

Ophthalmology Meaningful Use Attestation Guide

Ophthalmologists can register for the Medicare electronic health record (EHR) incentive program on the CMS website: <https://ehrincentives.cms.gov> Registration is a separate step from attestation, and it is not necessary to attest at the same time as registration. Once you have registered, you may return to the attestation portal at anytime.

For the first year that a physician participates in the Medicare EHR incentive program, he or she must attest to meeting the Stage 1 Meaningful Use objectives for any consecutive 90 day reporting period. Physicians who successfully attest to the meaningful use objectives beginning in 2011 or 2012 can earn up to \$18,000 for their first year of participation. (Please note that you cannot receive both a Medicare e-prescribing incentive and a Medicare EHR incentive in the same year, so many ophthalmologists may choose to wait until 2012 to attest to meaningful use to maximize their incentive payments).

Step 1: 15 Meaningful Use Core Measures

All physicians are required to report on all 15 measures, but some exclusions are available. Please note that many of the measures require that the measure be met for over a certain percentage of patients (e.g., 30 percent). In this case, any percentage that is **over** 30 percent will qualify (e.g., 30.3 percent, 31 percent, 50 percent). 30 percent will not qualify.

1. Computerized Physician Order Entry (CPOE) – More than 30% of all unique patients with at least one medication in their medication list seen by the eligible professional (EP) have at least one medication order entered using CPOE.

Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Reporting guidance:

Most ophthalmologists will be able to meet the objective or qualify for the exclusion.

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

In some cases, EHRs may include medication lists that are maintained by multiple physicians. In these circumstances, it may be difficult for the ophthalmologist to meet the reporting threshold due to the volume of entries for medications that are not managed by the ophthalmologist. CMS allows physicians that do not qualify for the exclusion (i.e. write 100 or more prescriptions) and maintain medication lists that include medications ordered by other providers to limit their CPOE measure calculation to only those patients for whom he or she has previously ordered a medication. Ophthalmologists facing this scenario should work with their EHR vendor to determine how to limit the measure calculation.

2. Drug-drug and drug-allergy interaction checks: The EP has enabled this functionality for the entire EHR reporting period.

Reporting Guidance:

All ophthalmologists should answer yes. This feature will be built in to every certified EHR.

3. Maintain an up-to-date problem list of current and active diagnoses: More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.

4. E-prescribing: More than 40 percent 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.

Reporting Guidance:

You must answer either “yes” or “no” to both exclusions. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

5. Maintain active medication list: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

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

7. Record Demographics: More than 50 percent of all unique patients seen by the EP have demographics (preferred language, gender, race, ethnicity, and date of birth) recorded as structured data.

Reporting Guidance:

If a patient declines to provide all or part of the demographic information, or if capturing a patient’s ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. If patients do not know their ethnicity, EPs should treat them as patients who decline to provide race or ethnicity (i.e., identify in the patient record that the patient declined to provide this information).

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or White.

Ethnicity: "Hispanic or Latino," or "Not Hispanic or Latino."

8. Record Vital Signs: For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.

Exclusion 1: Any EP who either sees no patients 2 years or older.

Exclusion 2: Any EP who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.

Reporting Guidance:

You must answer either “yes” or “no” to both exclusions. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

Many ophthalmologists will answer “yes” to exclusion 2. You must still input data on the measure as calculated by your EHR, but this will not prevent you from meeting the requirements of meaningful use.

9. Record Smoking Status: More than 50 percent 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 or older.

Reporting Guidance:

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

10. Clinical Quality Measures: Provide aggregate numerator, denominator, and exclusions through attestation.

Reporting Guidance:

All ophthalmologists should check “Yes” on the attestation form.

See the Clinical Quality Measures section of this document for details on reporting measures.

11. Clinical Decision Support Rule: Implement one clinical decision support rule relevant to the specialty or high clinical priority along with the ability to track compliance with that rule.

Reporting Guidance:

Consult with your vendor to determine the clinical decision support rule(s) your EHR has the capability to implement. All ophthalmologists should implement the appropriate rule and check “Yes” on the attestation form.

12. Electronic Copy of Health Information: More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.

Exclusion: An EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR period.

Reporting Guidance:

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

Information can be provided in any electronic format, including patient portal, PHR, CD, USB fob, etc.

13. Clinical Summaries: Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.

Exclusion: Any EP who has no office visits during the EHR reporting period.

Reporting Guidance:

Most ophthalmologists will not be able to check the exclusion for this objective. You must still answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, CD, USB fob, or printed copy.

14. Electronic Exchange of Clinical Information: Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

Reporting Guidance:

All ophthalmologists should perform the test and answer “Yes” on the attestation form.

The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy the objective.

The transmission of actual patient information is not required. A fictional patient may be used.

The test does not need to be successful to meet the requirement.

15. Protect Electronic Health Information: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

Reporting Guidance:

All ophthalmologists should review the security of their system, install any necessary updates, and answer “Yes” on the attestation form.

Step 2: the 10 Meaningful Use Menu Measures

All physicians must report on a total of 5 measures from the menu set. There are 2 public health measures and 8 additional measures. You must select 1 public health measure and 4 of the additional measures for a total of 5 measures.

