

Eligible Professional Menu Measure

Frequently Asked Questions

Drug Formulary Checks

1. If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.
2. How should EPs select menu objectives?

EPs are required to report on a total of 5 meaningful use objectives from the menu set. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set. We encourage EPs to select menu objectives that are relevant to their scope of practice, and 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. For example, we hope that EPs will report on 5 measures, if there are 5 measures that are relevant to their scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives. Please note that EPs must have complete certified EHR technology (or a complete set of certified EHR modules) capable of supporting all of the core and menu set objectives, including any objectives for which the EP can claim an exclusion and menu set objectives the EP does not select.

Clinical Lab Test Results

1. What lab tests should be included in the denominator of the measure for the "incorporate clinical lab-test results" objective?

For the "incorporate clinical lab-test results" objective, the denominator consists of the number of lab tests ordered during the EHR reporting period by the eligible professional (or authorized providers of the eligible hospital or critical access hospital (CAH) for patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 and 23)) whose results are expressed in a positive or negative affirmation or as a number. Providers may limit the denominator to only those lab tests that were ordered during the EHR reporting period and for which results were received during the same EHR reporting period.

2. One of the menu set meaningful use objectives requires EPs, eligible hospitals and CAHs to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test in order to count a structured lab result in the numerator for the measure of this objective? The only requirement to meet the measure of this objective is that more than 40 percent of all clinical lab tests results ordered during the EHR reporting are incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective in the Medicare and Medicaid EHR Incentive Programs.

3. What do the numerators and denominators mean in measures that are required to demonstrate meaningful use?

There are 15 measures for EPs and 14 measures for eligible hospitals that require the collection of data to calculate a percentage, which will be the basis for determining if the Meaningful Use objective was met according to a minimum threshold for that objective.

Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: one where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using certified EHR technology; and a second group where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using certified EHR technology. This grouping is designed to reduce the burden on providers. Table 3 in the Medicare and Medicaid EHR Incentive programs final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation. To view the final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

4. For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?
In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the clinic setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs.
5. Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology?
Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all Places of Service (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).

6. If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures?

Yes, an EP may include patients seen in locations without certified EHR technology in the numerators and denominators of meaningful use measures if the patients' information is entered into certified EHR technology at another practice location. However, EPs should be aware that it is unlikely that they will be able to include such patients in the numerator for the measure of the "use computerized provider order entry (CPOE)" objective or for the e-prescribing measure. As we explain in FAQ #10134, CPOE must be entered by someone who can exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Because information for patients seen in locations without certified EHR technology will be transcribed at a later date into the certified EHR system, it is unlikely that CPOE could occur before any action is taken on the order. For the e-prescribing measure, it is unlikely that EPs will be able to electronically transmit prescriptions for patients in locations without certified EHR technology.

Patient Electronic Access

1. For the Medicare and Medicaid EHR Incentive Programs, how does an eligible professional (EP) determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?

All cases where the EP and the patient have an actual physical encounter with the patient in which they render any service to the patient should be included in the denominator as seen by the EP. Also a patient seen through telemedicine would still count as a patient "seen by the EP." However, in cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures. For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all meaningful use measures that include patients "seen by the EP." EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies as least some of the services they render for patients as "seen by the EP" and this policy must be consistent for the entire EHR reporting period and across meaningful use measures that involve patients "seen by the EP" -- otherwise, these EPs would not be able to satisfy meaningful use, as they would have denominators of zero for some measures.

2. When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?

The EP can include or not include those patients in their denominator at their discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (NPs and certain physician assistants (PA)),

patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

Patient-specific Education Resources

1. To meet the meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?

In the patient-specific education resources objective, education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

Immunization Registries Data Submission

1. To meet the public health meaningful use objectives (submitting information to an immunization registry, reporting lab results to a public health agency, or reporting syndromic surveillance information), does a provider have to send information directly from their certified EHR technology to the appropriate receiving entity or can they use an intermediary such as an HIE or another third-party software vendor?

CMS recognizes that there are a variety of methods in which the exchange of public health information could take place. In order to promote the submission of public health information to appropriate entities, we do not seek to limit or define the receiving capacities of said entities. In order to satisfy the public health meaningful use objectives, a provider must conduct one test of information exchange according to the following criteria:

- The information required for the public health meaningful use objective must originate from the provider's certified EHR technology; and
- The information sent from the provider's certified EHR technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective. If an intermediary performs a capability specified in an adopted certification criterion and a provider intends to use the capability the intermediary provides to satisfy a correlated meaningful use requirement (submission to public health according to adopted standards), the capability provided by the intermediary would need to be certified as an EHR Module (see ONC FAQ 18 for more information).

2. If my certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs?

Submitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries."

3. If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion? If the immunization registry does not accept information in the standard to which your EHR technology has been certified-that is, if your EHR is certified to the HL7 2.3.1 standard and the immunization registry only accepts HL7 2.5.1, or vice versa-and if the immunization registry is the only immunization registry to which you can submit such information, then you can claim an exclusion to this Meaningful Use objective because the immunization registry does not have the capacity to receive the information electronically. The capacity of the immunization registry is determined by the ability of the immunization registry to test with an individual EP or eligible hospital. An immunization registry may have the capacity to accept immunization data from another EP or hospital, but if for any reason (e.g. waiting list, on-boarding process, other requirements, etc) the registry cannot test with a specific EP or hospital, that EP or hospital can exclude the objective. It is the responsibility of the EP or hospital to document the justification for their exclusion (including making clear that the immunization registry in question is the only one it can submit information to). If the immunization registry, due to State law or policy, would not accept immunization data from you (e.g., not a lifespan registry, etc), you can also claim the exclusion for this objective. Please note, this FAQ applies in principle to all of the Stage 1 public health meaningful use measures (syndromic surveillance and reportable lab conditions).
4. Under the Medicaid EHR Incentive Program, will the requirement that eligible professionals and eligible hospitals choose at least one public health objective among the meaningful use measures still apply to those States that ask CMS for approval to change the definition of meaningful use? That is, if a State wants to require Immunization reporting, is the provider still required to choose another public health objective or does the new meaningful use definition in that State supersede the general definition? If the State required any of the public health measures as core measures for the Medicaid EHR Incentive Program, then that would fulfill the eligible professional's (EP) requirement to select at least one public health measure. If the EP meets the exclusion criteria for any of the public health measures that a State has moved to the core set, with CMS approval, they would still have to select at least one public health measure from the menu set.