



# Medicaid EHR Incentive Program Provider User Manual

February 2014

Version 3.1



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## Introduction

The Utah Medicaid EHR Incentive Program will provide incentive payments to eligible providers, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Background information and registration procedures follow, but **if you are ready to start your EHR registration, please see “Registration for Eligible Providers” or “Registration for Eligible Hospitals.”**

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

Utah State Medicaid HIT Plan (SMHP) Version 1.0 located at [http://health.utah.gov/medicaid/pdfs/hit\\_SMHP3.pdf](http://health.utah.gov/medicaid/pdfs/hit_SMHP3.pdf)

Utah Medicaid EHR Application Portal located at <https://mmcs.health.utah.gov/registration/hit.html>

Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>

Office of the National Coordinator for Health Information Technology located at [http://healthit.hhs.gov/portal/server.pt/community/healthit\\_hhs\\_gov\\_\\_home/1204](http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204)

HealthInsight’s Regional Extension Center (REC) has been designated to provide technical assistance to Utah EPs. The REC can provide a full range of assistance related to EHR selection and training and is listed below:

- HealthInsight
- Website: <http://www.healthinsight.org>
- Phone: 800-483-0932
- Email: [rec@healthinsight.org](mailto:rec@healthinsight.org)

## Revisions

- Original March 23, 2011
- Version 1.1 Revised September 1, 2011
- Version 2.1 Revised December, 2012
- Version 2.2 Revised June 2013
- Version 3.1 Revised February 2014

## Background

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 providers (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner. The following definitions are provided with regards to this goal: “adopt” signifies acquiring and installing a certified system, “implement” indicates that a provider has commenced utilization of the certified system, and “upgrade” indicates that a provider has expanded their previous system by upgrading to a certified system or by adding new functionality to meet the definition of certified EHR technology.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems 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 improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Utah Department Health Medicaid & Health Financing Division (DMHF) will work closely with federal and state partners to ensure the Utah Medicaid EHR Incentive Program fits into the overall strategic plan for the Utah Health Information Technology Consortium, thereby advancing national and Utah goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system. CMS’ official website 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.

## Eligibility

While EPs can begin the program in Calendar Year (CY) 2011, they must begin the program no later than CY 2016 and EHs must begin by Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Utah Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the Utah Medicaid Management Information System (MMIS) provider data store does not correspond to the provider types and specialties approved for participation in the Utah Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, Utah Medicaid has determined that the following providers and hospitals are potentially eligible to enroll in the Utah Medicaid EHR Incentive Program:

- Physicians = Any provider who has a Provider Type 20 and/or 24 and Specialty other than 45 (Pediatrics)
- Physician Assistant [Provider Type 201] practicing in a FQHC [Provider Type 52] or RHC [Provider Type 57] led by a Physician Assistant. An FQHC or RHC is considered to be PA led in the following instances:
  - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
  - The PA is the clinical or medical director at a clinical site of the practice
  - The PA is the owner of the RHC
- Pediatrician = Any provider with a Provider Type 20 and/or 24 and Specialty 45
- Nurse Practitioner = Any provider with a Provider Type 47 and not Provider Type 37 Certified
- Certified Nurse Midwife = Any provider with a Provider Type 37
- Nurse Midwife (CNM) or Nurse Practitioner Group
- Dentist = Any provider with a Provider Type 40
- Acute Care Hospital = Any provider with a Provider Type 01
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 45
- Critical Access Hospital (CAH) = Any provider with a Provider Type 01
- Cancer Hospital = Any provider with a Provider Type 03

## Additional Requirements for the Eligible Provider

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based and must:

- Meet one of the following patient volume criteria:
  - Have a minimum of 30 percent patient volume attributable to individuals receiving TXIX Medicaid-funded services; or
  - Have a minimum of 20 percent patient volume attributable to individuals receiving TXIX Medicaid-funded services, **and** be a pediatrician; or
  - Practice predominantly in a FQHC or RHC and have a minimum of 30 percent patient volume attributable to needy individuals.
- Have no sanctions and/or exclusions.

An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National Level Registry (NLR) and must match a TIN linked to the individual provider in DMHF's system.

Hospital-based providers are eligible for the EHR incentive program ONLY if they can demonstrate that they funded the acquisition, implementation and maintenance of a certified EHR system including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital, and uses such certified EHR technology in the inpatient or emergency department of a hospital (instead of the hospital's certified EHR technology).

- Note also that some provider types eligible for the Medicare program, such as podiatrists, chiropractors and optometrists, are not currently eligible for the Utah Medicaid EHR Incentive Program.

### Additional Requirements for the Eligible Hospital

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

- An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment or
- A children's or cancer hospital (exempt from meeting a patient volume threshold).

### Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC -30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute Care Hospital	10%	
Children's Hospital	Exception	
Cancer Hospital	Exception	

## Out-of-State Providers

The Utah Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this program as long as they have at least one physical location in Utah. Utah must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Utah Medicaid program or CMS. Records must be maintained as specified by law in the state of practice or Utah, whichever is deemed longer.

## Establishing Patient Volume

A Medicaid provider must annually meet patient volume requirements of Utah's Medicaid EHR Incentive Program as established through the state's CMS-approved State Medicaid Health IT Plan (SMHP). Providers must demonstrate 30% Medicaid patient volume for a 90-day period. Pediatricians who do not reach the 30% threshold can qualify for a reduced payment by reaching 20-30% Medicaid patient volume. Providers may choose:

- Any consecutive 90-day period in the previous calendar year, OR
- Any consecutive 90-day period in the 12 months preceding the date of the provider's attestation.

Out of state Medicaid encounters may be included towards meeting the threshold; please calculate these separately.

The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) - CHIP. All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on TXIX Medicaid and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in an FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

## Eligible Providers

- EPs (except those practicing predominantly in an FQHC/RHC) – to calculate TXIX Medicaid patient volume, an EP must divide:
  - The total Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
  - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in an FQHC/RHC - to calculate needy individual patient volume, an EP must divide:
  - The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
  - The total patient encounters in the same 90-day period.

## Definition of an Eligible Provider Utah Medicaid Encounter

A Medicaid encounter is defined as service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes:

- Paid claims: Encounters where Utah Medicaid or another State’s Medicaid paid for part or all of the service; or part or all of their premiums, co-payments, and/or cost-sharing, (excluding Utah Premium Partnership (UPP) premium payments as the incentive program does not have a way of tracking patient utilization with this program)
- Claims denied due to service limitation audits
- Claims denied due to non-covered service
- Claims denied due to timely failing
- Services rendered on Medicaid members that were not billed due to the provider’s understanding of Medicaid billing rules (medical services that are not covered under the state’s Medicaid program.)
  - A patient list of non-billed encounters must be provided to verify patients' Medicaid eligibility.

### Definition of a Needy Individual Encounter

In addition to calculating the Medicaid encounters, an EP practicing predominantly in an FQHC/RHC can include encounters for medically needy individuals. A needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Paid for by TXIX Medicaid or TXXI Children’s Health Insurance Program funding including DMHF, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.

### Group Practices

In specific circumstances, eligible providers in a group or clinic can leverage the entire clinic’s volume to meet the Medicaid patient volume threshold. The group may receive one combined check for all providers deemed eligible. The following conditions apply:

- The clinic or organization must use the entire clinic’s or organization’s patient encounters and cannot limit it in any way. The patient volume calculation must include the encounters of ALL practitioners, both **eligible** and non-eligible. (Non-eligible practitioners may include physical therapists, social workers, etc.)
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP’s outside encounters.
- Each eligible professional using the group proxy calculation must have an active Medicaid contract and see Medicaid patients in order for the group patient volume to be an appropriate proxy.
- All eligible professionals in the group practice or clinic must use the same methodology for the payment year.
- If the proxy is completed at the organizational level, only in-state clinics may be included.

## Calculating Medicaid Patient Volume for a Group:

- **Dates for 90-Day Period:** Determine the start date and end date of the 90 calendar days used for patient volumes. Effective 10/1/12 for EHs, 1/1/13 for EPs, the consecutive 90-day period may cross over a calendar or federal year.
- **Number of Medicaid Encounters (Numerator):** Determine the Medicaid patient volume for ALL practitioners in your organization or clinic for the 90 calendar days identified above.
- **Number of Total Encounters (Denominator):** Determine the total number of patient encounters for ALL practitioners in your organization or clinic for the 90 calendar days identified; including Medicaid, CHIP, and non-Medicaid.
- **Calculated Medicaid Percentage:** When the numerator and denominator are entered into the EHR Attestation system, the percentage will auto calculate.

*Note: the calculated percentage must be greater than or equal to 30% (or greater than 20% for pediatricians).*

## Eligible Hospitals

To calculate Medicaid patient volume, an EH must divide:

The total TXIX DMHF and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year by:

The total encounters in the same 90-day period.

Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period.

An emergency department must be part of the hospital.

## Eligible Hospital DMHF Encounter

For purposes of calculating eligible hospital patient volume, a DMHF encounter is defined as services rendered to a Medicaid-enrolled individual, regardless of payment liability, 1) per inpatient discharge, or 2) on any one day in the emergency room. This includes zero-pay claims.

Exception - a cancer and/or children's hospital is not required to meet Medicaid patient volume requirements.

## Payment Methodology for Eligible Providers

The maximum incentive payment an EP could receive from Utah Medicaid equals \$63,750, over a period of six years, or \$42,500 for pediatricians with a 20-29 percent DMHF patient volume as shown below.

<b>Provider</b>	<b>EP</b>	<b>EP-Pediatrician</b>
<b>Patient Volume</b>	<b>30 Percent</b>	<b>20-29 Percent</b>
<b>Year 1</b>	\$ 21,250.00	\$ 14,167.00
<b>Year 2</b>	\$ 8,500.00	\$ 5,667.00
<b>Year 3</b>	\$ 8,500.00	\$ 5,667.00
<b>Year 4</b>	\$ 8,500.00	\$ 5,667.00
<b>Year 5</b>	\$ 8,500.00	\$ 5,667.00
<b>Year 6</b>	\$ 8,500.00	\$ 5,667.00
<b>Total Incentive Payment</b>	\$ 63,750.00	\$ 42,500.00

Since pediatricians are qualified to participate in the Utah Medicaid EHR incentive program as physicians, and are therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

### Payments for Eligible Providers

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated in the Utah MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to themselves (and not a group or clinic) will be required to provide DMHF with updated information. Each EP must have a current DMHF contract and be contracted for at least 90 days.

The Utah Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully use certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

Currently, all providers are required to submit a valid NPI as a condition of DMHF provider enrollment. Each EP or EH will be enrolled as a DMHF provider and will therefore, without any change in process or system modification, meet the requirement to receive an NPI. DMHF performs a manual NPPES search to validate NPIs during the enrollment process.

In the event DMHF determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

[Click here](#) for the Medicaid EHR payment schedule for eligible professionals.

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

## Payment Methodology for Eligible Hospitals

Statutory parameters placed on Utah Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children’s hospitals, cancer hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Utah is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Utah Medicaid incentive payments to those providers. Auditable data sources include:

- Providers’ Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Utah MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Utah Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

EH Payment = Overall EHR Amount X Medicaid Share

Where:

**Overall EHR Amount** = {Sum over 4 years of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

**Medicaid Share** = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

The overall hospital incentive payment amount is the sum over 4 years of (a) the base amount of \$2,000,000 plus (b) the discharge related amount defined as \$200 for the 1,150 through 23,000 discharge for the first payment year, then a prorated amount of 75% in year 2, 50% in year 3, and 24% in year 4. Hospitals will be informed that they must limit their discharges to those that stem from the acute care portion of the hospital (i.e. cannot use nursery bed days/discharges.) The web-based Oracle Solution that Utah has developed will allow eligible hospitals to do the following:

- Step 1) Compute their average growth rate over the previous 3 years
- Step 2) Compute their total discharge related amount
- Step 3) Compute their initial amount for 4 years
- Step 4) Apply the transition factor to the 4 years
- Step 5) Compute their overall EHR amount for 4 years which will equal the sum of the 4 year transition factor
- Step 6) Compute their Medicaid Share from the Medicare Cost report
- Step 7) Compute their Medicaid aggregate EHR incentive amount
- Step 8) Calculate their annual incentive payment amount

Utah intends to pay the aggregate hospital incentive payment amount over a period of four annual payments, contingent on the hospital's annual attestations and registrations for the annual Utah Medicaid payments.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 5 percent of the aggregate amount will be paid to the EH. In the fourth year, if all conditions for payment are met, the remaining 5 percent of the aggregate amount will be paid to the EH. The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

## Provider Registration

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system. CMS' official website for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>.

Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong.

EPs must select between Medicare and Medicaid's incentive program (a provider may switch from one to the other once during the incentive program prior to 2015.) If Medicaid is selected, the provider must choose only one state (EPs may switch states annually.) Providers must revisit the CMS Registration and Attestation site to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the CMS Registration site before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the site annually to attest to meaningful use before returning to the Utah Medicaid State Level Repository (SLR) system to attest for Utah's Medicaid EHR Incentive Program. DMHF will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The CMS Registration and Attestation site will assign the provider a CMS Registration Number and electronically notify DMHF of a provider's choice to access Utah's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the Utah Medicaid SLR system.

On receipt of CMS Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a contracted provider with the Utah Medicaid. If either of these conditions is not met, a message will be automatically sent back to the CMS registration site indicating the provider is not eligible. Providers may check back at the CMS level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, the CMS Registration site will be notified by DMHF that a payment has been made.

## Provider Attestation Process and Validation

DMHF will utilize the secure SLR system to house the attestation system. The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category. If an eligible provider registers at the CMS registration site and does not receive the link to the attestation system within two business days, assistance will be available by contacting the DMHF Healthcare Program Specialist at 801-538-6929.

Following is a description by eligible provider type of the information that a provider will have to report or attest to during the process.

## Eligible Provider

After registering for the incentive program with the CMS EHR Registration and Attestation (at <http://www.cms.gov/EHRIncentivePrograms/>), the EP will be asked to provide their NPI and CMS-assigned Registration Identifier.

The EP will then be asked to view the information that will be displayed with the pre-populated data received from the CMS registration site (if the provider entry does not match, an error message with instructions will be returned).

EPs will then enter two categories of data to complete the Eligibility Provider Details screen including 1) patient volume characteristics and 2) EHR details.

The EP will be asked to attest to:

- Assigning the incentive payment to a specific TIN (only asked if applicable); provider and TIN to which the payment was assigned at the CMS site will be displayed;
- Not working as a hospital based provider (this will be verified by DMHF through claims analysis);
- Not applying for an incentive payment from another state or Medicare;
- Not applying for an incentive payment under another DMHF ID; and
- Adoption, implementation or upgrade of certified EHR technology.
- The EP will be asked to electronically sign the amendment.
- The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify).
- The person filling out the form should enter his or her name.

*Note: For providers that are ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact. In subsequent years, DMHF will work with Utah Health Information Network (UHIN) Clinical Health Information Exchange (cHIE) to provide a mechanism for providers to submit Meaningful Use data to DMHF.*

## Eligible Hospital

After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>,

1. The EH will be asked to provide:
  - Completed patient volume information on the Utah SLR Web site;
  - Completed Hospital EHR Incentive Payment Worksheet;
  - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules); and
2. The EH will be asked to attest to:
  - Adoption, implementation or upgrade of certified EHR technology or meaningful use;

- Not receiving a Medicaid incentive payment from another state; and
3. The EH will be asked to electronically sign the amendment:
- The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
  - The person filling out the form should enter his or her name.

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMHF will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program, EPs will only be able to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EPs or EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at [www.healthit.hhs.gov](http://www.healthit.hhs.gov)). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

## Incentive Payments

DMHF plans to use the Supplemental Special Payments functionality in the Utah MMIS to set up financial transactions for incentive payments. To accomplish this, the Expenditure Panels will need be modified, and DMHF will ensure this functionality is added. This will enable staff to query payments by originator. Specific accounting codes will also be required for the transactions to enable DMHF to report the funds in the CMS-64 report. Different codes will be needed for each payment year.

Utah will ensure all reporting requirements and modifications to the MMIS are made to correctly report expenditures, attestation information, and approval information. This will include the creation of a new Management and Administrative Reporting (MAR) category of service for state and federal reporting. DMHF will also make the necessary changes to the CMS-64 reporting process to add the additional line item payment and administrative information, and, if required by CMS, the Medicaid Statistical Information System (MSIS) file will be modified to accommodate the incentive payment program.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of requested documentation and validation by DMHF, an incentive payment can be approved.

## **Program Integrity**

DMHF will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers and hospitals should keep all pertinent documentation

## **Administrative Appeals**

You may appeal the determination made by Utah Medicaid regarding your incentive payment application. Please send a Request for Hearing to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Utah Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Request for Hearing and mailed to the

Director's Office  
Formal Hearings Division of Medicaid & Health Financing  
PO Box 143105  
Salt Lake City, UT 84114-3105

See [Appealing an Incentive Program Decision](#) for additional instruction.

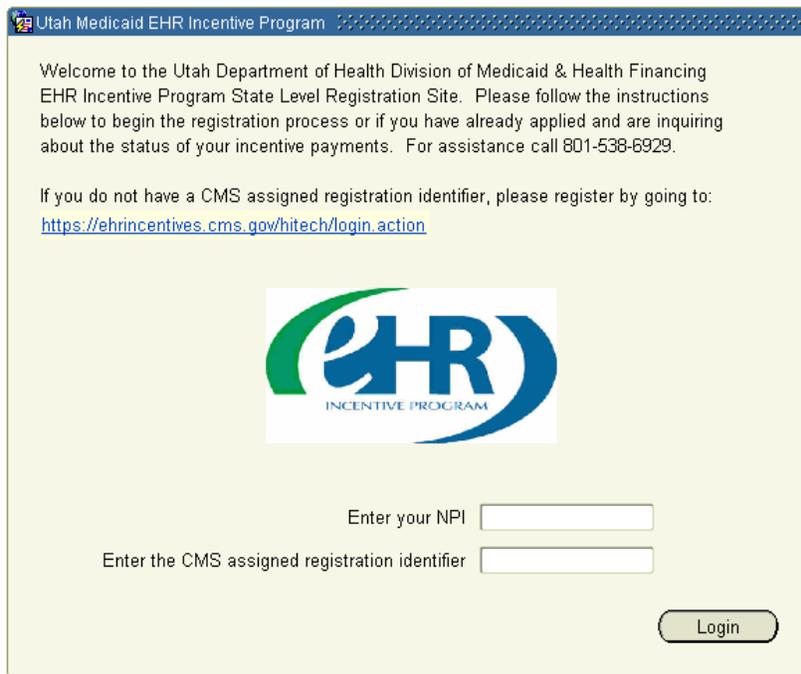
## Registration Process for Eligible Providers

Eligible providers will be required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation (more details follow in this manual.)

Step one is registering with the CMS Registration and Attestation System at <http://www.cms.gov/EHRIncentivePrograms/>. Please allow 24 hours for the data to flood through to Utah's system.

The provider then begins the Utah Medicaid EHR Incentive Program registration process by accessing the Utah SLR system at <https://mmcs.health.utah.gov/registration/hit.html> (sign-in screen shown below).

### Eligible Provider Sign-in Screen



The screenshot shows a web browser window titled "Utah Medicaid EHR Incentive Program". The page content includes a welcome message from the Utah Department of Health Division of Medicaid & Health Financing, instructions to follow the registration process, and a link to register if the user does not have a CMS assigned registration identifier. Below the text is the EHR Incentive Program logo, which features a stylized "EHR" in blue and green with the words "INCENTIVE PROGRAM" underneath. At the bottom of the page, there are two input fields: "Enter your NPI" and "Enter the CMS assigned registration identifier", followed by a "Login" button.

The provider will enter the NPI registered on the CMS Registration site and the CMS-assigned Registration Identifier. If the data submitted by the provider matches the data received from the CMS Registration and Attestation site, the CMS/NLR Provider Demographics Screen will display with the pre-populated data received from the CMS site. If the provider entry does not match, an error message with instructions will be returned. An example of the CMS/NLR Provider Demographics screen is illustrated in the screen below.

## Eligible Provider CMS NLR Demographics Screen

CMS NLR Registration Information

**REGISTER NOW TO GET YOUR  
MAXIMUM PAYMENT**



Demographic    Specialty    State Rejection Reason

The information presented here has been received from the CMS EHR Incentive Program Registration Site. The information we have received indicates you and/or your organization has been excluded from the program. If you have questions about this information please call the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program at 801-538-6929 or you may file an appeal regarding this decision by pressing the "Submit an Appeal" button below and completing a hearing request form.