Public Health Measures (Choose 1)

The public health measures are not applicable to ophthalmologists. To meet the attestation requirements, select one public health measure and attest to the exclusion.

1. Immunization registries data submission: 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.

Exclusion 1: An EP who administers no immunizations during the EHR reporting period.

Exclusion 2: There is no immunization registry that has the capacity to receive the information electronically.

Reporting Guidance:

Ophthalmologists who select this measure should check "Yes" for exclusion 1.

2. Syndromic Surveillance Data Submission: 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.

Exclusion 1: The EP does not collect any reportable syndromic information on their patients during the (EHR) reporting period.

Exclusion 2: There is no public health agency that has the capacity to receive the information electronically.

Reporting Guidance:

Ophthalmologists who select this measure should check "Yes" for exclusion 1.

Menu Measures (Choose 4 for a total of 5 measures)

All ophthalmologists must report on 4 of the remaining menu measures. The measures vary in their ease of reporting and relevance to ophthalmology practice. Each individual practice will need to determine which measures will be the smoothest for the practice to implement.

- **Implemented 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.

Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

- **Patient lists:** Generate at least one report listing patients of the EP with a specific condition.
- **Patient reminders:** More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.

Exclusion: An EP who has no patients 65 years or older or 5 years old or younger with records maintained using certified EHR technology.

Reporting Guidance:

Ophthalmologists have the discretion to choose the frequency, means of transmission, and form of the patient reminder.

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

- **Clinical lab test results:** More than 40 percent of all clinical lab test results ordered by the EP whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

Exclusion: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

Reporting Guidance:

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

- **Medication Reconciliation:** The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.

Reporting Guidance:

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

- **Transition of Care Summary:** The EP who transitions or refers their patient to another setting of care or provider or care provides a summary of care record for more than 50 percent of transitions of care and referrals.

Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

Reporting Guidance:

The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider.

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

- **Patient Electronic Access:** At least 10 percent 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)

electronic access to their health information subject to the EP's discretion to withhold certain information.

Exclusion: Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list during the EHR period.

Reporting Guidance:

You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

- **Patient Specific Education Resources:** More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.

Step 3: Clinical Quality Measures (CQMs)

There are 3 Core CQMs, 3 Alternate CQMs and 38 Additional CQMs, 4 of which are ophthalmology specific. All measure specifications are available at <https://www.cms.gov/EHRIncentivePrograms>

This section of the EHR attestation is based on participation, not successful reporting. Ophthalmologists will attest at the end of the section that the data presented was generated by the EHR. Therefore, all ophthalmologists should accurately report the measurement data calculated by the EHR and indicated exclusions where appropriate. There are no thresholds that must be met for the CQMs, and failure to meet the requirements of the measure will not prevent an ophthalmologist from earning the incentive payment as long as all required measures are reported.

Specifications for all of the available CQMs are available on the CMS website: https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp. Scroll to the Downloads section at the bottom of the page and click “EP Measure Specifications” to download a zip file that includes all of the available measures.

Core CQMs (Report all 3)

All ophthalmologists must report on the 3 Core CQMs. The Core CQMs are not relevant to most ophthalmology practices; however, reporting zeros in the numerator or denominator as appropriate will not prevent ophthalmologists from receiving a meaningful use incentive payment.

- **NQF 0013: Hypertension: Blood Pressure Measurement**
 - The percentage of patient visits with blood pressure measurement recorded among all patient visits for patients over 18 years of age with diagnosed hypertension
- **NQF0028: Preventive Care and screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention**

- The percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months b. The percentage of 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
- **NQF 0421/PQRS 128: Adult Weight Screening and Follow-up**
 - The 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

Alternate Core Measures

Because some ophthalmologists will report zeros in the denominators of one or more Core CQMs, they will be prompted to report on the 3 Alternate CQMs. Most ophthalmologists will also enter zeros in either the numerator or denominator for the Alternate CQMs. Reporting zeros in the numerator or denominator will not prevent ophthalmologists from receiving a meaningful use incentive payment.

- **NQF 0024: Weight Assessment and Counseling for Children and Adolescents**
 - The percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year
- **NQF 0041/PQRS 110: Preventive Care and Screening: Influenza Immunization for Patients Aged 50 Years and Older**
 - The percentage of patients aged 50 years and older who received and influenza immunization during the flu season (September through February)
- **NQF 0038: Childhood Immunization Status**
 - Percentage of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates

Additional Measures (Choose 3)

All ophthalmologists must choose 3 additional measures from the list of 38. There are 4 ophthalmology-specific measures. Ophthalmologists who cannot report on any of the 38 additional measures should exhaust the list of measures that the EHR is capable of reporting on, even if that means reporting zeros in the denominator. This will not prevent the ophthalmologist from earning an incentive payment.

- **NQF 0086/PQRS 12: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation**

- The percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months
- **NQF 0088/PQRS 18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**
 - The percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months
- **NQF 0089/PQRS 19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**
 - The 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 on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months
- **NQF 0055/PQRS 117: Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient**
 - Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam.