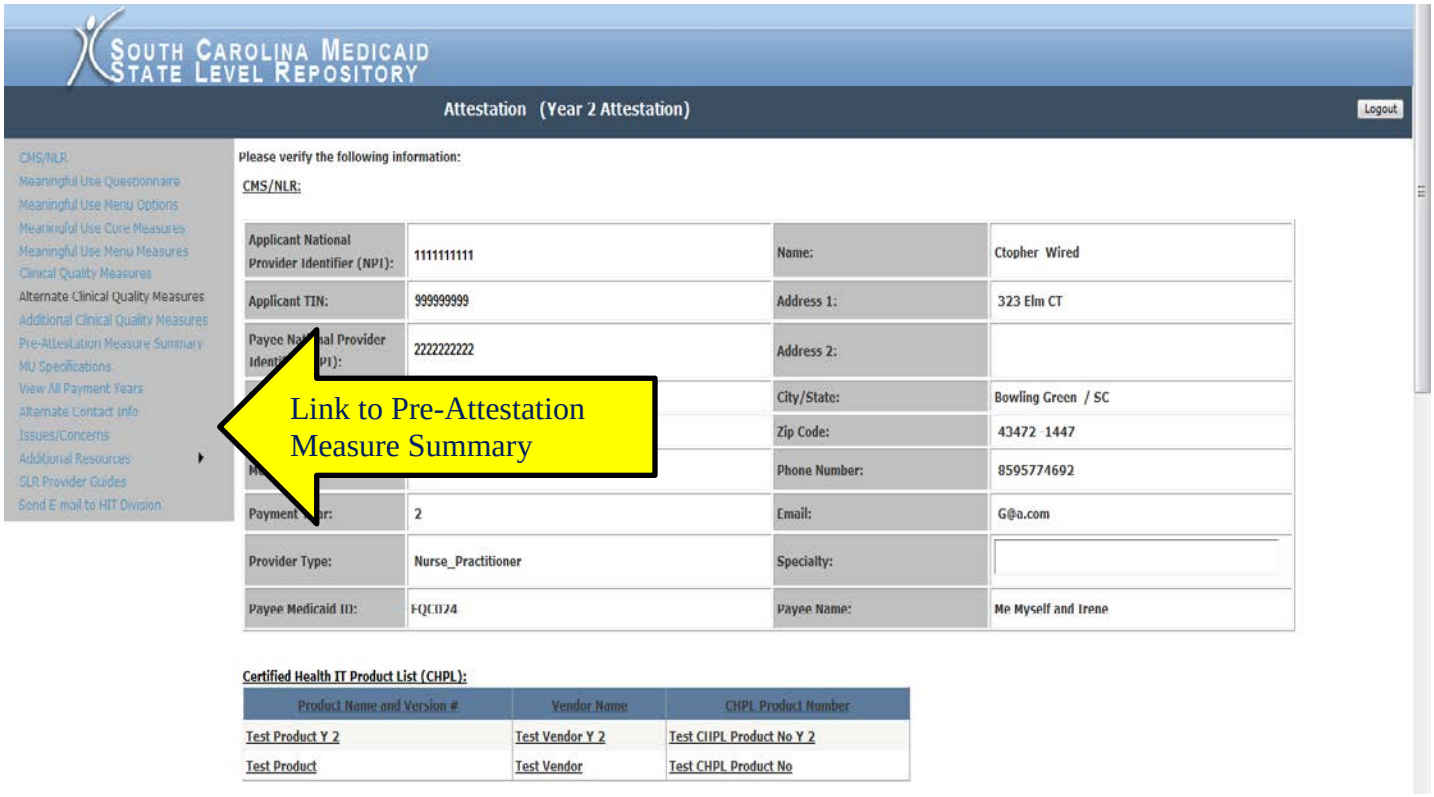
Attestation Screen

The Attestation screen displays a summary of information from the provider attestation; to also view the information from the provider attestation for the meaningful use objectives, the provider may select the **Pre-Attestation Measure Summary** navigation link located at the top left of the screen. If while reviewing the information the provider decides to revise information, he or she may return to the data entry field to modify information before submitting the attestation. Please note, however, that once the **Submit** button is selected, the attestation will be locked. In the screenshot that follows, a partial display of the Attestation Screen provides an example of the summary of information; note, too, that the link to the Pre-Attestation Measure Summary link is also shown.

Before submitting the attestation, read the Attestation Statement that is included on the Attestation Screen. To submit the attestation, enter the initials, the NPI, and select **Submit.**

Note: If the attestation to the meaningful use objectives has met the requirements, the Submit button will be displayed as active and will allow selection. If the attestation to the meaningful use objectives has not met the requirements, the Submit button will be grayed out, and the following error message will display: "Your MU attestation cannot be accepted. One or more of the measures did not meet MU requirements. Please select the navigation link to the Pre-Attestation Measure Summary to view all measures and the corresponding attestation data."

Once an attestation is successfully submitted for meaningful use, the EP may select the **Post-Attestation Measure Summary** to view all measures and the corresponding calculations.



This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I hereby agree to keep such records as are necessary to demonstrate that I met all S.C. Medicaid EHR Incentive Program requirements and to furnish those records to the South Carolina Department Health and Human Services, the U.S. Department of Health and Human Services, or contractor(s) acting on their behalf. I understand that I must retain all support documentation for incentive program requirements, including but not limited to that pertaining to patient volume determination, for a minimum of six years from the last year of my participation in the incentive program, and will make such information available for audit(s) conducted by the SCDHHS, the U.S. Department of Health and Human Services, or contractors acting on their behalf.

No EHR incentive payment may be paid unless this application is completed as required by existing law and regulations. Failure to provide required information will result in delay in payment or may result in denial of EHR incentive payment. Failure to furnish requested information of documents post incentive payment will result in the issuance of an overpayment demand letter, followed by recoupment procedures.

Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this application may, upon conviction, be subject to fine and imprisonment under applicable Federal laws. Information from this South Carolina Medicaid EHR Incentive Program application and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the EHR Incentive Program.

I understand that it is mandatory that I inform the South Carolina Department of Health and Human Services if I believe I have been overpaid under the EHR Incentive Program. I certify I am not receiving Medicaid incentive funds from any other state or commonwealth and have not received an EHR incentive payment from the South Carolina Department of Health and Human Services for this participation year.

I shall retain documentation for a minimum of six years that demonstrates acquisition, purchase, or access to certified EHR technology prior to the incentive. The documentation must show a LEGAL or FINANCIAL COMMITMENT to the adoption, implementation, or upgrade to certified EHR technology [naming the product(s) and version(s)]. Such documentation may include but is not limited to: an invoice and receipt for payment; purchase agreement; license agreement; binding contract (signed by both parties). Should the documentation not specify the certified EHR technology product (product name and version), a letter from the certified EHR technology vendor that clarifies the product name and version may be retained with the documentation as a SUPPLEMENT. Such a letter will not be regarded as stand-alone support documentation.

For this attestation of meaningful use of the certified EHR technology, I attest that the information I am submitting for Clinical Quality Measures was generated as output from an identified certified EHR technology; the information I am submitting includes information on all patients to whom the measure applies; a zero is reported in the denominator of a measure when I did not care for any patients in the denominator population during the EHR reporting period; and, as a meaningful EHR user, at least 50% of my patient encounters during the EHR reporting period occurred at a practice/location given in my Attestation information and that is equipped with certified EHR technology.

All * fields are required fields.

Initials: * AKT

NPI: * 1111111111

Note: Once you press the submit button below, your attestation will be locked.

Previous Submit Print

The following message appears in RED on the attestation screen if MU criteria are not met:

"Your MU attestation cannot be accepted. One or more of the measures did not meet MU requirements. Please select the navigation link to the Pre-Attestation Measure Summary to view all measures and the corresponding attestation data."

The submit button is also greyed out.

Once a provider has successfully submitted an attestation, the following screen will display:

Any provider attesting to receive an EHR incentive payment potentially can be subject to audit. **ALL** relative supporting documentation (in either paper or electronic format) used in the completion of the attestation responses must be retained and easily retrievable for a minimum of six years from the last year of participation in the Program.

Once the attestation is submitted, the SCDHHS Division of Health Information Technology (HIT) will review it to determine if it meets the requirements of the S.C. Medicaid EHR Incentive Program. Should the HIT Division staff have any questions concerning the attestation, they will contact the EP using the e-mail address provided by the EP to CMS during registration and, if necessary, alternate contact information provided by the EP in the SLR.

Approved incentives are incorporated into the SCDHHS' weekly claims payment cycle and paid as **credit** adjustments to the individual or entity designated by the EP as the Payee. If the EP has reassigned the incentive, the EP should forward this important information to the Payee.

Payment Notification
Providers will be notified by e-mail of payments. The payment e-mail will provide information to identify provider-specific information on the remittance advice (RA).

Payee Name
Eligible Provider Who Earned the Incentive
Payment Date
Incentive Amount
Provider Own Reference Number

Remittance Advice
Information about each EP's incentive will be displayed as a separate line item in the Adjustments section. The names of the individuals for whom incentives are being issued will not be detailed on the RA; however, each line item will display information in columns labeled Provider Own Reference Number, Claim Reference Number, Action, and Debit/Credit Amount.

An example of a remittance advice with information about 3 separate incentive credits follows on the next page.

PROVIDER ID. 000102248

XXXXXX

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 06/03/2011

PAGE 12

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
EHRFQH002	11147010540301 00U	-						INCENTIVE	21250.00	
EHRFQH003	11147010550301 00U	-						INCENTIVE	21250.00	
EHRFQH004	11147010560301 00U	-						INCENTIVE	21250.00	
							PAGE TOTAL:		63750.00	0.00

PROVIDER INCENTIVE CREDIT AMOUNT: 63750.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE: 0.00

YOUR CURRENT DEBIT BALANCE: 0.00

MEDICAID TOTAL: 8991.53

ADJUSTMENTS: 63750.00

* CHECK TOTAL: 72741.53

CERTIFIED AMT: 0.00

0.00

0.00

CHECK NUMBER: 6712051

TO BE REFUNDED IN THE FUTURE: 0.00

PROVIDER NAME AND ADDRESS

Provider Name

Street Address City, State Zip Code

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: SECURITY FEDERAL SAVINGS ACCOUNT #: XXXXXXXXXX
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.

Additional Resources

The following resources are available to assist providers with questions about the Medicaid EHR Incentive Program:

• Official CMS Medicare and Medicaid EHR Incentive Programs Web site: http://www.cms.gov/EHRIncentivePrograms

• 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

•42 CFR Parts 412, 413, and 495
Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

•45 CFR Part 170
Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology;
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17210.pdf

•Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-20982.pdf

• SCDHHS HIT Web site: http://www.scdhhs.gov/hit

• Dedicated SC e-mail address for questions concerning the S.C. Medicaid EHR Incentive Program: hitsc@scdhhs.gov

Eligible Professionals may attest to AIU (Adopt, Implement, or Upgrade) or to MU (Meaningful Use) in their first program year in the Medicaid EHR Incentive Program. In the remaining years of the Program, the Eligible Professional must meet the requirements of meaningful use of certified EHR technology for each program year. Providers will attest for two years at each stage of meaningful use. (AIU does not replace one of the two years for Stage 1.)

Medicaid Path to Payment (Year vs. Stage)

The chart below illustrates the Medicaid MU path providers must follow from AIU or Stage 1 through Stage 3, depending on the year they began participating.

1st Year	Medicaid EHR Incentive Payment Program for Eligible Professional (EPs) Usual[1] Paths through AIU/MU Stages[2] *(EPs may start at AIU or Stage 1)*										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021[4]
2011	AIU	1	1	2	2	3					
	1	1	1	2	2	3					
2012		AIU	1	1	2	2	3				
		1	1	2	2	3	3				
2013			AIU	1	1	2	2	3			
			1	1	2	2	3	3			
2014				AIU	1	1	2	2	3		
				1	1	2	2	3	3		
2015					AIU	1	1	2	2	3	
					1	1	2	2	3	3	
2016[3]						AIU	1	1	2	2	3
						1	1	2	2	3	3

1. Medicaid EPs may receive payments on a non-consecutive annual basis
2. AIU/MU Stages = Adopt, Implement or Upgrade/Meaningful Use Stages
3. The last year EPs may start is 2016
4. The last year for Medicaid EHR incentive payments is 2021

For an Eligible Professional attesting to **Meaningful Use**, the pages immediately following this page, beginning with Meaningful Use Questionnaire Screen, describe the SLR screens that will be used to enter attestation data.

For an Eligible Professional attesting to **Adopt, Implement, or Upgrade**, information pertaining to the attestation process continues at the SLR Guide's section on "Document Upload Screen."

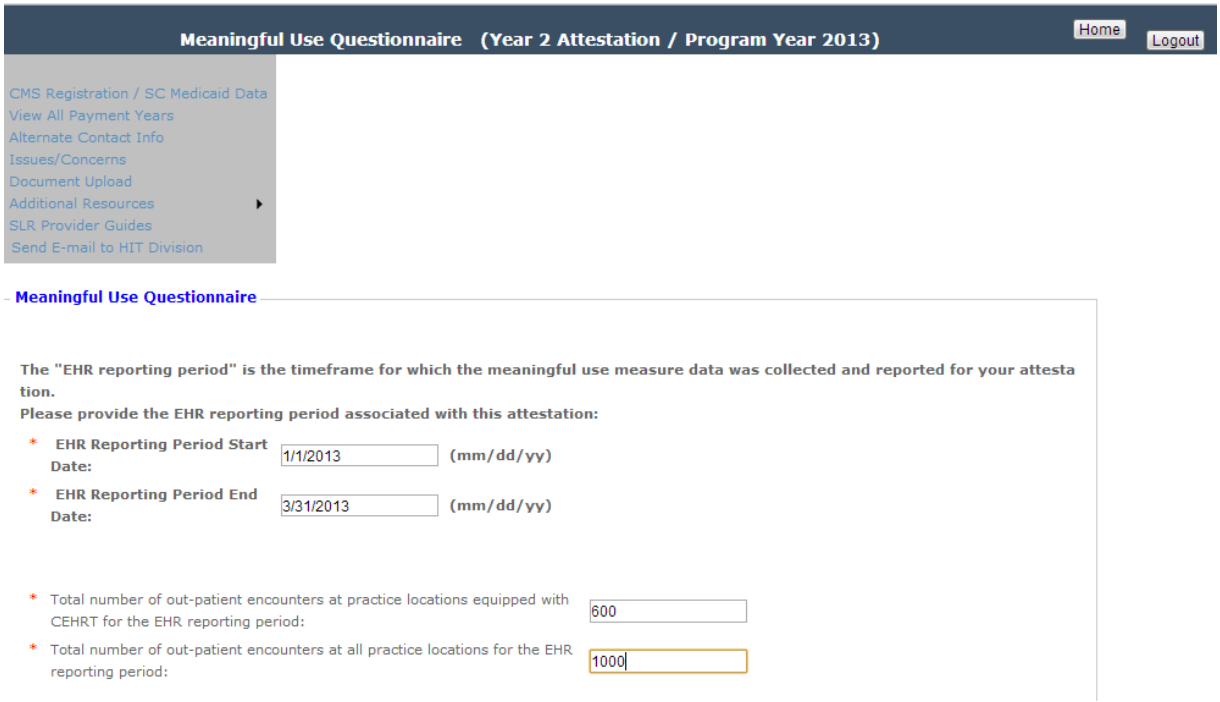
Meaningful Use Questionnaire Screen

After entering the provider eligibility details, an EP who has selected Meaningful Use will be directed to the Meaningful Use Questionnaire screen to enter additional data prior to entering data for their Core and Menu Measures and Clinical Quality Measures.

There are two general MU eligibility requirements necessary for meeting MU. These requirements include the following:

- At least 80% of unique patients must have their data in a certified EHR during the EHR reporting period.
- At least 50% of all encounters for providers who work in multiple healthcare sites must take place at locations equipped with certified EHR Technology.

Where the EP has entered information in the previous Provider Locations screen to indicate that the EP practices at multiple locations, and that one or more of those locations does not have certified EHR technology, the Meaningful Use Questionnaire screen will display fields to collect information from the provider regarding encounters at locations equipped with certified EHR technology, and encounters at all locations. (The screenshot below illustrates this display.) Should the EP only practice at locations equipped with certified EHR technology, the Meaningful Use Questionnaire screen will not display these fields.



For the first year of Meaningful Use (Stage 1), EPs are required to report on a continuous 90-day period within the participation year. For all other years, the EHR reporting period is the full-year period within the participation year.

Note: (For 2014PY only): All providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period. 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.

The following fields are required to continue with the attestation:

- **EHR Reporting Period Start Date** – This is the starting date for the period of time for which the EP is reporting Meaningful Use Measure data.

- **EHR Reporting Period End Date** – This is the end date for the period of time for which the EP is reporting Meaningful Use Measure data.

Where Displayed

- Total number of out-patient encounters at practice locations equipped with CEHRT for the EHR reporting period.

- Total number of out-patient encounters at all practice locations for the EHR reporting period

Enter the dates for the EHR reporting period (and, where required, encounter information). Select **Next** to proceed.

Meaningful Use Core Objectives
13 out of 13 Core Meaningful Use objectives' measures must be met according to CMS requirements.

- Exception – If CMS allows an exclusion to a measure and the EP attests to that exclusion, then the requirement for that measure is considered met.

Meaningful Use Menu Objectives
5 out of 10 Menu Measures must be met according to CMS requirements (including exclusions). At least 1 of the 5 Menu Measures must be from the Public Health menu measures.

- Exception - If an EP meets the criteria for and can claim exclusion for both of the public health menu objectives, the EP must still select one public health menu objective and attest that the EP qualifies for the exclusion. **This exclusion will count toward the 5 required menu objectives.

- EP must select 4 objectives from the remaining menu objectives that relate to his/her practice. If an exclusion applies to one or more of the selected measures, the EP must attest that the other measures did not relate to his practice or that they also would have been exclusions.

Clinical Quality Measures
EP must attest to a minimum of 6, and up to 9, Clinical Quality Measures

- 3 Core Clinical Quality Measures and/or up to 3 Alternate CQMs (Alternate CQMs are required where any Core CQM measures have a denominator of zero), and 3 Additional CQMs that relate to their practice (the EP must select 3 of the 38 Additional CQMs.)

- No patients in the measure population: It is acceptable to report zero in the denominator, even for 1 or more measures, as long as that is the value displayed and calculated by the certified EHR. The EP attests to this fact.

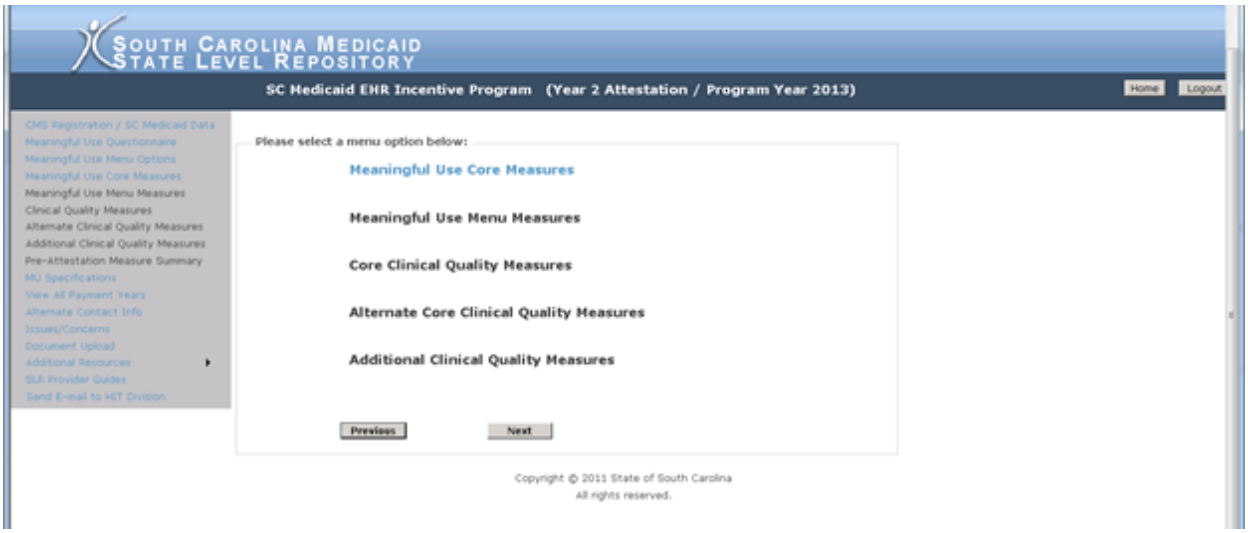
- If the EP reports zero in the denominator for any of the 3 chosen as Additional CQMs, the EP must attest that all remaining measures not chosen would also be zero.

- For the CQM that have multiple Denominators, the SLR only requires the entry of an alternate CQM if all of the Core CQM Denominators = 0 for the measure. Using NQF 0421 as an example, if the provider has entered a denominator of 150 for population 1 and a 0 for population 2, the provider would not be required to enter an Alternate CQM for that entry.

For additional information on Meaningful Use Measures, please visit the CMS Web site: https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage

For additional information on specific Meaningful Use Measures, please visit the CMS Web site and download the "EP Stage 1 Specification Sheets 2013" documents: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

Meaningful Use Menu Screen, Navigation, and Threshold Warnings



Navigation: The menu screen will only allow the user to select a group of measures as they are available.

Meaningful Use Core Measures Link – Takes the EP to the first screen of the Meaningful Use Core Measures. (This link is active when visiting the Meaningful Use Measure Menu Screen.)

Meaningful Use Menu Measures Link - Takes the EP to the first screen of the Meaningful Use Menu Measures. (This link is only active after the MU Core Measures have been completed.)

Core Clinical Quality Measures Link – Takes the EP to the first screen of the Core Clinical Quality Measures. (This link is only active after the MU Menu Measures have been completed.)

Alternate Core Clinical Quality Measures Link - Takes the EP to the first screen of the Alternate Core Clinical Quality Measures. (This link is only active after the Core Clinical Quality Measures have been completed and at least one of the entries for a denominator is zero.)

Additional Clinical Quality Measures Link - Takes the EP to the first screen of the Additional Clinical Quality Measures. (This link is only active after the Core Clinical Quality Measures have been completed and no entries for a denominator is zero, or after the Alternative Core Clinical Quality Measures are completed if at least one of the entries for the Core CQM for a denominator was zero.)

Core and Menu Threshold Warnings - If the EP's data entries in the MU Core and Menu screens do not meet the threshold of the measure, or the Yes/No, a pop-up message will display to alert the provider. The provider may select "OK" to continue on with attestation with the data left as is, or may select "Cancel" so that the data entry may be corrected. The text of the pop-up message displays as:

Your entries for this measure do not meet the requirement [of "more than x%] required to qualify for an incentive payment.

If your data entries are correct, please select "OK" to continue to the next MU objective screen.

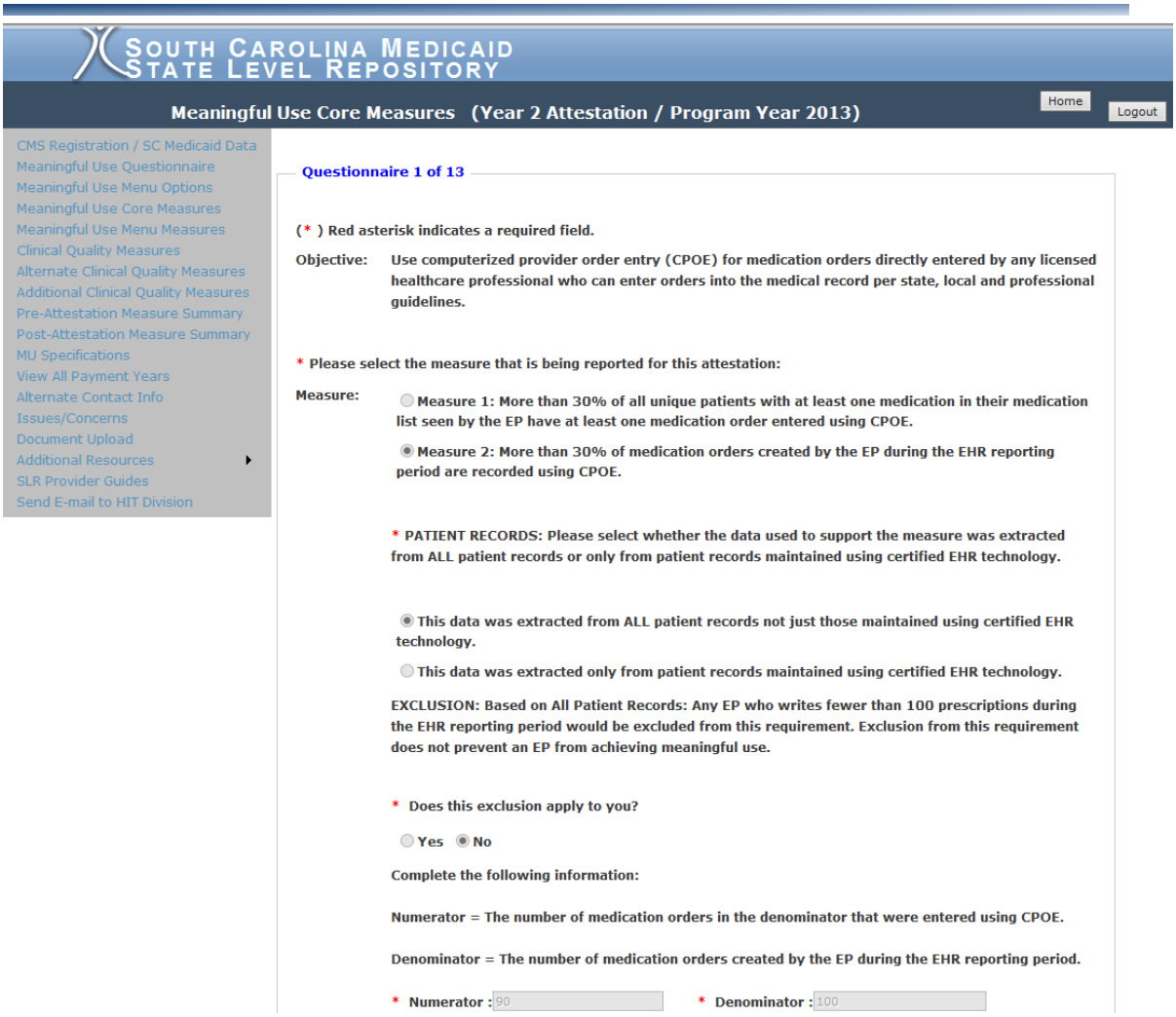
If your data entries are not correct, please select "CANCEL" and correct your data entry.

An example of a threshold warning is displayed in the screenshot below:

Previous – Returns the EP to the Meaningful Use Menu Screen

Next – Takes the EP to the first Core Meaningful Use Measure

Meaningful Use Core Objective 1 Screen – CPOE for Medication Orders



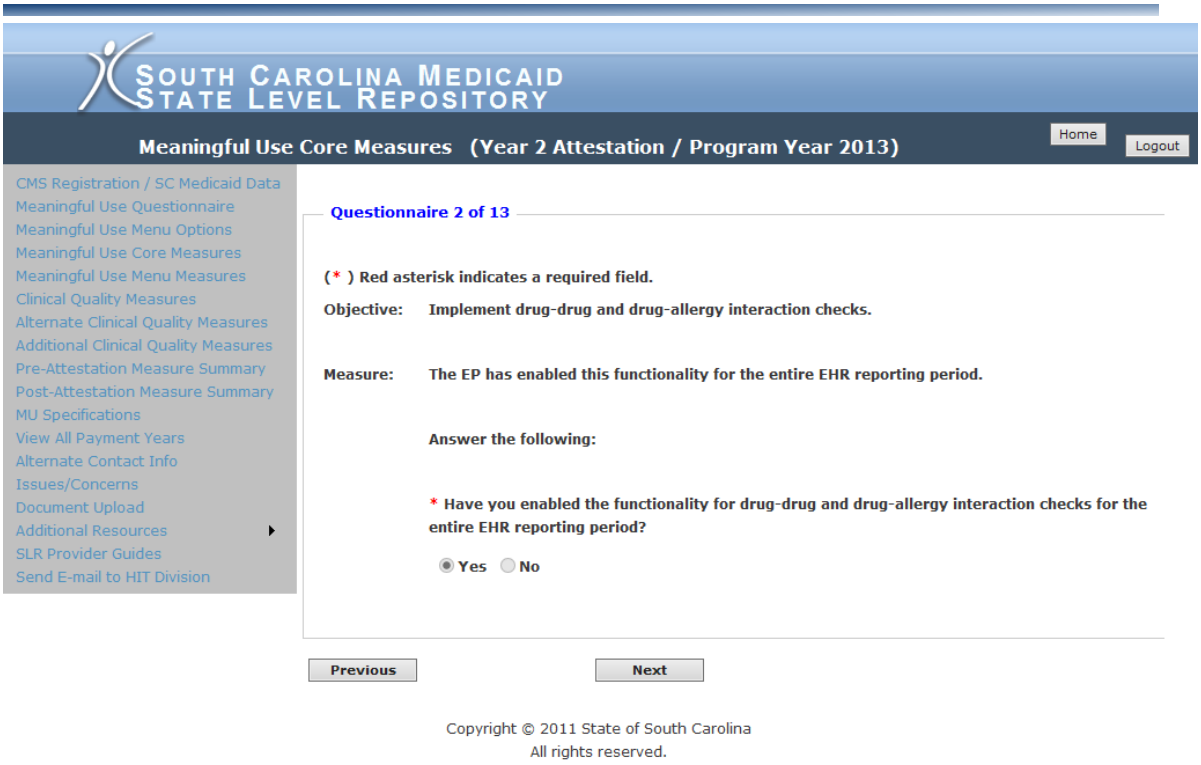
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP will be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator each must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >30% threshold, N/D > 30%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.
*Note: The Numerator and Denominator descriptions are associated with the measure selected for the attestation.