Applicant NPI	<input type="text" value="222222222"/>	Name	<input type="text" value="Test Provider2"/>
Applicant TIN	<input type="text" value="678696778"/>	Address 1	<input type="text" value="800 W 200 S"/>
Payee NPI	<input type="text"/>	Address 2	<input type="text"/>
Payee TIN/CCN	<input type="text"/>	City	<input type="text" value="SLC"/>
Program Option	<input type="text" value="MEDICAID"/>	State	<input type="text" value="UT"/>
Medicaid State	<input type="text" value="UT"/>	Zip Code	<input type="text" value="87656"/> - <input type="text" value="6755"/>
Provider Type	<input type="text" value="Physician"/>	Phone Number	<input type="text" value="801-555-8888"/> Ext <input type="text" value="2"/>
Payment Year	<input type="text" value="1"/>	Email	<input type="text" value="cfrailmc@utah.gov"/>

## Provider Eligibility Detail Screens

EPs must enter two categories of data to complete the Eligibility Provider Details screen including patient volume characteristics and EHR details. Providers will see the following data on the screen:

### Patient Volume

- Please indicate if your patient volume was calculated at a clinic or practice level for all eligible providers
- If yes, please enter the group name
- Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage (select from calendar)
- Medicaid patient encounters during this period
- Total patient encounters during this period
- Total number of Medicaid patients on your roster/panel with whom you did not have an encounter in this 90-day period, but you did have an encounter in the last 12 months
- Medicaid patient volume percentage (calculated).

EHR Incentive Provider Eligibility Details

Under the rules of the program, groups and clinics may use group volumes to determine eligibility for all providers associated with the group/clinic. In order to use the group volumes, all practitioners within the group must agree to use the group volumes to determine Medicaid patient volumes and eligibility to participate in the program. If one provider in the group/clinic chooses to use individual patient volumes rather than the group volumes, all other providers in the group must also use individual patient volumes. By registering as a group, your incentive payment will also be paid to the group designated below.

Indicate if you wish to register as a group

Group to whom payment will be issued to

Enter the EHR system details:

CMS EHR certification id

Name of your EHR software

Status of your EHR software

For assistance call 801-538-6929

## EHR Details

- Enter the CMS EHR Certification ID of your EHR
- Indicate the Status of your EHR – Choices: A/I/U/Meaningful User

EHR Incentive Provider Eligibility Details

Under the rules of the program, groups and clinics may use group volumes to determine eligibility for all providers associated with the group/clinic. In order to use the group volumes, all practitioners within the group must agree to use the group volumes to determine Medicaid patient volumes and eligibility to participate in the program. If one provider in the group/clinic chooses to use individual patient volumes rather than the group volumes, all other providers in the group must also use individual patient volumes. By registering as a group, your incentive payment will also be paid to the group designated below.

Do you wish to register as a group

Group to whom payment will be issued to

Enter the EHR system details.

Enter the CMS EHR certification id

Indicate the status of your EHR

For assistance call 801-538-6929

Save Previous Next

Upon entering the data for the Eligibility Provider Details screen, navigation will take EPs to a screen to enter data regarding their practice location details.

EHR Incentive Provider Eligibility Details

Enter the specified information regarding your practice below.

Utah Medicaid payment contract id

State in which your license was issued

Are you working with a Regional Extension Center

Are you working with the cHIE

Office manager name

Office manager phone  (000-000-0000)

Office manager email

Save Previous Next

EHR Incentive Provider Eligibility Details

You have indicated you are registering individually and must demonstrate 30% Medicaid patient volumes for a representative 90-day period in the previous calendar year. Please enter your FQHC or RHC patient volumes below.

Starting date of the 90-day calculation period

Utah CHIP patients during this period

Utah patients furnished services on a sliding scale during this period

Utah patients furnished uncompensated care during this period

Additional states CHIP patients during this period

Additional states patients furnished services on a sliding scale during this period

Additional states patients furnished uncompensated care during this period

Total medically needy patients during this period

Medicaid patient volume percentage

For information on how to determine the Medicaid Patient Volume, please refer to [Establishing Patient Volume](#).

## EHR Incentive Document Upload Screen

EHR Incentive Document Upload

This screen will allow you to upload requested documentation. Uploading documents is not required unless a program representative has requested you to do so. If you do not have documents to upload at this time, please click Next.

Upload files by selecting the type of document being uploaded, then press the upload button. A second screen outside of this program will appear which will allow you to browse to the documents you wish to upload. Uploaded files must be in a doc, docx, rtf, tif, pdf, jpeg or gif file format.

In order to View uploaded documents, be sure to click on the Upload Date field and then View.

Document Type	Upload Date	Upload	View
<input type="text"/>	<input type="text"/>	<input type="button" value="Upload"/>	<input type="button" value="View"/>
<input type="text"/>	<input type="text"/>	<input type="button" value="Upload"/>	<input type="button" value="View"/>
<input type="text"/>	<input type="text"/>	<input type="button" value="Upload"/>	<input type="button" value="View"/>
<input type="text"/>	<input type="text"/>	<input type="button" value="Upload"/>	<input type="button" value="View"/>
<input type="text"/>	<input type="text"/>	<input type="button" value="Upload"/>	<input type="button" value="View"/>

For assistance call 801-538-6929

## Provider Attestation Screen

EHR Incentive Attestation

CMS NLR Demographic Information | CMS NLR Specialty Information | Group Designation and EHR Details | Practice Information | Patient Volume | FQHC or RHC Patient Volume | Uploaded Documents

Please review the summary of the information you provided to apply for Utah Medicaid HIT/EHR Incentive Program. If this information is accurate please read and sign the attestation below. If not, please go back and correct your information and then sign the attestation below.

Applicant NPI	1669472643	Name	Test Provider
Applicant TIN	679767	Address 1	566 W 765 S
Payee NPI	1669444303	Address 2	
Payee TIN/CCN	697867896	City	SLC
Program Option	MEDICAID	State	UT
Medicaid State	UT	Zip Code	65444 - 6543
Provider Type	Physician	Phone Number	801-333-3332 Ext 4
Payment Year	1	Email	cfrailmc@utah.gov

Important Notice: No payment may be made unless this attestation form is completed and accepted as required by existing law and regulations (42 CFR 495.10). Anyone who misrepresents or falsifies essential information to receive a Utah Medicaid EHR Incentive Program payment requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

I certify that the foregoing information is true, accurate and complete. I understand that the Utah Medicaid EHR Incentive Program payment I have requested will be paid from Federal funds, that by completing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements or documents, or the concealment of a material fact used to obtain a Utah Medicaid EHR Incentive Program payment, maybe prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I hereby agree to keep such records as are necessary to demonstrate I meet the requirements and to furnish those records to the Utah Department of Health Medicaid & Health Financing Division, the Department of Health and Human Services or contractor acting on their behalf. For assistance call 801-538-6929.

Initials

NPI

Save Previous Submit EHR Incentive Registration

The provider enters his/her initials and NPI on the bottom of the Attestation Screen to complete the Utah Medicaid EHR Incentive Program Attestation process. By completing this step of the registration process, the provider will have attested to the validity of all data submitted for consideration by the Utah Medicaid EHR Incentive Program. Once the provider submits this data on the screen, the registration process is completed, and the provider may logout of the application.

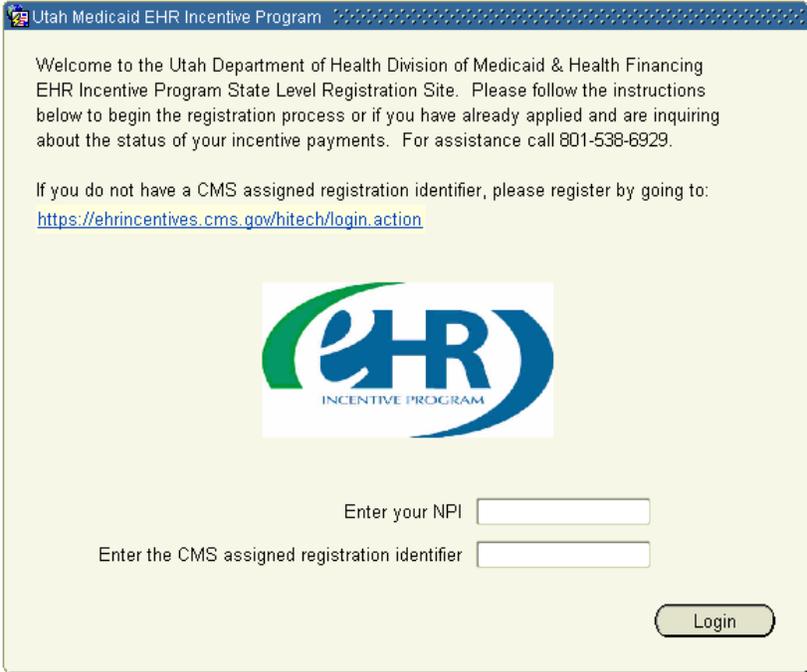
Program staff will begin reviewing your application at this time and you will be contacted if any additional information is required.

## Registration Process for Eligible Hospitals

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the CMS Registration and Attestation site at <http://www.cms.gov/EHRIncentivePrograms/>.

The hospital provider then begins the Utah Medicaid EHR Incentive Program registration process by accessing the Utah SLR system at <https://mmcs.health.utah.gov/registration/hit.html> (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

### Eligible Hospital Sign-in Screen



Utah Medicaid EHR Incentive Program

Welcome to the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program State Level Registration Site. Please follow the instructions below to begin the registration process or if you have already applied and are inquiring about the status of your incentive payments. For assistance call 801-538-6929.

If you do not have a CMS assigned registration identifier, please register by going to: <https://ehrincentives.cms.gov/hitech/login.action>



Enter your NPI

Enter the CMS assigned registration identifier

Login

## Eligible Hospital CMS Registration Information Screen

CMS NLR Registration Information

**REGISTER NOW TO GET YOUR  
MAXIMUM PAYMENT**



Demographic    Specialty

The information presented here has been received from the CMS EHR Incentive Program Registration Site. If changes are necessary, please call the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program at 801-538-6929 or visit: <https://ehrincentives.cms.gov/hitech/login.action>

If the information is accurate please continue with your application.

Applicant NPI	<input type="text" value="2341241234"/>	Name	<input type="text" value="Test Hospital"/>
Applicant TIN	<input type="text" value="890889099"/>	Address 1	<input type="text" value="3455 N 4345 W"/>
Payee NPI	<input type="text"/>	Address 2	<input type="text"/>
Payee TIN/CCN	<input type="text" value="898000"/>	City	<input type="text" value="SLC"/>
Program Option	<input type="text" value="MEDICAID"/>	State	<input type="text" value="UT"/>
Medicaid State	<input type="text" value="UT"/>	Zip Code	<input type="text" value="89089"/> - <input type="text" value="8888"/>
Provider Type	<input type="text" value="Acute Care Hospitals"/>	Phone Number	<input type="text" value="801-777-3232"/> <input type="text" value="5"/>
Payment Year	<input type="text" value="1"/>	Email	<input type="text" value="rnicol@utah.gov"/>

## Hospital Eligibility Detail Screens

**EHR Incentive Provider Eligibility Details**

Enter the EHR system details and Medicare cost report information.

Enter the CMS EHR certification id

Indicate the status of your EHR

Indicate which incentive payment you are applying for at this time

Have you filed a Medicare cost report

For assistance call 801-538-6929

**EHR Incentive Provider Eligibility Details**

**Enter Patient Volume**

Starting date of the 90-day calculation period  (MM/DD/YYYY)

Medicaid discharges during this period  Adjustments

Total discharges during this period  Adjustments

Medicaid Patient Volume Percentage %

**Enter Growth Rate**

End date of the most recent 12 month reporting period  (MM/DD/YYYY)

Total number of discharges for the current year

Total number of discharges for one year prior

Total number of discharges for two years prior

Total number of discharges for three years prior

**Enter Medicaid Share**

	Utah Medicaid	Adjustments	Other State Medicaid	Adjustments
Medicaid discharges	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Medicaid inpatient bed days	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Medicaid managed care inpatient bed days	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Enter Total Share**

Total hospital inpatient bed days  Adjustments

Total hospital charges  Adjustments

Total hospital charity care charges  Adjustments

For assistance call 801-538-6929

As shown above, hospitals must enter four categories of data to complete the Eligibility Details screens. Hospitals will enter the following data on the screens:

#### Patient volume

- Starting date of the 90-day period to calculate Medicaid patient volume percentage (select from calendar)
- Total Medicaid patient discharges during this period
- Total patient discharges during the period
- Medicaid patient volume percentage (calculated)

#### EHR details

- EHR certification ID of EHR
- Status of your EHR – Choices: A/I/U/Meaningful User

#### Growth rate

- End date of the hospital's most recently filed 12-month cost reporting period (select from calendar)
- Total number of discharges that fiscal year
- Total number of discharges one year prior
- Total number of discharges two years prior
- Total number of discharges three years prior
- Average annual growth rate (calculated)

#### Medicaid share

- Total Medicaid inpatient bed days
- Total Medicaid Health Maintenance Organization (HMO) Molina, Healthy U, Select Access, and Health Choice Utah inpatient bed days
- Total inpatient bed days
- Total hospital charges
- Total uncompensated care charges
- Estimated total payment (calculated)

## Eligibility Incentive Payment Calculations Screen

EHR Incentive Payment Methodology

Below is your estimated EHR/HIT Medicaid Incentive Payment based upon the information you have provided within this application. The data you provided is subject to verification. You will be contacted by Medicaid program staff, in the event there is a discrepancy found during the validation process and/or if the final payment(s) amount is different than what is currently displayed.

**Patient Volume Calculation**

Medicaid Patient Volume Percentage 19.349%

Rate of growth for prior year -2.848%

Rate of growth for two years prior -.06%

Rate of growth for three years prior -18.453%

Average rate of growth -7.12%

**EHR Amount Calculation**

	Discharges	Allowable Discharges	Discharge Related Amt	Base Amount	Aggregate EHR Amt	Transition Factor	EHR Amount
First Year	<span style="border: 1px solid gray; padding: 2px;">14,533</span>	<span style="border: 1px solid gray; padding: 2px;">13,384</span>	<span style="border: 1px solid gray; padding: 2px;">2,676,800</span>	<span style="border: 1px solid gray; padding: 2px;">2,000,000</span>	<span style="border: 1px solid gray; padding: 2px;">4,676,800</span>	<span style="border: 1px solid gray; padding: 2px;">1.00</span>	<span style="border: 1px solid gray; padding: 2px;">4,676,800</span>
Second Year	<span style="border: 1px solid gray; padding: 2px;">13,498</span>	<span style="border: 1px solid gray; padding: 2px;">12,349</span>	<span style="border: 1px solid gray; padding: 2px;">2,469,800</span>	<span style="border: 1px solid gray; padding: 2px;">2,000,000</span>	<span style="border: 1px solid gray; padding: 2px;">4,469,800</span>	<span style="border: 1px solid gray; padding: 2px;">0.75</span>	<span style="border: 1px solid gray; padding: 2px;">3,352,350</span>
Third Year	<span style="border: 1px solid gray; padding: 2px;">12,537</span>	<span style="border: 1px solid gray; padding: 2px;">11,388</span>	<span style="border: 1px solid gray; padding: 2px;">2,277,600</span>	<span style="border: 1px solid gray; padding: 2px;">2,000,000</span>	<span style="border: 1px solid gray; padding: 2px;">4,277,600</span>	<span style="border: 1px solid gray; padding: 2px;">0.50</span>	<span style="border: 1px solid gray; padding: 2px;">2,138,800</span>
Fourth Year	<span style="border: 1px solid gray; padding: 2px;">11,644</span>	<span style="border: 1px solid gray; padding: 2px;">10,495</span>	<span style="border: 1px solid gray; padding: 2px;">2,099,000</span>	<span style="border: 1px solid gray; padding: 2px;">2,000,000</span>	<span style="border: 1px solid gray; padding: 2px;">4,099,000</span>	<span style="border: 1px solid gray; padding: 2px;">0.25</span>	<span style="border: 1px solid gray; padding: 2px;">1,024,750</span>
<b>Total Amount</b>							<span style="border: 1px solid gray; padding: 2px;">11,192,700</span>

**Payment Calculation**

Total Medicaid and Medicaid managed care inpatient bed days	<span style="border: 1px solid gray; padding: 2px;">6,347</span>	Estimated year one payment	<span style="border: 1px solid gray; padding: 2px;">602,000</span>
Total hospital charges	<span style="border: 1px solid gray; padding: 2px;">435,257,292</span>	Estimated year two payment	<span style="border: 1px solid gray; padding: 2px;">481,600</span>
Total charity care charges	<span style="border: 1px solid gray; padding: 2px;">25,266,002</span>	Estimated year three payment	<span style="border: 1px solid gray; padding: 2px;">60,200</span>
Non charity percentage	<span style="border: 1px solid gray; padding: 2px;">94.195%</span>	Estimated year four payment	<span style="border: 1px solid gray; padding: 2px;">60,200</span>
Total hospital inpatient bed days	<span style="border: 1px solid gray; padding: 2px;">62,640</span>		
Medicaid percentage	<span style="border: 1px solid gray; padding: 2px;">10.757%</span>		
<b>Aggregate EHR incentive payment</b>	<span style="border: 1px solid gray; padding: 2px;">1,203,999</span>		

For assistance call 801-538-6929

Previous
Next

*Note: Sample data included to illustrate functionality.*

## Document Upload Screen

**EHR Incentive Document Upload**

This screen will allow you to upload requested documentation. Uploading documents is not required unless a program representative has requested you to do so. If you do not have documents to upload at this time, please click Next.

Upload files by selecting the type of document being uploaded, then press the upload button. A second screen outside of this program will appear which will allow you to browse to the documents you wish to upload. Uploaded files must be in a doc, docx, rtf, tif, pdf, jpeg or gif file format.

In order to View uploaded documents, be sure to click on the Upload Date field and then View.

Document Type	Upload Date	Upload	View
		Upload	View

For assistance call 801-538-6929

Save Previous Next

After EHS have completed the Eligibility Details screens and press “Next,” navigation will take them to the Attestation screen below.

## Attestation Screen

EHR Incentive Attestation

CMS NLR Demographic Information   CMS NLR Specialty Information   EHR and Cost Report Information   Hospital Eligibility Details   Hospital Contact Information   Uploaded Documents

Please review the summary of the information you provided to apply for Utah Medicaid HIT/EHR Incentive Program. If this information is accurate please read and sign the attestation below. If not, please go back and correct your information and then sign the attestation below.

Applicant NPI	<input type="text" value="5555555555"/>	Name	<input type="text" value="Test Hospital"/>
Applicant TIN	<input type="text" value="790787"/>	Address 1	<input type="text" value="333 E 777 N"/>
Payee NPI	<input type="text"/>	Address 2	<input type="text"/>
Payee TIN/CCN	<input type="text" value="2341241241"/>	City	<input type="text" value="SLC"/>
Program Option	<input type="text" value="MEDICAID"/>	State	<input type="text" value="UT"/>
Medicaid State	<input type="text" value="UT"/>	Zip Code	<input type="text" value="87666"/> - <input type="text" value="5434"/>
Provider Type	<input type="text" value="Childrens Hospitals"/>	Phone Number	<input type="text" value="801-444-2222"/> Ext <input type="text" value="2"/>
Payment Year	<input type="text" value="1"/>	Email	<input type="text" value="cfrailmc@utah.gov"/>

Important Notice: No payment may be made unless this attestation form is completed and accepted as required by existing law and regulations (42 CFR 495.10). Anyone who misrepresents or falsifies essential information to receive a Utah Medicaid EHR Incentive Program payment requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

I certify that the foregoing information is true, accurate and complete. I understand that the Utah Medicaid EHR Incentive Program payment I have requested will be paid from Federal funds, that by completing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements or documents, or the concealment of a material fact used to obtain a Utah Medicaid EHR Incentive Program payment, maybe prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I hereby agree to keep such records as are necessary to demonstrate I meet the requirements and to furnish those records to the Utah Department of Health Medicaid & Health Financing Division, the Department of Health and Human Services or contractor acting on their behalf. For assistance call 801-538-6929.

Initials

NPI

After submitting the initials and NPI, your attestation is complete.

## Appealing an Incentive Program Decision

If a provider or hospital is denied payment due to being determined ineligible, they will receive written notice of the decision. The decision will also be displayed on the web-based Oracle application system where a link to the appeals process will be made available to providers. A referral to HealthInsight for REC technical assistance will be included in the denial letter along with a **hearing request** form. (This form may also be accessed from the Registration screen, see below.) Providers who choose not to seek REC technical assistance will have the right to an appeal that would follow our existing Administrative Hearing Procedures/Provider Appeals Process. Providers may be able to avoid a formal appeal, should they choose to seek REC technical assistance and subsequently be able to present evidence of meeting the certain program eligibility requirement(s) for which they were initially determined ineligible. The Division of Medicaid and Health Financing's Administrative Hearing Unit's purpose is to review hearing requests and determine the outcome for the different Medicaid programs. These hearings are administrative hearings and governed by the **Utah Administrative Procedures Act**, Utah Code Annotated §63G-4-101 et seq., and the Utah Administrative Code, Title R410-14.

The Administrative Hearing process begins when a petitioner or provider receives a denial notice for a service or payment and then requests a hearing. **A written request from the provider is always required to initiate the hearing process, and must be received within 30 days of the denial.** If someone phones and requests a hearing, a hearing request form will be mailed with a return envelope, faxed, or emailed. The hearing request and the subsequent scheduling of the hearing(s) will be tracked by the EHR Incentive Payment Program Manager and the Administrative Hearing Unit's secretary until a recommended decision is made.

The assigned administrative law judge will conduct prehearing conference calls, and if necessary hold a formal hearing. After the hearing a written recommended decision, including findings of fact and conclusions of law and the reasons for the disposition, is submitted to the State Medicaid Director. The Director may affirm, reverse, modify or remand the Recommended Decision for further findings. This Final Agency Order includes details about subsequent appeal processes to be used if the petitioner disagrees with the Final Agency Order.

After the Final Agency Order is signed by the Director, the original is sent to the petitioner or his representative by certified mail with a return receipt and copies are sent to other interested parties.

Providers may reapply for incentive payments if and when they meet the eligibility criteria previously used to deny payment. The State would verify any changes made from the initial application and process accordingly.

The hearing request form can be accessed by using the 'submit an Appeal' button, as shown below.

CMS NLR Registration Information



Demographic | Specialty | State Rejection Reason

The information presented here has been received from the CMS EHR Incentive Program Registration Site. The information we have received indicates you and/or your organization has been excluded from the program. If you have questions about this information please call the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program at 801-538-6929 or you may file an appeal regarding this decision by pressing the "Submit an Appeal" button below and completing a hearing request form.

Applicant NPI	<input type="text" value="1770704157"/>	Name	<input type="text" value="Test Provider2"/>
Applicant TIN	<input type="text" value="600127333"/>	Address 1	<input type="text" value="193 E 860 S"/>
Payee NPI	<input type="text" value="1770704157"/>	Address 2	<input type="text" value="Ste 100"/>
Payee TIN/CCN	<input type="text" value="600127333"/>	City	<input type="text" value="Orem"/>
Program Option	<input type="text" value="MEDICAID"/>	State	<input type="text" value="UT"/>
Medicaid State	<input type="text" value="UT"/>	Zip Code	<input type="text" value="84058"/> - <input type="text" value="5012"/>
Provider Type	<input type="text" value="Physician"/>	Phone Number	<input type="text" value="801-221-1151"/> <input type="text" value="1234"/>
Payment Year	<input type="text" value="1"/>	Email	<input type="text" value="UtahEP2@test.com"/>

## Checking the Status of Your Incentive Payment Application

From the registration screen, applicants may click the View Registration Status button to see the progress of their application.

**CMS NLR Registration Information**

**REGISTER NOW TO GET YOUR MAXIMUM PAYMENT**

Demographic | **Specialty** | State Rejection Reason

The information presented here has been received from the CMS EHR Incentive Program Registration Site. The information we have received indicates you and/or your organization has been excluded from the program. If you have questions about this information please call the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program at 801-538-6929 or you may file an appeal regarding this decision by pressing the "Submit an Appeal" button below and completing a hearing request form.

Applicant NPI: 1770704157      Name: Test Provider2  
 Applicant TIN: 600127333      Address 1: 193 E 860 S  
 Payee NPI: 1770704157      Address 2: Ste 100  
 Payee TIN/CCN: 600127333      City: Orem  
 Program Option: MEDICAID      State: UT  
 Medicaid State: UT      Zip Code: 84058 - 5012  
 Provider Type: Physician      Phone Number: 801-221-1151 1234  
 Payment Year: 1      Email: UtahEP2@test.com

Submit an Appeal | View Registration Status | Continue EHR Incentive Registration

The following status descriptions will be used:

Applied:	Provider has submitted the required forms at the state level
Pending Approval:	Program reviewer has reviewed the application for completeness
Eligible Pending:	Provider was deemed eligible after review of application and documentation, pending a manager final review
Ineligible Pending:	Provider was deemed ineligible after review of application and documentation, pending a manager final review
Eligible:	Program manager has approved the provider for payment
Ineligible State Dec:	Program manager has disapproved the provider for payment
Ineligible Fed Dec:	CMS has denied the payment because another state has previously paid the provider
CMS Check Approval:	Eligible provider has been approved by the Manager and CMS has given approval to process a payment
Post Payment Audit:	After a payment has been made, a request was made to audit the payment
Appeal:	Provider has been denied payment and is appealing the decision

## Meaningful Use

Meaningful use of certified electronic technology is designed to happen in stages and the clinical quality measures tied to meaningful use will change over time. The State of Utah will revise this provider user manual as the rules and measures change over time. The documentation that follows provides screen shots of what the Utah SLR system will be requiring of eligible providers to complete a Meaningful Use Attestation.

Full descriptions of the most current measures and rules regarding Stage 1 and future Stages of Meaningful Use are available on the CMS Web for the Meaningful Use Core and Menu Measure Sets:

<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/>

## Stage 1 Meaningful Use

### Navigation and Tips

As of December 2012, the Utah SLR system located at <http://www.health.utah.gov/medicaid/provhtml/HIT.htm> will be prepared to accept attestations and capture meaningful use measures.

The Utah SLR system will allow eligible providers and hospitals to attest to the most current meaningful use measures. There are several features you should be made aware of from the start to facilitate your progress through this system.

First is the Meaningful Use Menu launch pad. This screen appears immediately after logging in and shows the status of what sections still need to be completed. With the exception of the eligibility details, once a section is marked Complete, no changes can be made to this section. (Contact program staff at 801-538-6929 if you need to make a correction.) After completing a section of measures, you will be returned to this launch pad to select the next set of measures to complete.

The screenshot shows a web application window titled "EHR Incentive Meaningful Use Menu". The main content area contains a list of menu options, each with a corresponding status indicator. The options are: "Meaningful Use Eligibility Details" (Incomplete), "Meaningful Use Core Measures", "Meaningful Use Menu Measures", "Clinical Quality Measures", "Alternate Clinical Quality Measures", "Additional Clinical Quality Measures", "Meaningful Use Attestation", and "View Estimated Payment". At the bottom of the window, there is a footer with the text "For assistance call 801-538-6929" and a "Previous" button.

Menu Option	Status
Meaningful Use Eligibility Details	Incomplete
Meaningful Use Core Measures	
Meaningful Use Menu Measures	
Clinical Quality Measures	
Alternate Clinical Quality Measures	
Additional Clinical Quality Measures	
Meaningful Use Attestation	
View Estimated Payment	

For assistance call 801-538-6929 Previous

Secondly, each page of the attestation offers the option to return to the previous screen, save progress in the current screen, or to move to the next screen once completed. Information is saved each time progression is made to the next screen or the attestation is exited. Enter the next screen by clicking Next.

A third feature applies to measures that offer an exclusion. If an exclusion applies to the practice situation, then clicking “Yes” will cause the remaining fields for the measure to disappear. Click “Next” to move forward just as if the measure is completed in full.

Core Measure 4 of 15

Red asterisk indicates a required field.

Objective: Generate and transmit permissible prescriptions electronically (eRx).

Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you?

Yes  No

For assistance call 801-538-6929

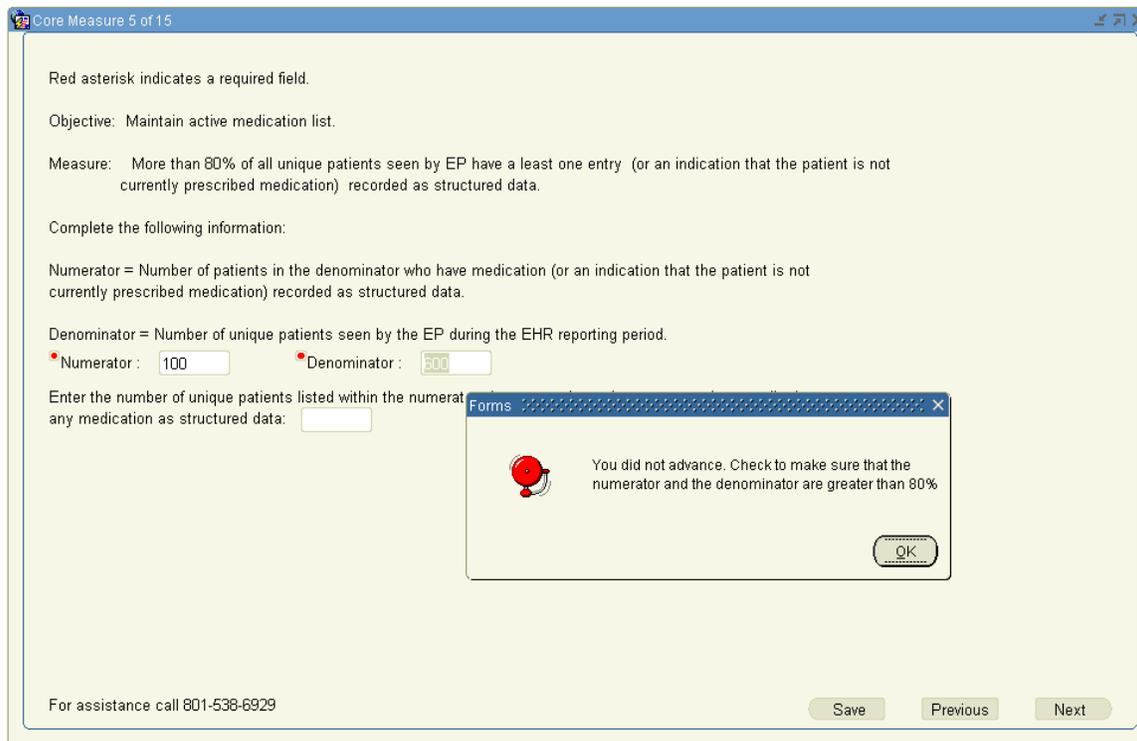
Save Previous Next

Lastly, the system will alert you if there are problems with the information you are submitting for any of the measures. You will receive an error if:

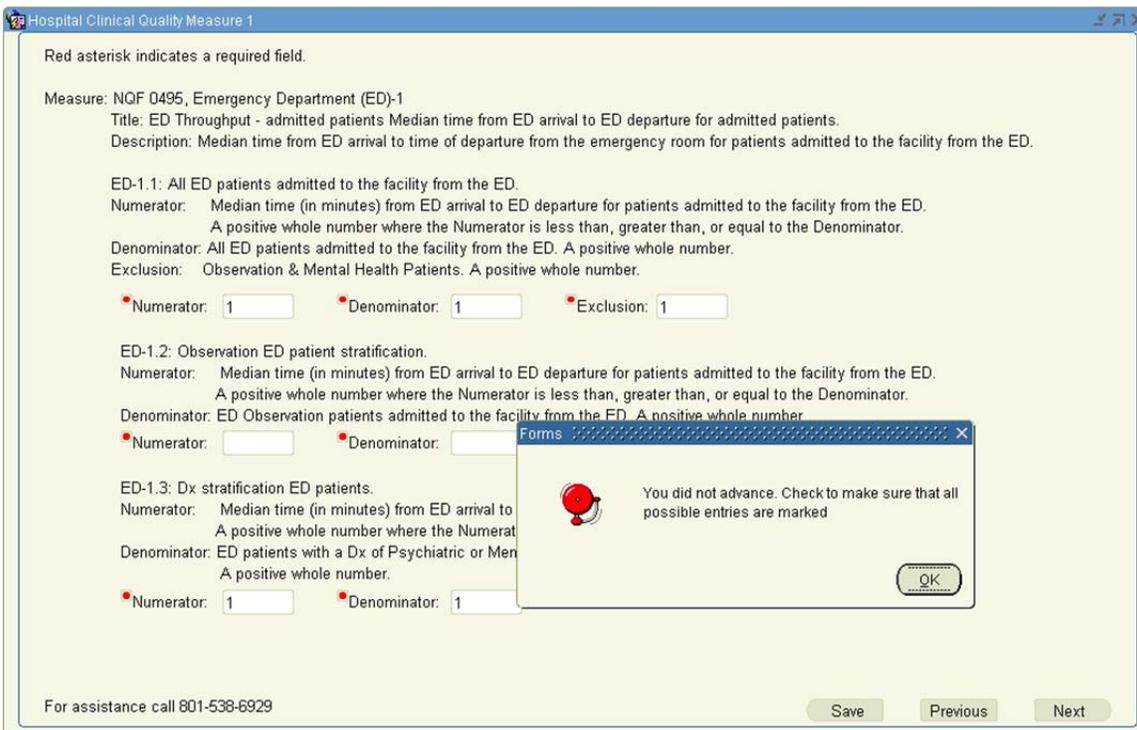
- A required field is left blank
- A radio button selection is not made
- The submitted response does not meet the menu measure threshold

You will not be able to proceed until the error is corrected, however you can use the Save or Previous buttons. Sample screen shots are displayed on the following pages.

Here is an example of the notification that is received when trying to progress to the next screen without meeting the minimum requirements of the measure:

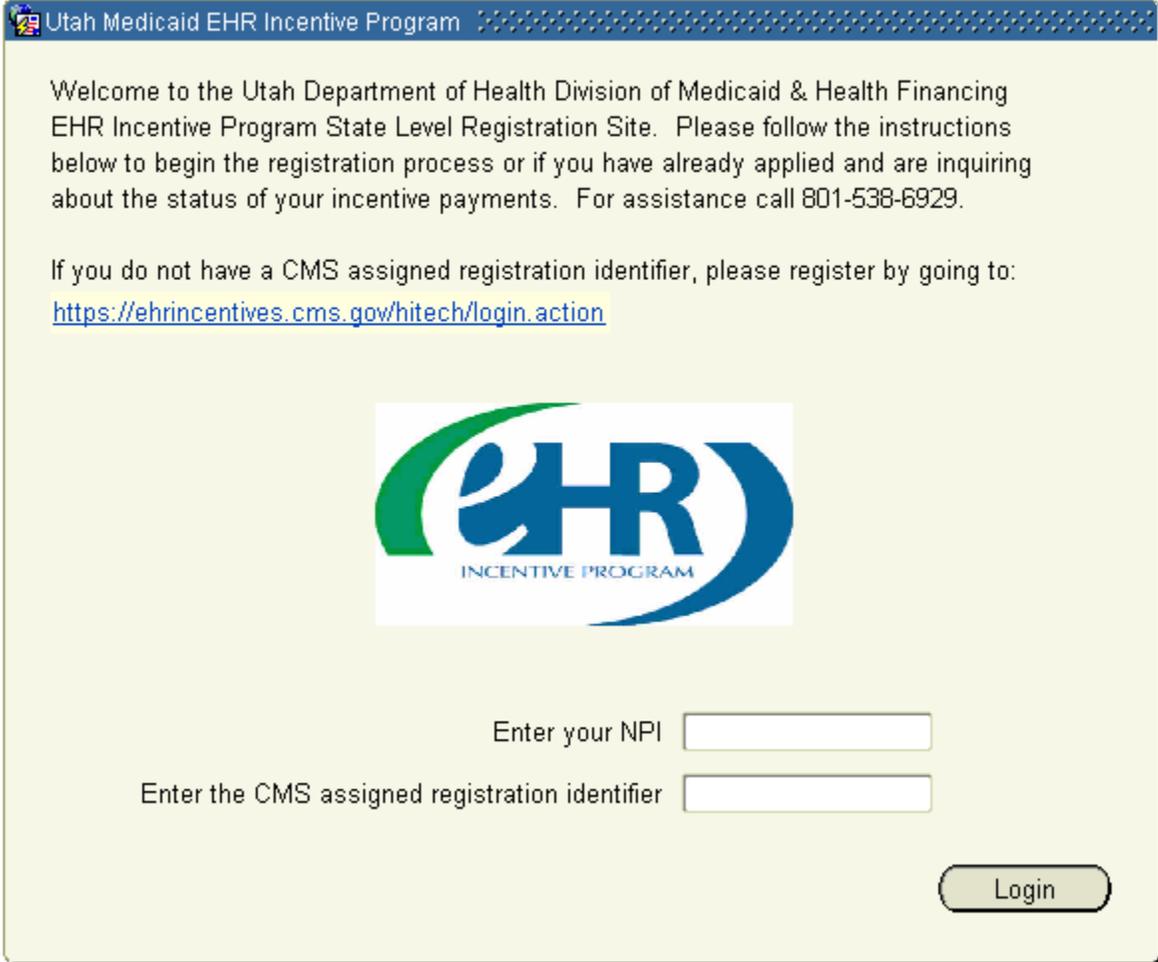


Here is an example of the message a provider will see if they try to move forward or backward with a required field that is not complete:



## EP Registration for Stage 1 Meaningful Use, Program Year 2013, Participation Year 2 or 3

### Eligible Provider Sign-In Screen



Utah Medicaid EHR Incentive Program

Welcome to the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program State Level Registration Site. Please follow the instructions below to begin the registration process or if you have already applied and are inquiring about the status of your incentive payments. For assistance call 801-538-6929.

If you do not have a CMS assigned registration identifier, please register by going to:  
<https://ehrincentives.cms.gov/hitech/login.action>



Enter your NPI

Enter the CMS assigned registration identifier

Login

A provider begins the process by entering the NPI registered with CMS and the CMS-assigned Registration Identifier that was returned by the CMS registration. The Provider Demographics Screen will display with the pre-populated data received from the CMS registration. If the provider entry does not match, an error message with instructions will be returned.

If you cannot locate your registration identifier, program staff can assist you at 801-538-6929.

(Note that if you have recently made changes to your CMS registration, the information will not be available in the state system until approximately 24 hours later.)

## Demographic Details

Review the demographic information previously entered. If there are no corrections needed, select the button to attest for Meaningful Use.

The button for payment year one will be disabled for all providers who have received a first year payment from Utah Medicaid. If you are a provider who has received a first year payment from another State or Medicare, please contact a program representative at 801-538-6929.

Demographic Specialty

The information presented here has been received from the CMS EHR Incentive Program Registration Site. Please review the specialty tab. If your specialty is not listed, please choose a specialty from the list of approved CMS provider specialties. If other changes are necessary, please call the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program at 801-538-6929 or visit: [https://ehrincentives.cms.gov/hitech/login\\_action](https://ehrincentives.cms.gov/hitech/login_action)

If the information is accurate please continue with your attestation.

Applicant NPI	<input type="text" value="234234"/>	Name	<input type="text" value="Jon Tester"/>
Applicant TIN	<input type="text" value="678689"/>	Address 1	<input type="text" value="111 N 222 W"/>
Payee NPI	<input type="text" value="234233"/>	Address 2	<input type="text"/>
Payee TIN/CCN	<input type="text" value="890898"/>	City	<input type="text" value="SLC"/>
Program Option	<input type="text" value="MEDICAID"/>	State	<input type="text" value="UT"/>
Medicaid State	<input type="text" value="UT"/>	Zip Code	<input type="text" value="84444"/> - <input type="text"/>
Provider Type	<input type="text" value="Nurse Practitioner"/>	Phone Number	<input type="text" value="801-444-2222"/> Ext <input type="text" value="12"/>
Payment Year	<input type="text" value="1"/>	Email	<input type="text" value="rnicol@utah.gov"/>

Payment Year	Current Status	Attestation
<input type="text" value="1"/>	Adopt/Implement/Upgrade Payment Processed	Attestation for Adopt/Implement/Upgrade
<input type="text" value="2"/>		Attestation Meaningful Use

## Utah's Meaningful Use Launch Pad

The following screen will show the progress made as the different sections of the attestation are completed. This screen will only allow the user to select a group of measures as they are available. For example once the Meaningful Use Core Measures are completed, the Meaningful Use Menu Measures will be active to select. Step one will be to enter the Meaningful Use Eligibility Details. Click the first button.

The screenshot shows a window titled "EHR Incentive Meaningful Use Menu". Inside the window, there is a section titled "Please select a menu option below:" followed by a list of menu options, each with a corresponding progress bar to its right. The progress bars are represented by grey rectangles of varying lengths. The first option, "Meaningful Use Eligibility Details", has a progress bar that is nearly full and is labeled "Incomplete". The other options have shorter progress bars. At the bottom of the window, there is a text prompt "For assistance call 801-538-6929" and a "Previous" button.

Menu Option	Progress Status
Meaningful Use Eligibility Details	Incomplete
Meaningful Use Core Measures	Partial
Meaningful Use Menu Measures	Partial
Clinical Quality Measures	Partial
Alternate Clinical Quality Measures	Partial
Additional Clinical Quality Measures	Partial
Meaningful Use Attestation	Partial
View Estimated Payment	Partial

For assistance call 801-538-6929 Previous

## EHR Incentive Provider Eligibility Details

The following screen identifies whether group methodology is being utilized to calculate the Medicaid patient volume by selecting Yes/No.

If yes, choose the name of the group from the drop-down box. Incentive program staff will maintain this list of groups. If you have not already done so, or there are changes to your group composition since receiving an AIU payment, please call the hotline at 801-538-6929 to arrange this.

Enter the name and version number of your EHR software and set the status of your EHR to (MU) Meaningful User.

The screenshot shows a web browser window titled "EHR Incentive Provider Eligibility Details". The main content area has a light yellow background and contains the following text and form elements:

Under the rules of the program, groups and clinics may use group volumes to determine eligibility for all providers associated with the group/clinic. In order to use the group volumes, all practitioners within the group must agree to use the group volumes to determine Medicaid patient volumes and eligibility to participate in the program. If one provider in the group/clinic chooses to use individual patient volumes rather than the group volumes, all other providers in the group must also use individual patient volumes. By registering as a group, your incentive payment will also be paid to the group designated below.

Indicate if you wish to register as a group

Group to whom payment will be issued to

Enter the EHR system details:

CMS EHR certification id

Name of your EHR software

Status of your EHR software

For assistance call 801-538-6929

Buttons: Save, Previous, Next

Enter the **Practice information**. Enter the next screen by clicking Next.

The screenshot shows a web form titled "EHR Incentive Provider Eligibility Details". The form contains the following fields and values:

- Utah Medicaid payment contract id: 234515151
- State in which your license was issued: Utah
- Working with a REC(Regional Extension Center): Yes
- Working with the cHIE(Clinical Health Information Exchange): Yes
- Practice office manager name: Test Manager
- Practice office manager phone: 801-333-2222 (000-000-0000)
- Practice office manager email: na@na.com

At the bottom of the form, there is a text prompt: "For assistance call 801-538-6929" and three buttons: "Save", "Previous", and "Next".

### Assigned Payee

If payment is assigned to another provider or practice, then the entity's NPI and tax ID (EIN) have been entered at the CMS registration site. Enter the payee name and address information. Proceed to the next screen by clicking Next.

The screenshot shows a web form titled "EHR Incentive Provider Eligibility Details". The form contains the following fields and values:

- Payee Name: Test Payee
- Use CMS Attestation and Registration Address
- Address 1: 111 N 222 W
- Address 2: (empty)
- City: SLC
- State: UT
- Zip Code: 84444

At the bottom of the form, there is a text prompt: "For assistance call 801-538-6929" and three buttons: "Save", "Previous", and "Next".

## Medicaid Patient Volume

Enter the 90 day period used to calculate the Medicaid patient volume, and patient encounter information. Providers may choose any consecutive 90-day period from the previous calendar year OR from the 12-month period prior to the date of attestation. It is permissible for this 90-day period to cross the calendar year.

Select Yes/No answers regarding hospital care and practice in an FQHC or RHC. If the answer to practice in an FQHC or RHC is Yes, the next screen will request FQHC or RHC patient volume information. Proceed to the next screen by clicking Next.

The screenshot shows a web form titled "EHR Incentive Provider Eligibility Details". The form contains the following fields and text:

You have indicated you are registering individually and must demonstrate 30% Medicaid patient volumes. You may use any consecutive 90-day period from the previous calendar year OR from the preceding 12-month period prior to the date of your attestation. Enter your patient volumes below:

Starting date of the 90-day calculation period: 10/01/2011 (MM/DD/YYYY)

Utah Medicaid patient encounters during this period: 233

Total Utah patient encounters during this period: 533

Other states Medicaid patient encounters during this period: [empty field]

Total other states patient encounters during this period: [empty field]

Did you render care in a hospital: [dropdown menu]

Are you an eligible professional who practices predominantly in an FQHC or RHC? You can use Medically Needy Patient visits to help achieve Medicaid eligibility. CMS defines "practice predominantly" as greater than 50% of encounters in a 6-month period within the prior calendar year OR preceding 12-month period from the date of attestation. [dropdown menu]

Medicaid patient volume percentage: 43.715%

For assistance call 801-538-6929

Buttons: Save, Previous, Next

Volume thresholds are calculated using as the numerator the hospital or the EP's total number of *Medicaid* member encounters for the 90-day period and the denominator is *all* patient encounters for the same EP or hospital over the same 90-day period. Refer to previous section **Establishing Patient Volume** if additional clarification is required.

## FQHC and RHC Patient Volume

Providers who indicated that they practice in designated Federally Qualified Health Centers or Rural HC will see the following screen to enter additional patient volume information. Enter the 90 day period used to calculate the Medicaid patient volume, and medically needy patient encounter information. Proceed to the next screen by clicking Next.

EHR Incentive Provider Eligibility Details

You have indicated you are registering individually and must demonstrate 30% combined Medicaid patient encounter and Medically Needy patient encounters for a 90-day period. You may use any consecutive 90-day period within the prior calendar year OR the preceding 12-month period from the date of attestation. Enter your FQHC or RHC patient volumes below:

Starting date of the 90-day calculation period	<input type="text" value="10/01/2011"/>
Utah CHIP patient encounters during this period	<input type="text"/>
Utah patient encounters furnished services on a sliding scale during this period	<input type="text"/>
Utah patient encounters furnished uncompensated care during this period	<input type="text"/>
Other states CHIP patient encounters during this period	<input type="text"/>
Other states patient encounters furnished services on a sliding scale during this period	<input type="text"/>
Other states patient encounters furnished uncompensated care during this period	<input type="text"/>
Total medically needy patient encounters during this period	<input type="text" value="0"/>
Medicaid patient volume percentage	<input type="text" value="43.715%"/>

For assistance call 801-538-6929

## EHR Incentive Meaningful Use Questionnaire

Enter the start and end date of 90 day period used to attest to Meaningful Use. For the first year of reporting Meaningful Use (second participation year), EPs are required to report on a continuous 90 day period within the program year being attested. For the second year of reporting Meaningful Use (third participation year), an entire year of reporting will be required.

**The calendar year of the Meaningful Use reporting period is tied to the program year. For your 2013 Meaningful Use payment, the reporting period must be from 2013.**

Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above. This should be the percentage of the total patients you have seen who have data recorded in your EHR.

Indicate with a Yes/No answer if there are multiple service locations. If the answer is yes, enter the total number of locations and then list how many of the locations have certified EHR Technology.

Indicate the service location that has certified EHR technology – Enter the address and service location of the practice using certified EHR technology. Enter the next screen by clicking Next.

The screenshot shows a web-based form titled "EHR Incentive Meaningful Use Questionnaire". The form is set against a light yellow background with a blue border. It contains several input fields and a dropdown menu. The fields are: "EHR Reporting Period Start Date" (01/01/2012), "EHR Reporting Period End Date" (03/31/2012), "Percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above" (85%), "Indicate if you have multiple practice locations" (Yes), "Total number of locations" (3), "Total number of locations with certified EHR technology" (2), "Service Location Address 1" (111 N 200 W), "Service Location Address 2" (empty), "Service Location City & State" (SLC, UT), and "Service Location Zip Code" (44444). At the bottom, there is a text prompt "For assistance call 801-538-6929" and three buttons: "Save", "Previous", and "Next".

Enter the EHR reporting period associated with this attestation:

EHR Reporting Period Start Date  (MM/DD/YYYY)

EHR Reporting Period End Date  (MM/DD/YYYY)

Percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above  %

Indicate if you have multiple practice locations

Total number of locations

Total number of locations with certified EHR technology

Enter the Service Location associated with this attestation:

Service Location Address 1

Service Location Address 2

Service Location City & State

Service Location Zip Code

For assistance call 801-538-6929

## Document Upload Screen

This screen will allow you to upload requested documentation. Uploading documents is not required unless a program representative has requested you to do so. If you do not have documents to upload at this time, please click Next.

Upload files by selecting the type of document being uploaded, then press the upload button. A second screen outside of this program will appear which will allow you to browse to the documents you wish to upload. Uploaded files must be in a doc, docx, rtf, tif, pdf, jpeg or gif file format.

In order to View uploaded documents, be sure to click on the Upload Date field and then View.

Document Type	Upload Date	Upload	View
		Upload	View

For assistance call 801-538-6929

Save Previous Next

If possible, upload a copy of the meaningful use report(s) that you will use for attestation. If you aren't prepared to do it at this time, make sure to **SAVE** or **PRINT** the report today to be retained with your incentive program materials. Program staff will request a copy of this report prior to payment. It's important to save or print the report on the day of attestation, as the data in the system is dynamic and your report may not return the same numerators or denominators if it is re-run at a later date.

Click Next to continue.

Once the eligibility information is complete, the system will return to this launch pad. The eligibility details section will now say “Complete.” If you need to change or add information to the eligibility details section the system will allow you to do so.

Proceed to the Meaningful Use Core Measures.

The screenshot shows a software window titled "EHR Incentive Meaningful Use Menu". Inside the window, there is a light yellow background with a blue border. At the top, it says "Please select a menu option below:". Below this, there are six rows of buttons. Each row consists of a larger button on the left and a smaller button on the right. The first row has "Meaningful Use Eligibility Details" and "Complete". The second row has "Meaningful Use Core Measures" and "0". The third row has "Meaningful Use Menu Measures" and "0". The fourth row has "Core Clinical Quality Measures" and "0". The fifth row has "Alternative Core Clinical Quality Measures" and "0". The sixth row has "Additional Clinical Quality Measures" and "0". At the bottom left, it says "For assistance call 801-538-6929". At the bottom right, there is a "Previous" button.

Menu Option	Status
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	0
Meaningful Use Menu Measures	0
Core Clinical Quality Measures	0
Alternative Core Clinical Quality Measures	0
Additional Clinical Quality Measures	0

For assistance call 801-538-6929

Previous

## Meaningful Use Core Measures

### CPOE

Core Measure number one (CPOE) offers an alternate measure. Select which method you have used to calculate this measure

Core measure 1 choice

Instructions:  
Choose which measure you want to use to report computerized provider order entry (CPOE).

OBJECTIVES	MEASURES	Select
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional (or credentialed medical assistant) 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.	<input checked="" type="checkbox"/>
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional (or credentialed medical assistant) who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of medication orders created by authorized providers of seen by the EP during the EHR reporting period are recorded using CPOE.	<input type="checkbox"/>

For assistance call 801-538-6929

Save Previous Next

Core Measure 1 of 13

Red asterisk indicates a required field.

TITLE: CPOE

Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional (or credentialed medical assistant) who can enter orders into the medical record per state, local and professional guidelines.

Measure: 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.

EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.  
Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.  
 This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator = Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

The alternate screen is as follows:

Core Measure 1a of 13

Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional (or credentialed medical assistant) who can enter orders into the medical record per state, local and professional guidelines.

Measure: More than 30% of the medication orders created by the EP during the EHR Reporting Period are recorded using CPOE.

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.  
 This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of medication orders in the denominator that are recorded using CPOE.

Denominator = Number of medication orders created by the provider during the EHR reporting period.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

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 >30% threshold, N/D > 30%
- If an EP responds Yes to the exclusion then they have met the measure threshold

## Drug Interaction Checks

Core Measure 2 of 13

Red asterisk indicates a required field.

TITLE: DRUG INTERACTION

Objective: Implement drug-drug and drug-allergy interaction checks.

Measure: The EP has enabled this functionality for the entire EHR reporting period.

Complete the following information

\* Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

Yes  No

For assistance call 801-538-6929

Save Previous Next

- Please select Yes or No to continue to the next screen.
- For guidance on what documentation to retain for non-percentage based (yes/no) measures, please refer to the [CMS Supporting Documentation for Audits](#) guide.

## Maintain Problem Lists

Core Measure 3 of 13

Red asterisk indicates a required field.

TITLE: PROBLEM LISTS

Objective: Maintain an up-to-date problem list of current and active diagnoses.

Measure: More than 80% of all unique patients seen by EP have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator that have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

Denominator = Number of unique patients seen by the EP during the EHR reporting period.

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

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 be a whole number
- The Numerator should be less than or equal to the Denominator
- The EP must meet the >80% threshold,  $N/D > 80\%$

## e-Prescribing (eRx)

Core Measure 4 of 13

Red asterisk indicates a required field.

TITLE: E-PRESCRIBE(eRx)  
Objective: Generate and transmit permissible prescriptions electronically (eRx).  
Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.  
EXCLUSION1: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.  
Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you?  
 Yes  No

EXCLUSION2: Any provider who has no pharmacy within their organization and no pharmacy within 10 miles that accepts electronic submissions would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you?  
 Yes  No

PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:  
Numerator = Number of prescriptions in the denominator generated and transmitted electronically.  
Denominator = Number of prescriptions for drugs requiring a prescription in order to be dispensed (other than controlled substances) during the EHR reporting period.

Numerator:  Denominator:

Which eRx Service is used?

Name one pharmacy that you transmit to?

For assistance call 801-538-6929

Save Previous Next

All fields must be completed unless either 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 either exclusion then they have met the measure threshold
- The EP must enter an answer on the last question on the page, if the information is unknown then type unknown as the answer.

## Active Medication List

Core Measure 5 of 13

Red asterisk indicates a required field.

TITLE: ACTIVE MED LIST

Objective: Maintain active medication list.

Measure: More than 80% of all unique patients seen by EP have a least one entry (or an indication that the patient is not currently prescribed medication) recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have medication (or an indication that the patient is not currently prescribed medication) recorded as structured data.

Denominator = Number of unique patients seen by the EP during the EHR reporting period.

\* Numerator :  \* Denominator :

Enter the number of unique patients listed within the numerator above as patients that are currently prescribed any medication as structured data:

For assistance call 801-538-6929

Save Previous Next

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 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 an answer on the last question on the page, if the count is unknown then type unknown as the answer.

## Active Medication Allergy List

Core Measure 6 of 13

Red asterisk indicates a required field.

TITLE: ACTIVE MED ALLERGY LIST

Objective: Maintain active medication allergy list.

Measure: More than 80% of all unique patients seen by EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

Complete the following information:

Numerator = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

Denominator = Number of unique patients seen by the EP during the EHR reporting period.

\* Numerator:  \* Denominator:

Enter the number of unique patients included in the numerator who had an indication of a known medication allergy recorded as part of their structured data:

For assistance call 801-538-6929

Save Previous Next

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 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 an answer on the last question on the page, if the count is unknown then type unknown as the answer.

## Record Demographics

Core Measure 7 of 13

Red asterisk indicates a required field.

TITLE: DEMOGRAPHICS

Objective: Record all of the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth

Measure: More than 50% of all unique patients seen by EP have demographics recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

Denominator = Number of unique patients seen by the EP during the EHR reporting period.

\* Numerator:  \* Denominator:

Enter the number (if any) of unique patients from the numerator that had ALL the demographic fields completed with valid patient information or a specific exclusion recorded as structured data:

For assistance call 801-538-6929

Save Previous Next

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 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 an answer the on last question on the page, if the count is unknown then type unknown as the answer.

## Record Vital Signs

Core Measure 8 of 13

Red asterisk indicates a required field.

TITLE: VITAL SIGNS

Objective: 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

Measure: More than 50% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients 3 and over only) and height and weight (for all ages) recorded as structured data.

EXCLUSION 1: Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.

Does this exclusion apply to you?  
 Yes  No

EXCLUSION 2: Sees no patients 3 years or older is excluded from recording blood pressure.

Does this exclusion apply to you?  
 Yes  No

EXCLUSION 3: Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.

Does this exclusion apply to you?  
 Yes  No

EXCLUSION 4: Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

Does this exclusion apply to you?  
 Yes  No

PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:  
Numerator = The number of patients in the denominator that have at least one height, weight and blood pressure recorded as structured data.  
Denominator = Number of unique patients age 3 or over seen by the EP during the EHR reporting period.

The descriptions for the numerator and denominator for this measure will change based on which exclusion is selected. Choosing Exclusion 1 will complete the measure and the provider can choose “next” to move forward. If the provider selects Exclusion 2, the form will collect information on height and weight only. If the provider selects Exclusion 3, the form will collect height and weight only. If the provider selects Exclusion 4, the form will collect blood pressure data only.

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 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%
- If an EP responds Yes to exclusion 1 then they have met the measure threshold

## Record Smoking Status

Core Measure 9 of 13

Red asterisk indicates a required field.

TITLE: SMOKING STATUS

Objective: Report smoking status for patients 13 years old or older.

Measure: More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

EXCLUSION: Any EP who sees no patients 13 years old or older would be excluded from this requirement.  
Exclusion from this from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the was extracted from all patient records or only from patient records maintained using certified EHR technology.  
 This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of patients in the denominator with smoking status recorded as structured data.

Denominator = Number of unique patients age 13 or older seen by the EP during the EHR reporting period.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

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 be a whole number
- The Numerator should be less than or equal to the Denominator
- The EP must meet the >50% threshold,  $N/D > 50\%$
- If an EP responds Yes to the exclusion then they have met the measure threshold.

## Implement Clinical Decision Support Rule

Core Measure 11 of 13

Red asterisk indicates a required field.

TITLE: IMPLEMENT CDS

Objective: Implement one clinical decision support (CDS) rule relevant to specialty or high clinical priority along with the ability to track compliance of that rule.

Measure: Implement one clinical decision support rule.

Complete the following information:

\* Have you implemented one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance of that rule?

Yes  No

Enter the CDS rule that was implemented:

For assistance call 801-538-6929

Save Previous Next

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 an answer on the last question on the page, if the information is unknown then type unknown as the answer.
- For guidance on what documentation to retain for non-percentage based (yes/no) measures, please refer to the [CMS Supporting Documentation for Audits](#) guide.

## Electronic Copy of Health Information

Core Measure 12 of 13

Red asterisk indicates a required field.

TITLE: ELECTRONIC COPY FOR PATIENTS

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

Measure: More than 50% of all patients who request an electronic copy of their health information are provided it within three business days.

EXCLUSION: BASED ON ALL PATIENT RECORDS: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you?

Yes  No

PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or "ONLY" from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

Denominator = Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

Numerator:   Denominator:

For assistance call 801-538-6929

Save Previous Next

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 be a whole number
- The Numerator should be less than or equal to the Denominator
- The EP must meet the >50% threshold,  $N/D > 50\%$
- If your report generates a 0/0 result for this measure, then you qualify for the exclusion
- If an EP responds Yes to the exclusion then they have met the measure threshold

## Clinical Summaries

Core Measure 13 of 13

Red asterisk indicates a required field.

TITLE: CLINICAL SUMMARIES

Objective: Provide clinical summaries to patients for each office visit.

Measure: Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.

EXCLUSION: BASED ON ALL PATIENT RECORDS: An EP who has no office visits during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or "ONLY" from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of office visits in the denominator for which a clinical summary was provided within three business days.

Denominator = Number of office visits for the EP during the EHR reporting period.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

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 be a whole number
- The Numerator should be less than or equal to the Denominator
- The EP must meet the >50% threshold,  $N/D > 50\%$
- If an EP responds Yes to the exclusion then they have met the measure threshold

## Security Review

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

Core Measure 15 of 15

Red asterisk indicates a required field.

TITLE: SECURITY REVIEW

Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement necessary and correct identified security deficiencies as part of its risk management process.

Complete the following information :

\* Have you conducted or reviewed a security risk analysis per 45 CFR 164.308 (a)(1) and implemented security updates as necessary and corrected identified security deficiencies as part of your risk management process?

Yes  No

For assistance call 801-538-6929

Save Previous Next

The following details other requirements of this screen:

- A response must be submitted
- Please select Yes or No
- For guidance on what documentation to retain for non-percentage based (yes/no) measures, please refer to the [CMS Supporting Documentation for Audits](#) guide.
- CMS has also provided a [Tipsheet](#) specifically for this measure.

After completing the 13 Core Measures the system will return to the Meaningful Use Launch Pad. The Core Measures details section will now say “Complete” and changes will not be able to be made to the completed section. (If changes need to be made, contact Incentive Program staff at 801-538-6929 and request that the attestation be unlocked.)

Menu Option	Status
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	Complete
Meaningful Use Menu Measures	0
Clinical Quality Measures	0
Alternate Clinical Quality Measures	0
Additional Clinical Quality Measures	0
Meaningful Use Attestation	N/A
View Estimated Payment	

For assistance call 801-538-6929

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Proceed to the Meaningful Use Menu Measures.

## Meaningful Use Menu Measures

A minimum of 5 Menu Measures must be selected. (You may select more than 5 if desired.) At least one of these measures must be from the Public Health Measure list. You must choose a measure that can be met unless an exclusion can be claimed for both Public Health measures open to eligible providers.

### Menu Measure Selection Menu 1 of 2

Menu Measure Select 1 of 2

Instructions:

EPs must report on a total of five (5) Meaningful Use Menu Measures. At least one of the five measures must be from the public health menu measure. Should the EP be able to successfully meet only one of the public health menu measures, the EP must select and report on that measure to CMS. Having met one public health menu measure, the EP must then select any combination of the remaining public health menu measure or from the additional Meaningful Use Menu Measures in the list below

If an EP meets the criteria for, and can claim an exclusion for both of the public health menu measures, the EP must still select one public health menu measures and attest that EP qualifies for the exclusion. The EP must then select any four measures from the menu measures, which can be any combination of the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below. CMS encourages EPs to select menu measures that are relevant to their scope of practice and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures that are relevant to their scope of practice.

You must submit at least one Meaningful Use Menu Measure from the public health list even if the Exclusion applies to both:

OBJECTIVES	MEASURES	Select
<p><b>TITLE: ELECTRONIC DATA to IMMUNIZATION REGISTRIES</b></p> <p>Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.</p>	<p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).</p>	<input type="checkbox"/>
<p><b>TITLE: ELECTRONIC SYNDROMIC SURVEILLANCE DATE</b></p> <p>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.</p>	<p>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).</p>	<input type="checkbox"/>

For assistance call 801-538-6929

## Menu Measure Selection Menu 2 of 2

Menu Measure Select 2 of 2

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measures Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected. (Total of five includes the 0 public health menu measure objectives selected.)

OBJECTIVES	MEASURES	Select
TITLE: Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	<input type="checkbox"/>
TITLE: 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 a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	<input type="checkbox"/>
TITLE: 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.	<input type="checkbox"/>
TITLE: Send reminders to 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.	<input type="checkbox"/>
TITLE: PATIENT ELECTRONIC ACCESS to THEIR INFO Provide patients with timely electronic access to their health information (including lab results, problem lists, medication lists, and allergies) within four 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.	<input type="checkbox"/>
TITLE: 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.	<input type="checkbox"/>
TITLE: SUMMARY of CARE 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.	<input type="checkbox"/>
TITLE: PROVIDES a SUMMARY of CARE The EP who transitions their patients to another setting of care or provider of care or refers their patient to another provider of care should provide a 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 or referrals.	<input type="checkbox"/>

For assistance call 801-538-6929

Save Previous Next

## Electronic Data to Immunization Registries

Public Health Menu Measure 1

Red asterisk indicates a required field.  
TITLE: ELECTRONIC DATA TO IMMUNIZATION REGISTRIES

Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submissions in accordance with applicable law and practice.  
Measure: 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).

EXCLUSION 1: Any EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement.  
\* Does this exclusion apply to you?  
 Yes  No

EXCLUSION 2: If there is no immunization registry that has the capacity to receive the information electronically, an EP would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.  
\* Does this exclusion apply to you?  
 Yes  No

Complete the following information:

\* Did you perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful?  
 Yes  No

\* What was the result of the test?  
 Successful  Failed

\* Has follow up data been submitted?  
 Yes  No

PLEASE NOTE: Neither a failed test nor failure to follow-up a test submission will prevent a provider from meeting Meaningful Use.

For assistance call 801-538-6929

Save Previous Next

This test must be completed during or prior to your meaningful use EHR reporting period.

All fields must be completed unless the exclusion was responded to with a “Yes” answer. 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 exclusion 1 and 2 has not been marked as yes
- The EP must enter answer the last two questions on the page, if response is yes
- Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.
- For additional guidance on the public health meaningful use measures, please consult the [Utah Public Health Reporting for Meaningful Use](#) website.

## Electronic Syndromic Surveillance Data

Public Health Menu Measure 2

Red asterisk indicates a required field.  
TITLE: ELECTRONIC SYNDROMIC SURVEILLANCE DATA

Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.  
Measure: 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 the EP submits such information have the capacity to receive the information electronically).

EXCLUSION 1: If an EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, then the EP is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?  
 Yes  No

EXCLUSION 2: If there is no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?  
 Yes  No

Complete the following information:

\* Did you perform at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful.  
 Yes  No

\* What was the result of the test?  
 Successful  Failed

\* Has follow up data been submitted?  
 Yes  No

PLEASE NOTE: Neither a failed test nor failure to follow-up a test submission will prevent a provider from meeting Meaningful Use.

For assistance call 801-538-6929

Save Previous Next

This test must be completed during or prior to your meaningful use EHR reporting period.

All fields must be completed unless the exclusion was responded to with a "Yes" answer. 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 exclusion 1 and 2 has not been marked as yes
- The EP must enter answer the last two questions on the page, if response is yes
- Selecting that the test failed or failure to send a follow-up submission will not prevent a provider from meeting Meaningful Use.
- For additional guidance on the public health meaningful use measures, please consult the [Utah Public Health Reporting for Meaningful Use](#) website.

## Drug Formulary

Additional menu Measure 1

Red asterisk indicates a required field.

TITLE: DRUG FORMULARY

Objective: Implement drug formulary checks.

Measure: The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?

Yes  No

Complete the following information :

\* Have you enabled the drug formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period?

Yes  No

For assistance call 801-538-6929

Save Previous Next

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 required if the exclusion has not been marked as yes
- For guidance on what documentation to retain for non-percentage based (yes/no) measures, please refer to the [CMS Supporting Documentation for Audits](#) guide.

## Clinical Lab Test Results

Additional Menu Measure 2

Red asterisk indicates a required field.

TITLE: CLINICAL LAB TEST RESULTS

Objective: Incorporate clinical lab test results into EHR as structured data.

Measure: More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are in either a positive/negative or numerical format are incorporated in the certified EHR technology as structured data.

EXCLUSION: Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?

Yes  No

Complete the following information:

Numerator = Number of lab test results whose results are expressed in a positive or negative affirmation or as number which are incorporated as structured data.

Denominator = Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be completed unless the exclusion was responded to with “Yes” answer. 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 then they have met the measure threshold

## Patient List

Additional Menu Measure 3

Red asterisk indicates a required field.

TITLE: PATIENT LIST

Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

Measure: Generate at least one report listing patients of the EP with a specific condition.

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

■ Have you generated at least one report listing your patients with a specific condition?

Yes  No

Name at least one specific condition for which a list was created:

For assistance call 801-538-6929

Save Previous Next

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 enter an answer on the last question on the page
- For guidance on what documentation to retain for non-percentage based (yes/no) measures, please refer to the [CMS Supporting Documentation for Audits](#) guide.

## Patient Reminders

Additional Menu Measure 4

Red asterisk indicates a required field.

TITLE: PATIENT REMINDERS

Objective: Send reminders to patients per patient preference for preventive/follow up care.

Measure: 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.

EXCLUSION: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you?

Yes  No

PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator who were sent the appropriate reminder.

Denominator = Number of unique patients 65 years old or older or 5 years old or younger.

Numerator:  Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be completed unless the exclusion was responded to with a "Yes" answer. 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 then they have met the measure threshold

## Patient Electronic Access to Their Health Information

Additional Menu Measure 5

Red asterisk indicates a required field.

TITLE: PATIENTS ELECTRONIC ACCESS to THEIR HEALTH INFORMATION

Objective: Provide patients with timely electronic access to their health information (including lab results, problem lists, medication lists and allergies) within 4 business days of the information being available to the EP.

Measure: At least 10% of all unique patients seen by the EP are provided timely electronic access (available to the patient within 4 business days of being updated in the certified EHR technology) to their health information subject to the EP's discretion to withhold certain information.

EXCLUSION: Any EP who neither orders nor creates lab tests or information that would be contained in the problem list, medication list, or medication allergy list during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of patients in the denominator who have timely electronic access (available to the patient within four business days of being updated in the certified EHR technology) to their health information online.  
Denominator = Number of unique patients seen by the EP during the EHR reporting period..

■ Numerator:  ■ Denominator:

Does your practice have an online patient portal?  
 Yes  No

For assistance call 801-538-6929

Save Previous Next

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 then they have met the measure threshold
- The EP must answer the last question; an EP does not have to have a patient portal to meet Meaningful Use

## Patient Education Resources

Additional Menu Measure b

Red asterisk indicates a required field.

TITLE: PATIRNT EDUCATION RESOURCES

Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

Measure: More than 10% of all unique patients seen by EP during the EHR reporting period are provided patient-specific education resources.

Complete the following information:

Numerator = Number of patients in the denominator who are provided patient-specific education resources.

Denominator = Number of unique patients seen by the EP during the EHR reporting period.

Numerator:  Denominator:

For assistance call 801-538-6929

Save Previous Next

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,  $N/D > 10\%$

## Medication Reconciliation

Additional Menu Measure

Red asterisk indicates a required field.

TITLE: SUMMARY of CARE

Objective: 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.

Measure: 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.

EXCLUSION: Any EP who was not on the receiving end of any transition of care during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.  
 This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of transitions of care in the denominator where medication reconciliation was performed.

Denominator = Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

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 then they have met the measure threshold

## Transition of Care Summary

Additional Menu Measure 8

Red asterisk indicates a required field.

TITLE TRANSITION OF CARE

Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.

Measure: 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.

EXCLUSION 1: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?

Yes  No

EXCLUSION 2: An EP who does not refer any patients to another provider during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?

Yes  No

\* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of transitions of care and referrals in the denominator where a summary of care record was provided.

Denominator = Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

\* Numerator:  \* Denominator:

For assistance call 801-538-6929

Save Previous Next

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 then they have met the measure threshold

After completing the Menu Measures the system will return to the Meaningful Use Menu. The Menu Measures details section will now say “Complete” and changes will not be able to be made to the completed section. (If changes need to be made, contact Incentive Program staff and request that the attestation be unlocked.) Proceed to the Core Clinical Quality Measures.

The screenshot shows a window titled "EHR Incentive Meaningful Use Menu". Inside the window, there is a section titled "Please select a menu option below:" followed by a list of menu items, each with a corresponding status button to its right. The items and their statuses are: "Meaningful Use Eligibility Details" (Complete), "Meaningful Use Core Measures" (Complete), "Meaningful Use Menu Measures" (Complete), "Clinical Quality Measures" (0), "Alternate Clinical Quality Measures" (0), "Additional Clinical Quality Measures" (0), "Meaningful Use Attestation" (N/A), and "View Estimated Payment" (no status button). At the bottom of the window, there is a text prompt "For assistance call 801-538-6929" and a "Previous" button.

Menu Option	Status
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	Complete
Meaningful Use Menu Measures	Complete
Clinical Quality Measures	0
Alternate Clinical Quality Measures	0
Additional Clinical Quality Measures	0
Meaningful Use Attestation	N/A
View Estimated Payment	

For assistance call 801-538-6929 [Previous](#)

## Core Clinical Quality Measures

Providers must report on all three Core Clinical Quality Measures. For each core measure that has a denominator of zero, you will be prompted to select a substitute from the Alternate Core Clinical Quality Measures.

### Hypertension: Blood Pressure Management

The screenshot shows a web-based form titled "Core Clinical Quality Measure 1". At the top, it says "Red asterisk indicates a required field." Below that, instructions state: "Instructions: All three Core Clinical Quality Management must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted." The form ID is "NQF0013" and the title is "Hypertension: Blood Pressure Measurement". The description reads: "Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least two office visits, with blood pressure (BP) recorded." It asks to "Complete the following information:" and shows two input fields: "Numerator: 1" and "Denominator: 1", both with red asterisks indicating they are required. At the bottom, there is a contact number "For assistance call 801-538-6929" and three buttons: "Save", "Previous", and "Next".

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.

## Preventive Care and Screening Measure Pair

Core Clinical Quality Measure 2

Red asterisk indicates a required field.

Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.

NQF 0028/PQRI 114

Title: Preventive Care and Screening Measure Pair

a. Tobacco Use Assessment  
Description: Percentage of patient visits for patients aged 18 years and older who have been seen for at least two office visits who were queried about tobacco use one or more times within 24 months.

Complete the following information:

\* Numerator:       \* Denominator:

b. Tobacco Cessation Intervention  
Description: Percentage of patient visits for patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.

## Adult Weight Screening and Follow-up

Core Clinical Quality Measure 3

Red asterisk indicates a required field.

Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.

NQF 0421

Title: Adult Weight Screening and Follow-up

Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

Complete the following information:

Population Criteria 1: \* Numerator:  Denominator:  Exclusion:

---

Population Criteria 2: \* Numerator:  Denominator:  Exclusion:

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For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.
- Exclusion must be greater than or equal to 0.
- Exclusion must be a whole number.

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Population 1	Ages < = 65
Population 2	Ages 18-64

## Alternate Core Clinical Quality Measure Selection Menu

Choose from this menu only if one or more Core Clinical Quality Measures have denominators of zero. (The instructions below adjust based on what was submitted in the Core Clinical Quality section, showing how many of the Alternate Core items need to be selected.) If none of the Denominators are zero for the Core Clinical Quality Measures, then go to the Additional Clinical Core Measures.

**Alternate Core Clinical Quality Measure Select**

Instructions:

You have entered a denominator of zero for 2 of your Core Clinical Quality Measures. You must submit 2 Alternate Clinical Quality Measure.

Please select 2 Alternate Clinical Quality Measure from the list below.

Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measures	Title	Description	Select
NQF 0024	Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.	<input checked="" type="checkbox"/>
NQF 0041/ PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients > 49 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	<input checked="" type="checkbox"/>
NQF 0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VSV);, four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (Flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	<input checked="" type="checkbox"/>

For assistance call 801-538-6929

## Weight Assessment and Counseling for Children and Adolescents

Alternate Core Clinical Quality Measure 1

Red asterisk indicates a required field.

NQF 0024

Title: Weight Assessment and Counseling for Children and Adolescents

Description: Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

Complete the following information :

Numerator 1:  Denominator 1:  
 Numerator 2:  Denominator 2:  
 Numerator 3:  Denominator 3:

---

Numerator 1:  Denominator 1:  
 Numerator 2:  Denominator 2:  
 Numerator 3:  Denominator 3:

---

Numerator 1:  Denominator 1:  
 Numerator 2:  Denominator 2:  
 Numerator 3:  Denominator 3:

---

For assistance call 801-538-6929

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Numerator must be a whole number.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- The Numerator should be less than or equal to the Denominator.

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Population 1	Ages 2 - 16
Population 2	Ages 2 - 10
Population 3	Ages 11 - 16
Numerator 1	BMI percentile
Numerator 2	Counseling for nutrition
Numerator 3	Counseling for physical activity

## Preventive Care and Screening: Influenza Immunization for Patients 50 years and Older

Alternate Core Clinical Measure 2

Red asterisk indicates a required field.

NQF 0041

Title: Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.

Description: Percentage of patients age 50 years and older who received an influenza immunization during the flu season (September through February).

Complete the following information:

Numerator:       Denominator:       Exclusion:

For assistance call 801-538-6929

Save    Previous    Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

## Childhood Immunization Status

Alternate Core Clinical Quality Measure 3

Red asterisk indicates a required field.

NQF 0038

Title: Childhood Immunization Status

Description: Percentage of children 2 years of age who had four diphtheria, typhus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type b (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (Flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Complete the following information :

Numerator 1: <input type="text"/>	Denominator 1: <input type="text"/>	Numerator 7: <input type="text"/>	Denominator 7: <input type="text"/>
Numerator 2: <input type="text"/>	Denominator 2: <input type="text"/>	Numerator 8: <input type="text"/>	Denominator 8: <input type="text"/>
Numerator 3: <input type="text"/>	Denominator 3: <input type="text"/>	Numerator 9: <input type="text"/>	Denominator 9: <input type="text"/>
Numerator 4: <input type="text"/>	Denominator 4: <input type="text"/>	Numerator 10: <input type="text"/>	Denominator 10: <input type="text"/>
Numerator 5: <input type="text"/>	Denominator 5: <input type="text"/>	Numerator 11: <input type="text"/>	Denominator 11: <input type="text"/>
Numerator 6: <input type="text"/>	Denominator 6: <input type="text"/>	Numerator 12: <input type="text"/>	Denominator 12: <input type="text"/>

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero. The following details other requirements of this screen:

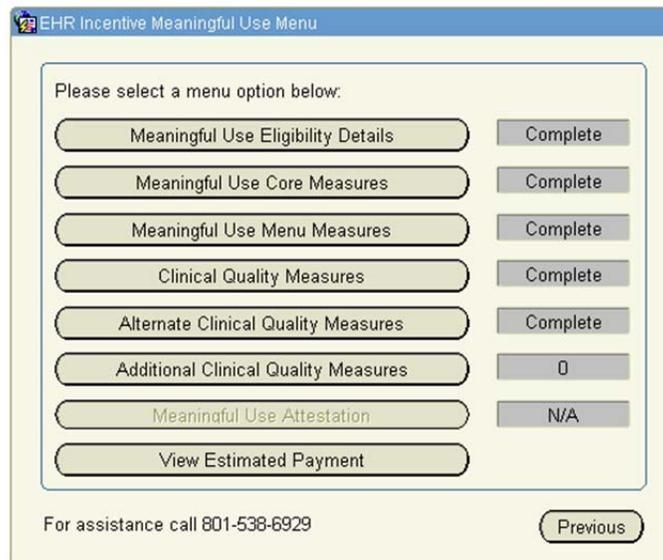
- Please enter a numerator, 0 is acceptable if that was reported by the EHR technology.
- Please enter a denominator, 0 is acceptable if there is no measure population.
- Please provide a whole number less than 1,000,000 for the Denominator.
- Please provide a whole number less than 1,000,000 for the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

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Numerator 1	4 or more counts DTaP vaccine
Numerator 2	3 or more counts IPV
Numerator 3	1 or more counts MMR
Numerator 4	2 or more counts HiB
Numerator 5	3 or more counts of hepatitis B vaccine
Numerator 6	1 or more counts VZV
Numerator 7	4 or more counts pneumococcal vaccine

Numerator 8	2 or more counts of hepatitis A vaccine
Numerator 9	2 or more counts of rotavirus vaccine
Numerator 10	2 or more counts of influenza vaccine
Numerator 11	4 or more counts of DTaP vaccine, 3 or more counts IPV, 1 or more counts MMR, 1 or more counts VZV, and 3 or more counts hepatitis B vaccine
Numerator 12	4 or more counts of DTaP vaccine, 3 or more counts IPV, 1 or more counts MMR, 1 or more counts VZV, 3 or more counts hepatitis B vaccine and 4 or more counts pneumococcal vaccine

After completing the Core Clinical Quality Measures and Alternate Core Clinical Quality Measures (if necessary) the system will return to the Meaningful Use Menu. The Alternate Core Clinical Quality Measures details section will now say “Complete” and changes will not be able to be made to the completed section. (If changes need to be made, contact Incentive Program staff and request that the attestation be unlocked.) Proceed to the Additional Clinical Quality Measures.



## Additional Clinical Quality Measures

### Selection Menu 1 of 5

Select a total of 3 measures from the 38 Additional Clinical Quality Measures. (You may only select 3.) 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.

Additional Clinical Quality Measure Select 1 of 5

Instructions: Select three(3) Additional Clinical Quality Measures from the next 5 screens. You will be prompted to enter Numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you make your selections.

Measures	Title	Description	Select
NQF 0001/ PQRI 64	Asthma Assessment	Percentage of patients 5-40 years of age with a diagnosis of asthma and who have been seen for at least two office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	<input type="checkbox"/>
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.	<input type="checkbox"/>
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation (b) Engagement	Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the visit.	<input type="checkbox"/>
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus for HIV infection during the first or second prenatal care visit.	Percentage of patients regardless of age, who gave birth during a 12-month period, who were screened	<input type="checkbox"/>
NQF 0014	Prenatal Care Anti-D Immune Globulin	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12 month period who received anti-D immune globulin at 26-30 weeks gestation.	<input type="checkbox"/>
NQF 0018	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	<input type="checkbox"/>
NQF 0027/ PQRI 115	Smoking and Tobacco Use Cessation Medical Assistance	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.	<input type="checkbox"/>

For assistance call 801-538-6929

Save Previous Next

## Selection Menu 2 of 5

Measures	Title	Description	Select
NQF 0031/ PQRI112	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	<input type="checkbox"/>
NQF 0032	Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	<input type="checkbox"/>
NQF 0033	Chlamydia Screening for Women	Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	<input type="checkbox"/>
NQF 0034/ PQRI 113	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	<input type="checkbox"/>
NQF 0036	Use of Appropriate Medication for Asthma	Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. Report three age stratifications (5-11 years, 12-50 years and total).	<input type="checkbox"/>
NQF 0043/ PQRI 111	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age or older who have ever received a pneumococcal vaccine.	<input type="checkbox"/>
NQF 0047/ PQRI 53	Asthma Pharmacologic Therapy	Percentage of patients aged 5-40 years with 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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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 negative retinal exam (no evidence of retinopathy) by an eye care professional.	<input type="checkbox"/>

## Selection Menu 3 of 5

Measures	Title	Description	Select
NQF 0056/ PQRI 163	Diabetes: Foot Exam	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament or pulse exam).	<input type="checkbox"/>
NQF 0059/ PQRI 1	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.	<input type="checkbox"/>
NQF 0061/ PQRI 3	Diabetes: Blood Pressure Management	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure < 140/90 mmHg.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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	<input type="checkbox"/>
NQF 0067/ PQRI 6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy	Percentage of patients 18 years of age or older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	<input type="checkbox"/>
NQF 0068/ PQRI 204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged 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	<input type="checkbox"/>
NQF 0070/ PQRI 7	Coronary Artery Disease (CAD): Beta-Blocker Therapy	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior Myocardial Infarction (MI) who were prescribed beta-blocker therapy.	<input type="checkbox"/>

For assistance call 801-538-6929

## Selection Menu 4 of 5

Measures	Title	Description	Select
NQF 0073/ PQRI 201	Ischemic Vascular Disease (IVD): Blood Pressure Management	Percentage of patients 18 years of age and older who were discharged for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from Jan 1-Nov 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).	<input type="checkbox"/>
NQF 0074/ PQRI 197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients age 18 years or older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current American College of Cardiology (ACC)/American Heart Association (AHA) guidelines).	<input type="checkbox"/>
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients aged 18 years and older who were discharged for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from Jan 1- Nov 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 a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dl.	<input type="checkbox"/>
NQF 0081/ PQRI 5	Heart Failure (HF): ACE or ARB Therapy	Percentage of adults aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) (LVEF <40%) who were prescribed angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy for LVSD.	<input type="checkbox"/>
NQF 0083/ PQRI 8	Heart Failure (HF): Beta-Blocker Therapy	Percentage of adults aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) (LVEF < 40%) who were prescribed beta-blocker therapy.	<input type="checkbox"/>
NQF 0084/ PQRI 200	Heart Failure (HF): Warfarin Therapy	Percentage of adults aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	<input type="checkbox"/>
NQF 0086/ PQRI 12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of adults 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.	<input type="checkbox"/>

For assistance call 801-538-6929

## Selection Menu 5 of 5

Measures	Title	Description	Select
NQF 0088/ PQRI 18	Diabetic Retinopathy: Documentation	Percentage of patients 18 years of age 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 retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	<input type="checkbox"/>
NQF 0089/ PQRI 19	Diabetic Retinopathy: Communication	Percentage of patients 18 years of age 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.	<input type="checkbox"/>
NQF 0105/ PQRI 9	Anti-depressant Medication: Management	Percentage of patients aged 18 years and older who were diagnosed with a new episode of major depression treated with anti-depressant medication (effective acute phase treatment) and who remained on an anti-depressant medication (effective continuation phase treatment).	<input type="checkbox"/>
NQF 0385/ PQRI 72	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of adults aged 18 years and older with stage IIIA through IIIC colon cancer who were referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.	<input type="checkbox"/>
NQF 0387/ PQRI 71	Oncology Breast Cancer: Hormonal Therapy	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period.	<input type="checkbox"/>
NQF 0389/ PQRI 102	Prostate Cancer: Avoidance of Overuse of Bone Scans	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.	<input type="checkbox"/>
NQF 0575	Diabetes: Hemoglobin A1c Control	Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c < 8.0%.	<input type="checkbox"/>

For assistance call 801-538-6929

## Asthma Assessment

Additional Clinical Quality Measure UI

Red asterisk indicates a required field.

NQF 0001 / PQRI 64

Title: Asthma Assessment

Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Appropriate Testing for Children with Pharyngitis

Additional Clinical Quality Measure 2

Red asterisk indicates a required field.

NQF 0002 / PQRI 66

Title: Appropriate Testing for Children with Pharyngitis

Description: 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.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
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- Please provide a whole number less than 1,000,000 for the Numerator.
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## Initial Visit and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation and Engagement

Additional Clinical Quality Measure 03

Red asterisk indicates a required field.  
NQF 0004

Title: Initial Visit and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initial visit.

Complete the following information :

Numerator 1: Patients ages 13-17 with one treatment or inpatient admission within 14 days of the diagnosis.  
 \* Numerator 1:  \* Denominator 1:

Numerator 2: Patients ages 13-17 with one treatment or inpatient admission within 30 days of the diagnosis.  
 \* Numerator 2:  \* Denominator 2:

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Numerator 3: Patients 18 years or older with one treatment or inpatient admission within 14 days of the diagnosis.  
 \* Numerator 3:  \* Denominator 3:

Numerator 4: Patients 18 years or older with one treatment or inpatient admission within 30 days of the diagnosis.  
 \* Numerator 4:  \* Denominator 4:

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Numerator 5: Patients 13 years or older with one treatment or inpatient admission within 14 days of the diagnosis.  
 \* Numerator 5:  \* Denominator 5:

Numerator 6: Patients 13 years or older with with one treatment or inpatient admission within 30 days of the diagnosis.  
 \* Numerator 6:  \* Denominator 6:

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For assistance call 801-538-6929

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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 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.
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Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Population 1	Ages 13 - 17
Population 2	Patients who will reach age 18 years or greater during the reporting period
Population 3	Patients who will reach age 13 years or greater during the reporting period

Numerator 1	Patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
Numerator 2	Patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

## Prenatal Care: Screening for Human Immunodeficiency Virus

Additional Clinical Quality Measure 4

Red asterisk indicates a required field.

NQF 0012

Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)

Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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 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.

## Prenatal Care: Anti-D Immune Globulin

Additional Clinical Quality Measure 5

Red asterisk indicates a required field.

NQF 0014

Title: Prenatal Care: Anti-D Immune Globulin

Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

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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.

## Controlling High Blood Pressure

Additional Clinical Quality Measure 6

Red asterisk indicates a required field.

NQF 0018

Title: Controlling High Blood Pressure

Description: The percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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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## Smoking and Tobacco Use Medical Assistance

Additional Clinical Quality Measure 7

Red asterisk indicates a required field.

NQF 0027 / PQRI 115

Title: 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

Description: Percentage of patients 13 years 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.

Complete the following information:

Numerator: Patients in the group that are documented tobacco users.

Numerator:  \* Denominator:  \*

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Numerator: Patients in the groups who were documented and counseled tobacco users.

Numerator 2:  \* Denominator 2:  \*

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For assistance call 801-538-6929

Save Previous Next

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Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Numerator 1	Patient is a tobacco user <=1 year before or simultaneously to the measurement period
Numerator 2	Encounter with patient for tobacco use cessation counseling <=1 year before or simultaneously to the measurement period or communicated to patient about tobacco use cessation counseling <+1 year before or simultaneously to the measurement end date

## Breast Cancer Screening

Additional Clinical Quality Measure 8

Red asterisk indicates a required field.

NQF 0031 / PQRI 112

Title: Breast Cancer Screening

Description: Percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
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- Please provide a whole number less than 1,000,000 for the Numerator.
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## Cervical Cancer Screening

Additional Clinical Quality Measure 9

Red asterisk indicates a required field.

NQF 0032

Title: Cervical Cancer Screening

Description: The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

Complete the following information:

▪ Numerator:       ▪ Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Chlamydia Screening for Women

Additional Clinical Quality Measure 10

Red asterisk indicates a required field.

NQF 0033

Title: Chlamydia Screening for Women

Description: The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Complete the following information:

Patients in the group aged 15 to 24.

\* Numerator:  \* Denominator:  \* Exclusion:

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Patients in the group aged 15 to 19.

\* Numerator:  \* Denominator:  \* Exclusion:

---

Patients in the group aged 20 to 24.

\* Numerator:  \* Denominator:  \* Exclusion:

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For assistance call 801-538-6929

Save Previous Next

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- 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.

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Population 1	Ages 15 - 24
Population 2	Ages 14 - 19
Population 3	Ages 20 - 24

## Colorectal Cancer Screening

Additional Clinical Quality Measure 11

Red asterisk indicates a required field.

NQF 0034 / PQRI 113

Title: Colorectal Cancer Screening

Description: Percentage of adults 50 - 75 years of age who had appropriate screening for colorectal cancer.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

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- 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.
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## Use of Appropriate Medications for Asthma

Additional Clinical Quality Measure 12

Red asterisk indicates a required field.

NQF 0036

Title: Use of Appropriate Medications for Asthma

Description: The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).

Complete the following information:

Patients in the 5 to 50 group.

Numerator:  \* Denominator:  \* Exclusion:

---

Patients in the group aged 5 to 11.

Numerator:  \* Denominator:  \* Exclusion:

---

Patients in the group aged 12 to 50.

Numerator:  \* Denominator:  \* Exclusion:

---

For assistance call 801-538-6929

Save Previous Next

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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.

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Population 1	Ages 5 - 11
Population 2	Ages 12 - 50
Population 3	Ages 5 - 50

## Pneumonia Vaccination Status for Older Adults

Additional Clinical Quality Measure 13

Red asterisk indicates a required field.

NQF 0043 / PQRI 111

Title: Pneumonia Vaccination Status for Older Adults

Description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

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- Please enter a denominator, 0 is acceptable if there is no measure population.
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## Asthma Pharmacologic Therapy

Additional Clinical Quality Measure 14

Red asterisk indicates a required field.

NQF 0047 / PQRI 53

Title: Asthma Pharmacologic Therapy

Description: 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.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

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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.

## Low Back Pain: Use of Imaging Studies

Additional Clinical Quality Measure 15

Red asterisk indicates a required field.

NQF 0052

Title: Low Back Pain: Use of Imaging Studies

Description: The percentage of patients with a primary diagnosis of low back pain who did have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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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## Diabetes: Eye Exam

Additional Clinical Quality Measure 16

Red asterisk indicates a required field.

NQF 0055 / PQRI 117

Title: Diabetes: Eye Exam

Description: Percentage of patients 18 - 75 with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or negative retinal exam (no evidence of retinopathy) by an eye care professional.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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 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.

## Diabetes: Foot Exam

Additional Clinical Quality Measure 17

Red asterisk indicates a required field.

NQF 0056 / PQRI 163

Title: Diabetes: Foot Exam

Description: Percentage of patients 18 - 75 with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Diabetes: Hemoglobin A1c Poor Control

Additional Clinical Quality Measure 18

Red asterisk indicates a required field.

NQF 0059 / PQRI 1

Title: Diabetes: Hemoglobin A1c Poor Control

Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c >90%.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

## Diabetes: Blood Pressure Management

Additional Clinical Quality Measure 19

Red asterisk indicates a required field.

NQF 0061 / PQRI 3

Title: Diabetes: Blood Pressure Management

Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure < 140/90 mmHg.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

## Diabetes: Urine Screening

Additional Clinical Quality Measure 20

Red asterisk indicates a required field.

NQF 0062 / PQRI 119

Title: Diabetes: Urine Screening

Description: Percentage of patients 18 - 75 with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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 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.

## Diabetes: Low Density Lipoprotein (LDL) Management and Control

Additional Clinical Quality Measure 21

Red asterisk indicates a required field.

NQF 0064 / PQRI 2

Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control

Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL.

Complete the following information:

Denominator: All patients in the group.  
Exclusion: Polycystic ovaries and Active diabetes or Active diabetes.

Numerator: Patients with LDL test result.

Numerator:  Denominator:  Exclusion:

---

Numerator: Patients with LDL test result < 100 mg/dl.

Numerator:  Denominator:  Exclusion:

---

For assistance call 801-538-6929

Save Previous Next

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

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Numerator 1	LDL Test
Numerator 2	LDL test with a value < 100 mg/dL

## Coronary Artery Disease: Oral Antiplatelet Therapy Prescribed for Patients with CAD

Additional Clinical Quality Measure 22

Red asterisk indicates a required field.

NQF 0067 / PQRI 6

Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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 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.

## Ischemic Vascular Disease: use of Aspirin or Another Antithrombotic

Additional Clinical Quality Measure 23

Red asterisk indicates a required field.

NQF 0068 / PQRI 204

Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

Description: 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.

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

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

## Coronary Artery Disease: Beta -Blocker Therapy for CAD Patients with Prior Myocardial Infarction

Additional Clinical Quality Measure 24

Red asterisk indicates a required field.

NGF 0070 / PQRI 7

Title: Coronary Artery Disease (CAD) Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

Description: Percentage of patients 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

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

## Ischemic Vascular Disease: Blood Pressure Management

Additional Clinical Quality Measure 25

Red asterisk indicates a required field.

NQF 0073 / PQRI 201

Title: Ischemic Vascular Disease (IVD); Blood Pressure Management

Description: Percentage of patients 18 years of age and older who were discharged for acute myocardial infarction (AMI, coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTC) from January 1 November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic disease (IVD) during the measurement year and whose recent blood pressure is in control (<140/90 mmHG).

Complete the following information:

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Coronary Artery Disease: Drug Therapy for Lowering LDL Cholesterol

Additional Clinical Quality Measure 26

Red asterisk indicates a required field.

NQF 0074 / PQRI 197

Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current American College of Cardiology (ACC)/ American Heart Association (AHA) guidelines).

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Ischemic Vascular Disease: Complete Lipid Panel and LDL Control

Additional Clinical Quality Measure 27

Red asterisk indicates a required field.

NQF 0075

Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

Description: The 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 a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.

Denominator: All patients in the group.  
Complete the following information:

Numerator: Patients in the group who had a complete lipid profile.

\* Numerator:  \* Denominator:

---

Numerator: Patients in the group who had a complete lipid profile with LDL < 100 mg/dl or triglyceride test < 400 mg/dl.

\* Numerator:  \* Denominator:

---

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Numerator 1	LDL test and/or HDL, total cholesterol and triglycerides tests performed
Numerator 2	LDL-C<100 mg/dL and/or triglycerides value < 400 mg/dL, total cholesterol value, HDL value, triglyceride value/5 < 100 mg/dL

## Heart Failure: Angiotensin-Converting Enzyme Inhibitor or Angiotensin Receptor Blocker Therapy for LVSD

Additional Clinical Quality Measure 28

Red asterisk indicates a required field.

NQF 0081 / PQRI 5

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

Description: Percentage of patients 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.
- Exclusion must be greater than or equal to 0.
- Please provide a whole number less than 1,000,000 for the Exclusion.

## Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction

Additional Clinical Quality Measure 29

Red asterisk indicates a required field.

NQF 0083 / PQRI 8

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

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and also have LVSD (LVEF < 40%) who were prescribed beta-blocker therapy.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation

Additional Clinical Quality Measure 30

Red asterisk indicates a required field.

NQF 0084 / PQRI 200

Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation

Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Primary Open Angle Glaucoma: Optic Nerve Evaluation

Additional Clinical Quality Measure 31

Red asterisk indicates a required field.

NQF 0086 / PQRI 12

Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Description: 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.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Additional Clinical Quality Measure 32

Red asterisk indicates a required field.

NQF 0088 / PQRI 18

Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

Description: Percentage of patients aged 18 years an 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.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

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

Additional Clinical Quality Measure 33

Red asterisk indicates a required field.

NQF 0089 / PQRI 19

Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Description: 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.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Anti-Depressant Medication Management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment

Additional Clinical Quality Measure 34

Red asterisk indicates a required field.

NQF 0105 / PQRI 9

Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment

Description: Percentage of patients 18 years and older diagnosed with a new episode of major depression treated with anti-depressant medication and who remained on an anti-depressant medication treatment.

Complete the following information:

Effective Acute Phase Treatment:

\* Numerator:  \* Denominator:

---

Effective Continuation Phase Treatment:

\* Numerator:  \* Denominator:

---

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

Fields with multiple definitions for population criteria or numerators have tool tips associated to assist the provider in attesting their numbers correctly. The following tool tips are associated with this screen:

Field	Tool Tip
Numerator 1	Patients who were dispensed antidepressant medication 84 days or longer after being diagnosed with a new episode of major depression
Numerator 2	Patients who were dispensed antidepressant medication 180 days or longer after being diagnosed with a new episode of major depression

## Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

Additional Clinical Quality Measure 35

Red asterisk indicates a required field.

NQF 0385 / PQRI 72

Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients

Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who were referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC ER/PR Positive Breast Cancer

Additional Clinical Quality Measure 36

Red asterisk indicates a required field.

NQF 0387 / PQRI 71

Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer

Description: 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.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Additional Clinical Quality Measure 37

Red asterisk indicates a required field.

NQF 0389 / PQRI 102

Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Description: 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.

Complete the following information:

Numerator:  Denominator:  Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Diabetes: Hemoglobin Control <8%

Additional Clinical Quality Measure 38

Red asterisk indicates a required field.

NQF 0575

Title: Diabetes: Hemoglobin Control < 8%

Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.

Complete the following information:

\* Numerator:       \* Denominator:       \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

All fields must be entered to continue to the next measure screen. The responses entered must be reported from your 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.

## Submitting The Attestation

Upon completing all required sections, providers will be returned to the meaningful use menu launch pad. No changes can be made at this time to completed sections. Two buttons are active from this launch pad: the View Estimated Payment Button, and the Meaningful Use Attestation Button.

To submit your attestation to the state of Utah, click the Meaningful Use Attestation Button.

The screenshot shows a software window titled "EHR Incentive Meaningful Use Menu". Inside the window, there is a section titled "Please select a menu option below:" followed by a list of menu items, each with a corresponding button to its right:

Menu Option	Action Button
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	Complete
Meaningful Use Menu Measures	Complete
Clinical Quality Measures	Complete
Alternate Clinical Quality Measures	Complete
Additional Clinical Quality Measures	Complete
Meaningful Use Attestation	OK
View Estimated Payment	(No button)

At the bottom of the window, there is a text prompt "For assistance call 801-538-6929" and a "Previous" button.

## Attestation Statements Screen

Below is the attestation screen that will launch. All check boxes must be completed. Upon successful submission, a summary report (PDF format) will be generated and emailed to the address entered in the eligibility details screen. This will allow providers to view and store a record of their answers to each measure. Again, no changes can be made to completed sections without contacting program staff at 801-538-6929.

Check all checkboxes and enter the provider initials and NPI. Click Next in order to submit the attestation.

*Note: Selecting 'Previous' prior to saving will result in the data on the current screen not being saved. To submit the completed attestation, click on Next. After your attestation is submitted you will be returned to the Meaningful Use Menu launch pad. You may view your payment estimate or review the attestation statement again (view only) from this screen. Close your browser to exit the program.*

Program staff will be in touch to let you know if any additional documentation or action is required.

## Eligible Hospital Registration for Stage 1 Meaningful Use

As of December 2012, the Utah SLR system located at <http://www.health.utah.gov/medicaid/provhtml/HIT.htm> will be prepared to accept attestations and capture meaningful use measures.

A hospital begins the process by entering the NPI registered on with CMS and the CMS-assigned Registration Identifier that was assigned at registration. Upon successful logon, the Provider Demographics Screen will display with the pre-populated data received from CMS. If the hospital entry does not match, an error message with instructions will be returned.

(Note that if you have recently made changes to your CMS registration, the information will not be available in the state system until approximately 24 hours later.)

The Utah SLR system will allow eligible hospitals to attest to the most current measures but has several features you should be made aware of from the start. See [Navigation and Tips](#).

## Eligible Hospital Sign-In Screen

Sign into the Utah EHR Incentive Program website:

- <http://health.utah.gov/medicaid/provhtml/HIT.htm>
- Hospitals will use their NPI and CMS-assigned identifier to access the Utah system. If you cannot locate your CMS registration identifier please call program staff at 801-538-6929.
- Clicking LOGIN will advance to the next screen.



The screenshot shows a web browser window titled "Utah Medicaid EHR Incentive Program". The page content includes a welcome message from the Utah Department of Health Division of Medicaid & Health Financing, instructions for registration, and a link for those without a CMS assigned registration identifier. Below the text is the EHR Incentive Program logo, which features a stylized "EHR" in blue and green with a white swoosh underneath. At the bottom of the page, there are two input fields: "Enter your NPI" and "Enter the CMS assigned registration identifier", followed by a "Login" button.

After the login screen, the system will display the hospital demographic information entered at the CMS Program Registration Site. If any information on this screen appears incorrect, please access the CMS registration site at: <https://ehrincentives.cms.gov/hitech/login.action> .

The screenshot shows a web interface with two tabs: "Demographic" (selected) and "Specialty". Below the tabs is a text block: "The information presented here has been received from the CMS EHR Incentive Program Registration Site. Please review the specialty tab. If your specialty is not listed, please choose a specialty from the list of approved CMS provider specialties. If other changes are necessary, please call the Utah Department of Health Division of Medicaid & Health Financing EHR Incentive Program at 801-538-6929 or visit: <https://ehrincentives.cms.gov/hitech/login.action>".

Below this is the instruction: "If the information is accurate please continue with your attestation." followed by a grid of input fields:

Applicant NPI	[Redacted]	Name	[Redacted]
Applicant TIN	[Redacted]	Address 1	[Redacted]
Payee NPI	[Redacted]	Address 2	[Redacted]
Payee TIN/CCN	[Redacted]	City	[Redacted]
Program Option	DUALLY_ELIGIBLE	State	UT
Medicaid State	UT	Zip Code	[Redacted] - [Redacted]
Provider Type	Acute Care Hospitals	Phone Number	[Redacted] Ext [Redacted]
Payment Year	1	Email	[Redacted]

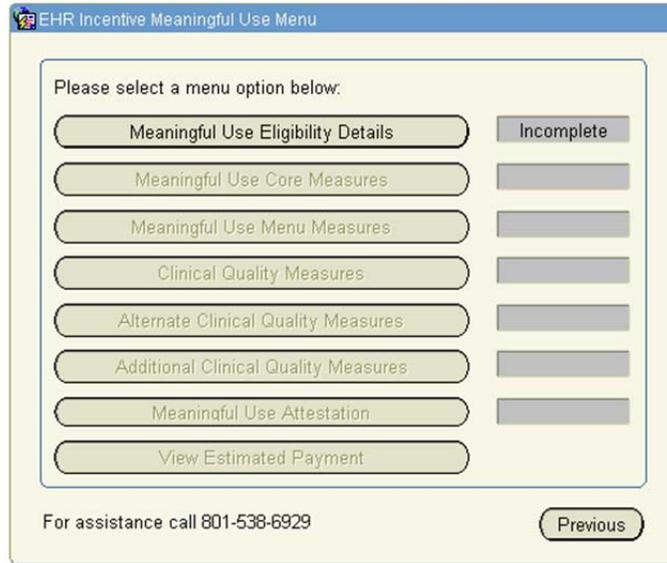
Below the form is a table with two columns: "Payment Year" and "Current Status".

