Ophthalmology Meaningful Use Attestation Guide
Stage 1 – 2014 Edition

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.

If 2014 is 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 90-day period during the calendar year to be eligible for incentives up to $24,000 per physician over 3 years. In order to avoid the 2015 meaningful use penalty, physicians who are attesting for the first time must begin their continuous 90-day reporting period no later than July 3, 2014 and attest by Oct. 1, 2014. It is suggested that these physicians begin their 90-day reporting period prior to July 3, 2014 to allow time to submit the attestation.

Physicians who are reporting their second year of Stage 1 meaningful use in 2014 may choose any 3 month calendar quarter as their reporting period. These physicians have already successfully avoided the 2015 penalty by attesting to meaningful use in 2013. Successful attestation in 2014 avoids the 2016 meaningful use penalty.

CMS Participation timeline:

Step 1: 13 Meaningful Use Core Measures

All physicians are required to report on all 13 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 (CPOR) – 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.

-or-

1. Computerized Physician Order Entry (CPOE) – More than 30% of medication orders created by the EP during the EHR reporting period are recorded 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.

Certified ophthalmic assistants and certified ophthalmic technicians are now permitted to enter medication orders for purposes of meaningful use.

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 confirm that the feature is turned on within the EHR and answer yes.

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 1: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.

Exclusion 2: Any EP who does not have a pharmacy within their organization and for whom there are no pharmacies that accept electronic prescriptions within 10 miles from the practice location at the start of the EHR reporting period.

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

**Exclusion 1:** Any EP who either sees no patients 3 years or older is excluded from recording blood pressure.

**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 is excluded from recording them.

**Exclusion 3:** Any EP who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.

**Exclusion 4:** Any EP who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

**Reporting Guidance:**

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

Many ophthalmologists will answer “yes” to exclusion 2 or exclusion 4. 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. Ophthalmologists who only occasionally record height and weight and/or blood pressure (e.g., for high-risk surgical patients or patients on certain types of medication) are still permitted to claim the exclusions for this measure if they do not normally regard this data as relevant to their scope of practice.
<table>
<thead>
<tr>
<th>9. Record Smoking Status:</th>
<th>More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.</th>
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<tbody>
<tr>
<td>Exclusion:</td>
<td>Any EP who sees no patients 13 years or older.</td>
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<tr>
<td>Reporting Guidance:</td>
<td>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.</td>
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<tr>
<td>10. Clinical Decision Support Rule:</td>
<td>Implement one clinical decision support rule relevant to the specialty or high clinical priority along with the ability to track compliance with that rule.</td>
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<td>Reporting Guidance:</td>
<td>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.</td>
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<td>11. Patient Electronic Access-</td>
<td>More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.</td>
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<tr>
<td>Reporting Guidance:</td>
<td>This measure can be satisfied by making an online patient portal available to patients.</td>
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<td>The following information must be made available online: Patient name, provider’s name and office contact information, current and past problem list, procedures, laboratory test results, current medication list and medication history, current medication allergy list and medication allergy history, vital signs, smoking status, demographic information, care plan fields including goals and instructions, and any known care team members including the PCP of record unless the information is not available in the EHR or is restricted from disclosure by law.</td>
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<tr>
<td>12. Clinical Summaries:</td>
<td>Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.</td>
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<td>Exclusion:</td>
<td>Any EP who has no office visits during the EHR reporting period.</td>
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<tr>
<td>Reporting Guidance:</td>
<td>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.</td>
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<td>The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, CD, USB fob, or printed copy.</td>
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<td>13. Protect Electronic Health Information:</td>
<td>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.</td>
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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. Physicians should first select from the measures that they are not excluded from. Only choose measures for which you can report an exclusion after you have exhausted the number of measures in which you can fully participate.

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 except where prohibited 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 except where prohibited 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 may be able to report the exclusion. CMS will publish a guide to state and local public health reporting requirements late in 2013. Physicians should verify via the guide or directly with the applicable public health agencies whether or not they collect reportable syndromic information and whether or not the agency can receive the information electronically.
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. CMS requires that you choose measures for which you can report data before choosing measures from which you are excluded.

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

**Step 3: Choose 9 CQMs in 3 Domains**
Beginning in 2014, the reporting requirements for clinical quality measures will change. To meet the requirements of Meaningful Use Stage 2, ophthalmologists must choose a total of 9 clinical quality measures (CQMs) that cover at least 3 of the National Quality Strategy measurement “domains”: patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources, and clinical process/effectiveness.

Physicians in their first reporting period for meaningful use will submit their CQMs through attestation along with their Core and Menu objective data. Physicians who are in their second reporting period of Stage 1 will submit their measures electronically either directly through your EHR or through a certified “EHR data submission vendor” such as the Academy’s IRIS™ Registry. The electronic measure submission period will be open from Jan. 1 – Feb. 28 of the year following the meaningful use reporting period. Though physicians are only required to submit one calendar quarter of CQM data in 2014, submitting a full year of data can help the physicians in their second year of meaningful use to qualify for the Physician Quality Reporting System incentive payment (see below).

**Suggested CQMs for Ophthalmology**
There are a total of 64 CQMs in the meaningful use program. However, not all EHR systems will be capable of submitting all of the available CQMs. You can verify the available CQMs for your system by checking the Certified Health IT Product List (CHPL): [http://oncchpl.force.com/ehrcert?q=chpl](http://oncchpl.force.com/ehrcert?q=chpl)
The Academy has compiled a suggested list of CQMs that will meet the requirement to report 9 CQMs in at least 3 domains. If your EHR is unable to report the Academy-recommended list, you can still qualify for meaningful use by reporting the measures that are available in your system. As before, it is acceptable to report measures that have zero values in the numerator and/or denominator as long as you first select measures for which you have non-zero values.

<table>
<thead>
<tr>
<th>Measure No.</th>
<th>Measure Title and Description</th>
<th>Domain</th>
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| NQF 0022    | **Use of High-Risk Medications in the Elderly**<br>Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.  
  a. Percentage of patients who were ordered at least one high-risk medication.  
  b. Percentage of patients who were ordered at least two different high-risk medications. | Patient Safety |
<p>| NQF 0028    | <strong>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</strong>&lt;br&gt;Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. | Population/Public Health |
| NQF 0055    | <strong>Diabetes: Eye Exam</strong>&lt;br&gt;Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the past 12 months prior to the measurement period. | Clinical Process/Effectiveness |
| NQF 0086    | <strong>Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</strong>&lt;br&gt;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. | Clinical Process/Effectiveness |
| NQF 0088    | <strong>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</strong>&lt;br&gt;Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed within 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. | Clinical Process/Effectiveness |
| NQF 0089    | <strong>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</strong>&lt;br&gt;Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus | Clinical Process/Effectiveness |</p>
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<tr>
<th>NQF 0101</th>
<th>Falls: Screening for Future Fall Risk</th>
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<td>Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.</td>
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<tr>
<th>NQF 0419</th>
<th>Documentation of Current Medications in the Medical Record</th>
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<td>Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary (nutritional) supplements and must contain the medication’s name, dosage, frequency and route of administration.</td>
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<tr>
<th>NQF 0564</th>
<th>Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures</th>
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<td>Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.</td>
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<tr>
<th>NQF 0565</th>
<th>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</th>
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<td>Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.</td>
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**Physician Quality Reporting System**

Clinical Quality Measures reported for meaningful use can be used to satisfy the physician’s obligation to report measures for the Medicare Physician Quality Reporting System if the physician is beyond their first reporting period of meaningful use. In order for CQM reporting to count for PQRS and well as for meaningful use, at least one measure must have non-zero performance data in both the numerator and the denominator. If the EP is reporting at least one measure that meets this criteria, their electronically submitted CQMs can also be used for PQRS.

Group practices that are attesting for more than one physician have the option to submit group data for the CQMs in lieu of individual EP data to improve the likelihood of having measures with non-zero values in both the numerator and the denominator. Groups that wish to utilize this option should
register for the PQRS Group Practice Reporting Option (GPRO) through the PV-PQRS portal and work with their EHR vendor or a data submission vendor, such as the IRIS™ Registry to ensure timely submission of all of the necessary data.

Though the 2014 meaningful use reporting period is one calendar quarter, physicians must submit a full year of CQM data if they wish to also qualify for the PQRS incentive.

For additional resources on Meaningful Use, visit EHR Central: www.aao.org/ehr.