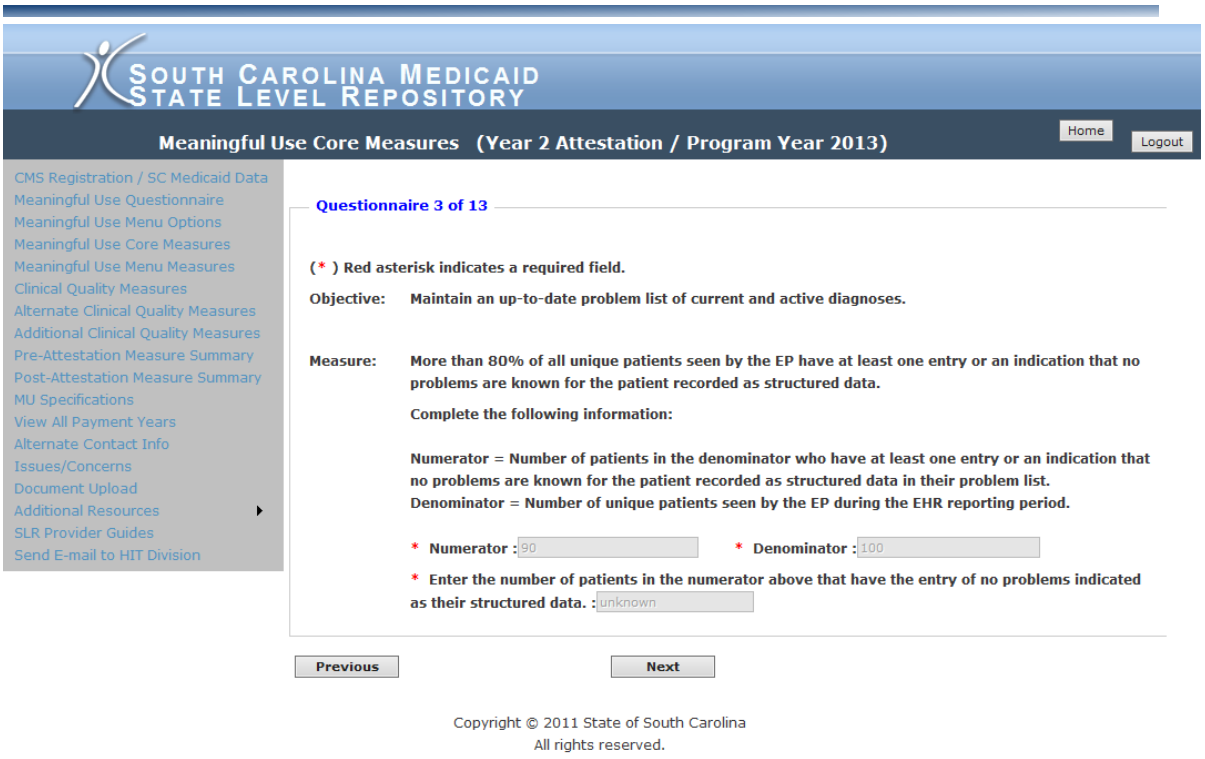
Meaningful Use Core Objective 2 Screen – Drug Interaction Checks



Please answer **Yes** or **No.**

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 3 Screen – Maintain Problem List



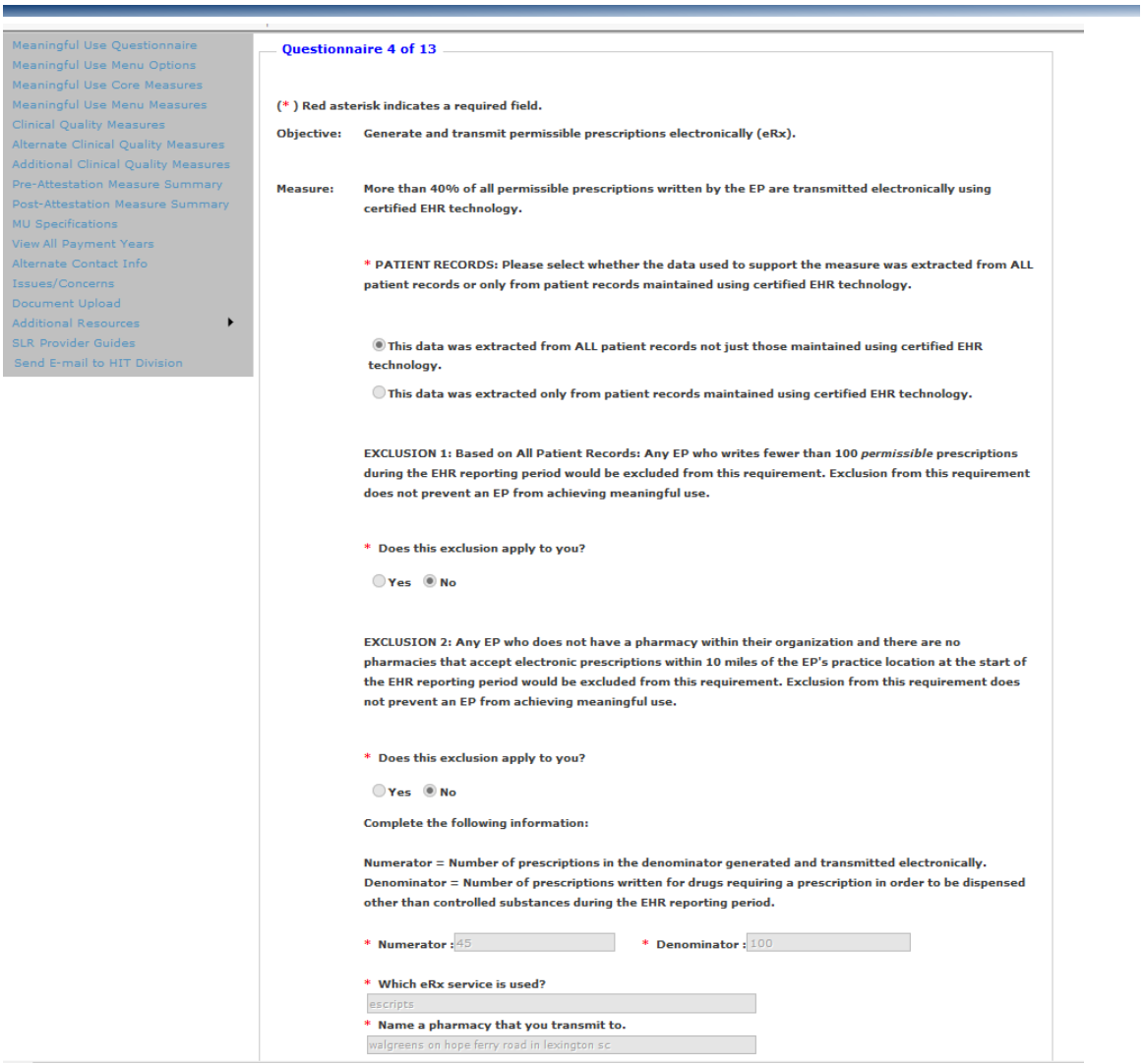
All fields must be completed before the EP is allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator are required and each must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EP must meet the >80% threshold, N/D > 80%
- The EP must enter answer the last question on the page. If the count is unknown, then type “Unknown” as the answer.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 4 Screen – e-Prescribing



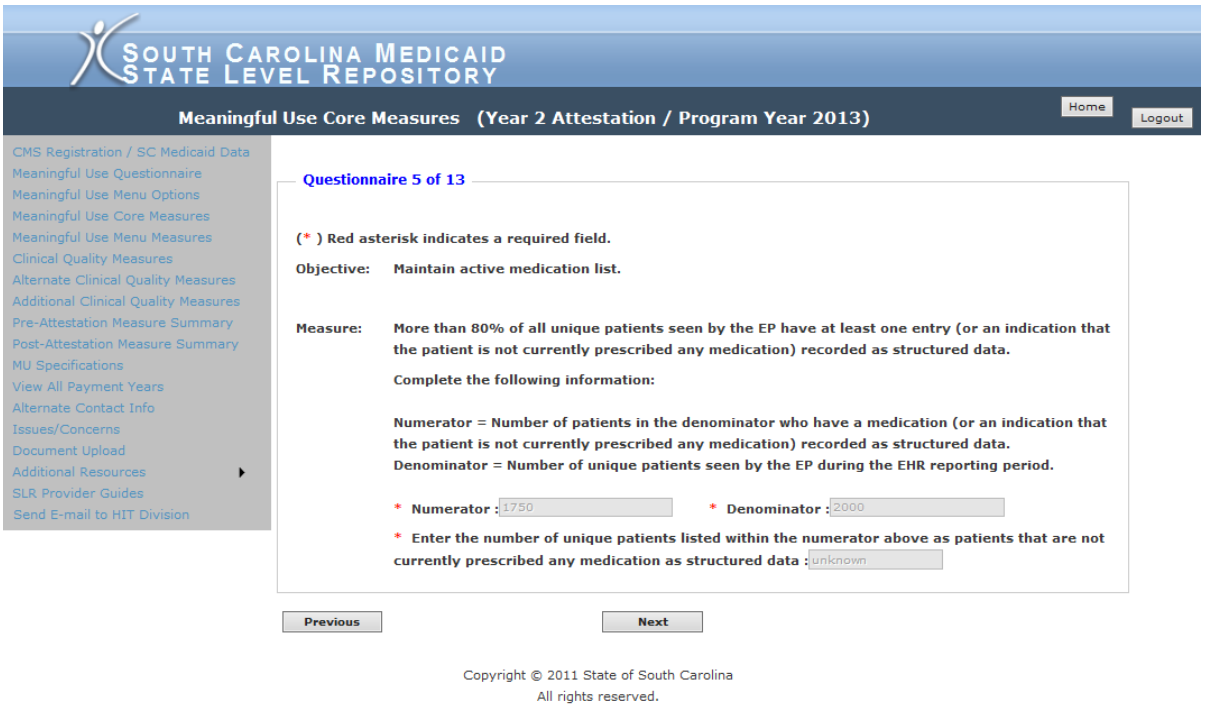
All fields must be completed unless an Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >40% threshold, N/D > 40%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.
- The EP must enter answer the last two questions on the page. (eRx service examples: Sure Scripts, Doctors First, etc.) If the EP does not know the eRx service that is used, the EP may need to contact the EHR vendor for information.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 5 Screen – Active Medication List



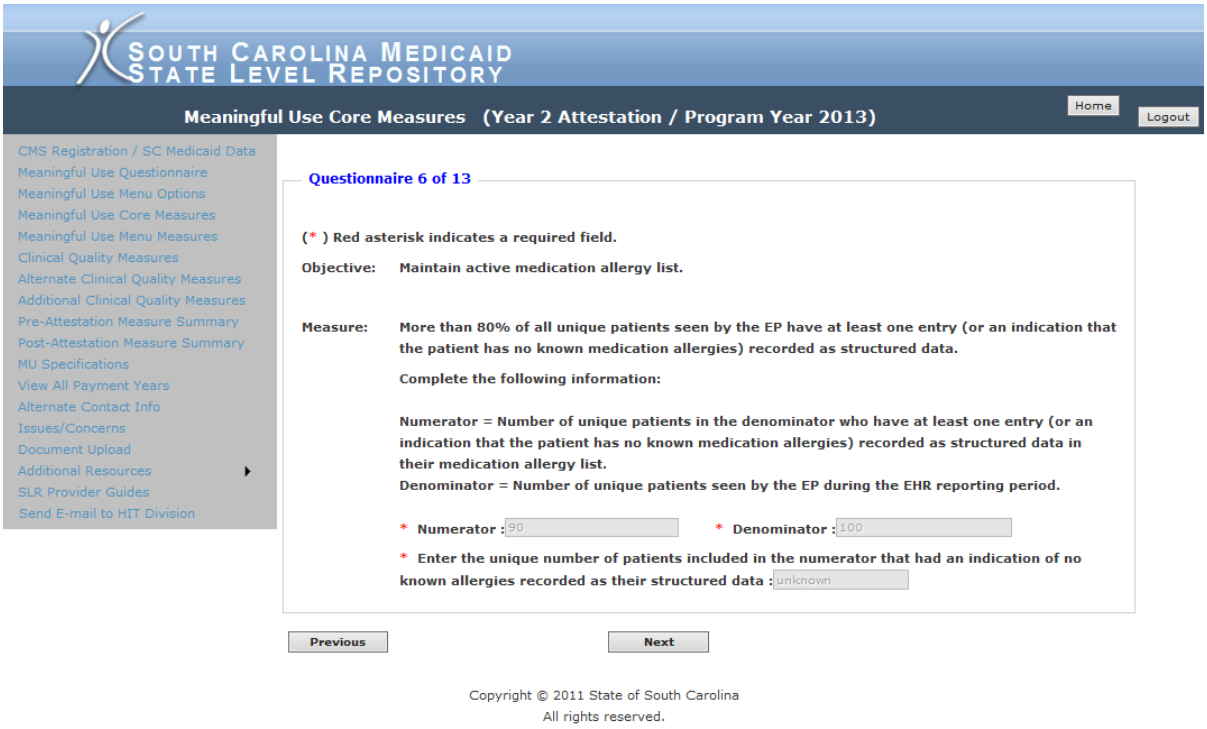
All fields must be completed before the EP is allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator are required and must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EP must meet the >80% threshold, N/D > 80%
- The EP must enter answer the last question on the page. If the count is unknown, then type "Unknown" as the answer.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 6 Screen – Medication Allergy List



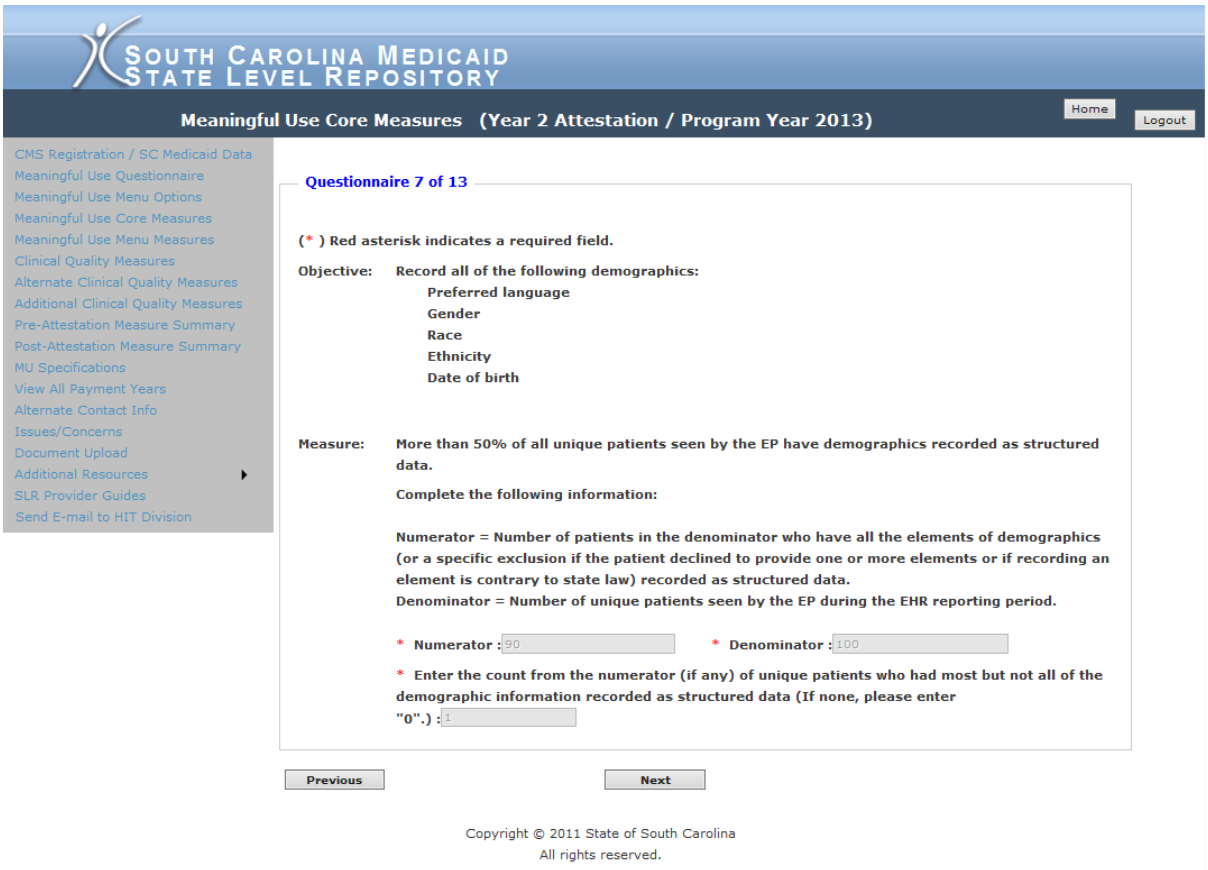
All fields must be completed before the EP is allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator are required and must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EP must meet the >80% threshold, N/D > 80%
- The EP must enter answer the last question on the page. If the count is unknown, then type "Unknown" as the answer.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 7 Screen – Record Demographics



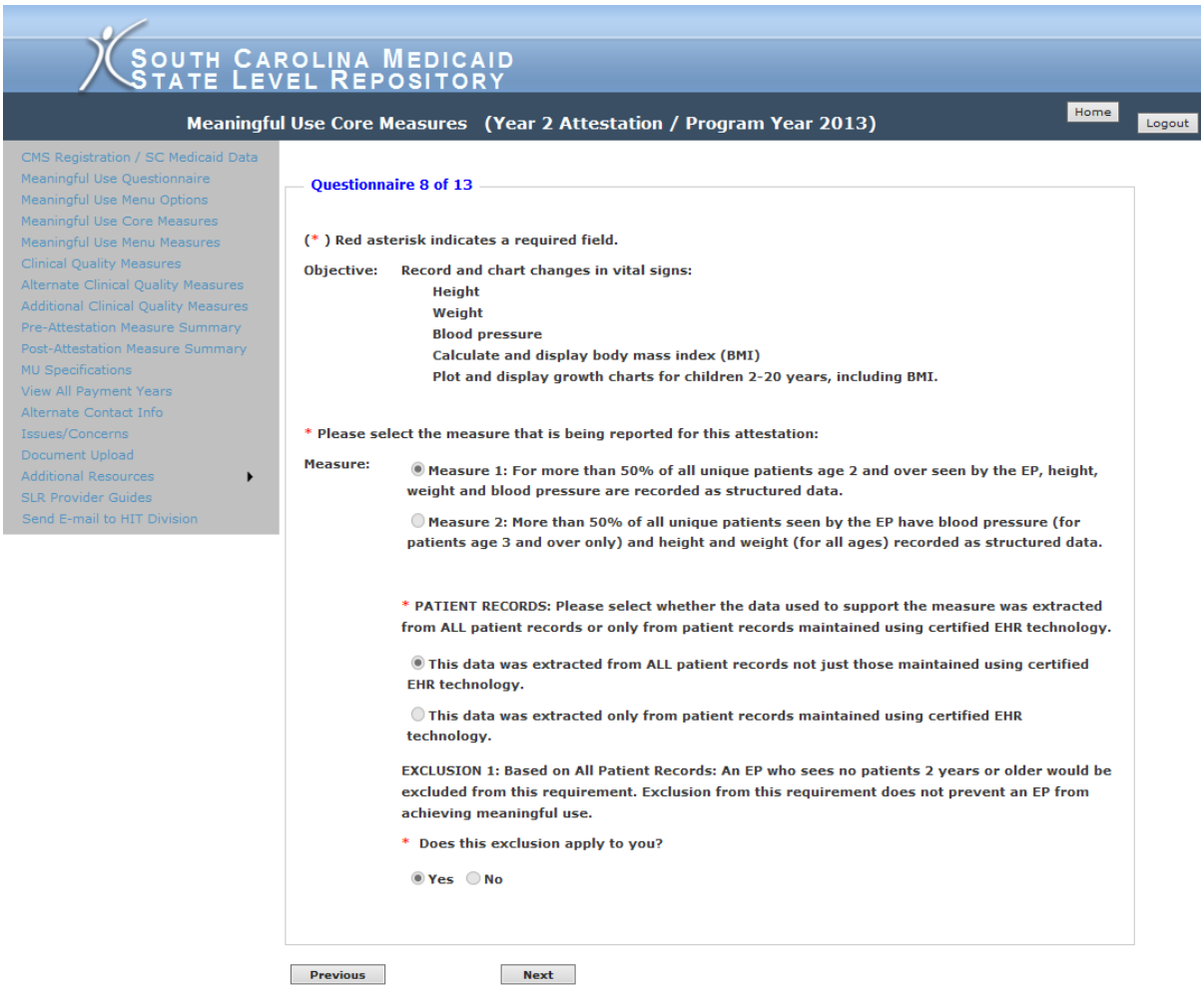
All fields must be completed before the EP is allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator are required and each must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EP must meet the >50% threshold, N/D > 50%
- The EP must enter answer the last question on the page. If the count is unknown, then type "Unknown" as the answer.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 8 Screen – Record Vital Signs



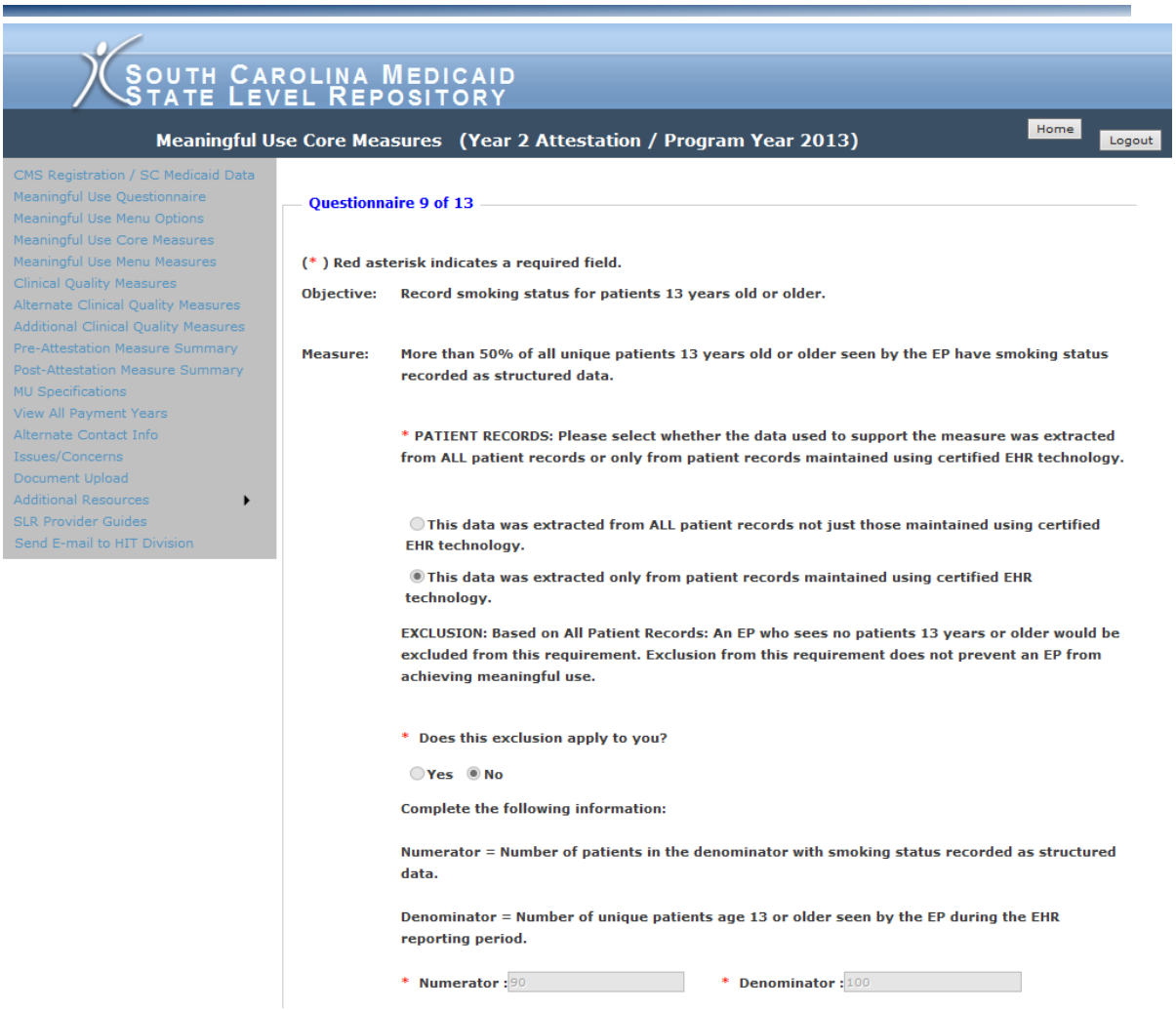
All fields must be completed unless an Exclusion was responded to with "**Yes**;" in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >50% threshold, N/D > 50%
- If an EP responds **Yes** to Exclusion 1 or 2, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 9 Screen – Record Smoking Status



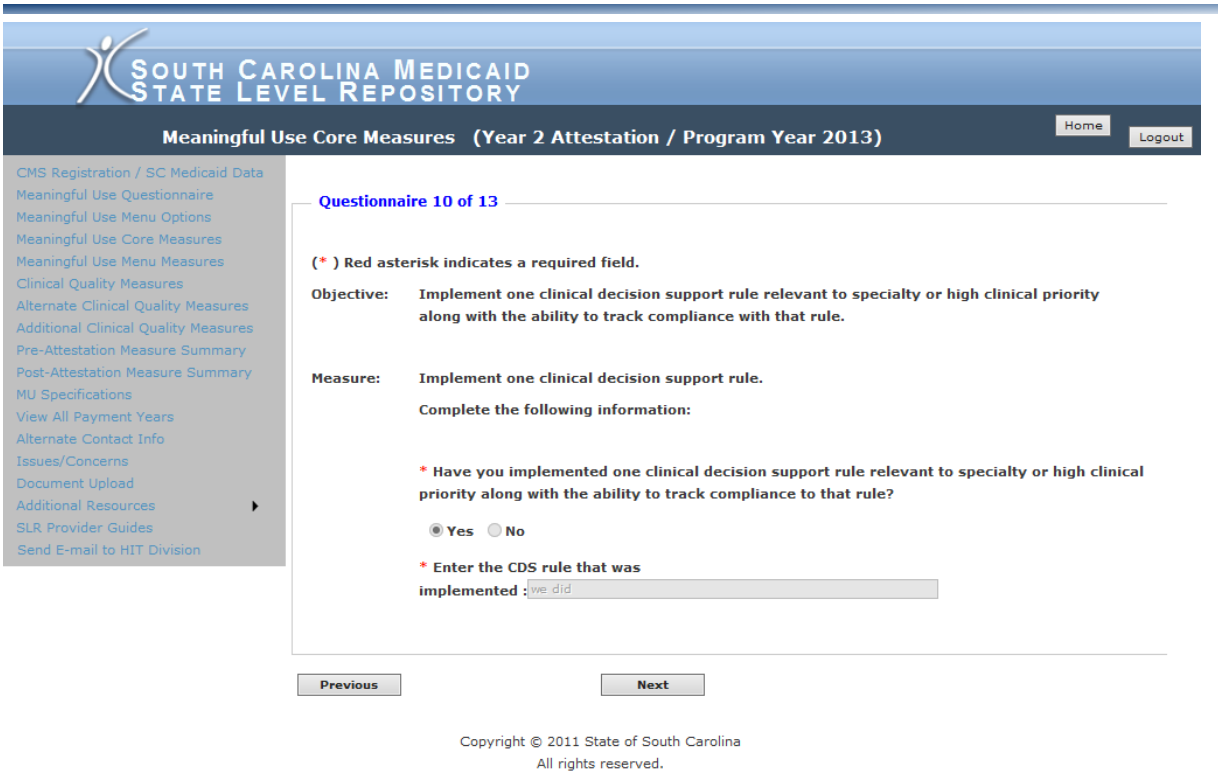
All fields must be completed unless the Exclusion was responded to with "**Yes**;" in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >50% threshold, N/D > 50%
- If an EP responds **Yes** to the exclusion, then they have met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 10 Screen – Clinical Decision Support Rule



All fields must be completed before the EP will be allowed to save and continue to the next measure.

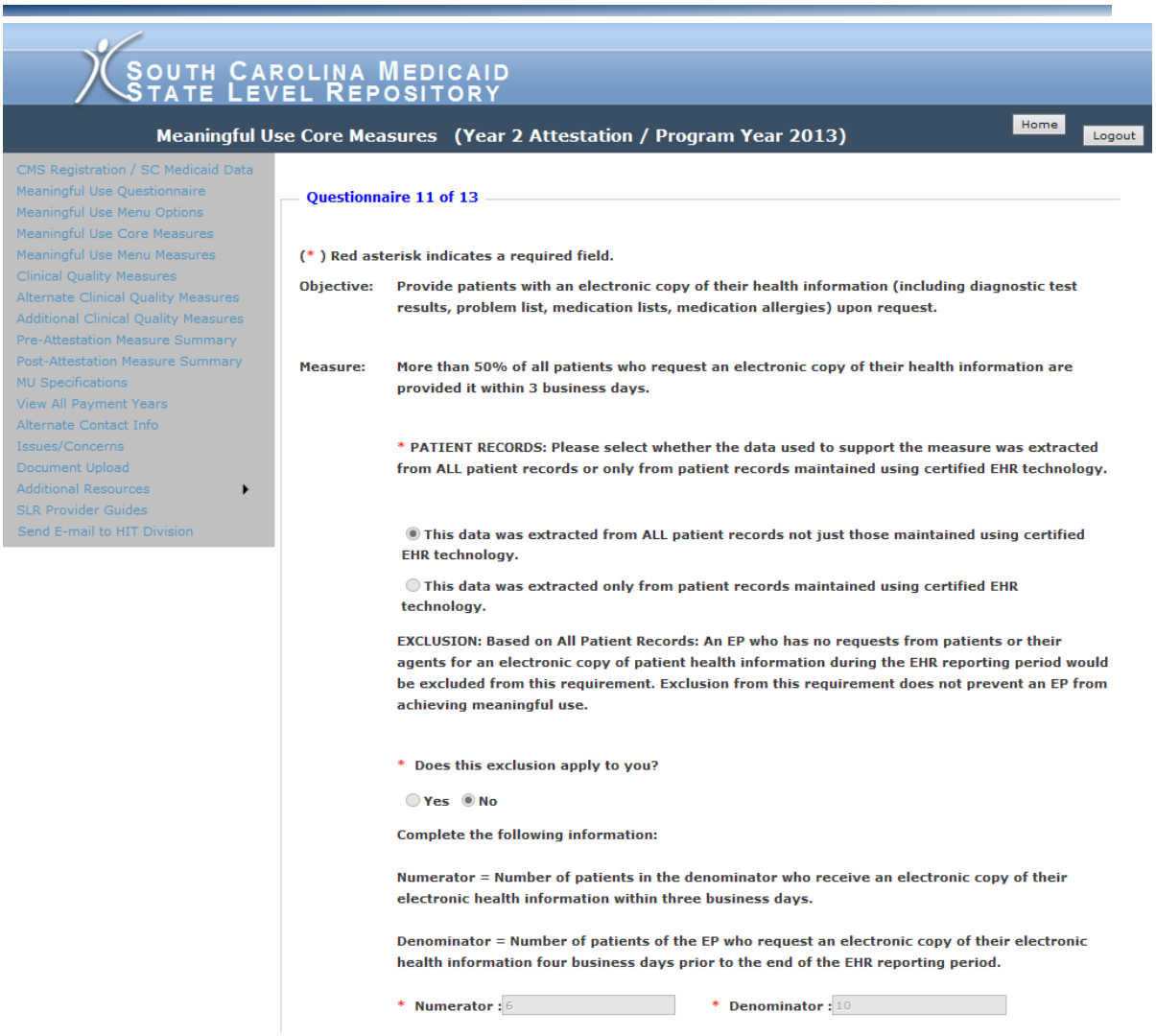
The following details other requirements of this screen:
• Please select **Yes** or **No**.
• The EP must enter answer the last question on the page.

Automated, electronic CDS rules are based on data elements included in problem list, medication list, demographics, and laboratory test results. The CEHRT will automatically and electronically generate, and indicate in real-time, notifications and care suggestions based upon CDS rules.

The EP may not use drug/drug or drug/allergy contraindication checking as a clinical decision support rule.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 11 Screen – Electronic Copy of Health Info



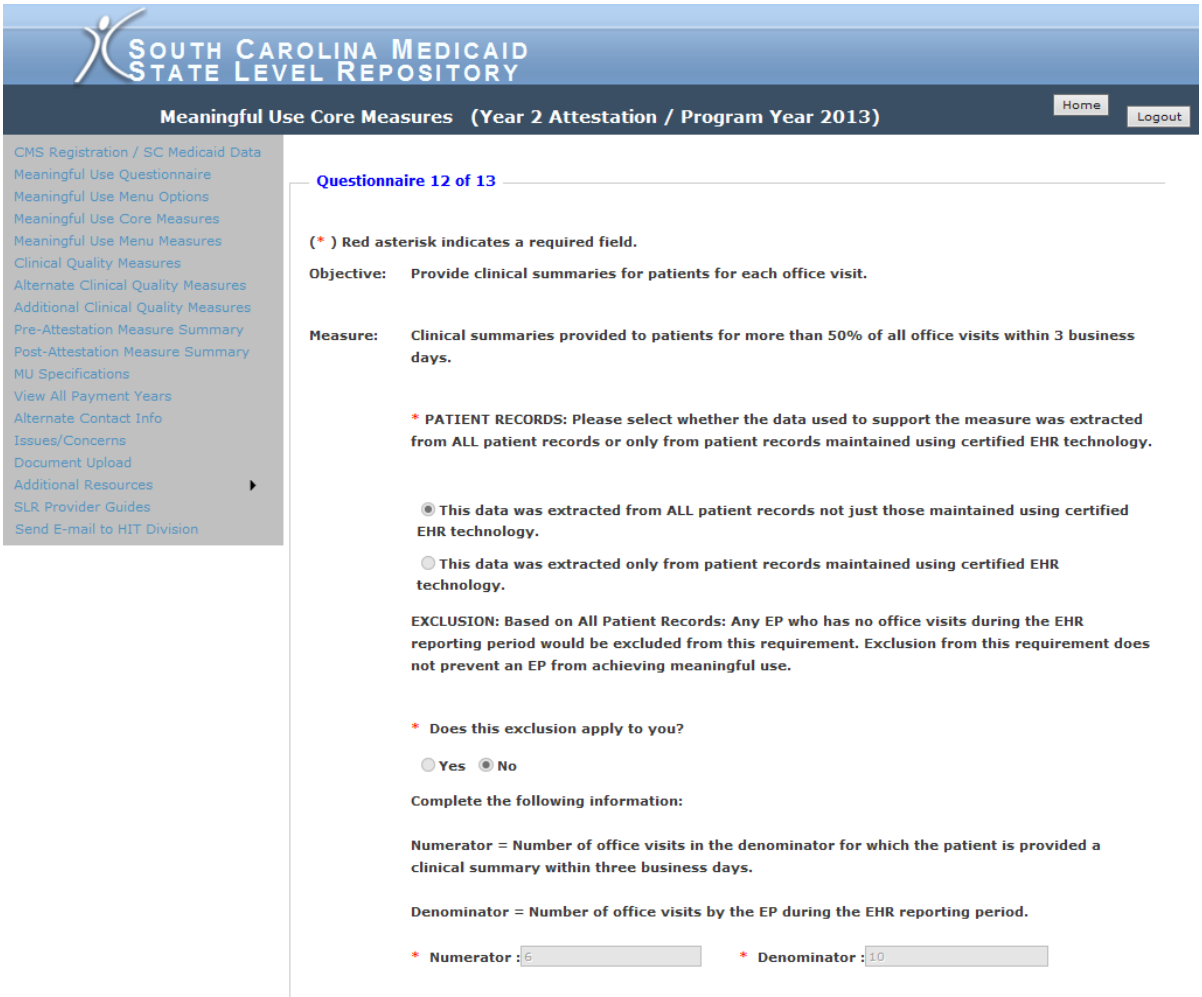
All fields must be completed unless the Exclusion was responded to with '**Yes**;' in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >50% threshold, N/D > 50%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Objective 12 Screen – Clinical Summaries



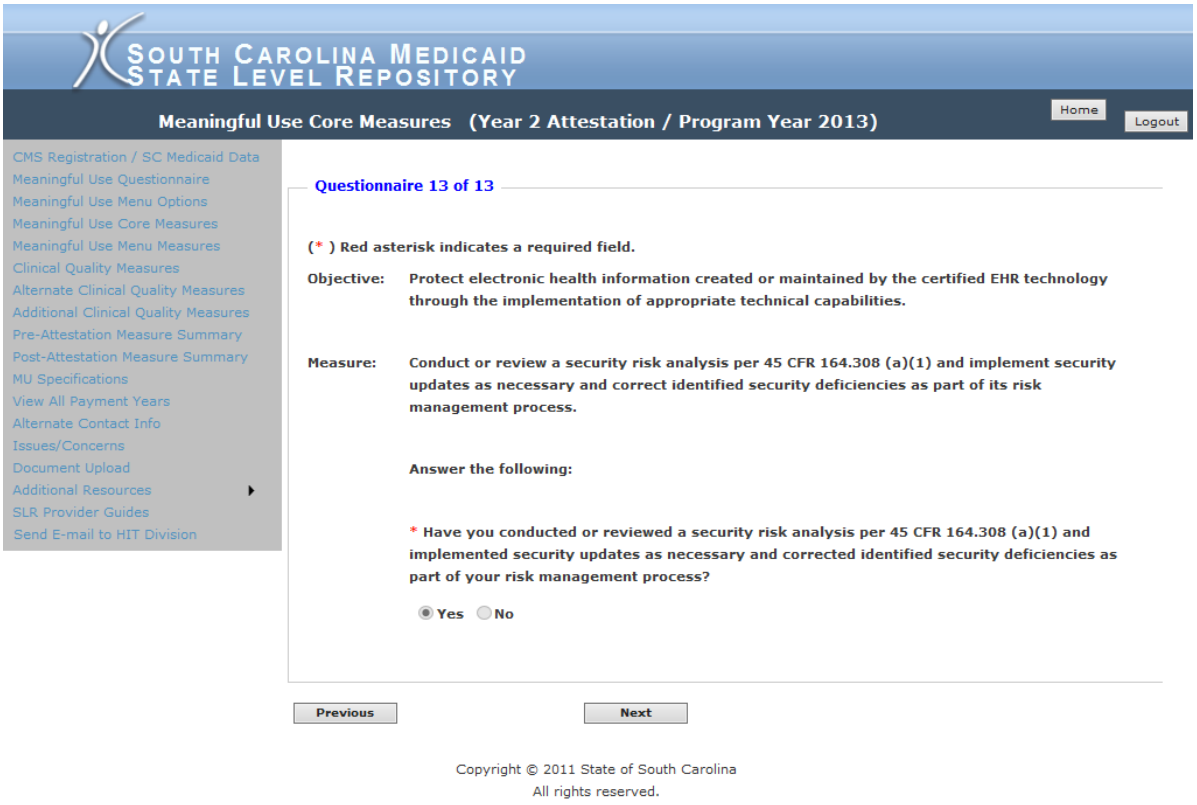
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must each be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >50% threshold, N/D > 50%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Core Measure 13 Screen – Protect Electronic Health Info



All fields must be completed before the EP will be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- Please select **Yes** or **No**.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

CMS encourages EPs to select and report on meaningful use menu objectives that are relevant to the EP's scope of practice, and to claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives for which they quality or if there are no remaining menu objectives that are relevant to their scope of practice.

EPs must report on a total of five (5) meaningful use menu objectives.

The five meaningful use menu objectives selected must include at least one of the two public health (PH) menu objectives. Where the EP can be excluded from both PH menu objectives, the EP is limited to only selecting one PH menu objective.

- If the EP is able to meet the measure of one of the PH menu objectives, but can be excluded from the other, the EP must select and report on the PH menu objective the EP is able to meet. The EP may choose to report on the other PH objective (as an Exclusion) to count towards the remaining 4 menu objectives. (Said differently, the EP must report on the PH menu objective that the EP can meet, and then may select the other four menu objectives from any combination of the remaining nine menu objectives.)

- If an EP can be excluded from both PH menu objectives, the EP must only claim an exclusion from one of the PH menu objectives; then, the EP must report on four additional menu objectives selected from outside of the PH menu set.

Meaningful Use Menu Measures Selections Screens and Navigation:

Title Bar – Meaningful Use Menu Measures

Logout button – Returns the EP to the login page

Previous button –Returns the EP to the MU Core Measure 13 screen. This will **not** save the data to the database. The EP should be warned "Do you wish to continue without saving?"

Next button –The EP will be directed to the first MU Menu Measure screen. This will save the data to the database if no errors are present. This data will be updatable until the attestation has been completed by the EP.

Select the menu objectives for which the EP is reporting; then, select **Next** to proceed.

SOUTH CAROLINA MEDICAID
STATE LEVEL REPOSITORY

Meaningful Use Menu Measures (Year 2 Attestation / Program Year 2013)

Home Logout

- CMS Registration / SC Medicaid Data
- Meaningful Use Questionnaire
- Meaningful Use Menu Options
- Meaningful Use Core Measures
- Meaningful Use Menu Measures
- Clinical Quality Measures
- Alternate Clinical Quality Measures
- Additional Clinical Quality Measures
- Pre-Attestation Measure Summary
- Post-Attestation Measure Summary
- MU Specifications
- View All Payment Years
- Alternate Contact Info
- Issues/Concerns
- Document Upload
- Additional Resources
- SLR Provider Guides
- Send E-mail to HIT Division

Questionnaire

Instructions:

CMS encourages EPs to select and report on meaningful use menu objectives that are relevant to the EP's scope of practice, and to claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice.

EPs must report on a total of five (5) meaningful use menu objectives.

The five meaningful use menu objectives selected must include at least one of the two public health (PH) menu objectives. Where the EP can be excluded from both PH menu objectives, the EP is limited to only selecting one PH menu objective.

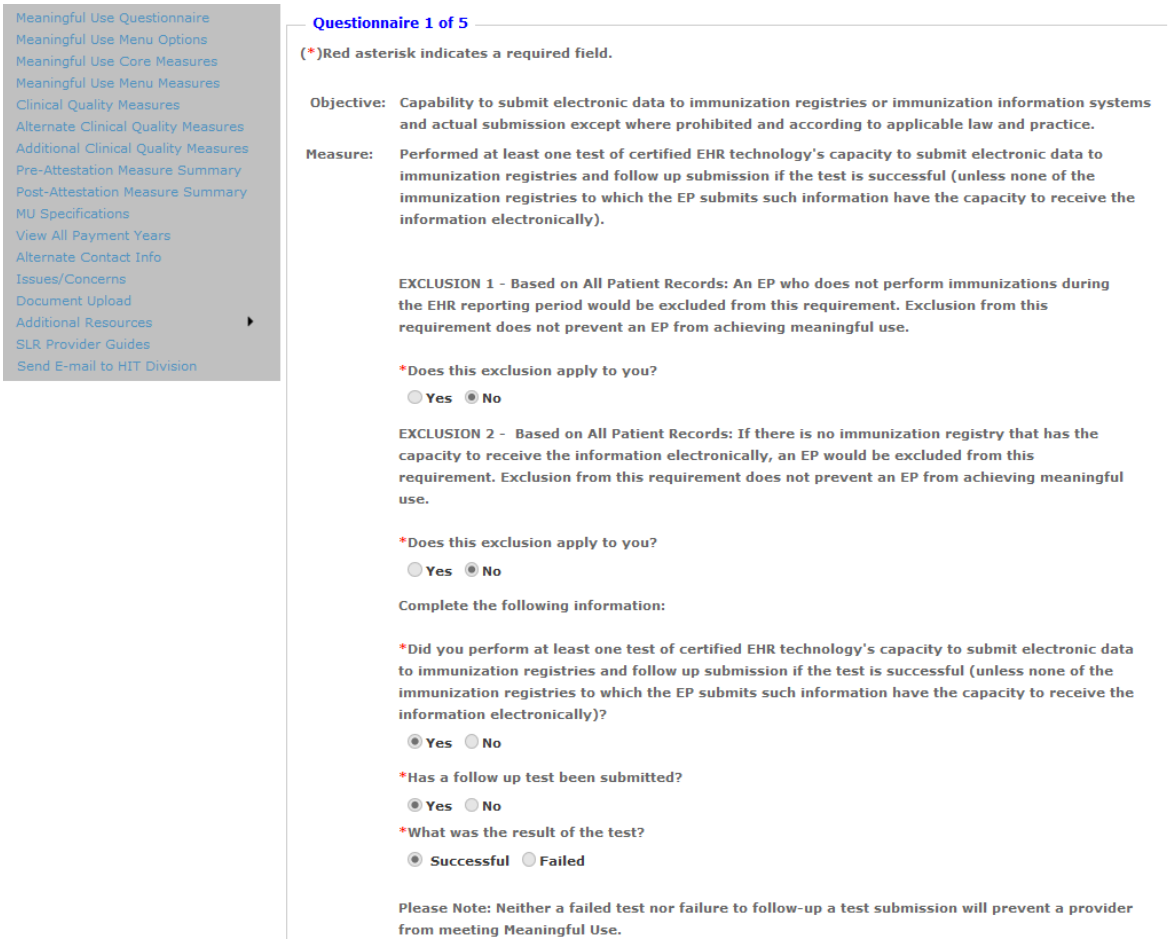
- If the EP is able to meet the measure of one of the PH menu objectives, but can be excluded from the other, the EP must select and report on the PH menu objective the EP is able to meet. The EP may choose to report on the other PH objective (as an Exclusion) to count towards the remaining 4 menu objectives. (Said differently, the EP must report on the PH menu objective that the EP can meet, and then may select the other four menu objectives from any combination of the remaining nine menu objectives.)
- If an EP can be excluded from both PH menu objectives, the EP must only claim an exclusion from one of the PH menu objectives; then, the EP must report on four additional menu objectives selected from outside of the PH menu set.

Objective	Measure	Select
Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited and according to applicable law and practice.	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).	☑
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and according to 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 submits such information have the capacity to receive the information electronically).	☐

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measure Objectives have been selected, even if an Exclusion applies to all of the menu measure objectives that are selected (total of five includes the public health menu measure objectives):

Objective	Measure	Select
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.	☐
Incorporate clinical lab test results into EHR as structured data.	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in 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.	☐
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.	☐
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.	At least 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.	☑
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 during the EHR reporting period are provided patient-specific education resources.	☑
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.	☑

Meaningful Use Menu Objective Screen – Immunization Registries Data Submission



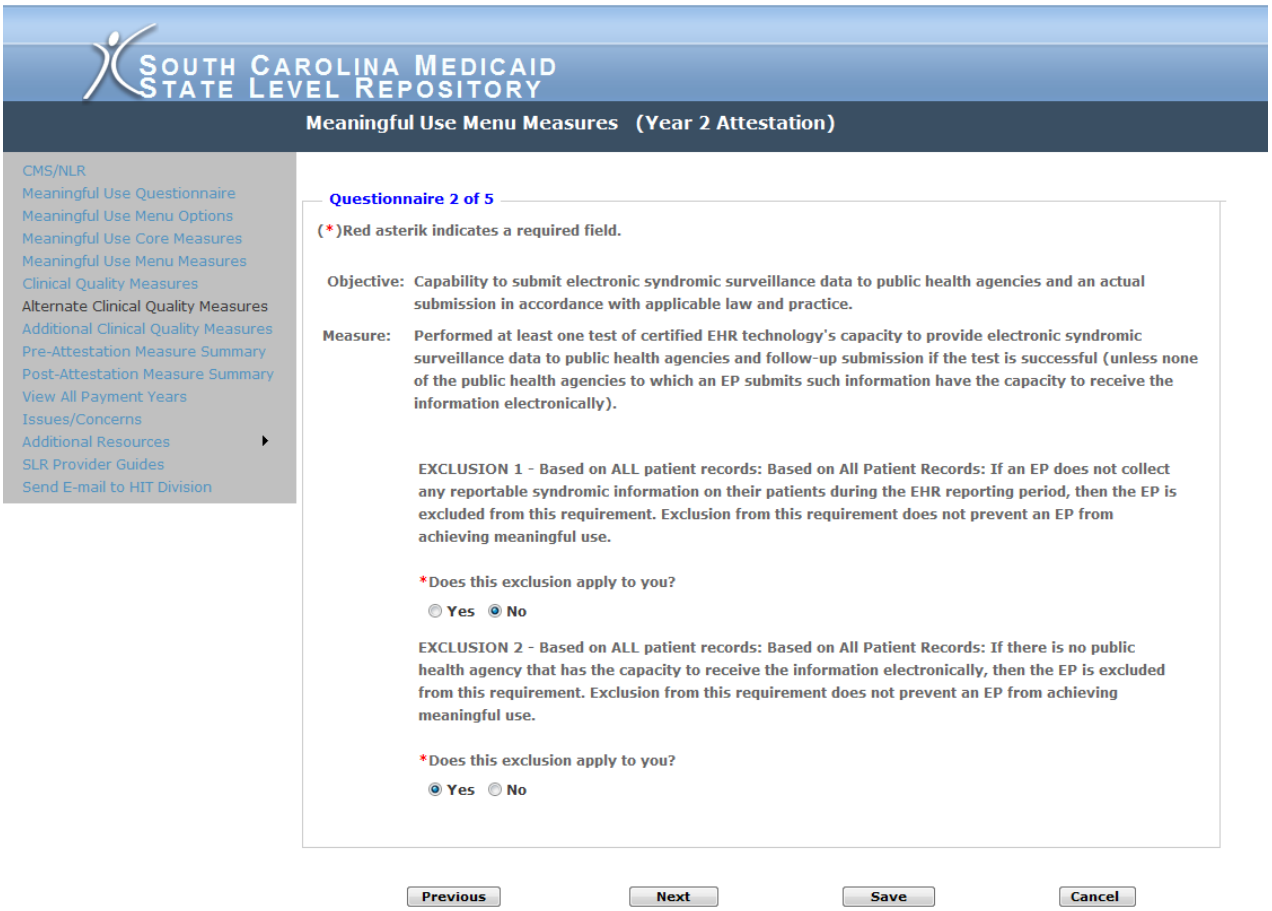
All fields must be completed unless an Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure. The following details other requirements of this screen:

- Exclusion response required.
- Response of **Yes** or **No** required if the Exclusion has not been marked as Yes.
- The EP must answer the last two questions on the page.

Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use. If there has been no follow-up submission, please retain documentation of what prevented follow-up submission. **Documentation to support the attestation of testing an HL7 file exchange with the immunization registry must be uploaded to the attestation (see Document Upload Screen).**

Additional information is available at www.scdhhs.gov/hit: "Stage 1 Meaningful Use Menu Objective: Immunization Registries Data Submission."
Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Syndromic Surveillance Data Submission



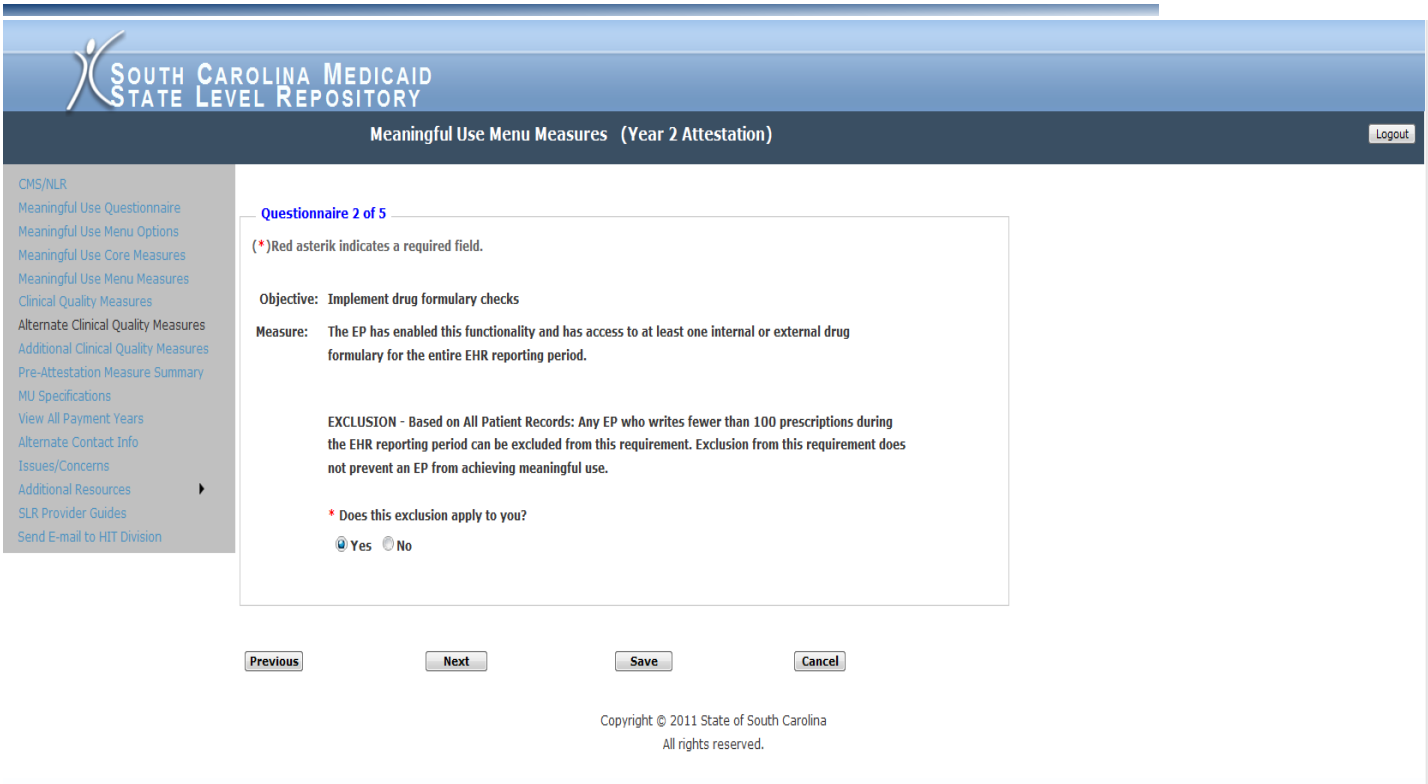
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- Exclusion response required.
- Response of **Yes** or **No** is required if the Exclusion has not been marked as Yes**.**
- The EP must enter answer the last two questions on the page.
- Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Drug Formulary Checks



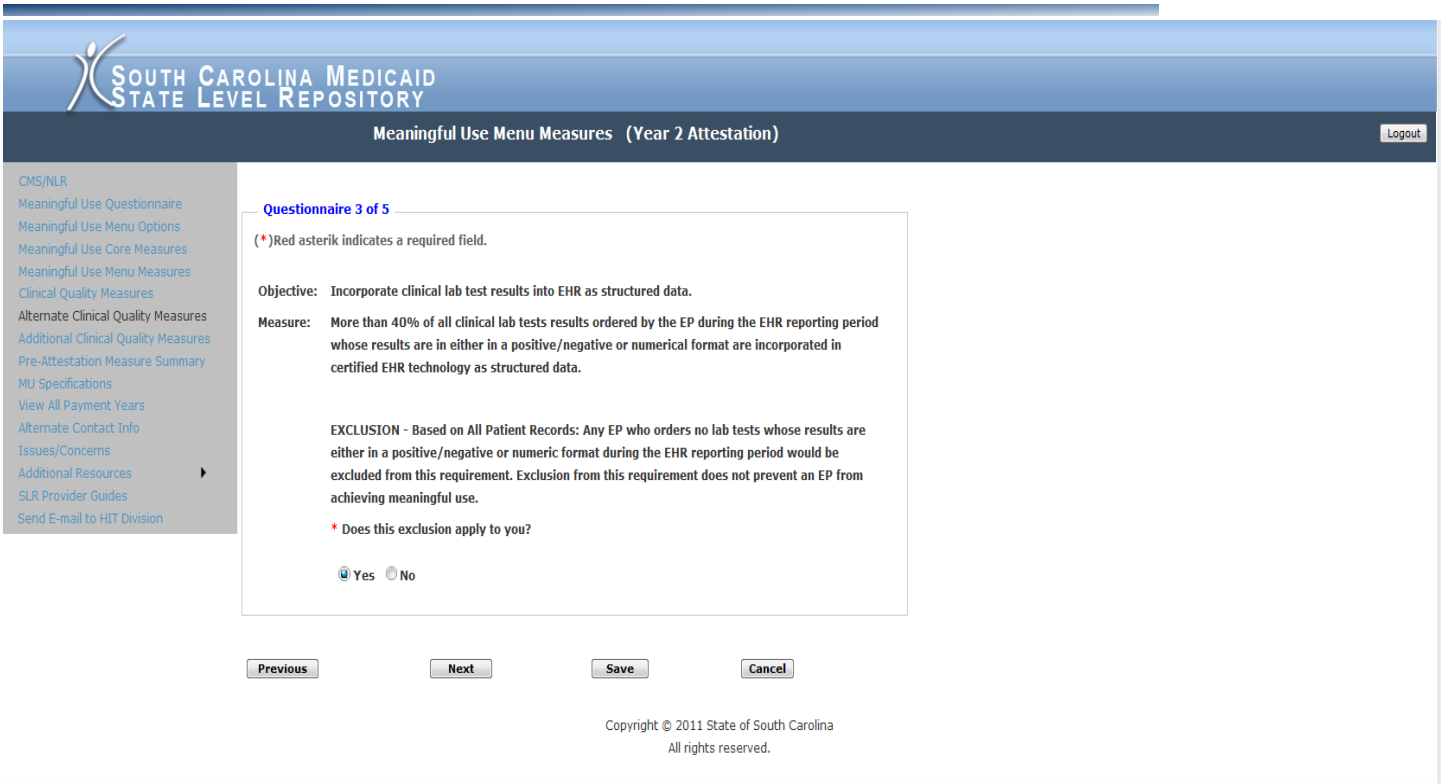
All fields must be completed unless the Exclusion was responded to with **Yes;** in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- Exclusion response is required.
- Response of **Yes** or **No** is required if the Exclusion has not been marked as **Yes.**

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Clinical Lab Test Results



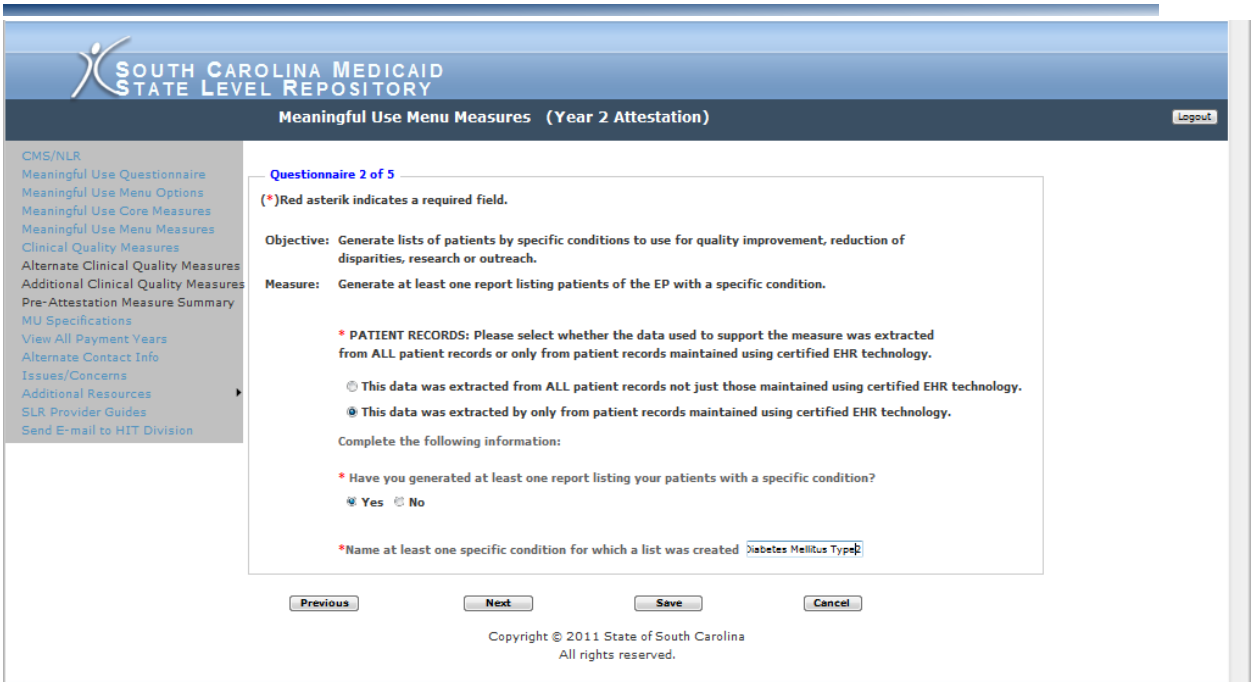
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >40% threshold, N/D > 40%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objectives Screen – Patient Lists



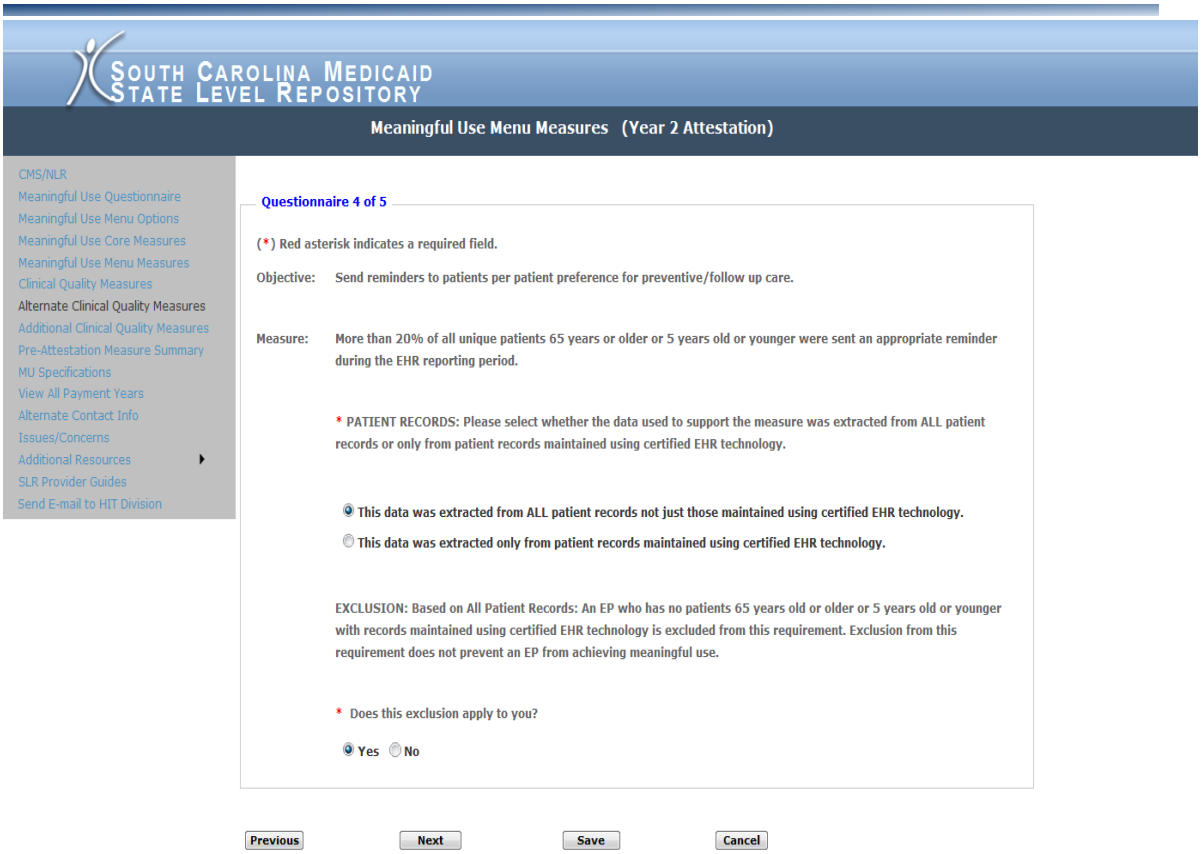
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- Patient Record response required.
- Response of **Yes** or **No** required.
- The EP must answer the last question on the page.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Patient Reminders