Payment Year	Current Status
1	Adopt/Implement/Upgrade Payment Processed
2	Year 2 Meaningful Use Attestation In Progress

At the bottom of the form are several buttons: "View Attestation Status History", "Submit an Appeal", "Attestation for Adopt/Implement/Upgrade", and "Attestation for Meaningful Use".

Click "Attestation for Meaningful Use".

From the Meaningful Use Menu, select “Meaningful Use Eligibility Details”.



The Meaningful Use Menu screen will show the progress made as the different sections of the attestation are completed. The menu screen will only allow the user to select a group of measures as they are available. For example once the Meaningful Use Core Measures are completed, the Meaningful Use Menu Measures will be active to select. Step one will be to enter the Meaningful Use Eligibility Details. Click the first button.

*Note: Buttons for Alternate Core Clinical Quality Measures and Additional Clinical Quality Measures are marked with N/A – hospitals will not access these areas.*

Each screen offers the option to return to the previous screen, save progress in the current screen, or to move to the next screen once completed. Information is saved each time progression is made to the next screen or the attestation is exited. Enter the next screen by clicking “Next”.

## Meaningful Use Eligibility Details

EHR Incentive Provider Eligibility Details

Enter the EHR system details and Medicare cost report information:

CMS EHR certification id

Name of your EHR software

Status of your EHR software

Indicate which incentive payment you are applying for at this time

Have you filed a Medicare cost report

Emergency Department(ED) Admissions: An eligible hospital must choose one of two methods to designate how patients admitted to the Emergency Department(ED) will be included in the denominators of certain Meaningful Use Core and Menu Measures. Please select the method that will be used for ALL Meaningful Use Core and Menu Measures:

Please provide the EHR reporting period associated with this attestation:

EHR Reporting Period Start Date  (MM/DD/YYYY)

EHR Reporting Period End Date  (MM/DD/YYYY)

For assistance call 801-538-6929

- Enter the details that apply to your hospital EHR system.
- The certification ID number is obtained from the ONC site.
- For this stage of the payment, the status of your software should be Meaningful User.
- Indicate whether your hospital is attesting for a Dually Eligible MU payment or a Medicaid Hospital MU Payment.
- Select a Yes/No answer if a cost report has been filed.
- An eligible hospital must choose one of the two methods to designate how patients admitted to the Emergency Department will be included in the denominator of certain Meaningful Use Core and Menu measures. This option will be in effect for ALL Core and Menu Measures.
- Enter (or verify) the start and end date of the 90 day reporting period to which you are attesting. If you are attesting as a dually eligible hospital then these dates should be the same date as the one used for your Medicare meaningful Use attestation. The system will locate the file from Medicare form this date and you will not be requested to re-enter those measures already submitted to Medicare.

**EHR Incentive Provider Eligibility Details**

**Enter Patient Volume**

Starting date of the 90-day calculation period  (MM/DD/YYYY)

Medicaid discharges during this period  Adjustments

Total discharges during this period  Adjustments

Medicaid Patient Volume Percentage

You may now adjust the previous attestation discharges, inpatient bed days and hospital charges. Please save your changes.

**Enter Growth Rate**

End date of the most recent 12 month reporting period  (MM/DD/YYYY)

Total number of discharges for the current year  Adjustments

Total number of discharges for one year prior  Adjustments

Total number of discharges for two years prior  Adjustments

Total number of discharges for three years prior  Adjustments

**Enter Medicaid Share**

	Utah Medicaid	Adjustments	Other State Medicaid	Adjustments
Medicaid discharges	<input type="text" value="293"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Medicaid inpatient bed days	<input type="text" value="772"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Medicaid managed care inpatient bed days	<input type="text" value="152"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Enter Total Share**

Total hospital inpatient bed days  Adjustments

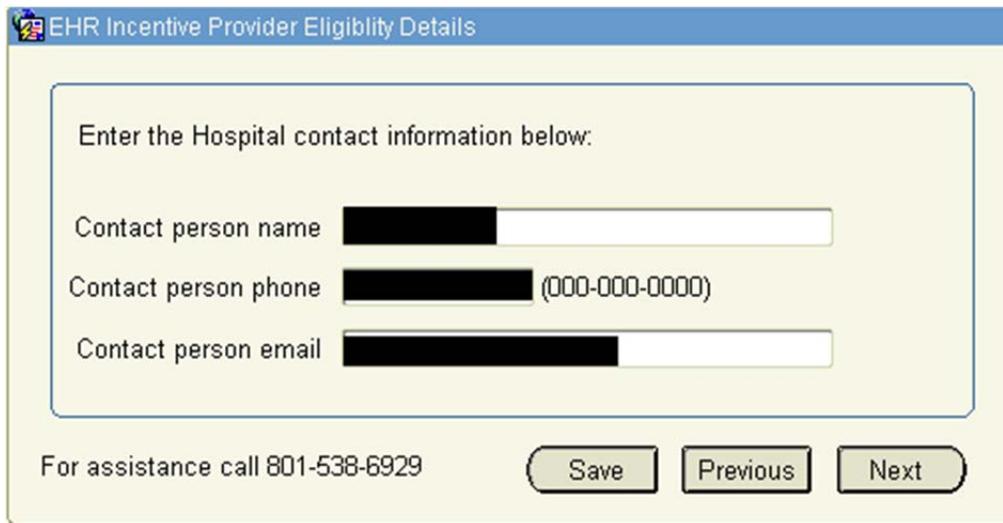
Total hospital charges  Adjustments

Total hospital charity care charges  Adjustments

For assistance call 801-538-6929

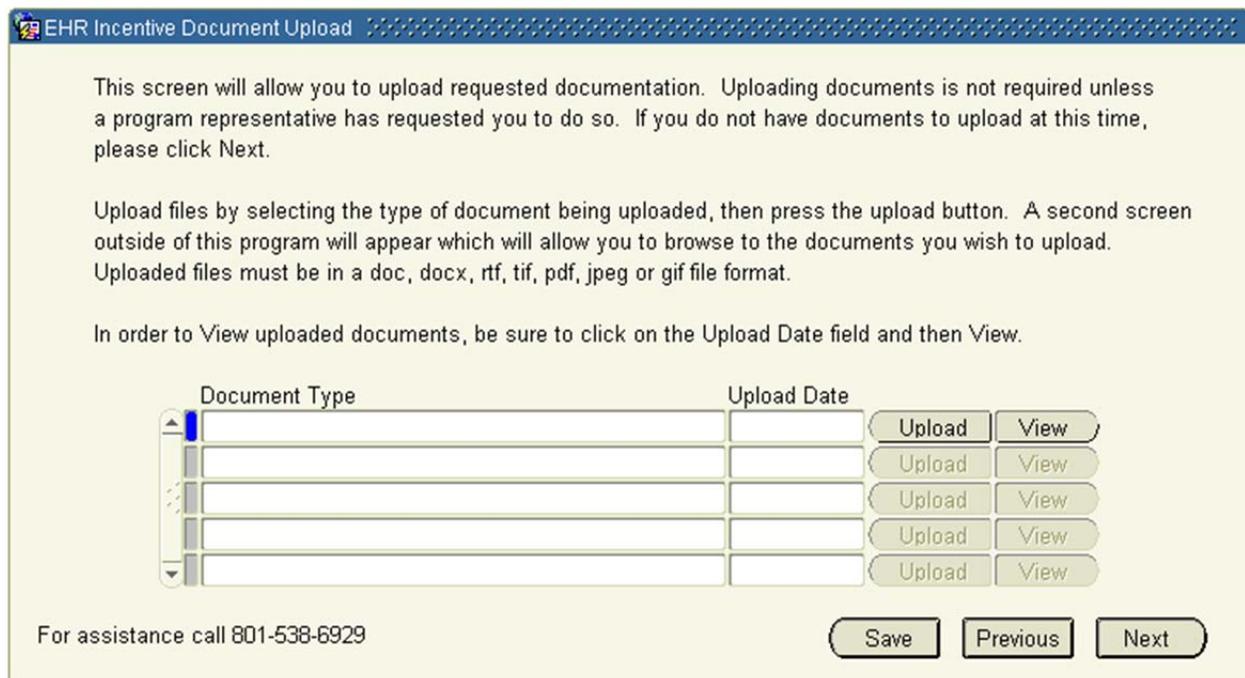
- This screen is prepopulated based on the base year data that was entered for the first year incentive payment. Prepopulated fields cannot be changed.
- Hospitals must enter Medicaid discharges and total patient discharges for a 90 day period in the prior fiscal year. See previous section **Establishing Patient Volume** for additional detail.
- If any adjustments need to be made to the cost report data that was originally submitted, check the box on the upper left to open up the Adjustment fields for the individual data elements.
- If adjustments are made, click Save before proceeding to the next screen.

Enter Hospital contact information in this screen. Incentive program staff will communicate directly with this designated contact.



The screenshot shows a window titled "EHR Incentive Provider Eligibility Details". Inside the window, there is a text box that says "Enter the Hospital contact information below:". Below this text box are three input fields: "Contact person name", "Contact person phone", and "Contact person email". Each field has a blacked-out portion, indicating that the information has been entered but is obscured. At the bottom of the window, there is a text box that says "For assistance call 801-538-6929" and three buttons: "Save", "Previous", and "Next".

This next screen provides the functionality to attach any supporting documentation relative to the attestation.



The screenshot shows a window titled "EHR Incentive Document Upload". The window contains the following text:

This screen will allow you to upload requested documentation. Uploading documents is not required unless a program representative has requested you to do so. If you do not have documents to upload at this time, please click Next.

Upload files by selecting the type of document being uploaded, then press the upload button. A second screen outside of this program will appear which will allow you to browse to the documents you wish to upload. Uploaded files must be in a doc, docx, rtf, tif, pdf, jpeg or gif file format.

In order to View uploaded documents, be sure to click on the Upload Date field and then View.

Document Type	Upload Date	Upload	View
		Upload	View

At the bottom of the window, there is a text box that says "For assistance call 801-538-6929" and three buttons: "Save", "Previous", and "Next".

Clicking on the upload and browse buttons will allow the EH to search and select the documents they would like to attach.

After selecting the document to upload, click on submit. Clicking on view will allow the EH to view the document that has been uploaded.

Once the eligibility information is complete, the system will return to the Meaningful Use Menu Screen. The eligibility details section will now say “Complete” and changes will not be able to be made to the completed section. (If changes need to be made, contact Incentive Program staff and request that the attestation be unlocked.)

Please select a menu option below:	
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	0
Meaningful Use Menu Measures	0
Clinical Quality Measures	0
Alternate Clinical Quality Measures	N/A
Additional Clinical Quality Measures	N/A
Meaningful Use Attestation	N/A
View Estimated Payment	

For assistance call 801-538-6929 Previous

*Note: The “View Estimated Payment” option is functional now that the eligibility information is confirmed and can be accessed at any point throughout the remainder of the attestation. Proceed to the Meaningful Use Core Measures.*

### Attesting to Meaningful Use Measures

For Hospitals who have attested to 90 days of Meaningful Use with CMS during the current program year, the measure screens will be prepopulated to match the Medicare attestation. Continue to move through each measure as confirmation of the information that has been received.

Medicaid-only hospitals will be required to manually enter each measure. Dually-eligible hospitals who have not attested for 90 days of Meaningful Use with Medicare or whose data is too old for Utah to reuse must manually enter each screen.

## Hospital Core Meaningful Use Measures

### Hospital Core Measure 1: CPOE

Hospital Core Measure 1 of 14

Red asterisk indicates a required field.

Objective: 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.

Measure: More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital (EH) or Critical Access Hospitals (CAH) inpatient or emergency department (Place of Service 21 or 23) have at least one medication order entered using CPOE.

**\*** PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator = Number of unique patients with at least one medication in their medication list seen by the EH or CAH during the EHR reporting period.

**\*** Numerator:       **\*** Denominator:

For assistance call 801-538-6929

Save Previous Next

Each screen offers the option to return to the previous screen, save progress in the current screen, or to move to the next screen once completed. Information is saved each time progression is made to the next screen or the attestation is exited. Enter the next screen by clicking Next.

The following details 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 EH must meet the >30% threshold,  $N/D > 30\%$

## Hospital Core Measure 2: Drug Interaction

Hospital Core Measure 2 of 14

Red asterisk indicates a required field.

Objective: Implement drug-drug and drug-allergy interaction checks.

Measure: The EH or CAH has enabled this functionality for the entire EHR reporting period.

Complete the following information:

\* Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

Yes  No

For assistance call 801-538-6929

Save Previous Next

- Answer Yes or No for performing the individual Menu Measure

## Hospital Core Measure 3: Maintain Problem List

Hospital Core Measure 3 of 14

Red asterisk indicates a required field.

Objective: Maintain an up-to-date problem list of current and active diagnoses.

Measure: More than 80% of all unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator that have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

Denominator = Number of unique patients seen by the EHs or the CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period

Numerator:  Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details 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 EH must meet the >80% threshold,  $N/D > 80\%$

## Hospital Core Measure 4: Active Medication List

Hospital Core Measure 4 of 14

Red asterisk indicates a required field.

Objective: Maintain active medication list.

Measure: More than 80% of all unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) have a least one entry (or an indication that the patient is not currently prescribed medication) recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have medication (or an indication that the patient is not currently prescribed medication) recorded as structured data.

Denominator = Number of unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:       \* Denominator:

Enter the number of unique patients listed within the numerator above as patients that are currently prescribed any medication as structured data:

For assistance call 801-538-6929

The following details 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 EH must meet the >80% threshold,  $N/D > 80\%$

## Hospital Core Measure 5: Active Medication Allergy List

hospital Core Measure 5 of 14

Red asterisk indicates a required field.

Objective: Maintain active medication allergy list.

Measure: More than 80% of all unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

Complete the following information:

Numerator = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

Denominator = Number of unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:       \* Denominator:

Enter the unique number of patients included in the numerator that had an indication of no known allergies recorded as their structured data:

For assistance call 801-538-6929

The following details 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 EH must meet the >80% threshold,  $N/D > 80\%$
- If available, provide the number of unique patients included in the denominator with an indication of “no known allergies” in their structured data. (This is not a required field.)

## Hospital Core Measure 6: Record Demographics

Hospital Core Measure 6 of 14

Red asterisk indicates a required field.

Objective: Record all of the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of Birth
- Date and preliminary cause of death in the event of mortality in the EH or the CAH.

Measure: More than 50% of all unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

Denominator = Number of unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:       \* Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details 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 EH must meet the >50% threshold,  $N/D > 50\%$

## Hospital Core Measure 7: Record Vital Signs

Hospital Core Measure 7 of 14

Red asterisk indicates a required field.

Objective: 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

Measure: More than 50% of all unique patients age 2 and older admitted to the EHs or CAHs inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data.

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator that have at least one entry of their height, weight and blood pressure recorded as structured data.

Denominator = Number of unique patients age 2 or over admitted to the EHs or CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

■ Numerator:       ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details 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 EH must meet the >50% threshold, N/D > 50%

## Hospital Core Measure 8: Record Smoking Status

Hospital Core Measure 8 of 14

Red asterisk indicates a required field.  
Objective: Report smoking status for patients 13 years old or older.

Measure: More than 50% of all unique patients 13 years old or older admitted to the EHS or CAHs inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.

EXCLUSION: An EH or CAH that sees no patients 13 years old or older would be excluded from this requirement. Exclusion from this from this requirement does not prevent an EH or CAH from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

Complete the following information:

Numerator = Number of patients in the denominator with smoking status recorded as structured data.

Denominator = Number of unique patients age 13 or older seen by the EH or CAH during the EHR reporting period.

■ Numerator  ■ Denominator

For assistance call 801-538-6929

Save Previous Next

The following details 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 EH must meet the >50% threshold,  $N/D > 50\%$
- If the hospital responds Yes to the exclusion then it has met the measure threshold

## Hospital Core Measure 9: Report Clinical Quality Measures

Hospital Core Measure 9 of 14

Red asterisk indicates a required field.

Objective: Report hospital clinical quality measures to CMS or, in the case of Medicaid EHs, to the State.

Measure: Provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of the final rule.

I will submit Clinical Quality Measures.

Yes  No

For assistance call 801-538-6929

Save Previous Next

- Please select Yes or No to continue to the next screen.

## Hospital Core Measure 10: Implement Clinical Decision Support Rule

Hospital Core Measure 10 of 14

Red asterisk indicates a required field.

Objective: Implement one clinical decision support (CDS) rule related to specialty or high clinical priority along with the ability to track compliance with that rule.

Measure: Implement one clinical decision support rule.

Complete the following information:

**\*** Have you implemented one clinical decision support rule?

Yes  No

Enter the CDS rule that was implemented

For assistance call 801-538-6929

- Please select Yes or No to continue to the next screen.
- If you have the CDS rule that your hospital implemented available, please provide it.

## Hospital Core Measure 11: Electronic Copy of Health Information

Hospital Core Measure 11 of 14

Red asterisk indicates a required field.

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

Measure: More than 50% of all patients of the inpatient or emergency department of the EH or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.

EXCLUSION: BASED ON ALL PATIENT RECORDS: An EH or CAH who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

■ Does this exclusion apply to you?

Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or "ONLY" from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

Denominator = Number of patients of the of the inpatient or emergency department of the EH or CAH (POS 21 or 23) who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

■ Numerator :  ■ Denominator :

For assistance call 801-538-6929

Save Previous Next

The following details 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 EH must meet the >50% threshold,  $N/D > 50\%$
- If the hospital responds Yes to the exclusion then it has met the measure threshold

## Hospital Core Measure 12: Electronic Copy of Discharge Instructions

Hospital Core Measure 12 of 14

Red asterisk indicates a required field.

Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

Measure: More than 50% of all patients who are discharged from an EHs or CAHs inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

EXCLUSION: BASED ON ALL PATIENT RECORDS: An EH or CAH who has no requests from patients or their agents for an electronic copy of their discharge instructions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or "ONLY" from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of patients in the denominator who are provided an electronic copy of discharge instructions.

Denominator = Number of patients discharged from an EHs or CAHs inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions during the EHR reporting period.

■ Numerator  ■ Denominator :

For assistance call 801-538-6929

Save Previous Next

The following details 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 EH must meet the >50% threshold,  $N/D > 50\%$
- If the hospital responds Yes to the exclusion then it has met the measure threshold

## Hospital Core Measure 13: Electronic Exchange of Clinical Information

Hospital Core Measure 13 of 14

Red asterisk indicates a required field.

Objective: 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.

Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

Complete the following information :

▪ Have you performed at least one test of the certified EHR technology's capacity to exchange information electronically?

Yes  No

For assistance call 801-538-6929

Save Previous Next

- Please select Yes or No to continue to the next screen.

## Hospital Core Measure 14: Security Review

Hospital Core Measure 14 of 14

Red asterisk indicates a required field.

Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Measure: 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.

Complete the following information :

\* Have you conducted or reviewed a security risk analysis per 45 CFR 164.308 (a)(1) and implemented security updates as necessary and corrected identified security deficiencies as part of your risk management process?

Yes  No

For assistance call 801-538-6929

Save Previous Next

- Please select Yes or No to continue to the next screen.

After the Core Measure section is completed, the hospital is returned to the Meaningful Use Menu Screen.

EHR Incentive Meaningful Use Menu

Please select a menu option below:

Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	Complete
Meaningful Use Menu Measures	0
Clinical Quality Measures	0
Alternate Clinical Quality Measures	N/A
Additional Clinical Quality Measures	N/A
Meaningful Use Attestation	N/A
View Estimated Payment	

For assistance call 801-538-6929

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## Hospital Meaningful Use Menu Measures

At this time the system will accept reporting on only five Meaningful Use Menu Measures, which is the minimum requirement. Hospitals have the ability to report on more than five menu measures and future programming will allow for this to occur.

At least one measure must be selected from the public health menu measures, which are listed on the first page of the menu measure selection screen. The remaining four measures can be any combination of the remaining public health menu measures or the additional Meaningful Use menu measures from the next page.

### Hospital Meaningful Use Menu Measure Select (page 1 of 2)

Instructions:

The EH or CAH must report on a total of five (5) Meaningful Use Menu Measures. At least one of the five measures must be from the public health menu measures. Should the EH or CAH be able to successfully meet only one of the public health menu measures, the EH or CAH must select and report on that measure to CMS. Having met one public health menu measure, the EH or CAH must then select any combination of the remaining public health menu measure or from the additional Meaningful Use Menu Measures in the list below.

OBJECTIVES	MEASURES	Select
Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and submission if the test is successful (unless none of the public health agencies to which the EH or CAH submits such information have the capacity to receive the information electronically).	<input checked="" type="checkbox"/>
Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic submission of reportable lab results to public health agencies and follow-up submission is successful.	<input checked="" type="checkbox"/>
Capability to submit electronic syndromic surveillance data to public health agencies and 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).	<input checked="" type="checkbox"/>

For assistance call 801-538-6929

Save Previous Next

## Hospital Meaningful Use Measure Select (page 2 of 2)

This screen will calculate how many of the public health measures were selected and (at this time) will only allow the hospital to select additional measures up to the limit of five.

Hospital Menu Measure Select 2 of 2

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measures Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected. (Total of five includes the 0 public health menu measure objectives selected)

OBJECTIVES	MEASURES	Select
Implement drug formulary checks.	The EH or CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	<input checked="" type="checkbox"/>
Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to EHRs or CAHs inpatient department (POS 21) have an indication of an advance directive status recorded as structured data	<input checked="" type="checkbox"/>
Incorporate clinical lab-test results into EHR as structured data	More than 40% of all clinical lab tests results ordered by an authorized provider of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are in either a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	<input checked="" type="checkbox"/>
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, or outreach.	Generate at least one report listing patients of the EH or CAH with a specific condition.	<input checked="" type="checkbox"/>
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients admitted to the EHRs or CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.	<input checked="" type="checkbox"/>
The EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EH or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the EHRs or CAHs inpatient or emergency department (POS 21 or 23).	<input checked="" type="checkbox"/>
The EH or CAH who transitions their patients to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EH or CAH 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 or referrals.	<input checked="" type="checkbox"/>

For assistance call 801-538-6929

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## Hospital Meaningful Use Menu Measure 1

Hospital Public Health Measure 1

Red asterisk indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.

Measure: 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 EH or CAH submits such information have the capacity to receive the information electronically).

EXCLUSION 1: An EH or CAH that does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?  
 Yes  No

EXCLUSION 2: If there is no immunization registry that has the capacity to receive the information electronically, an EH or CAH would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

\* Does this exclusion apply to you?  
 Yes  No

Complete the following information:

\* Did you perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful?  
 Yes  No

\* What was the result of the test?  
 Successful  Failed

\* Has a follow up test been submitted?  
 Yes  No

PLEASE NOTE: Neither a failed test nor failure to follow-up a test submission will prevent a EH or CAH from meeting Meaningful Use.

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- If the hospital responds Yes to Exclusion 1 then it has met the measure threshold
- Utah's Statewide Immunization Information System (**USIIS**) is currently accepting meaningful use test submissions. Hospitals should not select Yes to Exclusion 2
- The three remaining questions are all required. As long as a test submission has been made, the result of the test and follow-up status will not affect the satisfaction of this measure.

## Hospital Meaningful Use Menu Measure 2

Hospital Public Health Measure 2

Red asterisk indicates a required field.

Objective: Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and an actual submission in accordance with applicable law and practice.

Measure: Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow up submissions if the test is successful.

EXCLUSION: If no public health agency to which the EH or CAH submits such information has the capacity to receive the information electronically, then the EH or CAH would be excluded from this requirement.  
Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

\* Does this exclusion apply to you?

Yes  No

Complete the following information:

\* Did you perform at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if test was successful?

Yes  No

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- If the hospital responds Yes to the Exclusion then it has met the measure threshold
- The Utah Bureau of Epidemiology is currently accepting meaningful use test submissions through its **Electronic Laboratory Reporting** initiative. Hospitals should not select Yes to Exclusion 2
- Answer Yes or No for performing the individual Menu Measure

## Hospital Meaningful Use Menu Measure 3

Hospital Public Health Measure 3

Red asterisk indicates a required field.

Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Measure: 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 the EH or CAH submits such information have the capacity to receive the information electronically).

EXCLUSION 1: If an EH or CAH who does not collect any reportable syndromic information on their patients during the EHR reporting period, then the EH or CAH is excluded from this requirement. Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

\* Does this exclusion apply to you?  
 Yes  No

EXCLUSION 2: If there is no public health agency that has the capacity to receive the information electronically, then the EH or CAH is excluded from this requirement. Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

\* Does this exclusion apply to you?  
 Yes  No

Complete the following information:

\* Did you perform at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful?  
 Yes  No

\* What was the result of the test?  
 Successful  Failed

\* Has a follow up test been submitted?  
 Yes  No

PLEASE NOTE: Neither a failed test nor failure to follow-up a test submission will prevent an EH or CAH from meeting Meaningful Use.

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- If the hospital responds Yes to Exclusion 1 then it has met the measure threshold
- Utah is currently accepting **Syndromic Surveillance Reporting** meaningful use test submissions. Hospitals should not select Yes to Exclusion 2
- The three remaining questions are all required. As long as a test submission has been made, the result of the test and follow-up status will not affect the satisfaction of this measure.

## Hospital Meaningful Use Menu Measure 4

Hospital Additional Menu Measure 4

Red asterisk indicates a required field.

Objective: Implement drug formulary checks.

Measure: The EH or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

\* PATIENT Records: Please select whether data was extracted from "All" patient records or "Only" from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information :

\* Did you enabled the drug-formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period?

Yes  No

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Select the appropriate option under patient records
- Answer Yes or No for performing the individual Menu Measure

## Hospital Meaningful Use Menu Measure 5

Hospital Additional Menu Measure 5

Red asterisk indicates a required field.

Objective: Record advance directives for patients 65 years old or older.

Measure: More than 50% of all unique patients 65 years old or older admitted to the EHs or CAHs inpatient department (POS 21) have an indication of an advance directive status recorded as structured data.

EXCLUSION: An EH or CAH that admitted no patients 65 years or older during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

■ Does this exclusion apply to you?  
 Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.  
 This data was extracted from All patient records not just those maintained using certified EHR technology.  
 This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator with an indication of an advance directive entered using structured data.

Denominator = Number of unique patients 65 years old or older admitted to an EHs or CAHs inpatient department (POS 21) during the EHR reporting period.

■ Numerator:       ■ Denominator:

For assistance call 801-538-6929

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The following details requirements of this screen:

- If the hospital responds Yes to the Exclusion then it has met the measure threshold
- Select the appropriate option under patient records
- The numerator and denominator should be positive whole numbers where the numerator is less than or equal to the denominator.

## Hospital Meaningful Use Menu Measure 6

Hospital Additional Menu Measure 6

Red asterisk indicates a required field.

Objective: Incorporate clinical lab test results into EHR as structured data.

Measure: More than 40% of all clinical lab test results ordered by an authorized provider of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in the certified EHR technology as structured data.

EXCLUSION: Any EH or CAH that has no lab tests results ordered by an authorized provider whose results are either in a positive/negative or numeric format would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?

Yes  No

Complete the following information:

Numerator = Number of lab test results whose results are expressed in a positive or negative affirmation or as number which are incorporated as structured data.

Denominator = Number of lab tests ordered during the EHR reporting period by authorized providers of the EH or CAH for patients admitted to an EHs or CAHs inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- If the hospital responds Yes to the Exclusion then it has met the measure threshold
- The numerator and denominator should be positive whole numbers where the numerator is less than or equal to the denominator.

## Hospital Meaningful Use Menu Measure 7

Hospital Additional Menu Measure 7

Red asterisk indicates a required field.

Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

Measure: Generate at least one report listing patients of the EH or CAH with a specific condition.

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

■ Have you generated at least one report listing patients of the EH or CAH with a specific condition?

Yes  No

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Select the appropriate option under patient records
- Answer Yes or No for performing the individual Menu Measure

## Hospital Meaningful Use Menu Measure 8

Additional Hospital Menu Measure 8

Red asterisk indicates a required field.

Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

Measure: More than 10% of all unique patients admitted to the EHs or CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.

Complete the following information:

Numerator = Number of patients in the denominator who are provided patient-specific education resources.

Denominator = Number of unique patients admitted to the EHs or CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:  \* Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- The numerator and denominator should be positive whole numbers where the numerator is less than or equal to the denominator
- The EH must meet the >10% threshold, N/D >10%

## Hospital Meaningful Use Menu Measure 9

Additional Menu Measure 9

Red asterisk indicates a required field.

Objective: The EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Measure: The EH or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the EHs or CAHs inpatient or emergency department (POS 21 or 23).

EXCLUSION: Any EH or CAH who did not on the receiving end of any transition of care during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?

Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of transitions of care in the denominator where medication reconciliation was performed.

Denominator = Number of transitions of care during the EHR reporting period for which the EHs or CAHs inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.

■ Numerator:  ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- If the hospital responds Yes to the Exclusion then it has met the measure threshold
- Select the appropriate option under patient records
- The numerator and denominator should be positive whole numbers where the numerator is less than or equal to the denominator
- The EH must meet the >50% threshold,  $N/D > 50\%$

## Hospital Meaningful Use Menu Measure 10

Additional Hospital Menu Measure 10

Red asterisk indicates a required field.

Objective: The EH or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.

Measure: The EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

EXCLUSION 1: An EH or CAH that does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

■ Does this exclusion apply to you?

Yes  No

EXCLUSION 2: An EH or CAH that does not refer any patients to another provider during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EH or CAH from achieving meaningful use.

■ Does this exclusion apply to you?

Yes  No

■ PATIENT RECORDS: Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using certified EHR technology.

This data was extracted from All patient records not just those maintained using certified EHR technology.

This data was extracted "Only" from patients records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of transitions of care and referrals in the denominator where a summary of care record was provided.

Denominator = Number of transitions of care and referrals during the EHR reporting period for which the EHs or CAHs was inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

■ Numerator:       ■ Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- If the hospital responds Yes to either Exclusion then it has met the measure threshold
- Select the appropriate option under patient records
- The numerator and denominator should be positive whole numbers where the numerator is less than or equal to the denominator
- The EH must meet the >50% threshold,  $N/D > 50\%$

After completion of the Menu Section the provider is once again returned to the Meaningful Use Menu. Click the Clinical Quality Measure button to proceed to the final section.

The screenshot shows a window titled "EHR Incentive Meaningful Use Menu". Inside the window, there is a section titled "Please select a menu option below:" followed by a list of menu items, each with a corresponding status button to its right:

Menu Option	Status
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	Complete
Meaningful Use Menu Measures	Complete
Clinical Quality Measures	0
Alternate Clinical Quality Measures	N/A
Additional Clinical Quality Measures	N/A
Meaningful Use Attestation	
View Estimated Payment	

At the bottom of the window, there is a text prompt: "For assistance call 801-538-6929" and a "Previous" button.

## Hospital Clinical Quality Measures

### Hospital Clinical Quality Measure 1

Hospital Clinical Quality Measure 1

Red asterisk indicates a required field.

Measure: NQF 0495, Emergency Department (ED)-1  
Title: ED Throughput - admitted patients Median time from ED arrival to ED departure for admitted patients.  
Description: Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED.

ED-1.1: All ED patients admitted to the facility from the ED.  
Numerator: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.  
A positive whole number where the Numerator is less than, greater than, or equal to the Denominator.  
Denominator: All ED patients admitted to the facility from the ED. A positive whole number.  
Exclusion: Observation & Mental Health Patients. A positive whole number.

\* Numerator:  \* Denominator:  \* Exclusion:

ED-1.2: Observation ED patient stratification.  
Numerator: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.  
A positive whole number where the Numerator is less than, greater than, or equal to the Denominator.  
Denominator: ED Observation patients admitted to the facility from the ED. A positive whole number.

\* Numerator:  \* Denominator:

ED-1.3: Dx stratification ED patients.  
Numerator: Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED.  
A positive whole number where the Numerator is less than, greater than, or equal to the Denominator.  
Denominator: ED patients with a Dx of Psychiatric or Mental Health Disorder admitted to the facility from the ED.  
A positive whole number.

\* Numerator:  \* Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 2

Hospital Clinical Quality Measure 2

Red asterisk indicates a required field.

Measure: NQF 0497, Emergency Department (ED)-2  
Title: ED Throughput - admitted patients Admission decision time to ED departure time for admitted patients  
Description: Median time from admit decision time departure from the department of emergency department patients admitted to inpatient status.

ED-2.1: All ED patients admitted to inpatient status.  
Numerator: Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status .  
A positive whole number where the Numerator is less than , greater than, or equal to the Denominator.  
Denominator: All ED patients admitted to the facility from the ED. A positive whole number.  
Exclusion: Observation & Mental Health Patients. A positive whole number.

\* Numerator:  \* Denominator:  \* Exclusion:

ED-2.2: Observation ED patient strtfication.  
Numerator: Median time (in minutes) from admit decision to time of departure from the ED for patients admitted to inpatient status.  
A positive whole number where the Numerator is less than , greater than, or equal to the Denominator.  
Denominator: ED Observation patients admitted to the facility from the ED. A positive whole number.

\* Numerator:  \* Denominator:

ED-2.3: Dx strtfication ED patients.  
Numerator: Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status.  
A positive whole number where the Numerator is less than , greater than, or equal to the Denominator.  
Denominator: ED patients with a Dx of Psychiatric or Mental Health Disorder admitted to the facility from the ED.  
A positive whole number.

\* Numerator:  \* Denominator:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 3

Red asterisk indicates a required field.

Measure: NQF 0435, Stroke-2

Title: Ischemic stroke - Discharge on anti-thrombotics

Numerator: a positive whole number where the Numerator is less than or equal to the Denominator

Denominator: a positive whole number

Exclusion: a positive whole number

\* Numerator:  \* Denominator:  \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 4

Hospital Core Measure 4 of 14

Red asterisk indicates a required field.

Objective: Maintain active medication list.

Measure: More than 80% of all unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) have a least one entry (or an indication that the patient is not currently prescribed medication) recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have medication (or an indication that the patient is not currently prescribed medication) recorded as structured data.

Denominator = Number of unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:       \* Denominator:

Enter the number of unique patients listed within the numerator above as patients that are currently prescribed any medication as structured data:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 5

hospital Core Measure 5 of 14

Red asterisk indicates a required field.

Objective: Maintain active medication allergy list.

Measure: More than 80% of all unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

Complete the following information:

Numerator = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

Denominator = Number of unique patients admitted to the EHs or the CAHs inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

\* Numerator:       \* Denominator:

Enter the unique number of patients included in the numerator that had an indication of no known allergies recorded as their structured data:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 6

Red asterisk indicates a required field.

Measure: NQF 0438, Stroke-5

Title: Ischemic or hemorrhagic stroke - Antithrombotic therapy by day 2

Numerator: a positive whole number where the Numerator is less than or equal to the Denominator

Denominator: a positive whole number

Exclusion: a positive whole number

\* Numerator:  \* Denominator:  \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 7

Red asterisk indicates a required field.

Measure: NQF 0439, Stroke-6

Title: Ischemic stroke - Discharge on statins

Numerator: a positive whole number where the Numerator is less than or equal to the Denominator

Denominator: a positive whole number

Exclusion: a positive whole number

\* Numerator:  \* Denominator:  \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 8

Red asterisk indicates a required field.

Measure: NQF 0440, Stroke-8

Title: Ischemic or hemorrhagic stroke - Stroke Education

Numerator: a positive whole number where the Numerator is less than or equal to the Denominator

Denominator: a positive whole number

Exclusion: a positive whole number

\* Numerator:  \* Denominator:  \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Clinical Quality Measure 9

Red asterisk indicates a required field.

Measure: NQF 0441, Stroke-10

Title: Ischemic or hemorrhagic stroke - Rehabilitation assessment

Numerator: a positive whole number where the Numerator is less than or equal to the Denominator

Denominator: a positive whole number

Exclusion: a positive whole number

\* Numerator:  \* Denominator:  \* Exclusion:

For assistance call 801-538-6929

Save Previous Next

The following details requirements of this screen:

- Enter the numerator, denominator and exclusion (if applicable)
- There are no minimum thresholds for the clinical quality measures

## Hospital Attestation Screen

Upon completing all required sections, hospitals will be returned to the meaningful use menu launch pad. No changes can be made at this time to completed sections. Two buttons are active from this launch pad: the View Estimated Payment Button, and the Meaningful Use Attestation Button.

Menu Option	Status
Meaningful Use Eligibility Details	Complete
Meaningful Use Core Measures	Complete
Meaningful Use Menu Measures	Complete
Clinical Quality Measures	Complete
Alternate Clinical Quality Measures	N/A
Additional Clinical Quality Measures	N/A
Meaningful Use Attestation	OK
View Estimated Payment	

For assistance call 801-538-6929

Previous

To submit your attestation to the state of Utah, click the Meaningful Use Attestation Button.

Below is the hospital attestation screen that will launch. All check boxes must be completed. The administrator attesting to the information will use his/her initials and the hospital NPI to sign the attestation.

Upon completing your attestation, a summary report (PDF format) will be generated and emailed to the address entered in the eligibility details screen. This will allow hospitals to view and store a record of their answers to each measure.

Hospital Attestation Statement

Red asterisk indicates a required field.

**Attestation Statements**

**Important Notice:** No payment may be made unless this attestation form is completed and accepted as required by existing law and regulations (42 CFR 495.10). Anyone who misrepresents or falsifies essential information to receive a Utah Medicaid EHR Incentive Program payment requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

I certify that the foregoing information is true, accurate and complete. I understand that the Utah Medicaid EHR Incentive Program payment I have requested will be paid from Federal funds, that by completing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements or documents, or the concealment of a material fact used to obtain a Utah Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I hereby agree to keep such records as are necessary to demonstrate I meet the requirements and to furnish those records to the Utah Department of Health Medicaid & Health Financing Division, the Department of Health and Human Services, or contractor acting on their behalf.

Please check the box next to each statement below to attest, then initial, then fill in NPI. Select the NEXT button to complete your attestation.

- The information submitted for CQMs was generated as output from an identified, certified EHR technology.
- The information submitted is accurate to the knowledge and belief of the official submitting on behalf of the EH or CAH.
- The information submitted is accurate and complete for numerators, denominators, exclusions, and measures applicable to the EH or CAH.
- The information submitted includes information on all patients to whom the measure applies.
- For CQMs, a zero was reported in the denominator of a measure when an EH or CAH did not care for any patients in the denominator population during EHR reporting period.

Initial:

NPI:

Note: Once you press the NEXT button below you will not be able to change your information.

For assistance call 801-538-6929

Save Previous Next

After your attestation is submitted you will be returned to the Meaningful Use Menu launch pad. You may view your payment estimate or review the attestation statement again (view only) from this screen. Close your browser to exit the program.

Program staff will be in touch to let you know if any additional documentation or action from you is needed.

## Payment Estimate Screen

EHR Incentive Payment Methodology

Below is your estimated EHR/HIT Medicaid Incentive Payment based upon the information you have provided within this application. The data you provided is subject to verification. You will be contacted by Medicaid program staff, in the event there is a discrepancy found during the validation process and/or if the final payment(s) amount is different than what is currently displayed.

**Patient Volume Calculation**

Medicaid Patient Volume Percentage

Rate of growth for prior year

Rate of growth for two years prior

Rate of growth for three years prior

Average rate of growth

**EHR Amount Calculation**

	Discharges	Allowable Discharges	Discharge Related Amt	Base Amount	Aggregate EHR Amt	Transition Factor	EHR Amount
First Year	<input type="text" value="2,301"/>	<input type="text" value="1,152"/>	<input type="text" value="230,400"/>	<input type="text" value="2,000,000"/>	<input type="text" value="2,230,400"/>	<input type="text" value="1.00"/>	<input type="text" value="2,230,400"/>
Second Year	<input type="text" value="2,460"/>	<input type="text" value="1,311"/>	<input type="text" value="262,200"/>	<input type="text" value="2,000,000"/>	<input type="text" value="2,262,200"/>	<input type="text" value="0.75"/>	<input type="text" value="1,696,650"/>
Third Year	<input type="text" value="2,630"/>	<input type="text" value="1,481"/>	<input type="text" value="296,200"/>	<input type="text" value="2,000,000"/>	<input type="text" value="2,296,200"/>	<input type="text" value="0.50"/>	<input type="text" value="1,148,100"/>
Fourth Year	<input type="text" value="2,812"/>	<input type="text" value="1,663"/>	<input type="text" value="332,600"/>	<input type="text" value="2,000,000"/>	<input type="text" value="2,332,600"/>	<input type="text" value="0.25"/>	<input type="text" value="583,150"/>
<b>Total Amount</b>							<input type="text" value="5,658,300"/>

**Payment Calculation**

Total Medicaid and Medicaid managed care inpatient bed days	<input type="text" value="924"/>	Estimated year one payment	<input type="text" value="428,051"/>
Total hospital charges	<input type="text" value="102,748,308"/>	Estimated year two payment	<input type="text" value="342,440"/>
Total charity care charges	<input type="text" value="618,569"/>	Estimated year three payment	<input type="text" value="42,805"/>
Non charity percentage	<input type="text" value="99.398%"/>	Estimated year four payment	<input type="text" value="42,805"/>
Total hospital inpatient bed days	<input type="text" value="6,144"/>		
Medicaid percentage	<input type="text" value="15.13%"/>		
Aggregate EHR incentive payment	<input type="text" value="856,101"/>		

For assistance call 801-538-6929 Previous

*Note: Sample data included to illustrate functionality.*