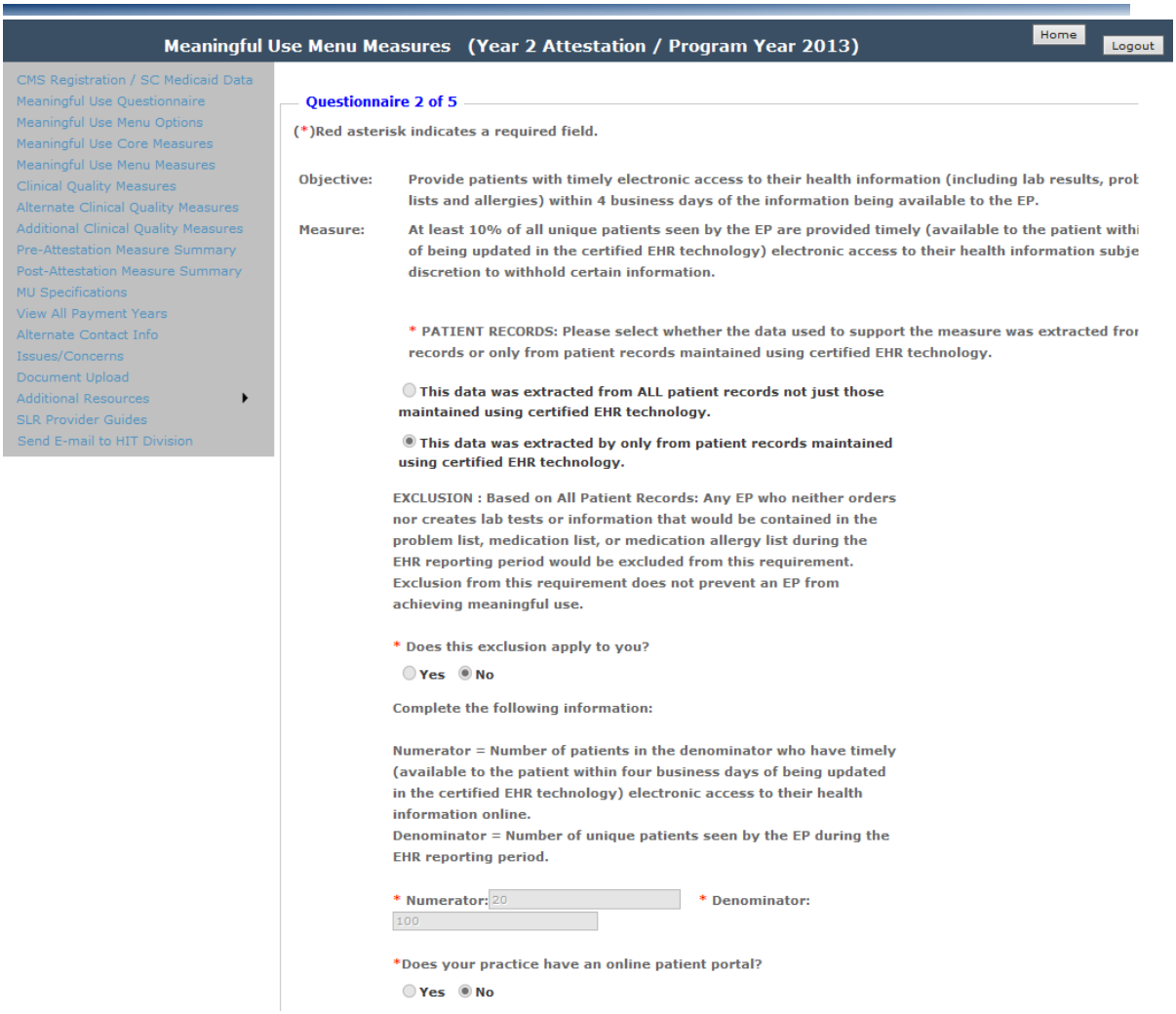
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >20% threshold, N/D > 20%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen - Patient Electronic Access



All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >10% threshold, N/D > 10%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.
- The EP must answer the last question.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Patient-Specific Education Resources

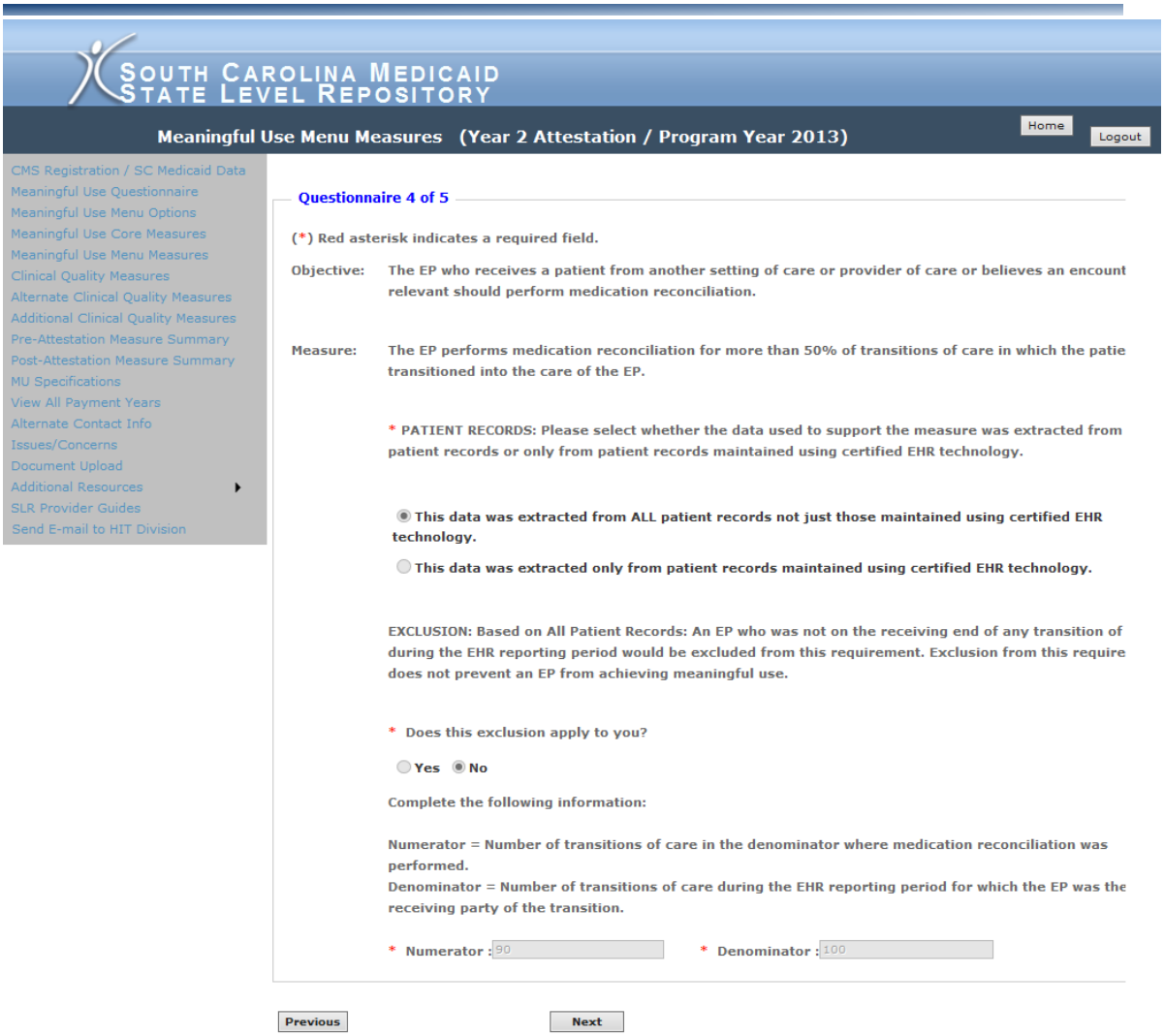
All fields must be completed before the EP will be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The EP must meet the >10% threshold, N/D > 10%

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Medication Reconciliation



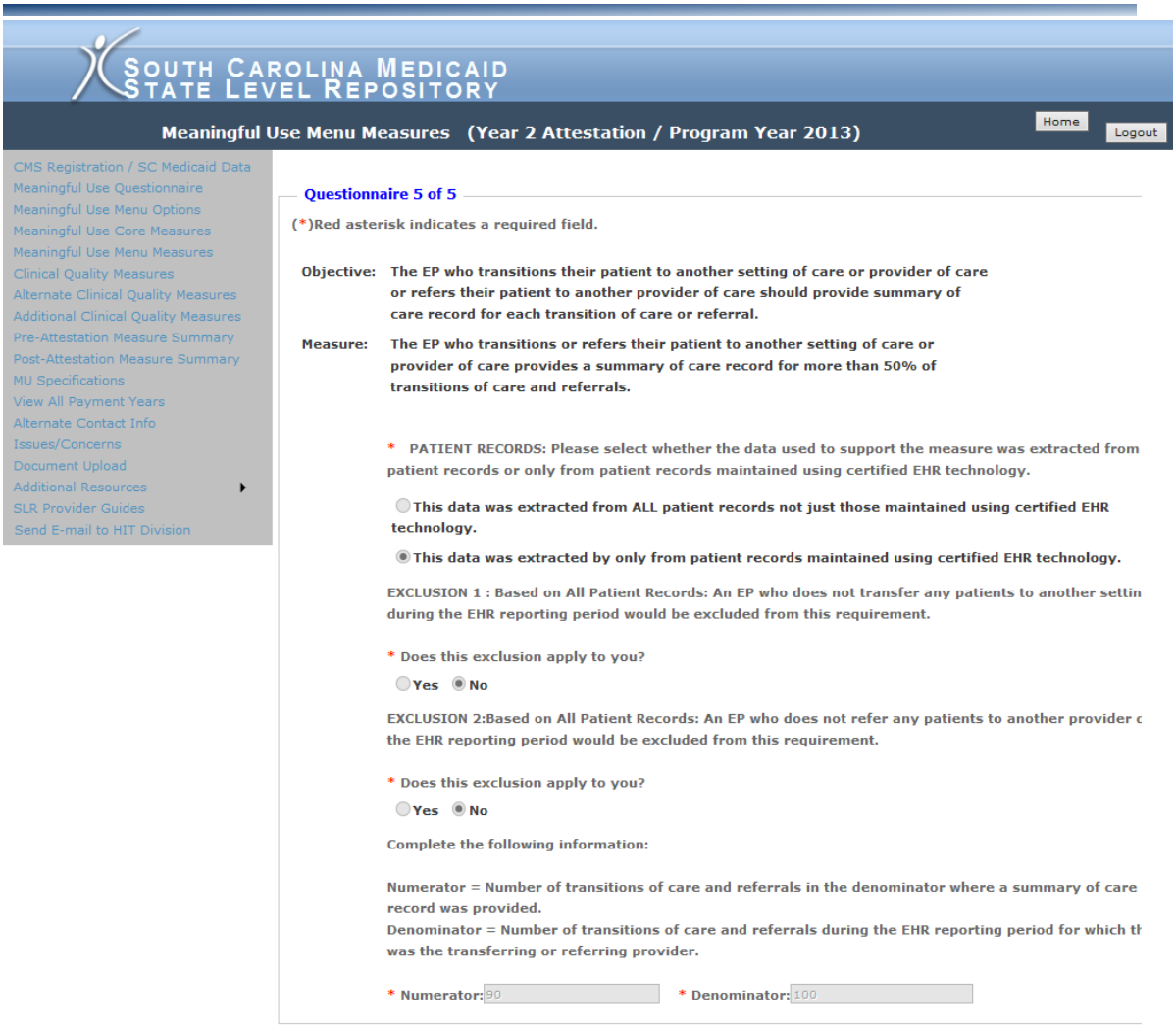
All fields must be completed unless the Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- If not excluded, the EP must meet the >50% threshold, N/D > 50%
- If an EP responds **Yes** to the Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Menu Objective Screen – Transition of Care Summary



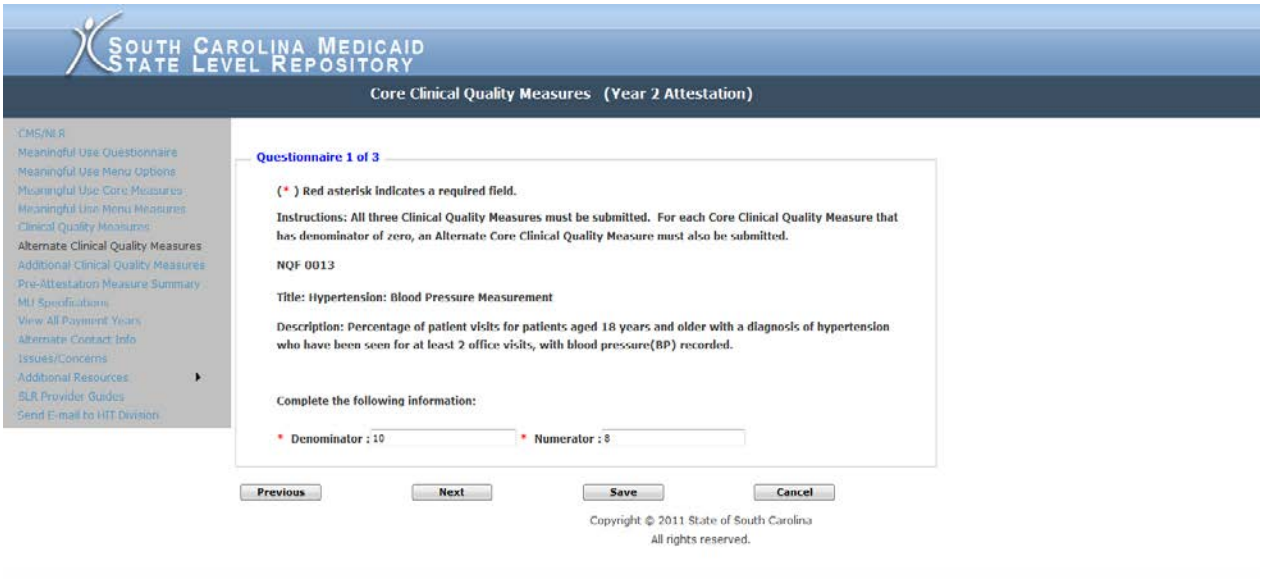
All fields must be completed unless an Exclusion was responded to with **Yes**; in that case, no other field is required and the EP should be allowed to save and continue to the next measure.

The following details other requirements of this screen:

- The Numerator and Denominator must be a whole number
- The Numerator should be less than or equal to the Denominator
- If not excluded, the EP must meet the >50% threshold, N/D > 50%
- If an EP responds **Yes** to an Exclusion, the EP has met the measure threshold.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Core Clinical Quality Measure 1 Screen: NQF 0013



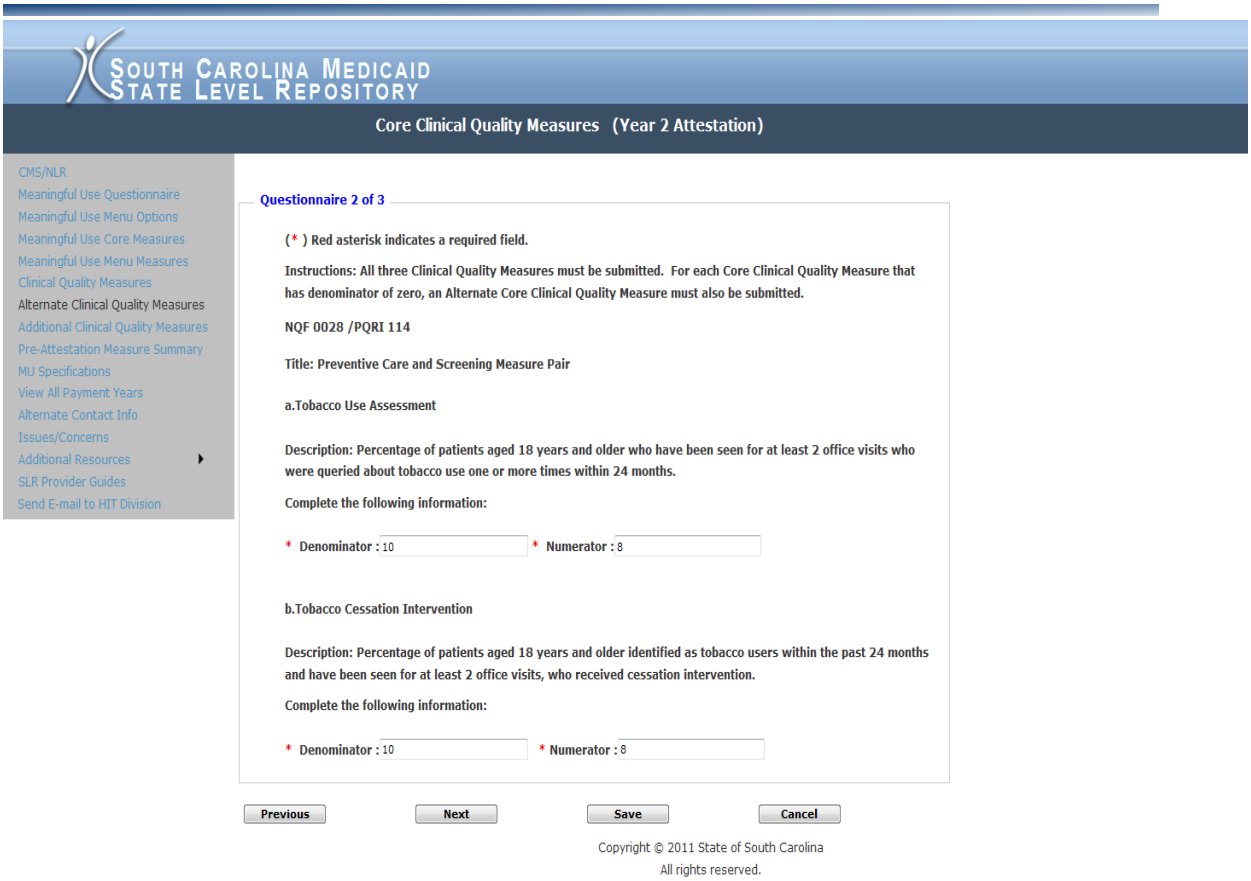
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- The Numerator must be a whole number.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- The Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Core Clinical Quality Measure 2 Screen: NQF 0028



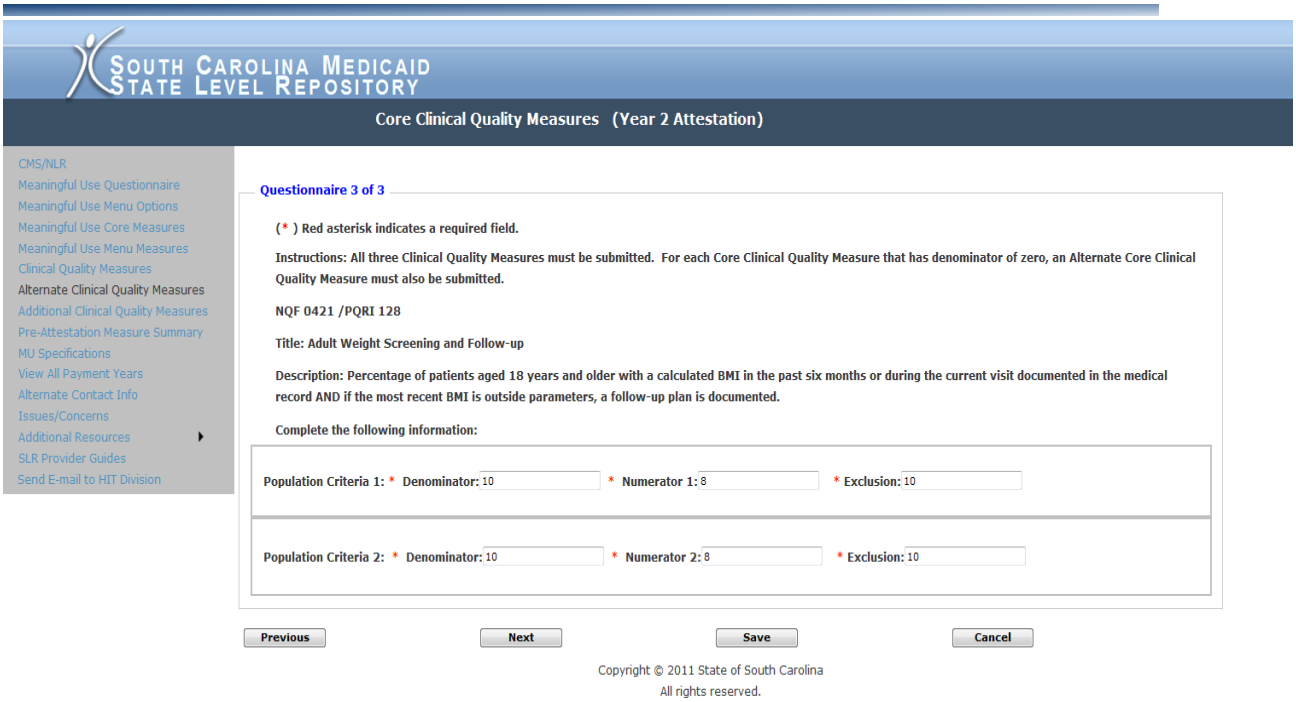
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- The Numerator must be a whole number.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- The Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Core Clinical Quality Measure 3 Screen: NQF 0421



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

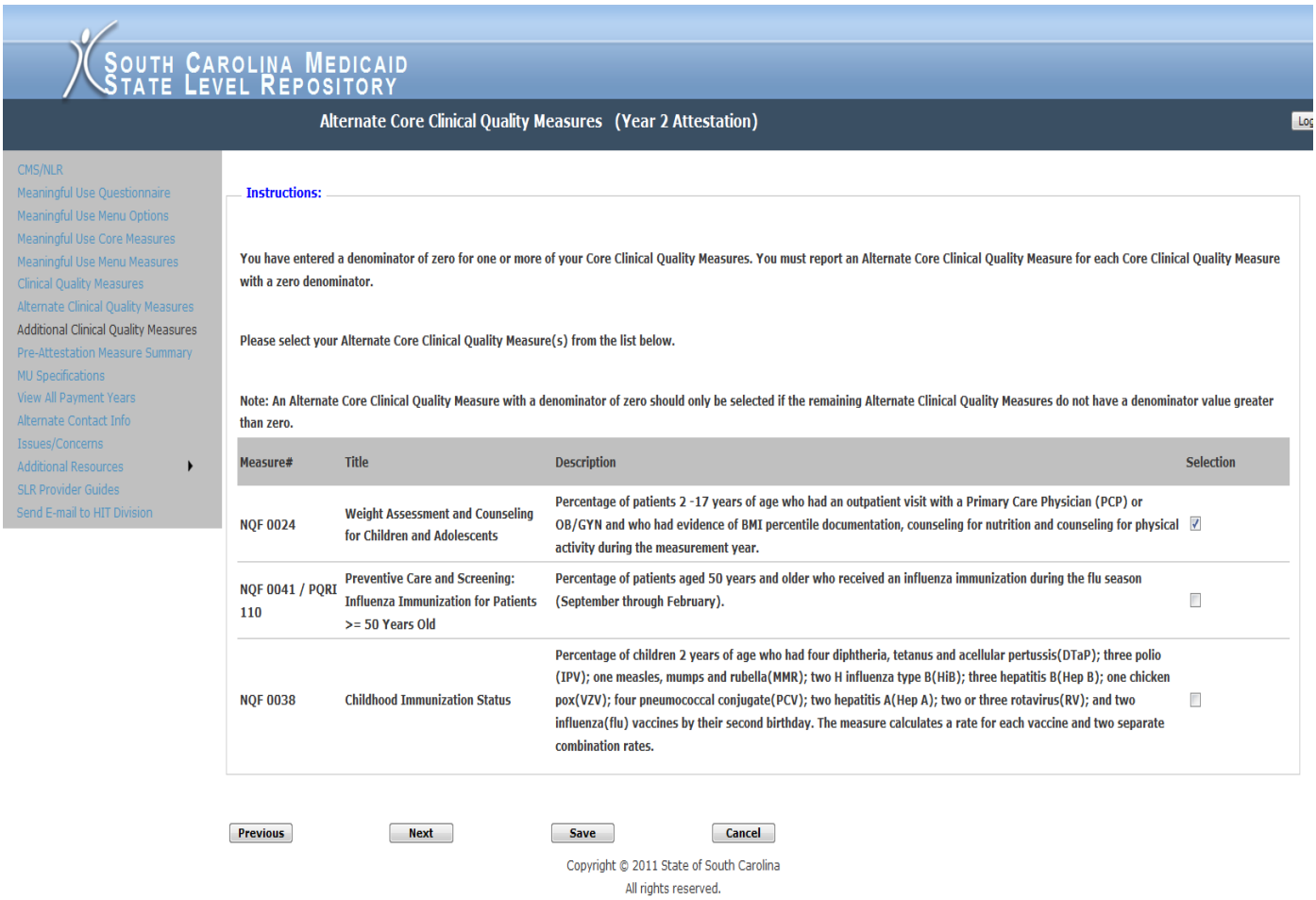
- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- The Numerator must be a whole number.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- The Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- The Exclusion must be greater than or equal to 0.
- The Exclusion must be a whole number.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Alternate Core Clinical Quality Measures (CCQM) Selection Screen

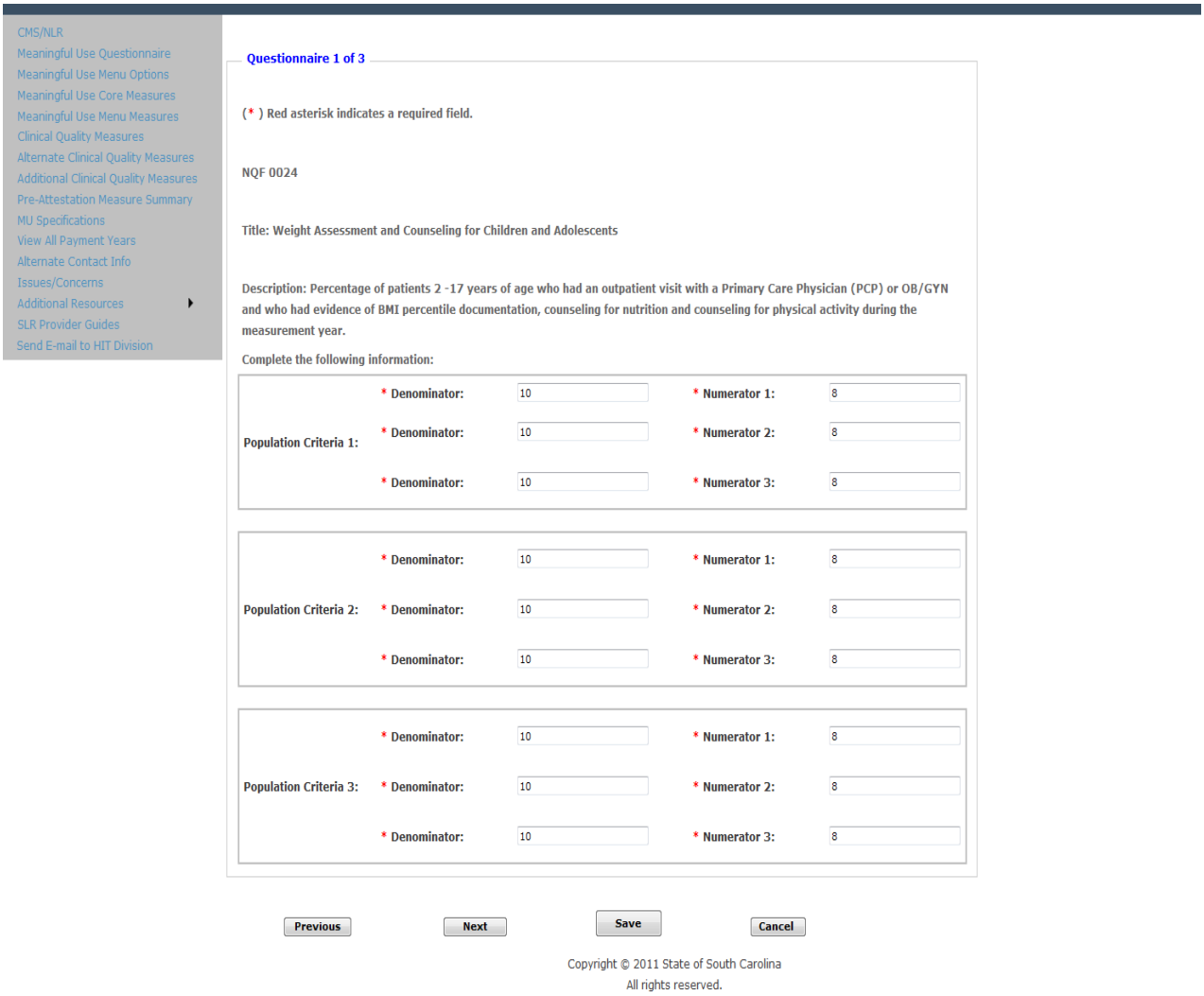
If an EP indicates a zero in the denominator for one or more Core Clinical Quality Measures, the EP must choose an Alternate Clinical Quality Measure to equal the number of Core Clinical Quality Measures that had a zero in the denominator.

Special Navigation - This menu only appears after the Core Clinical Quality Measures if 1 or more of the entries for the denominator of the CCQMs are zero. If none of the denominators are zero for the Core Clinical Quality Measures, the Menu for Additional Clinical Core Measures will display.



Select the Alternate Core Clinical Quality Measure(s) for which the EP is reporting; then, select **Save** & **Next** to proceed.

Alternate Core Clinical Measure 1 Screen: NQF 0024



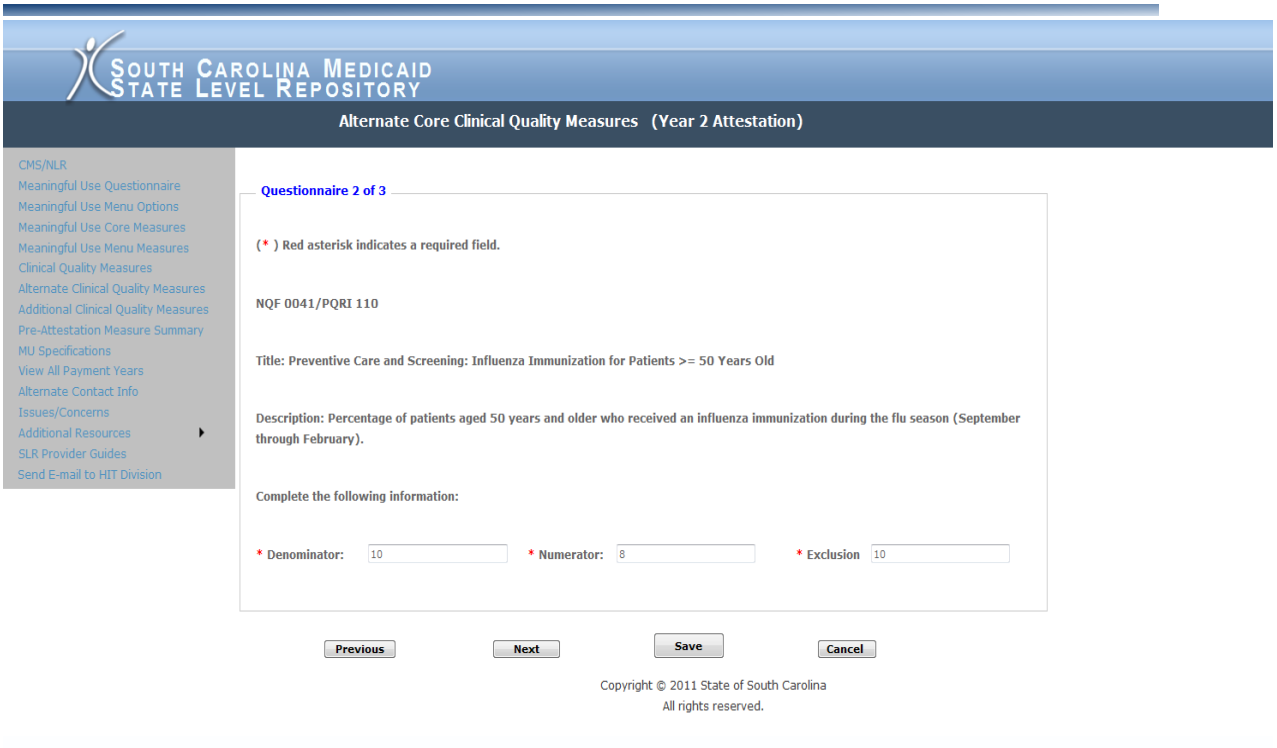
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- The Numerator must be a whole number.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- The Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Alternate Core Clinical Quality Measure 2 Screen: NQF 0041



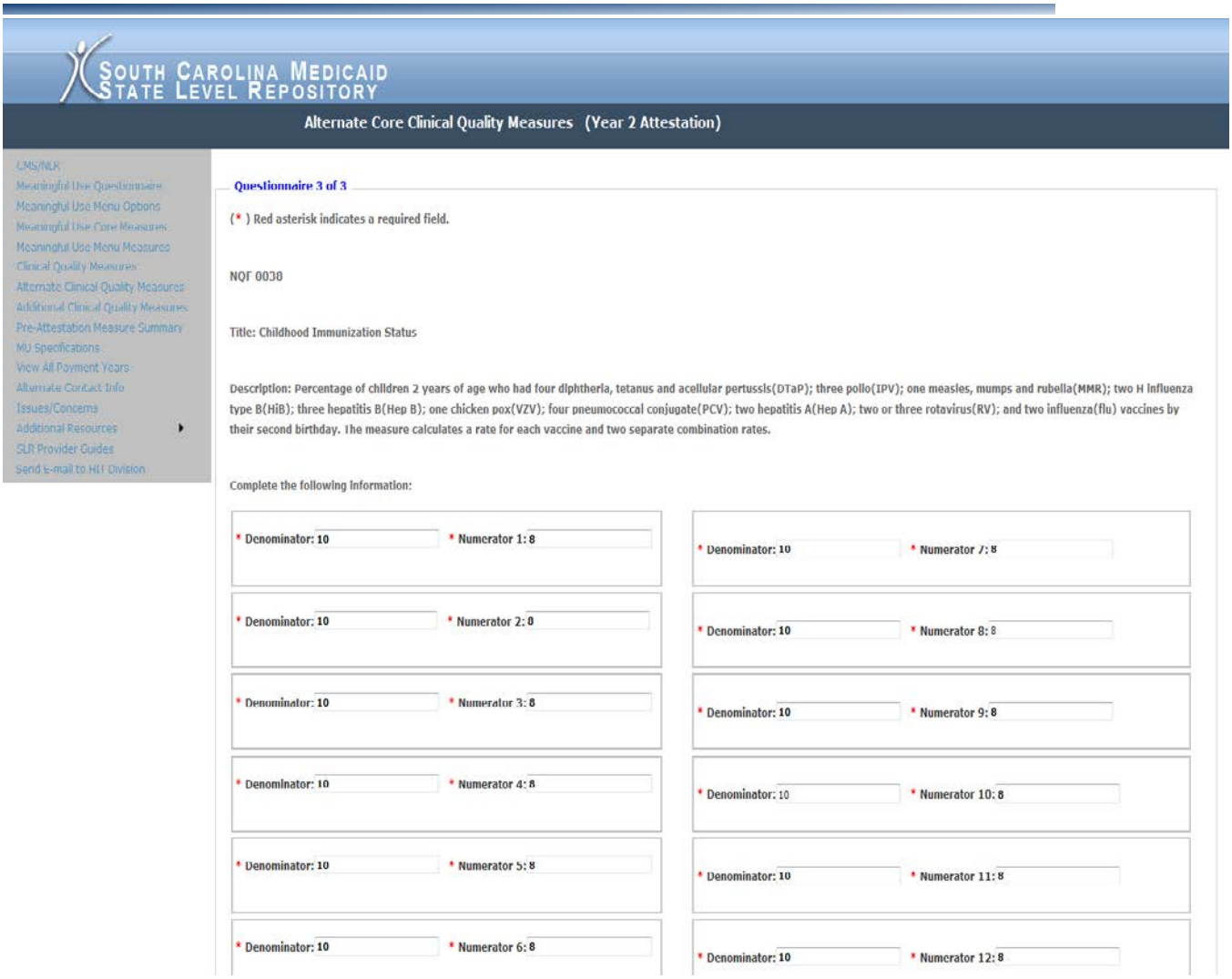
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.
- The Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Alternate Core Clinical Quality Measure 3 Screen: NQF 0038



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

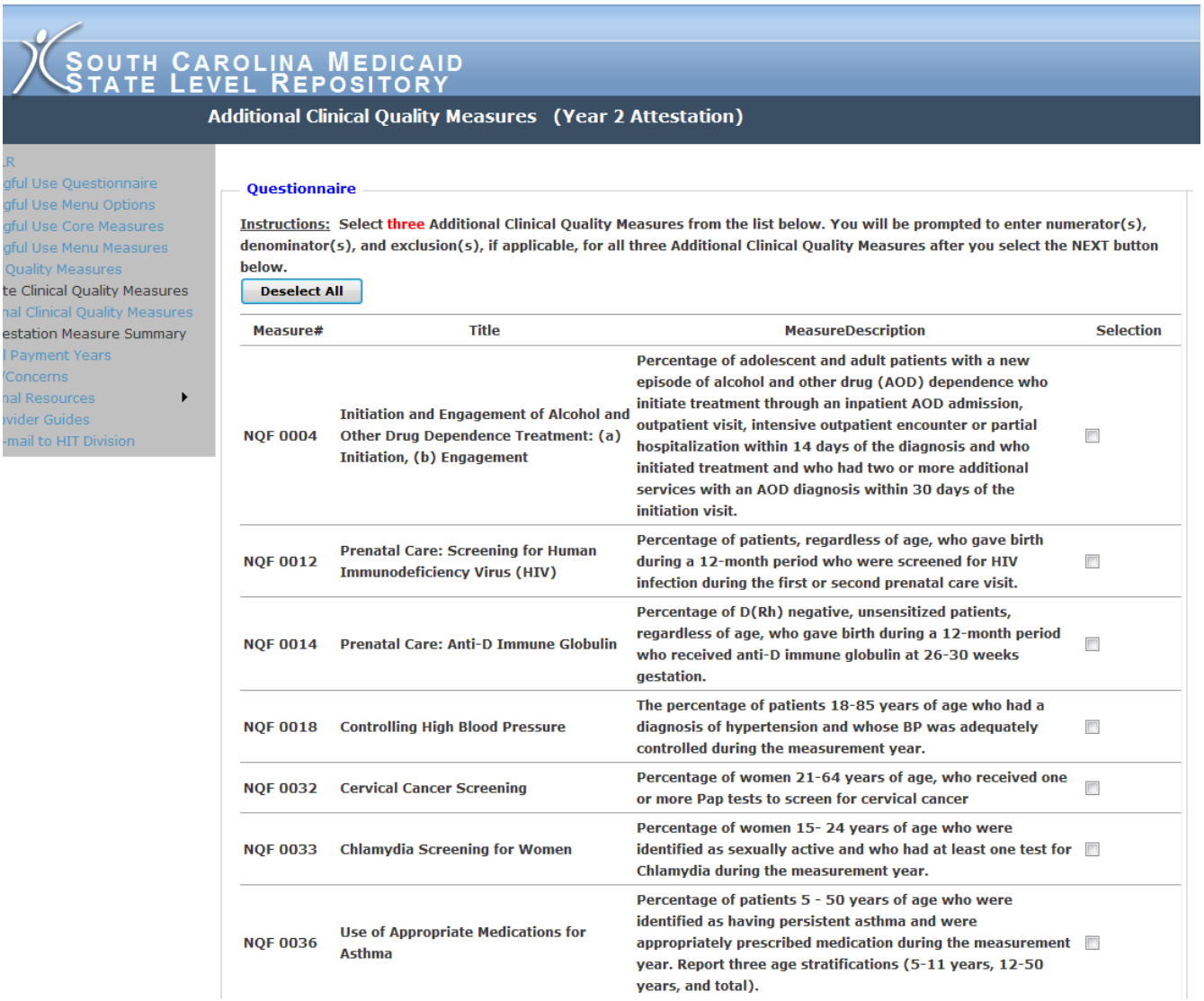
The following details other requirements of this screen:

- Please enter a Numerator, 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator, 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Additional Clinical Quality Measures Selection Screen

A total of three Additional Clinical Quality Measures must be selected by the EP.

If there are not any patients in the measure population, it is acceptable to report zero in the denominator, even for one or more measures, as long as that is the value displayed and calculated by the certified EHR.



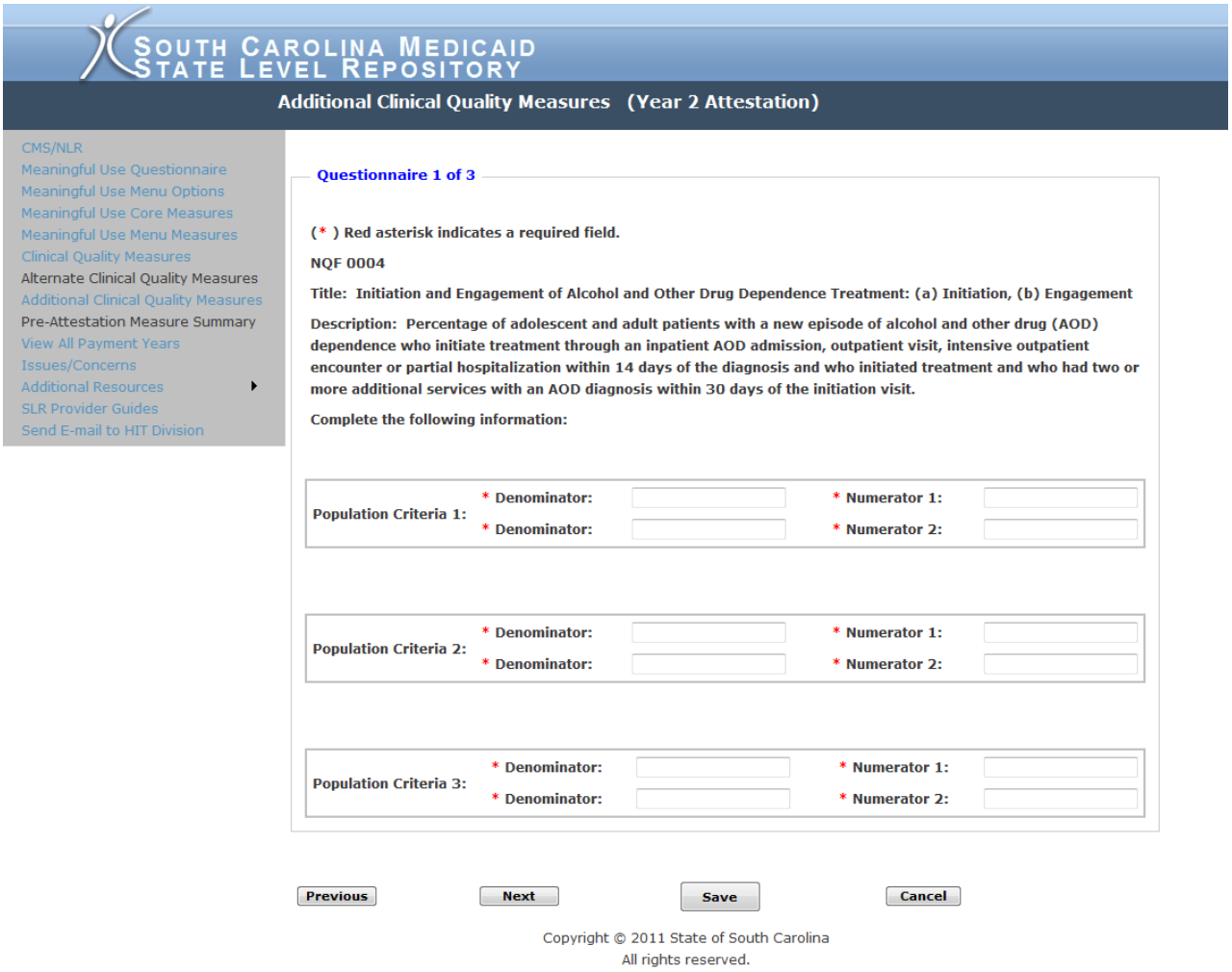
Select the Additional Clinical Quality Measures for which the EP is reporting; then, select **Save & Next** to proceed.

NQF 0052	Low Back Pain: Use of Imaging Studies	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	☐
NQF 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 transluminal angioplasty (PTCA) from January 1-November1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.	☐
NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.	☐
NQF 0059/PQRI 1	Diabetes: Hemoglobin A1c Poor Control.	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.	☐
NQF 0389/PQRI 102	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.	☐
NQF 0043/PQRI 111	Pneumonia Vaccition Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	☐
NQF 0031/PQRI 112	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	☐
NQF 0034/PQRI 113	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	☐
NQF 0027/PQRI 115	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	☐
NQF 0055/PQRI 117	Diabetes: Eye Exam	Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	☐
NQF 0062/PQRI 119	Diabetes: Urine Screening	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.	☐
NQF 0086/PQRI 12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.	☐
NQF 0056/PQRI 163	Diabetes: Foot Exam	The percentage of patients aged 18 - 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	☐
NQF 0088/PQRI 18	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.	☐

NQF 0089/PQRI 19	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.	☐
NQF 0074/PQRI 197	Corory Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who was prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	☐
NQF 0064/PQRI 2	Diabetes Low Density Lipoprotein (LDL) Management and Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL.	☐
NQF 0084/PQRI 200	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation that were prescribed warfarin therapy.	☐
NQF 0073/PQRI 201	Ischemic Vascular Disease (IVD): Blood Pressure Management	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 transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).	☐
NQF 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 transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.	☐
NQF 0061/PQRI 3	Diabetes: Blood Pressure Magement	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.	☐
NQF 0081/PQRI 5	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 and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	☐
NQF 0047/PQRI 53	Asthma Pharmacologic Therapy	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication(inhaled corticosteroid) or an acceptable alternative treatment.	☐
NQF 0067/PQRI 6	Corory Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	☐
NQF 0001	Asthma Assessment	Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, which were evaluated during at least one office visit within 12 months for the frequency(numeric) of daytime and nocturnal asthma symptoms.	☐
NQF 0002/PQRI 66	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus(strep) test for the episode.	☐
NQF 0070/PQRI 7	Corory Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	☐
NQF 0387/PQRI 71	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC 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.	☐
NQF 0385/PQRI 72	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.	☐
NQF 0083/PQRI 8	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 who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	☐
NQF 0105/PQRI 9	Anti-depressant medication magement: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment	Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.	☐

Previous Save & Next

Additional Clinical Quality Measure 1 Screen: NQF 0004



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

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- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 2 Screen: NQF 0012

All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

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- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
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- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.
- Please provide a whole number less than 1,000,000 for the Exclusion.

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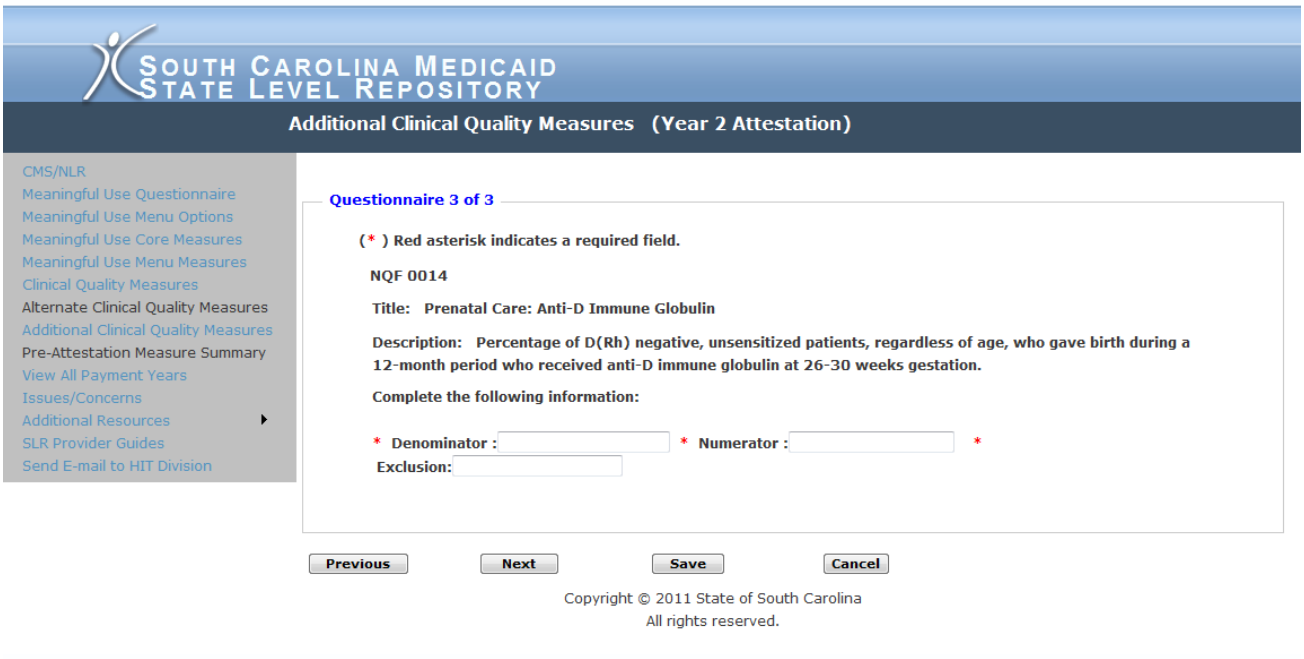
Additional Clinical Quality Measure 3 Screen: NQF 0014



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- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
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- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
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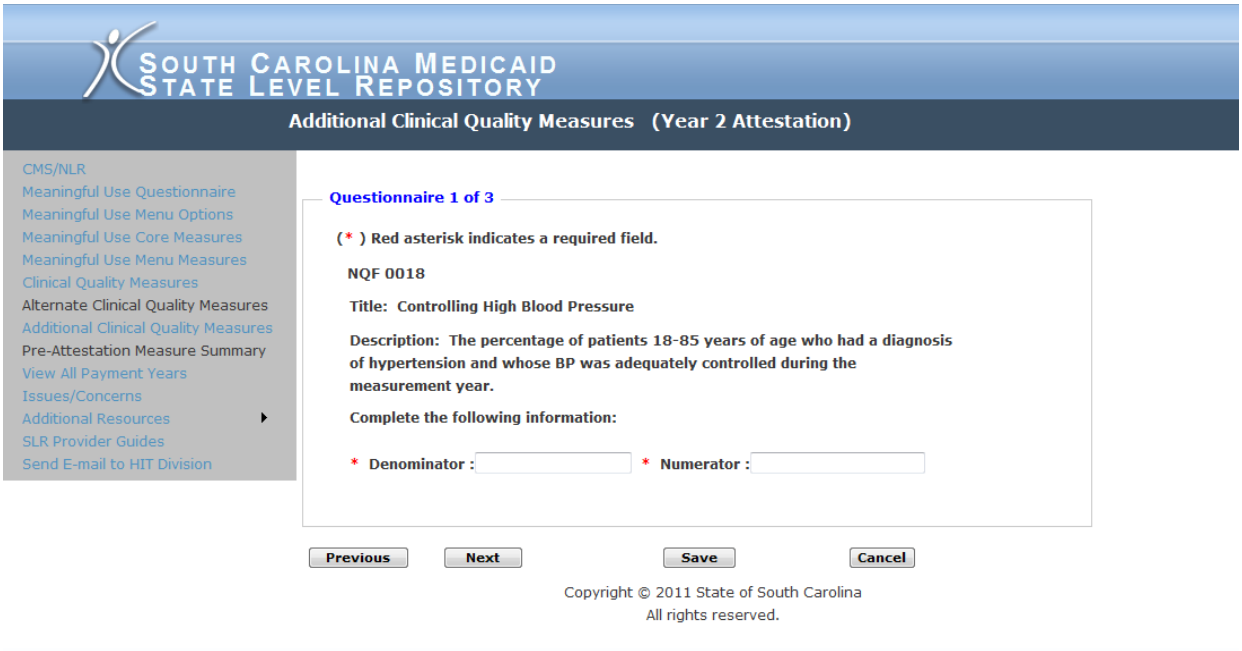
Additional Clinical Quality Measure 4 Screen: NQF 0018



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- Please provide a whole number less than 1,000,000 for the Numerator.
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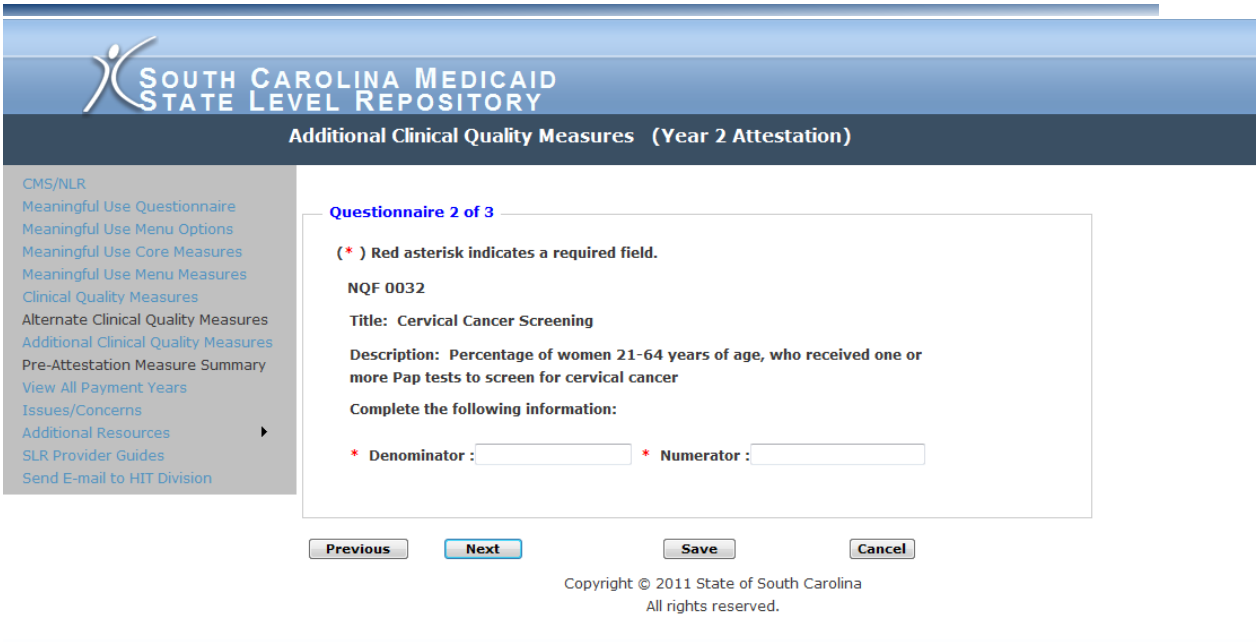
Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 5 Screen: NQF 0032



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- Please provide a whole number less than 1,000,000 for the Numerator.
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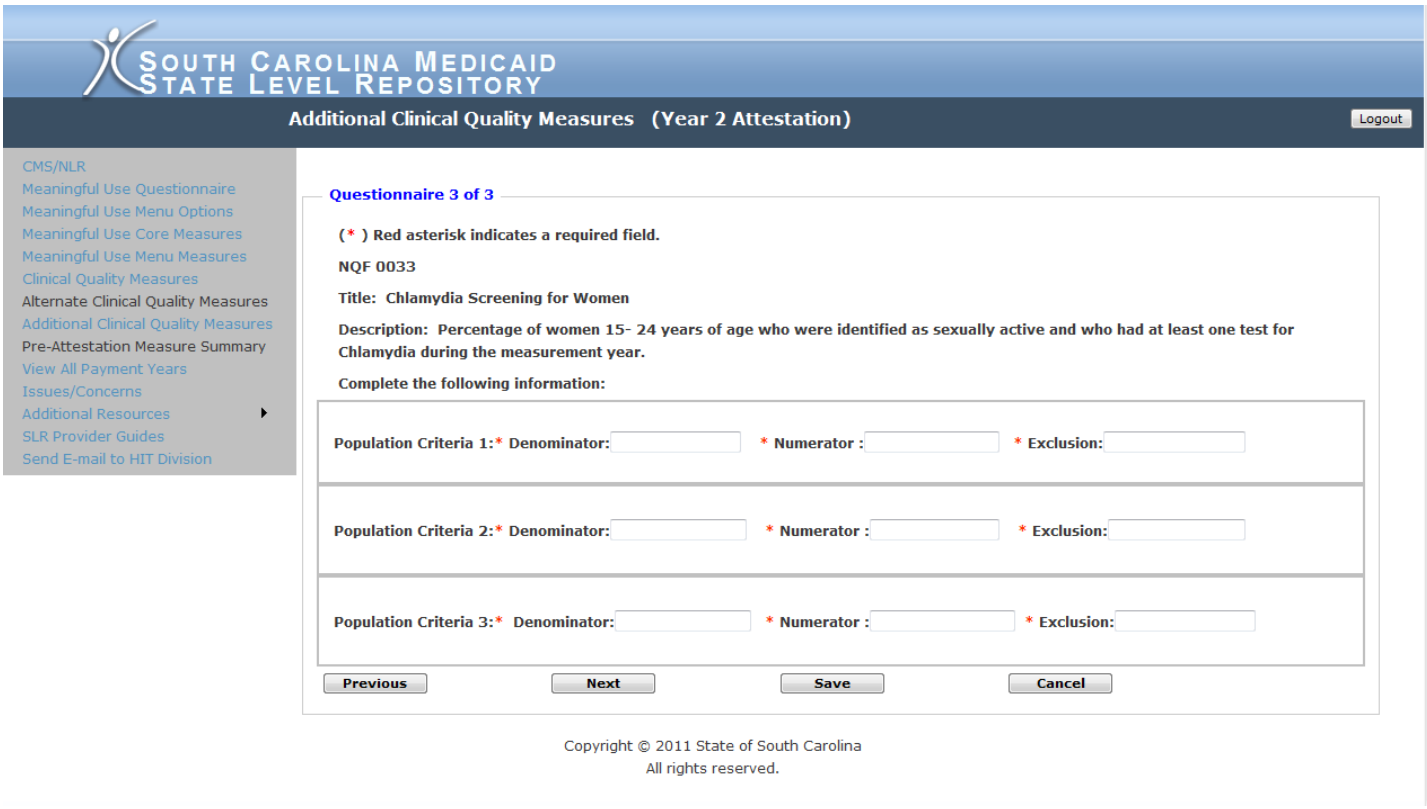
Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 6 Screen: NQF 0033



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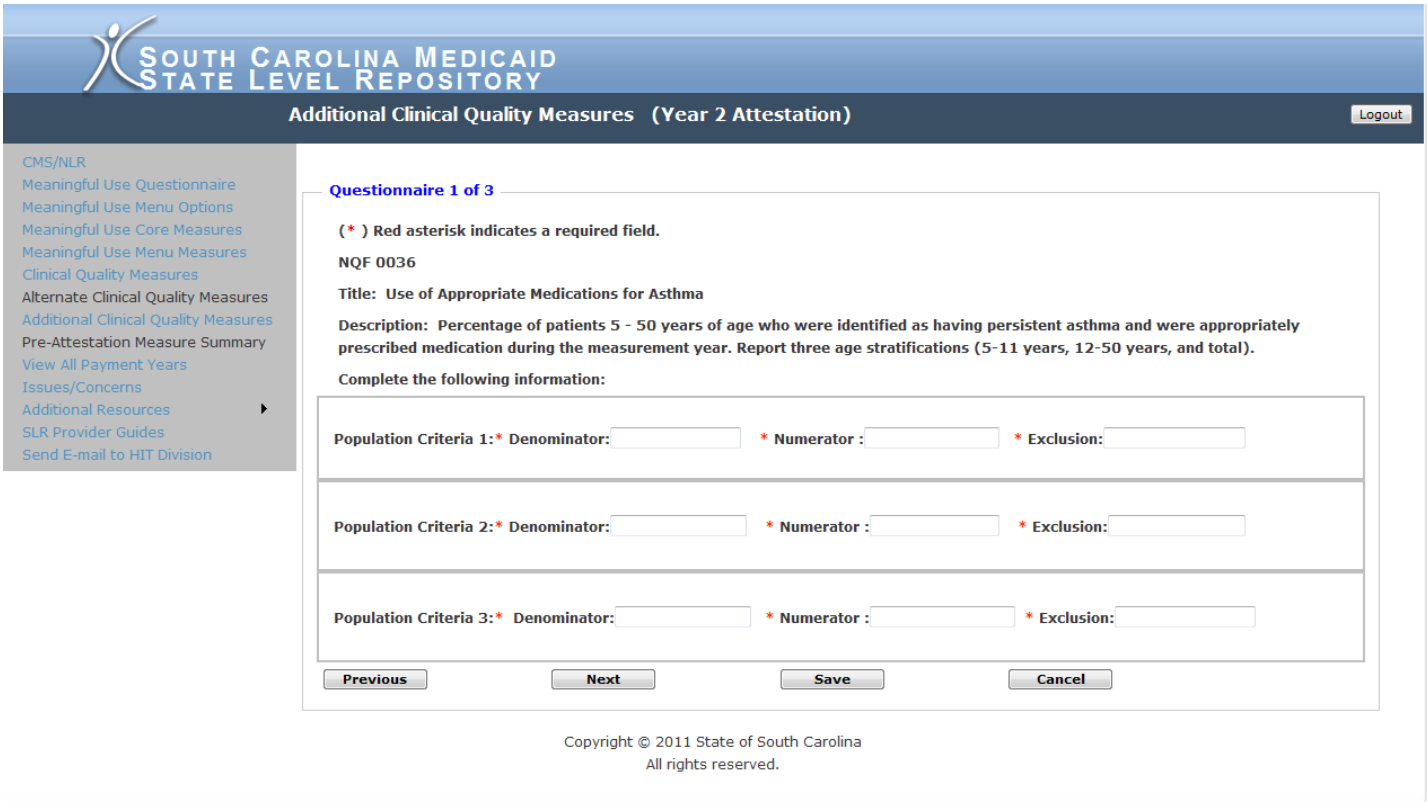
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 7 Screen: NQF 0036



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- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
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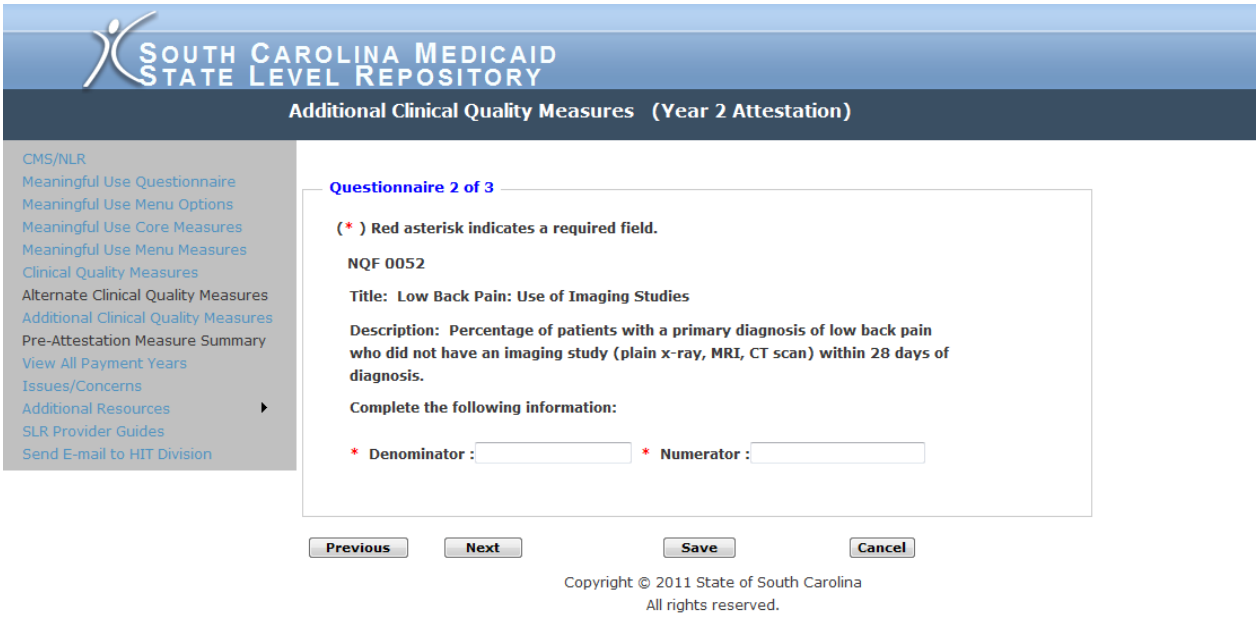
Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 8 Screen: NQF 0052



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- Please provide a whole number less than 1,000,000 for the Numerator.
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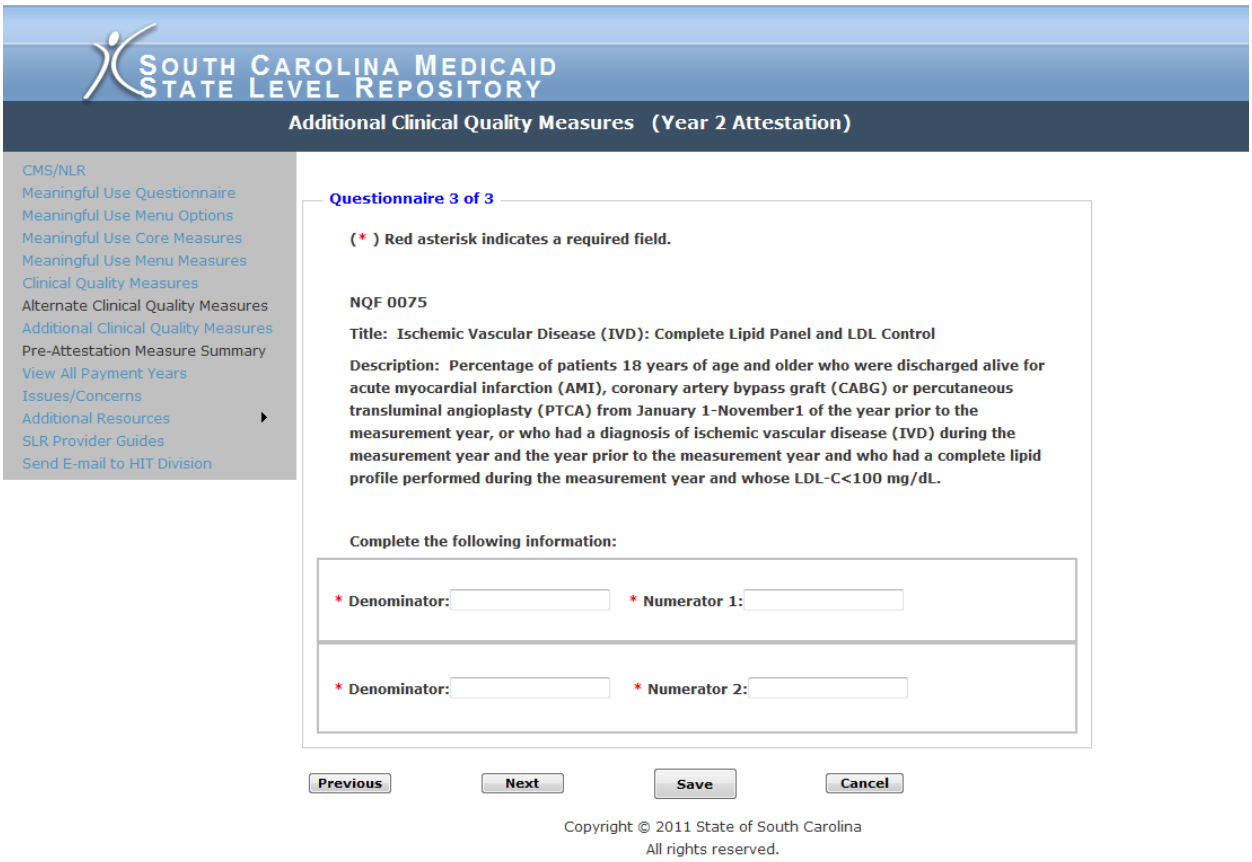
Additional Clinical Quality Measure 9 Screen: NQF 0075



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- Please provide a whole number less than 1,000,000 for the Numerator.
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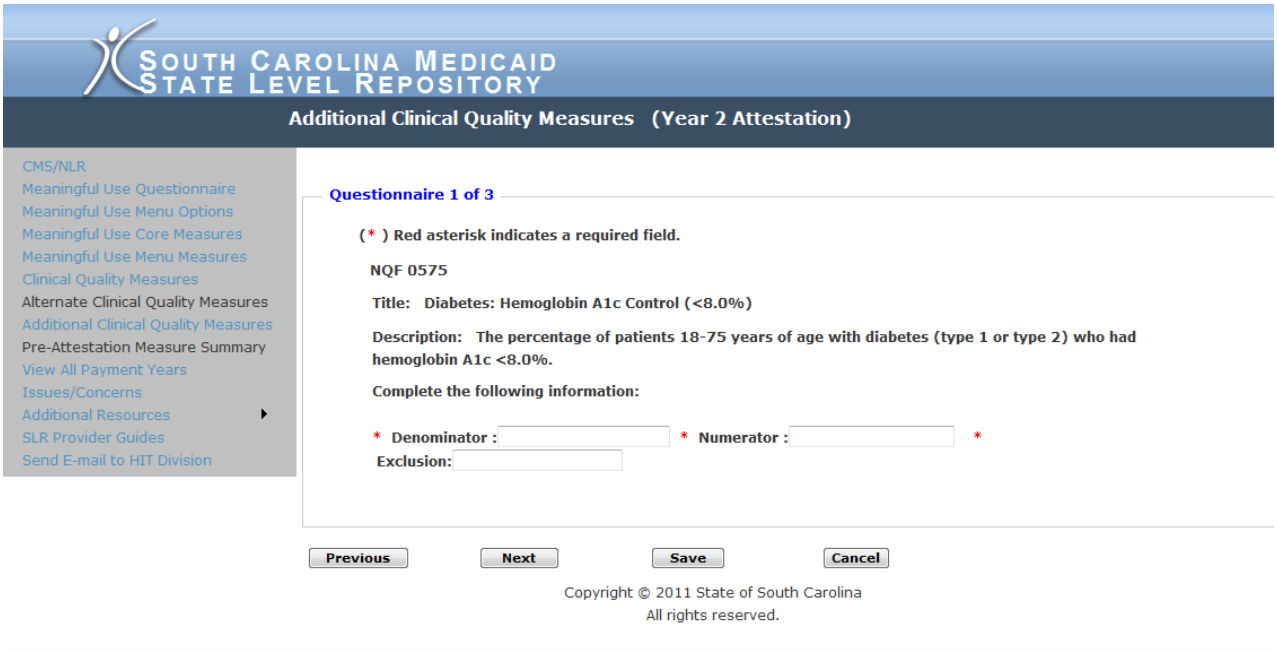
Additional Clinical Quality Measure 10 Screen: NQF 0575



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

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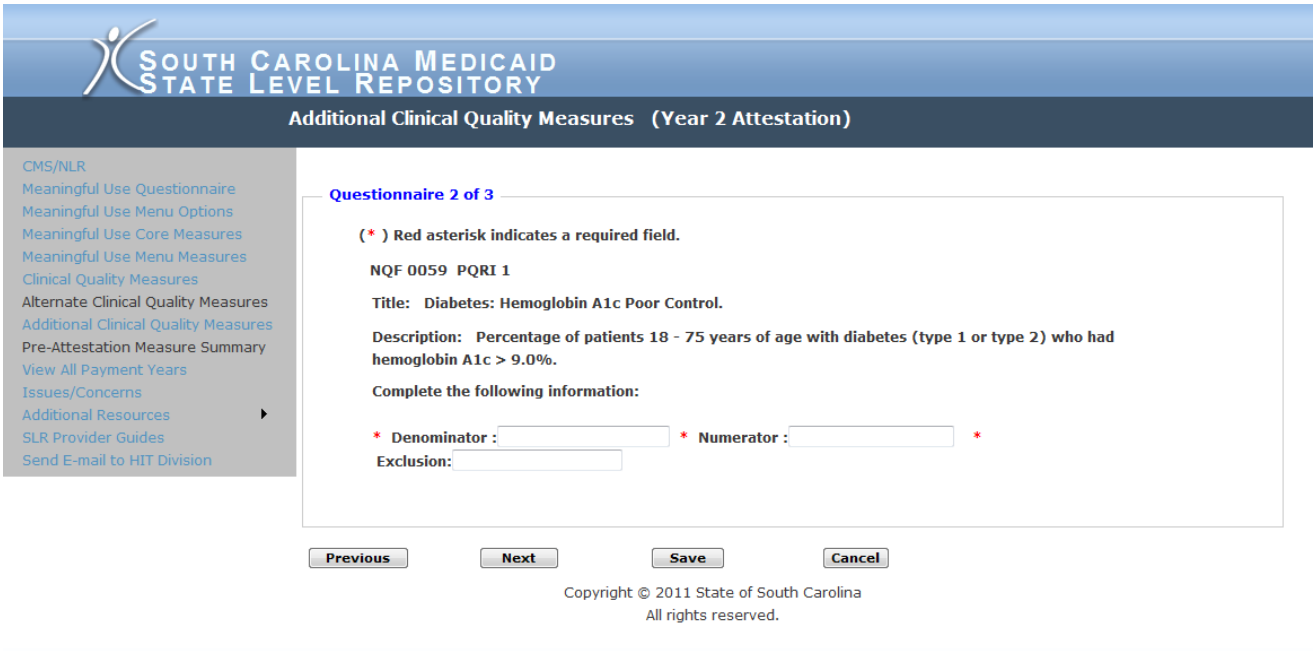
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 11 Screen: NQF 0059



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

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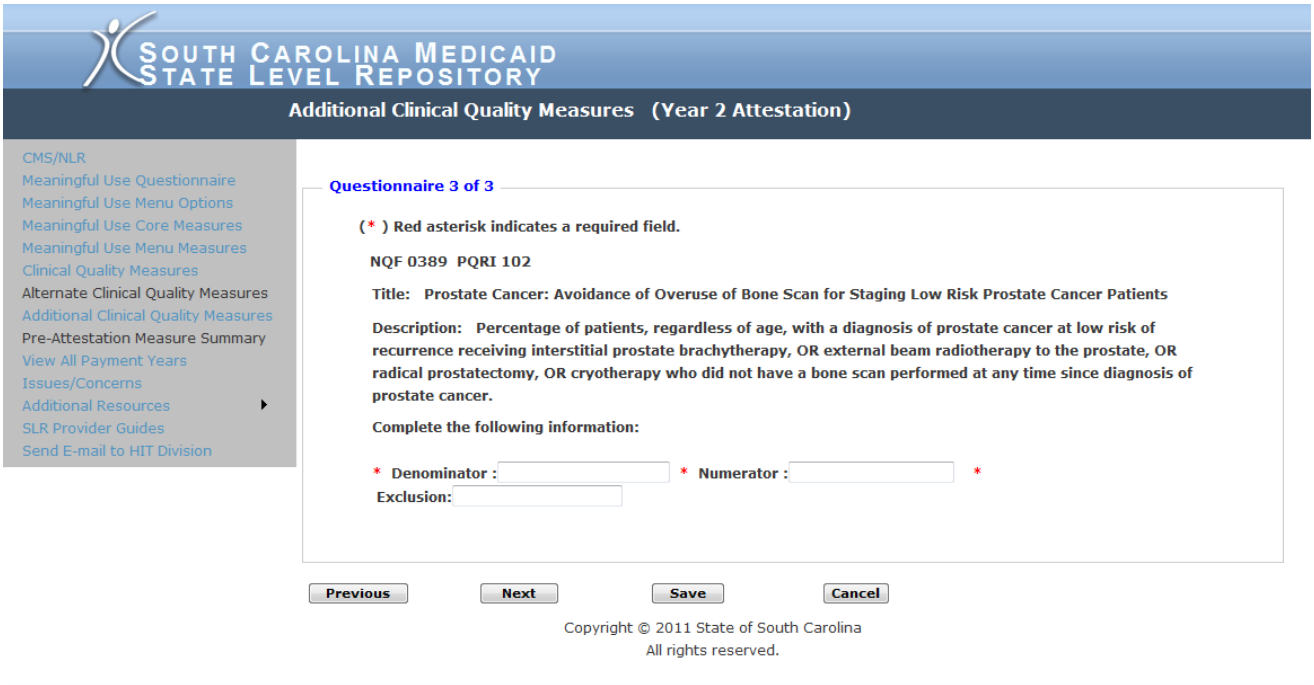
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Exclusion must be greater than or equal to 0.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 12 Screen: NQF 0389



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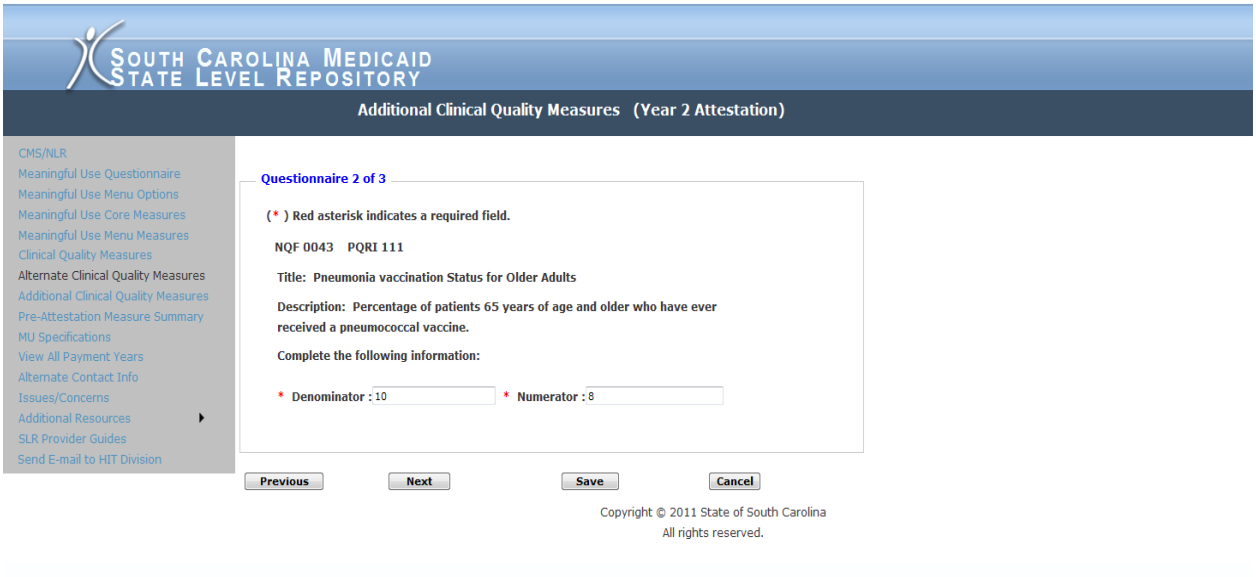
Additional Clinical Quality Measure 13 Screen: NQF 0043



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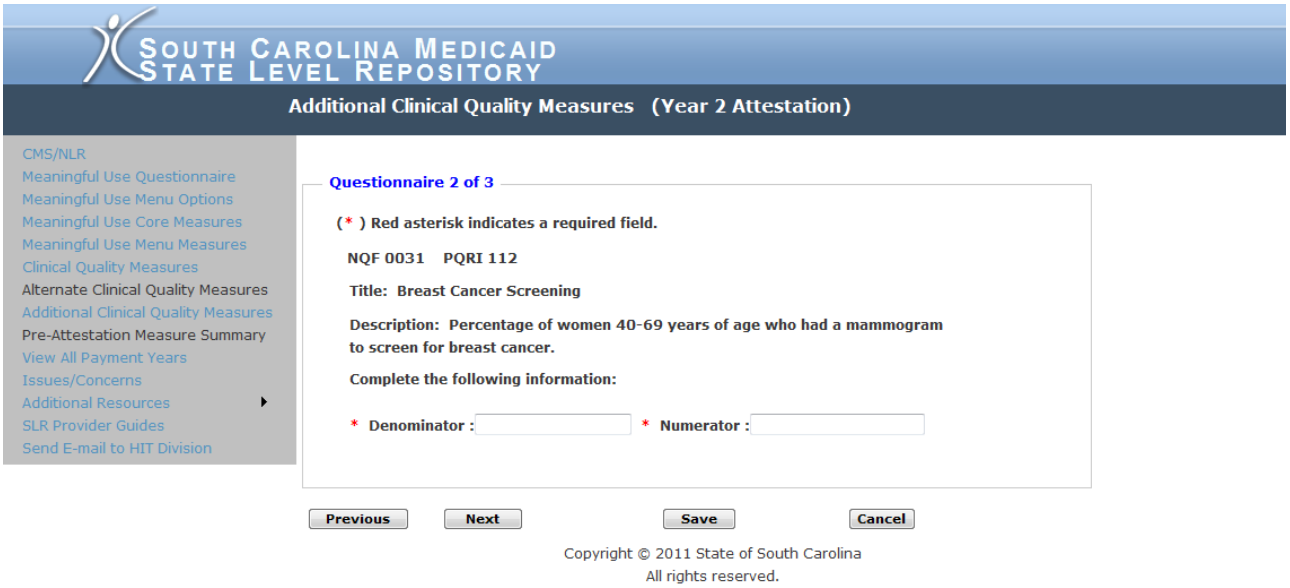
Additional Clinical Quality Measure 14 Screen: NQF 0031



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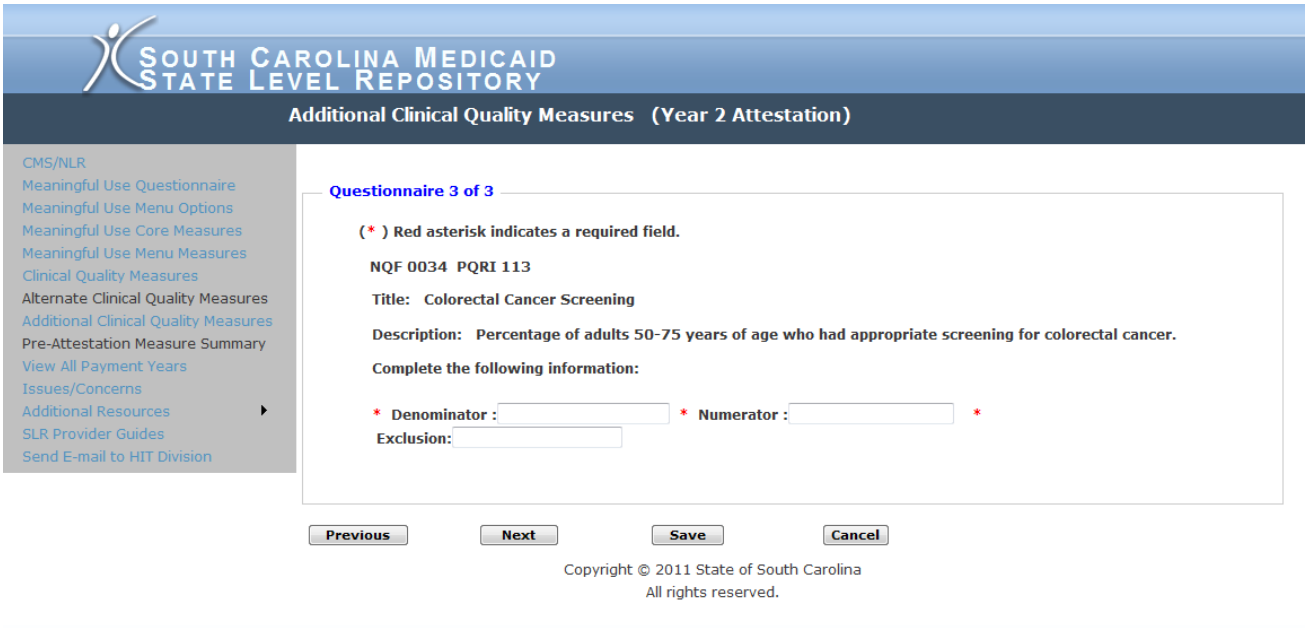
Additional Clinical Quality Measure 15 Screen: NQF 0034



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- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

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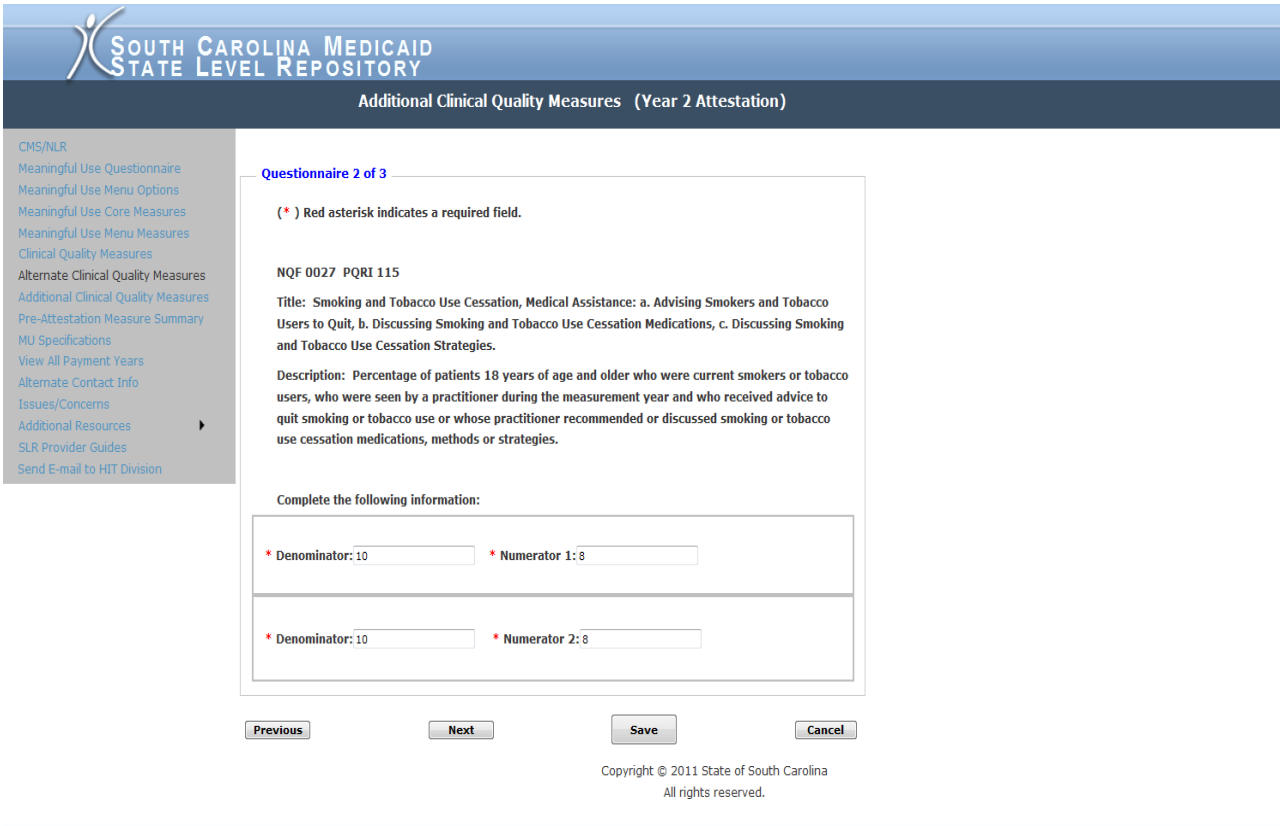
Additional Clinical Quality Measure 16 Screen: NQF 0027



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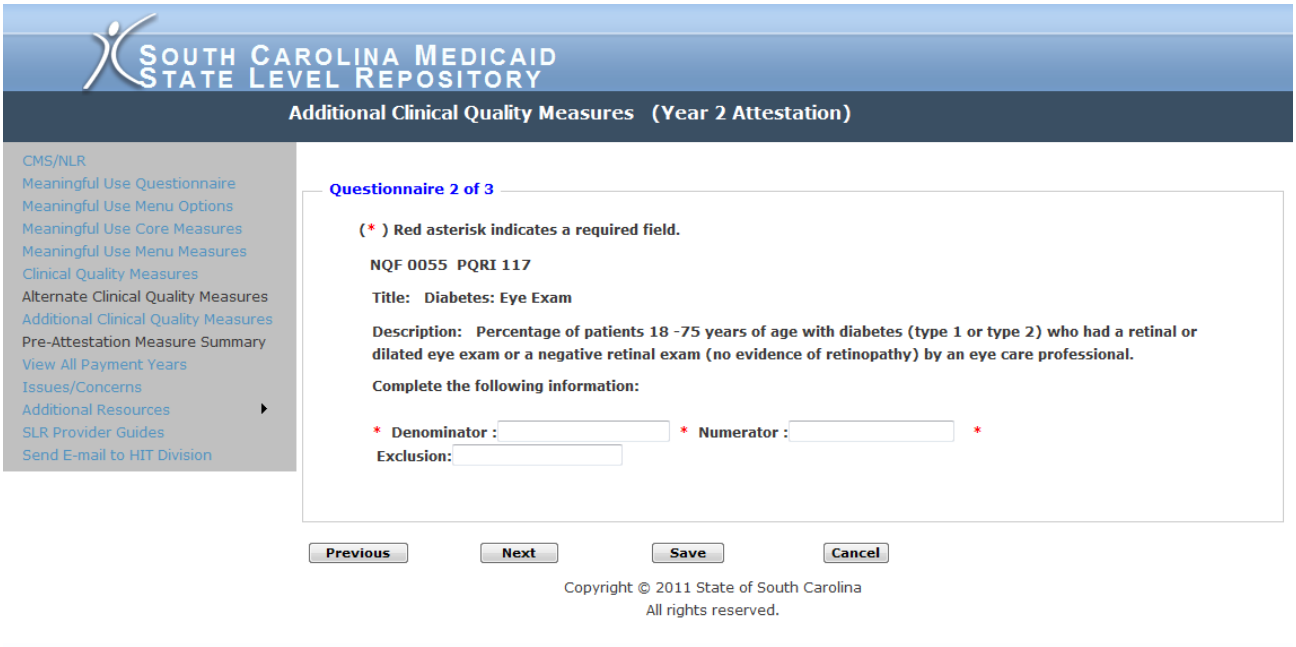
Additional Clinical Quality Measure 17 Screen: NQF 0055



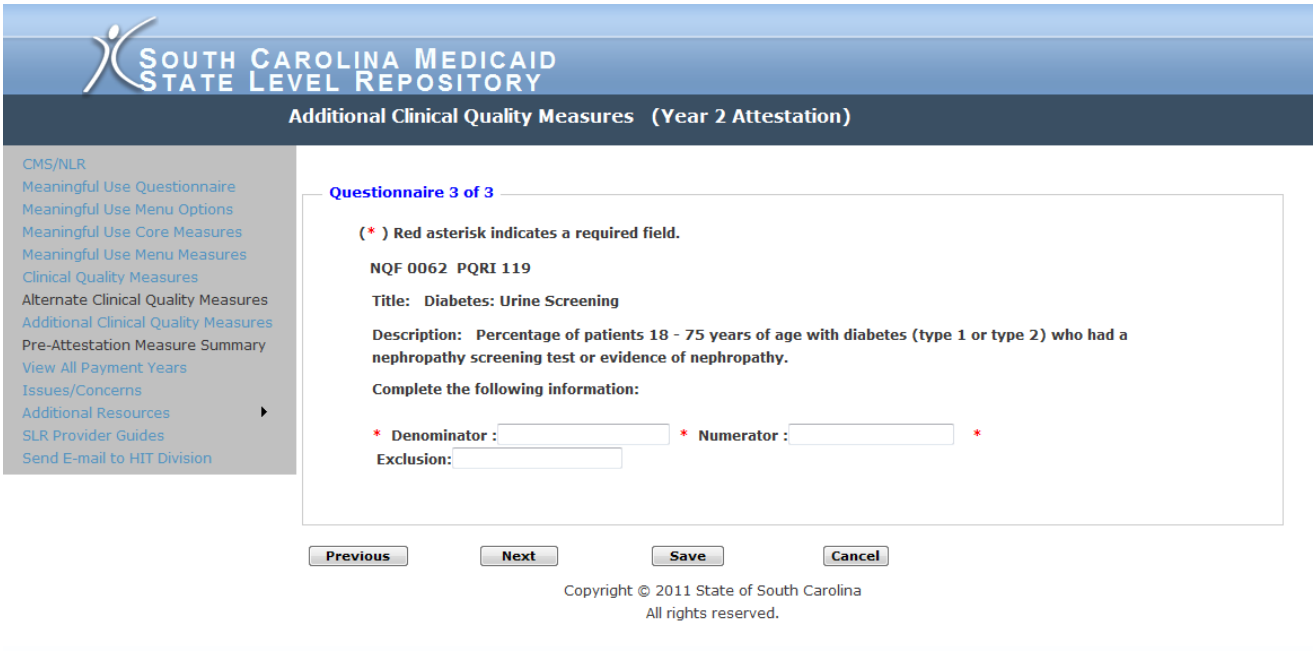
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 18 Screen: NQF 0062



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 19 Screen: NQF 0086

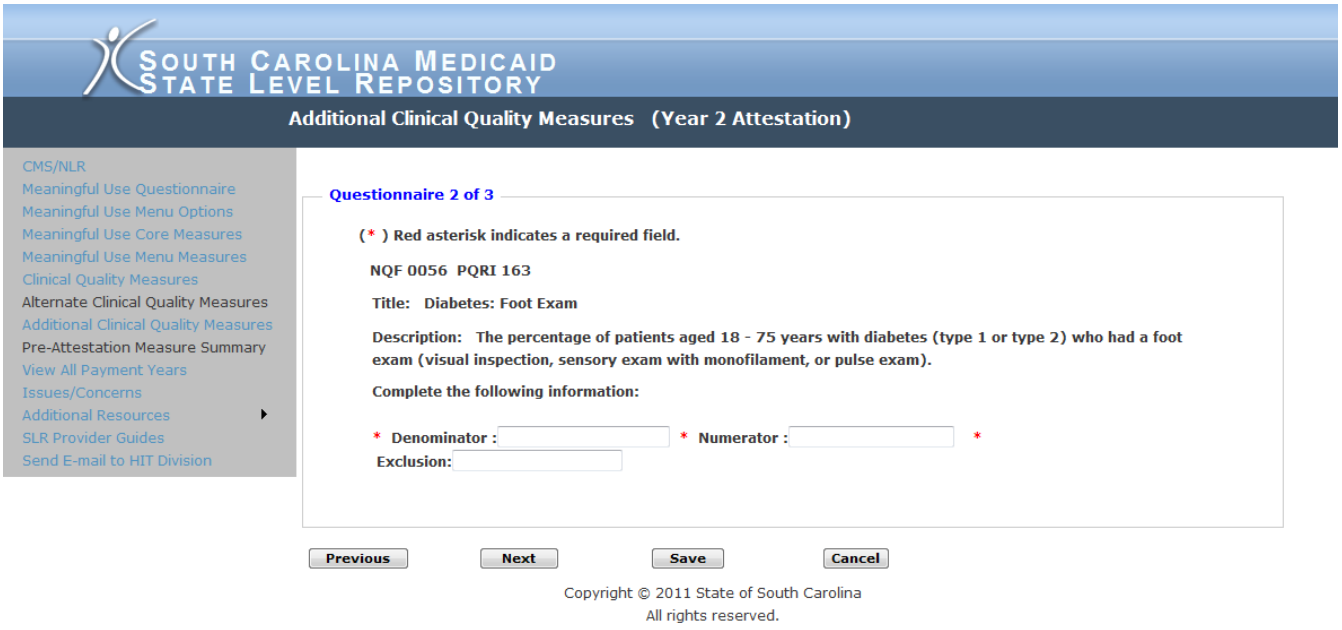
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 20 Screen: NQF 0056



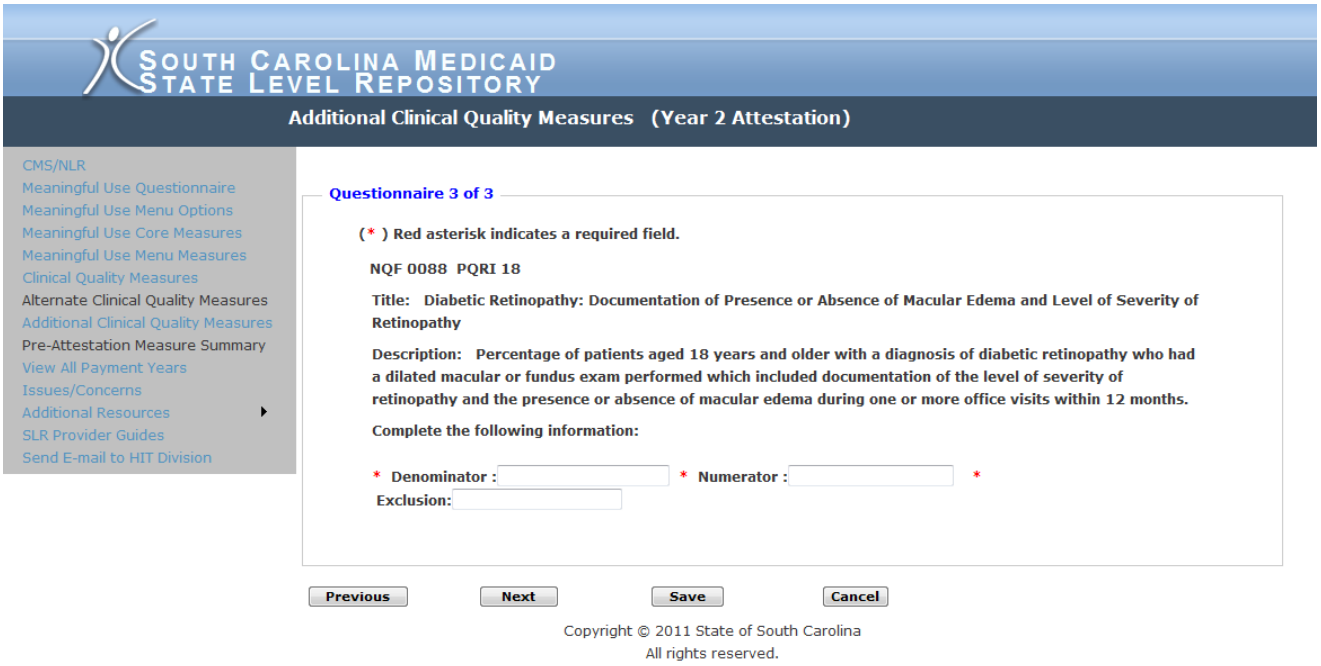
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 21 Screen: NQF 0088



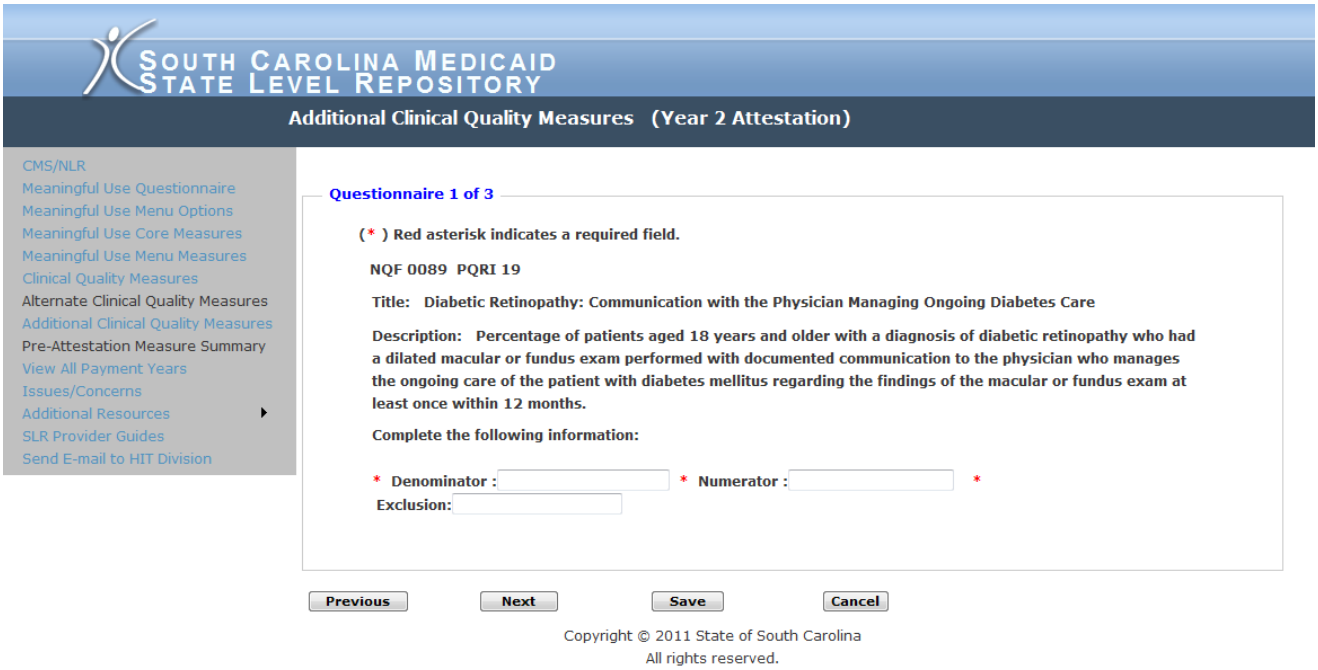
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 22 Screen: NQF 0089



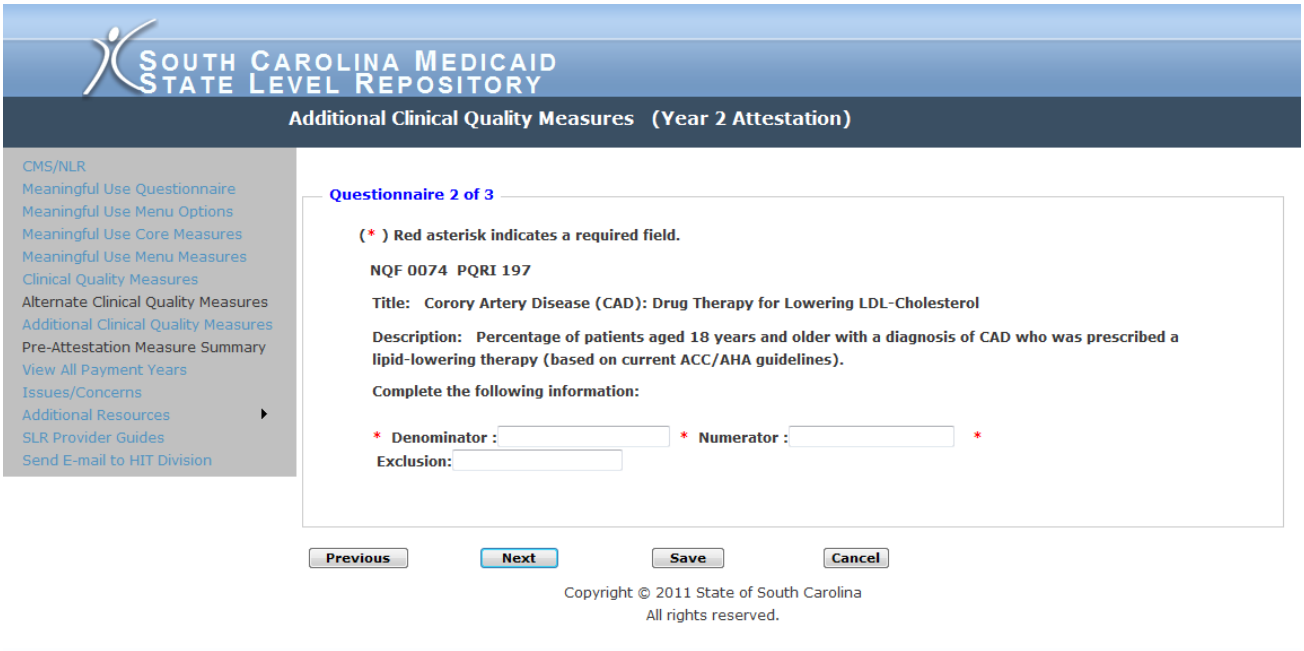
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 23 Screen: NQF 0074



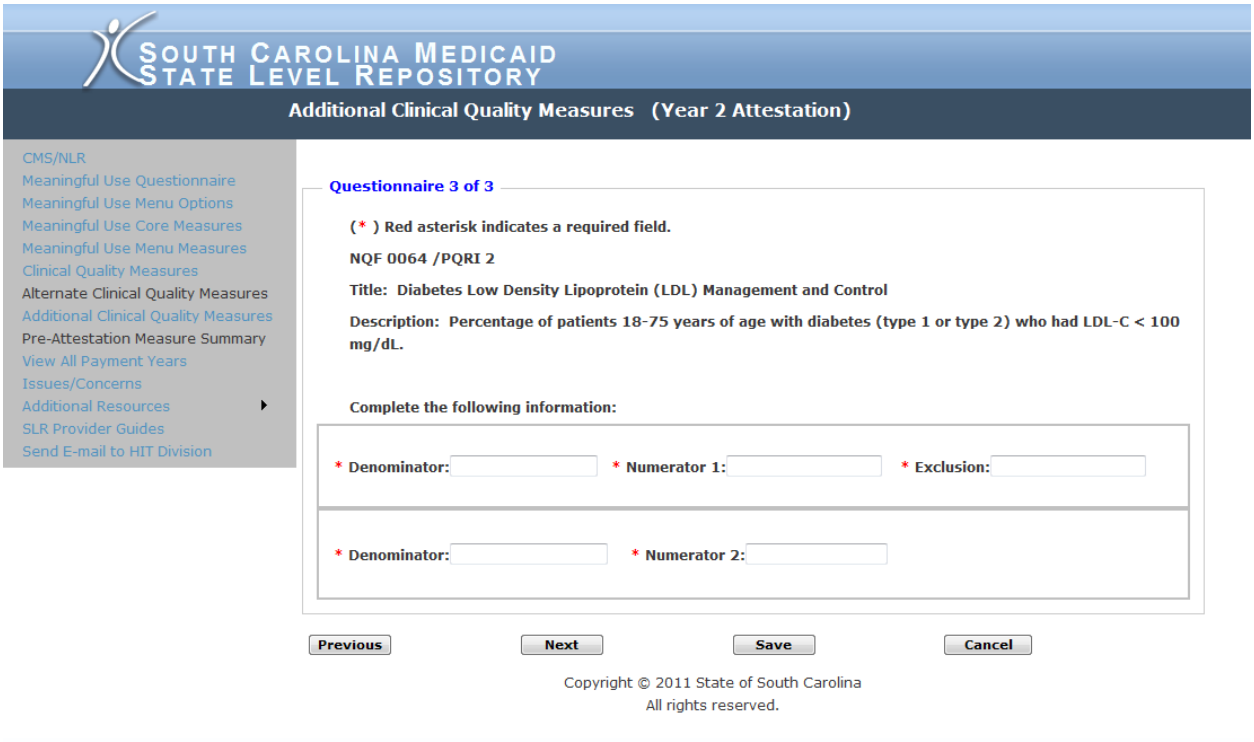
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 24 Screen: NQF 0064



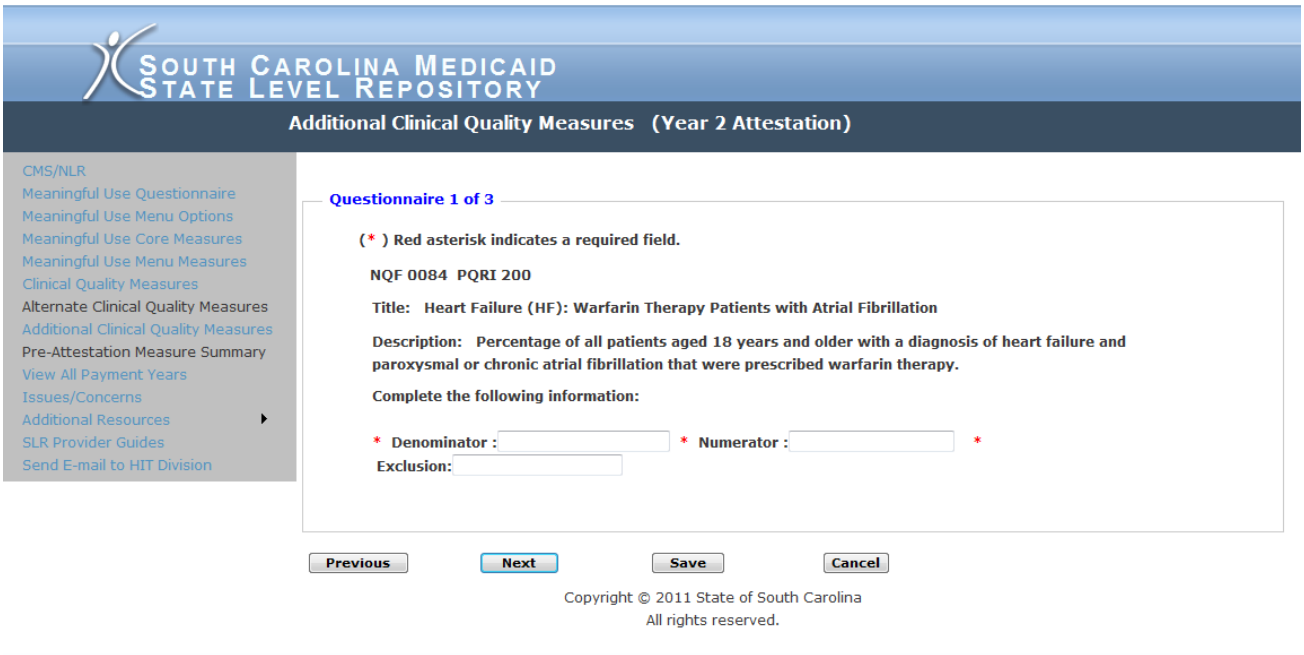
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.
- The Exclusion must be greater than or equal to 0.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 25 Screen: NQF 0084



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 26 Screen: NQF 0073

All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 27 Screen: NQF 0068

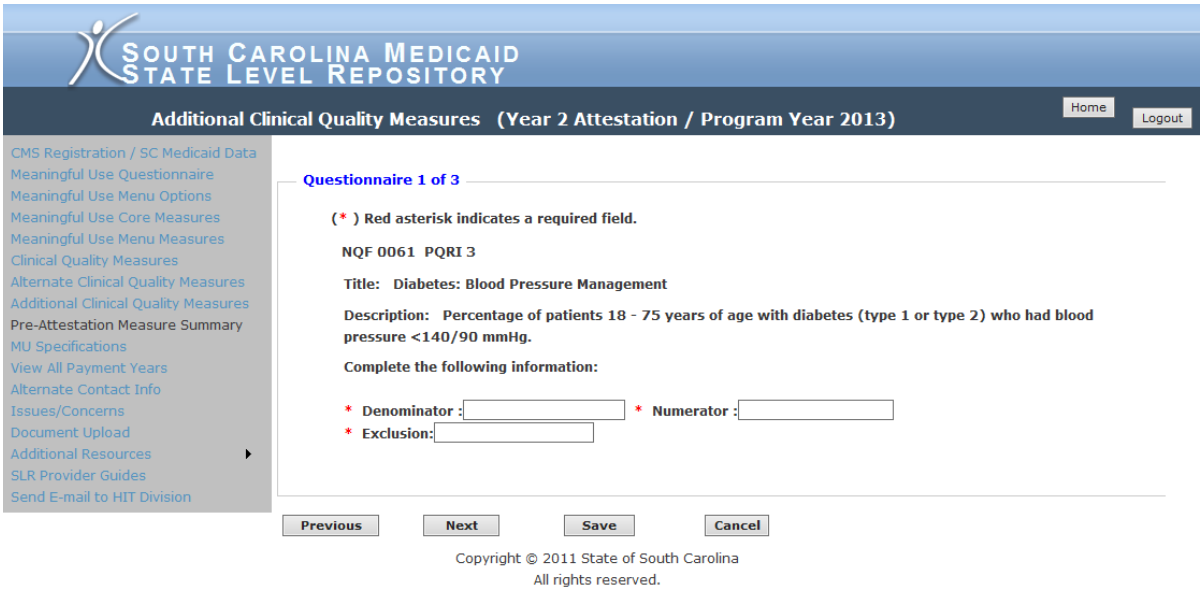
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 28 Screen: NQF 0061



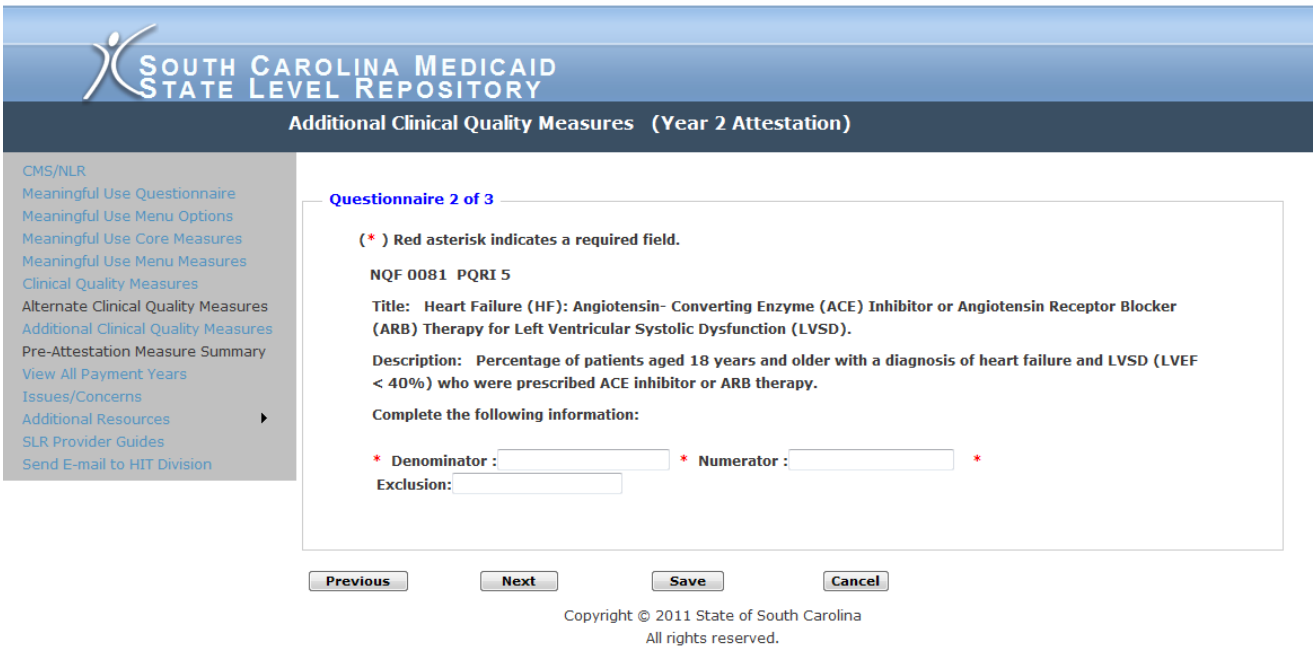
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.
- The Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 29 Screen: NQF 0081



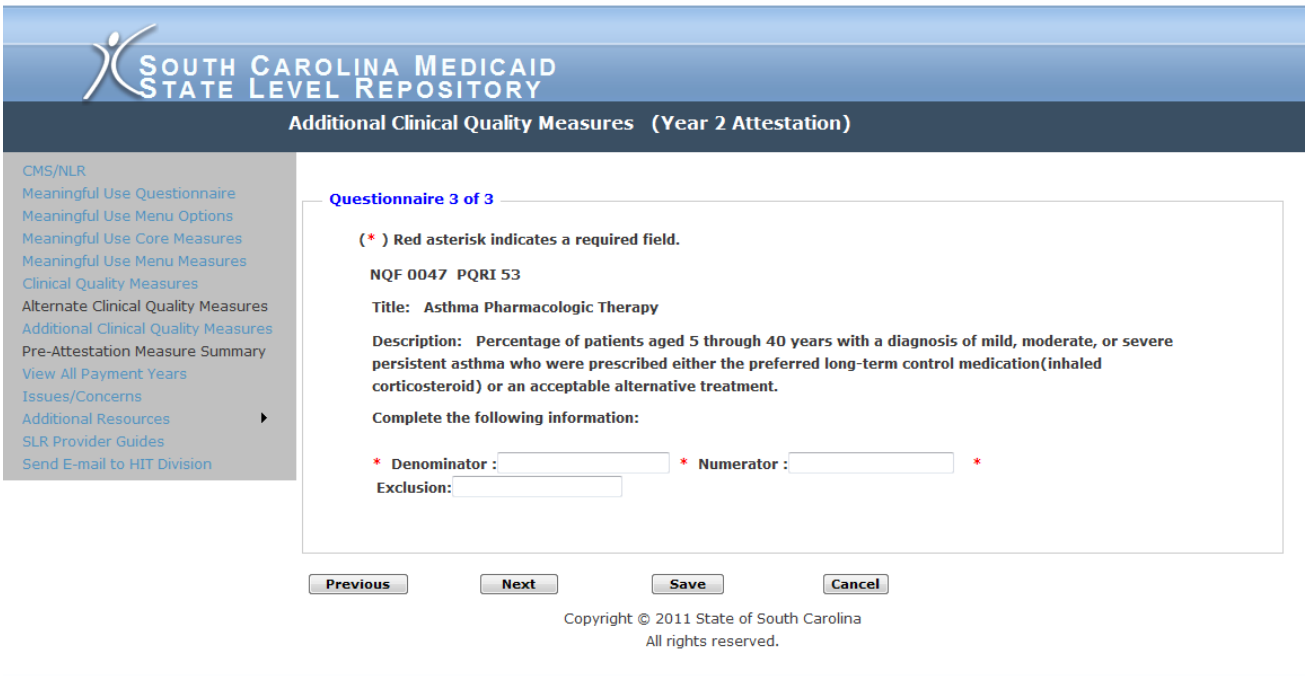
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.
- The Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 30 Screen: NQF 0047



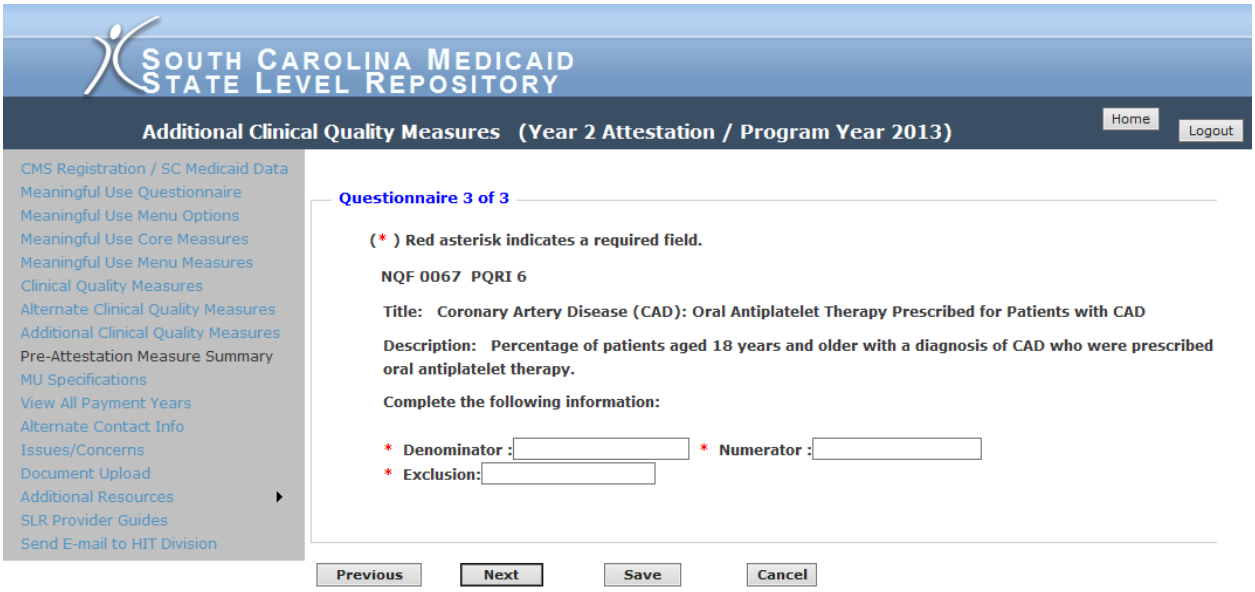
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 31 Screen: NQF 0067



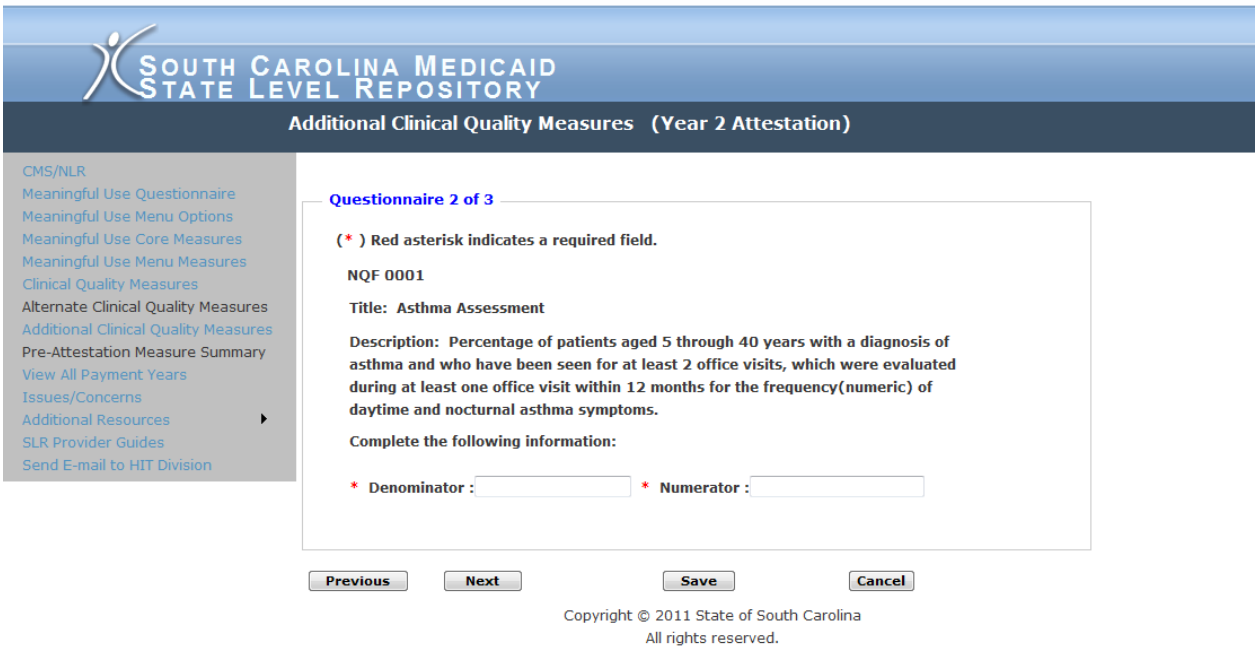
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 32 Screen: NQF 0001



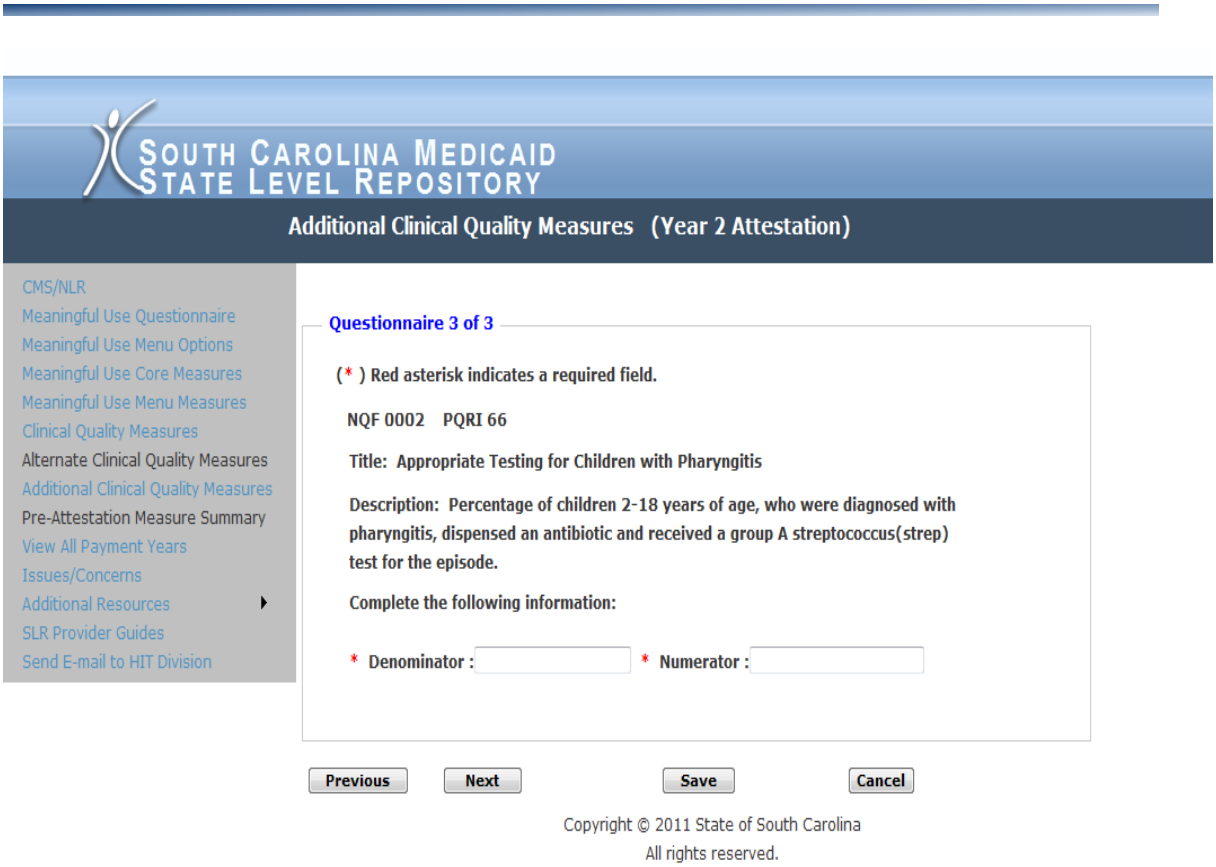
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 33 Screen: NQF 0002



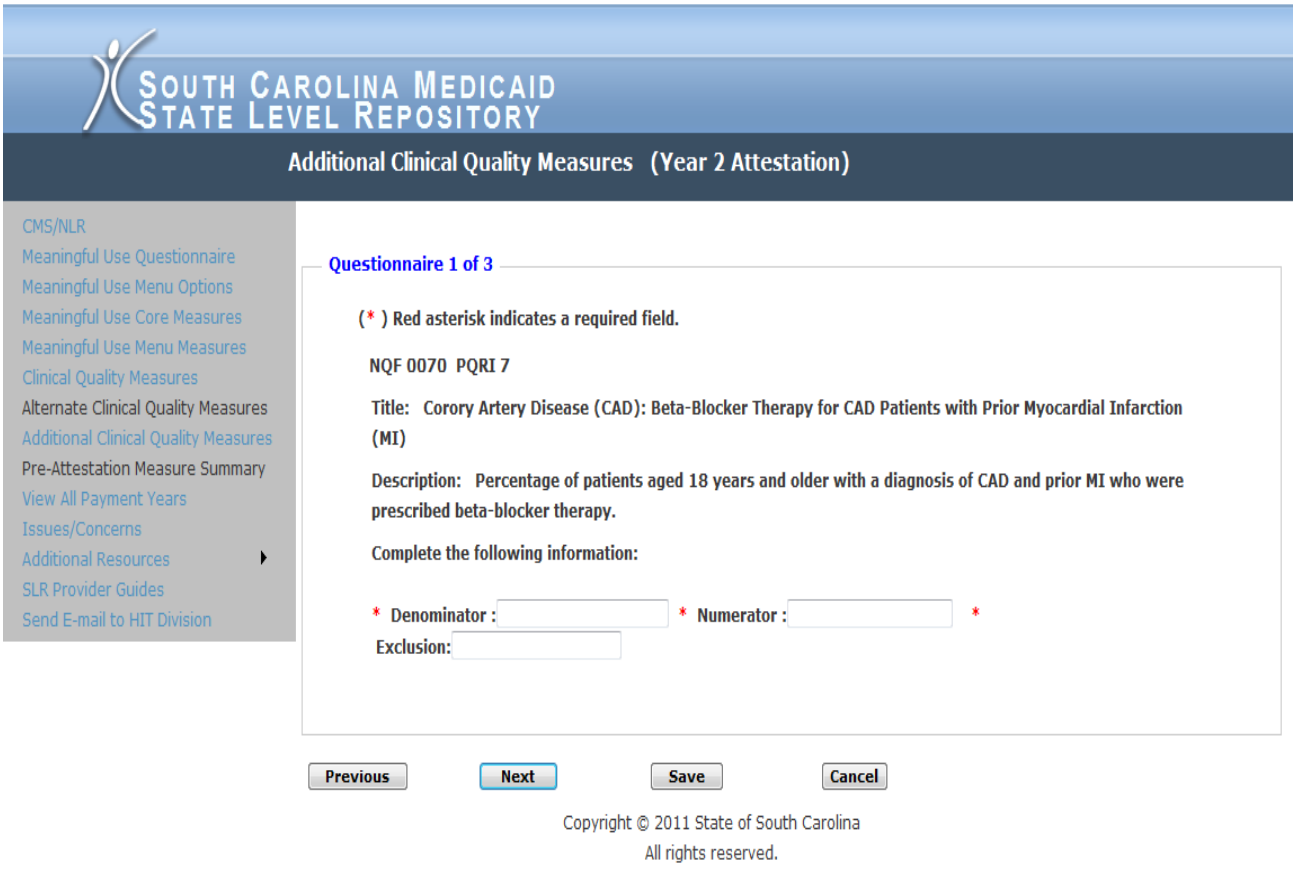
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 34 Screen: NQF 0070



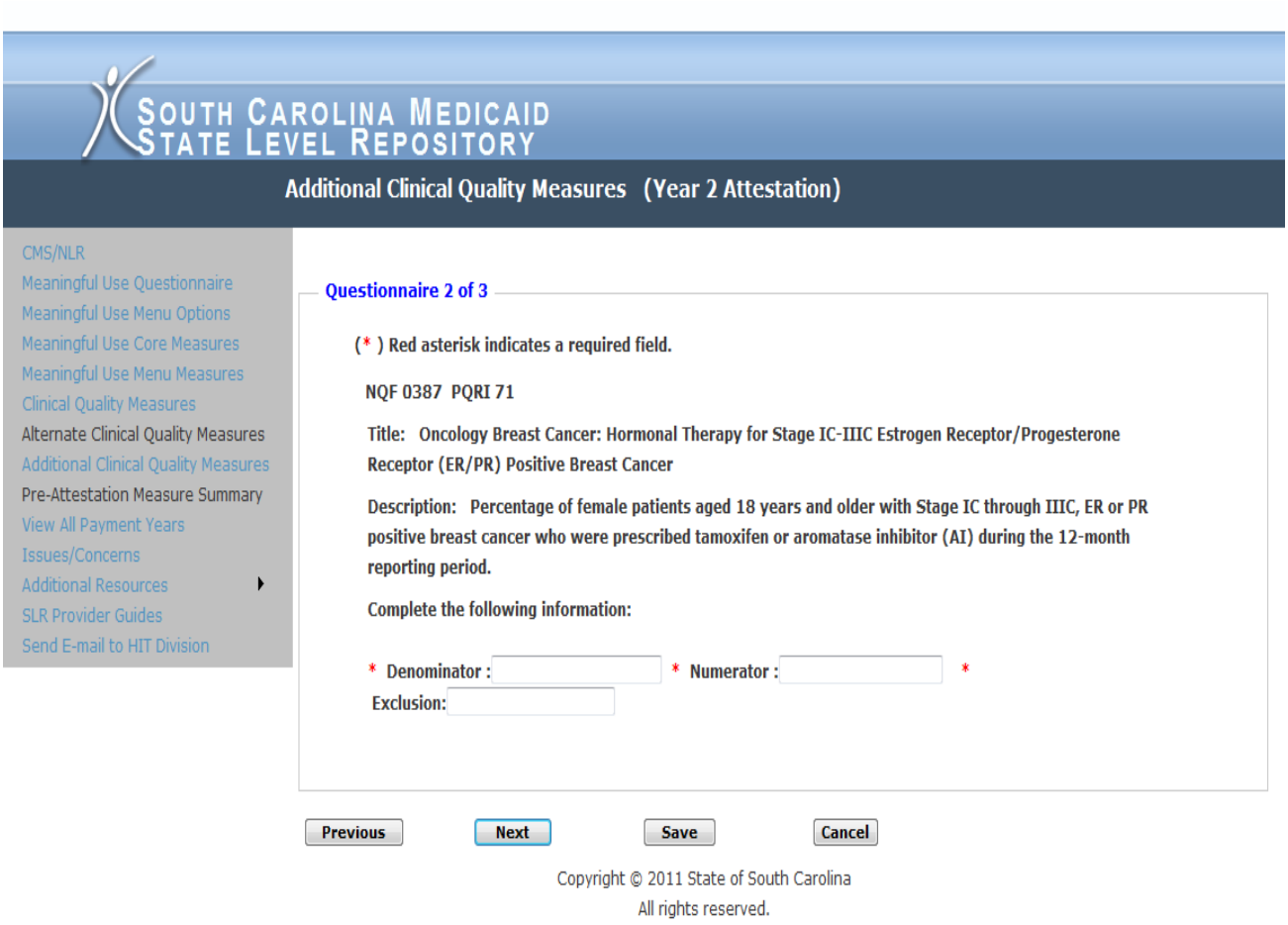
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. The Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 35 Screen: NQF 0387



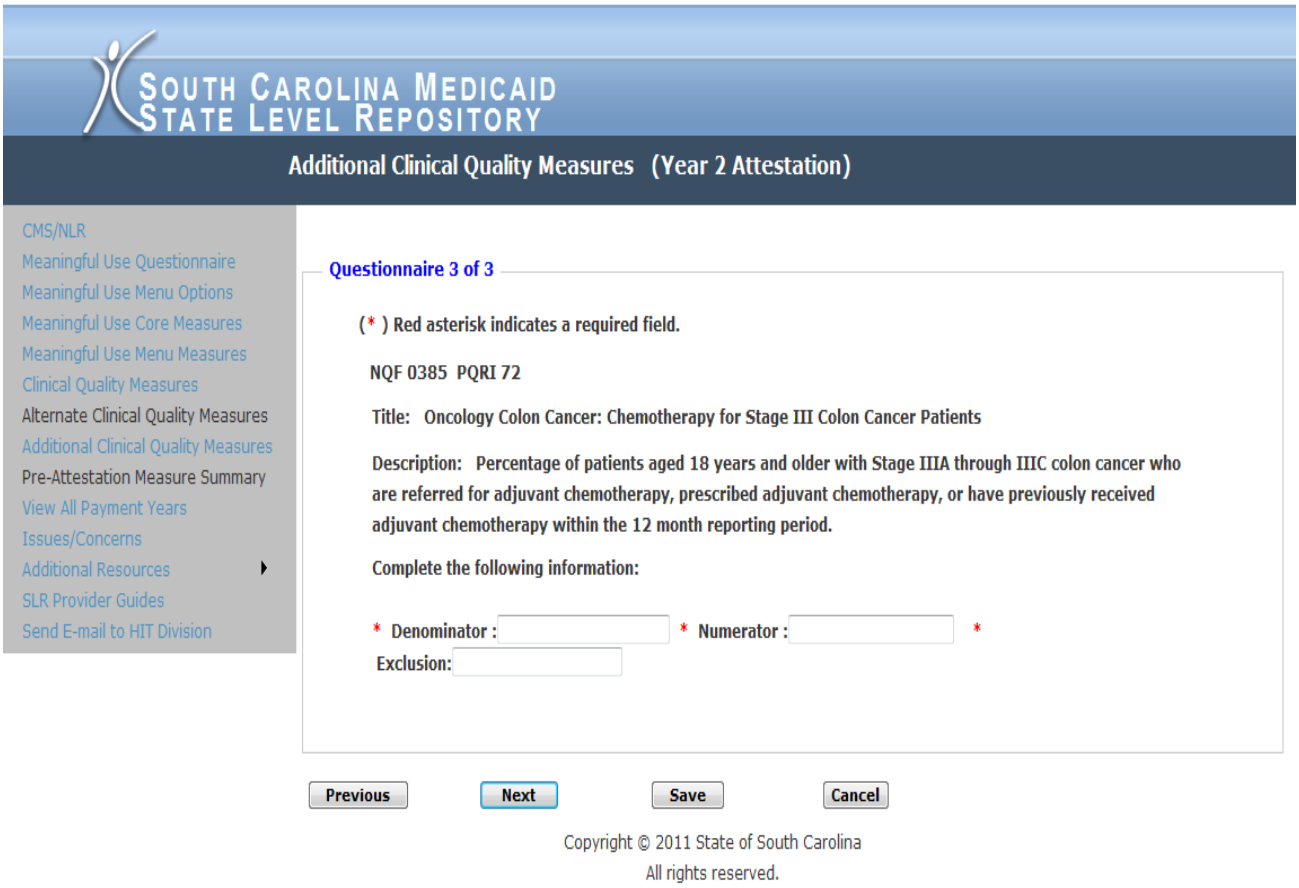
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 36 Screen: NQF 0385



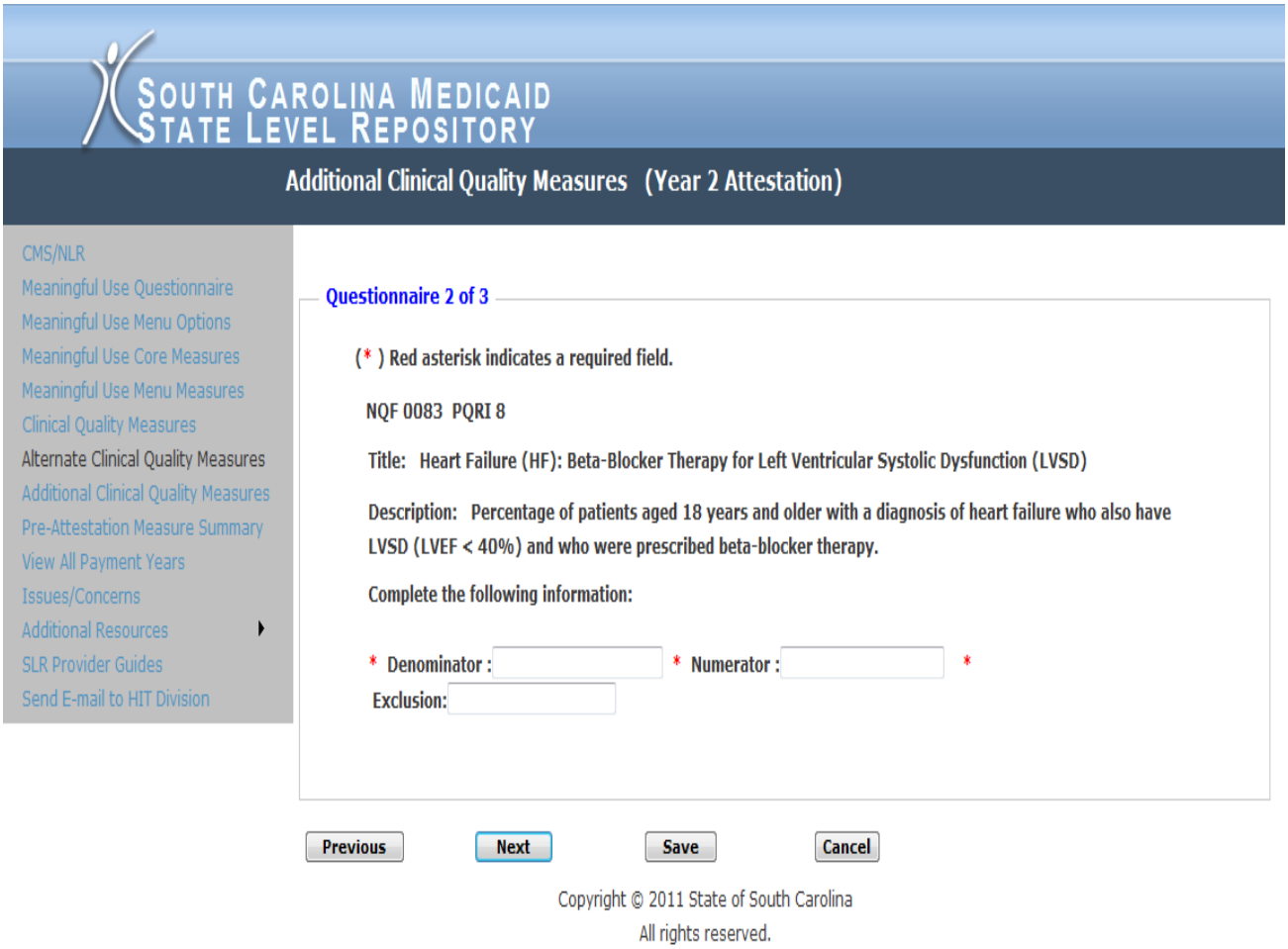
All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 37 Screen: NQF 0083



All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- Please provide a whole number less than 1,000,000 for the Exclusion.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Additional Clinical Quality Measure 38 Screen: NQF 0105

All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of this screen:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the Numerator.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Meaningful Use Summary of Measures Selection Screen

The Meaningful Use Summary of Measures Selection Screen allows the EP to return to the various MU attestation sections prior to submitting the final attestation. Please note that the EP may return to this screen from within the attestation by selecting the "Pre-Attestation Measure Summary" left navigation link located at the top left of the screen.

Select any summary link(s) to review the details of the attestation.

If no review is desired, select **Next** to proceed to the next screen.

Meaningful Use Core Measures Summary

ObjectiveText	Description	Data Entered	Selection
Use computerized provider order entry (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 all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Excluded	Edit
Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period.	Yes	Edit
Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator = 90 Denominator = 100	Edit
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.	Excluded	Edit
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.	Numerator = 90 Denominator = 100	Edit
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.	Numerator = 90 Denominator = 100	Edit
Record all of the following demographics: Preferred language Gender Race Ethnicity Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	Numerator = 90 Denominator = 100	Edit
Record and chart changes in vital signs: Height Weight Blood pressure Calculate and display body mass index (BMI) Plot and display growth charts for children 2-20 years, including BMI.	More than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structure data.	Excluded	Edit
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 recorded as structured data.	Excluded	Edit
Report ambulatory clinical quality measures to CMS or the Commonwealth of Kentucky.	Successfully report ambulatory clinical quality measures to CMS or the Commonwealth of Kentucky selected by CMS in the manner specified by the Commonwealth of Kentucky.	Yes	Edit
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	Yes	Edit
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 who request an electronic copy of their health information are provided it within 3 business days.	Excluded	Edit
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.	Excluded	Edit
Capability to exchange key clinical information (for example, problem list, medication list, 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.	Yes	Edit
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.	Yes	Edit

This screen lists the Objective, Measure, and data entered by the EP for each Core Meaningful Use Measure. The EP may click on **Edit** on a measure row to return to that Measure and update their entry.

Meaningful Use Menu Measures Summary

SOUTH CAROLINA MEDICAID
STATE LEVEL REPOSITORY

Summary of Meaningful Use Menu Measures (Year 2 Attestation)

Logout

CMS/NLR
Meaningful Use Questionnaire
Meaningful Use Menu Options
Meaningful Use Core Measures
Meaningful Use Menu Measures
Clinical Quality Measures
Alternate Clinical Quality Measures
Additional Clinical Quality Measures
Pre-Attestation Measure Summary
View All Payment Years
Issues/Concerns
Additional Resources
SLR Provider Guides
Send E-mail to HIT Division

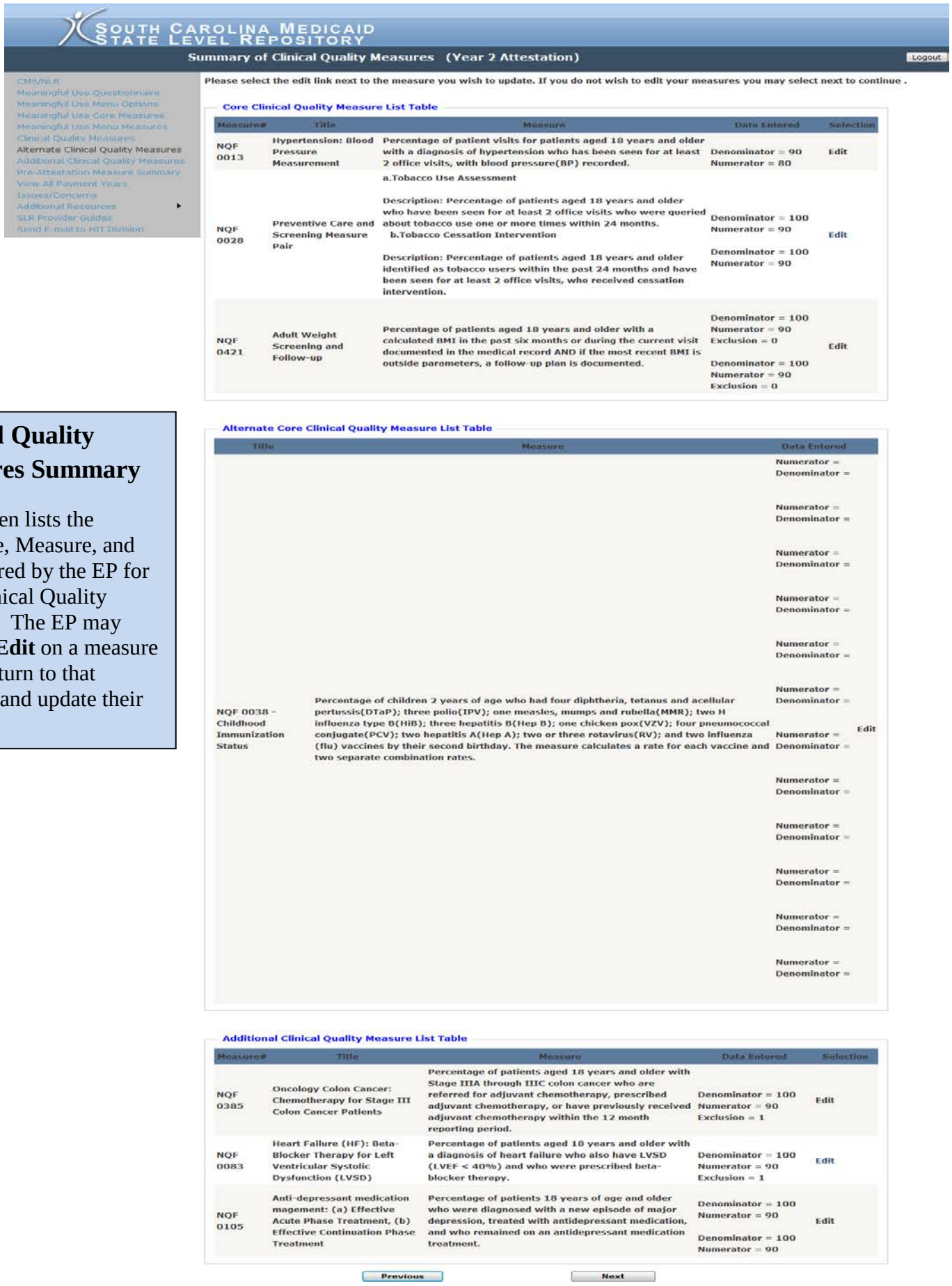
Meaningful Use Menu Measure List Table

Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

Object	Measure	Entered	Selection
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.	At least 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.	Excluded	Edit
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 during the EHR reporting period are provided patient-specific education resources.	Numerator = 90 Denominator = 100	Edit
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.	Excluded	Edit
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.	Excluded	Edit
Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission 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 submits such information have the capacity to receive the information electronically).	Yes	Edit

Previous Next

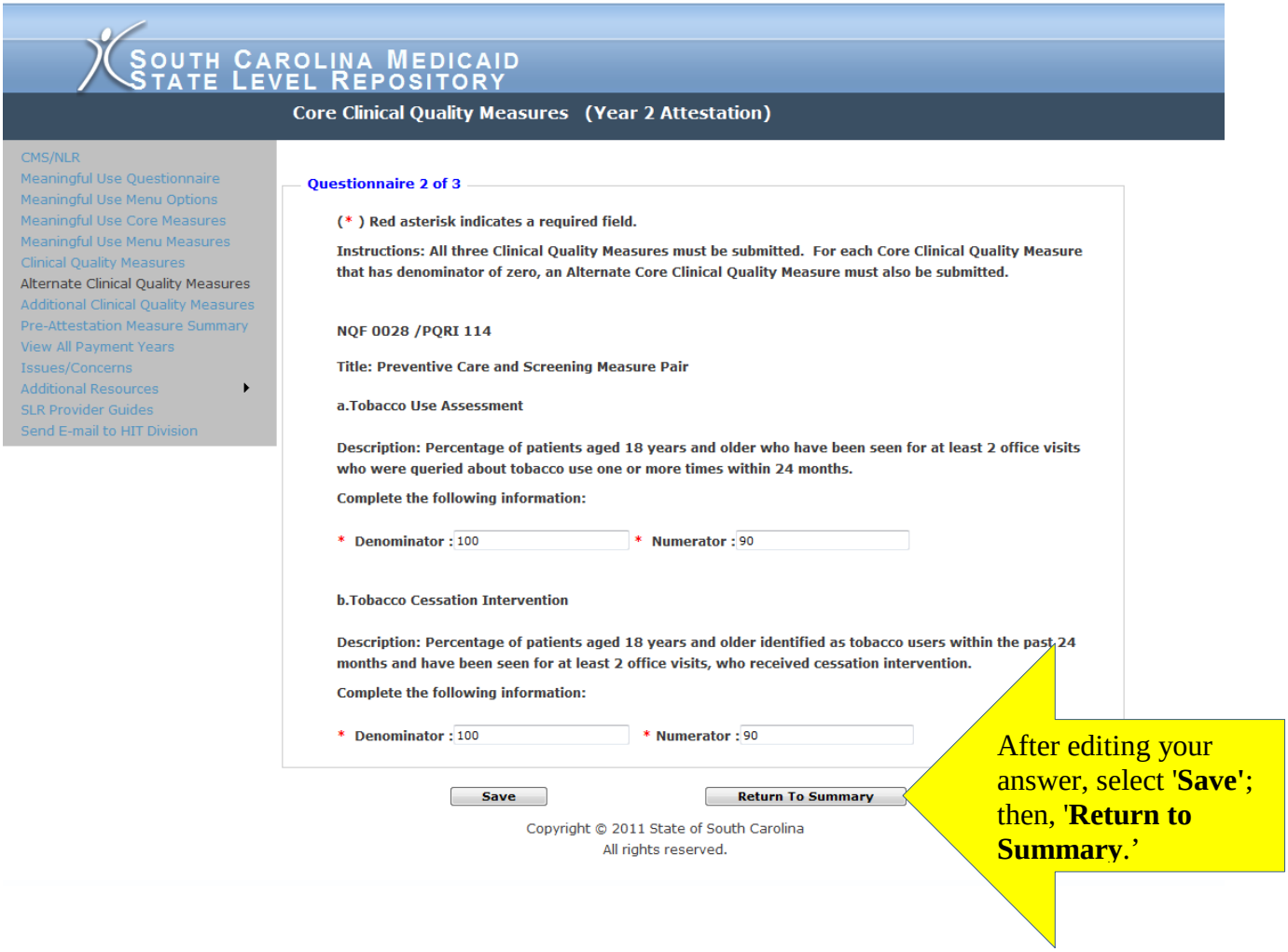
This screen lists the Objective, Measure, and data entered by the EP for each Menu Meaningful Use Measure. The EP may click on **Edit** on a measure row to return to that Measure and update their entry.



Clinical Quality Measures Summary

This screen lists the Objective, Measure, and data entered by the EP for each Clinical Quality Measure. The EP may click on **Edit** on a measure row to return to that Measure and update their entry.

The EP may update any field on the measure that they have previously entered. The field editing for the measure will still apply upon the EP clicking **Save.**



Navigation

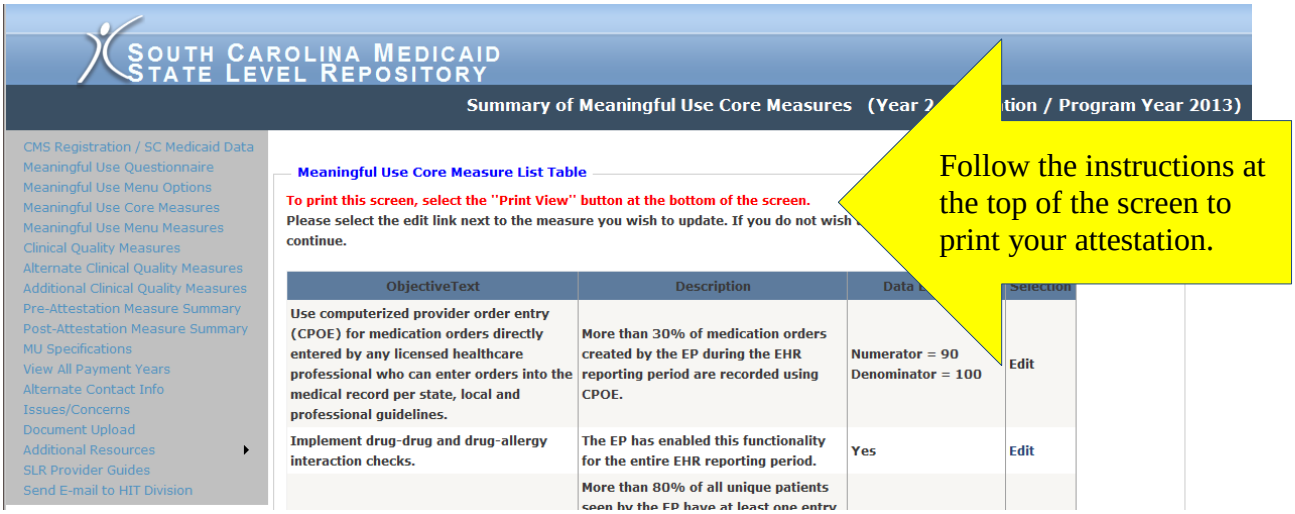
Title Bar – Updated depending on the Measure screen chosen to update
Logout Button – Returns the EP to the login page
Save Button – Saves the data once all applicable edits are resolved.
Return to Summary Button – Takes the EP back to the Measure Summary selection page.

After completing the meaningful use attestation screens, the next screens to display will be the Document Upload screen and the Attestation screen. (**Please select this link to be directed to the Document Upload and Attestation screens**).

After the EP has submitted the attestation for review, the EP may log back in to the attestation should he or she wish to review the attestation and the meaningful use data. Please note that the meaningful use left navigation links will not display until the EP proceeds past the Meaningful Use Questionnaire screen.

After attestation submission, there will be two meaningful use left navigation links enabled: Pre-Attestation Measure Summary, and Post-Attestation Measure Summary.

- The Pre-Attestation Measure Summary provides the data entered by the EP during attestation (numerators and denominators). There is also an option available from these screens for the EP to print their MU attestation data for the Core and Menu measures, and CQM.



- The Post-Attestation Measure Summary provides the percentages arrived at from the entry of the numerators and denominators.

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
12/19/2013	All	All	**Meaningful Use screens and explanations added as related to Stage 1 2013 Participation Year changes from the Stage 2 Final Rule**: 1) an optional alternate measure for the MU objective for CPOE; 2) an additional exclusion for the MU objective for electronic prescribing; 3) an optional measure for the MU objective for recording and charting changes in vital signs; 4) clarifying language to the public health objectives that providers perform at least one test of their certified EHR technology's capability to send data to public health agencies, except where prohibited (even if it is not required by law or practice). **Meaningful Use screens and explanations removed as related to Stage 1 2013 Participation Year changes from the Stage 2 Final Rule**: 1) the Core objective for Electronic Exchange of Key Clinical Information; 2) the Core objective for Clinical Quality Measures (though EP are still required to report on clinical quality measures). **Other screens and explanations added/revised as related to 2013 Participation Year changes from the Stage 2 Final Rule:** 1) text to reflect the change in definition of encounter for purposes of determining patient volume; 2) Provider Eligibility Details screen: Added additional option for the time period from which the 90-day patient volume period may be derived; removed CHIP county selection and functional offset to patient volume; revised Panel methodology description to reflect 24-months instead of previous 12-months; 3) added new Provider Locations screen to collect EP out-patient practice locations with details about CEHRT and patient volume; 4) revised MU Questionnaire screen to collect encounter information for EP attestation to meeting requirement that at least 50% of EP outpatient encounters occurred at location(s) equipped with CEHRT;

12/19/2013	All	All	5) revised Attestation Statement screen to include information about the process for determining "not hospital-based" for an EP who funds the acquisition, implementation, and maintenance of CEHRT without reimbursement from an EH or CAH, and uses such CEHRT at a hospital in lieu of using the EH's or CAH's CEHRT. **Addition of Change Control Record:** to facilitate EP awareness of future changes to the SLR Guide **Minor updates to SLR screen names and layout, SLR Guide text, and SLR Guide formatting.**
01/04/2014	CMS Registration/ SC Medicaid Data Screen	4	Further clarified information regarding EPs who decide to switch between states/programs