# Table of Contents

**Introduction** ........................................................................................................................................................................... 1

**Before You Begin** ........................................................................................................................................................................ 2
  - Complete your R&A registration ................................................................................................................................. 2
  - Identify one individual to complete the MAPIR application .................................................................................. 3
  - Gather the necessary information to facilitate the completion of the required data ........................................ 3

**Using MAPIR** ............................................................................................................................................................................... 4

**Step 1 – Getting Started** .......................................................................................................................................................... 6

**Step 2 – Confirm R&A and Contact Info** ..................................................................................................................................... 10

**Step 3 – Eligibility** ................................................................................................................................................................. 14

**Step 4 - Patient Volumes** ........................................................................................................................................................ 19
  - Patient Volume Practice Type (Part 1 of 3) .................................................................................................................. 21
  - Patient Volume 90 Day Period (Part 2 of 3) ................................................................................................................. 22
  - Patient Volume (Part 3 of 3) ....................................................................................................................................... 24
    - Patient Volume – Individual .................................................................................................................................. 25
    - Patient Volume – Group ......................................................................................................................................... 31
    - Patient Volume – FQHC/RHC Individual .................................................................................................................... 37
    - Patient Volume – FQHC/RHC Group ......................................................................................................................... 43

**Step 5 – Attestation** .......................................................................................................................................................... 50
  - Attestation Phase (Part 1 of 3) .............................................................................................................................. 51
  - Adoption Phase ......................................................................................................................................................... 53
  - Implementation Phase (Part 2 of 3) .......................................................................................................................... 54
  - Upgrade Phase (Part 2 of 3) .................................................................................................................................. 58
  - Meaningful Use Phase ............................................................................................................................................. 62
  - Attestation Meaningful Use Measures ...................................................................................................................... 66
    - Meaningful Use General Requirements ................................................................................................................... 68
    - Meaningful Use Core Measures ............................................................................................................................. 70
    - Meaningful Use Menu Measures ............................................................................................................................ 97
    - Meaningful Use Core Clinical Quality Measures ................................................................................................. 125
    - Meaningful Use Alternate Core Clinical Quality Measures .................................................................................. 133
    - Meaningful Use Additional Clinical Quality Measures ......................................................................................... 143
    - Meaningful Use Measures Summary ..................................................................................................................... 192
    - Attestation Phase (Part 3 of 3) ............................................................................................................................... 198

**Step 6 – Review Application** ............................................................................................................................................... 200

**Step 7 – Submit Your Application** ....................................................................................................................................... 204

**Post Submission Activities** ................................................................................................................................................... 220
Introduction

The American Recovery and Re-investment Act of 2009 was enacted on February 17, 2009. This act provides for incentive payments to Eligible Professionals (EP), Eligible Hospitals (EH), and Critical Access Hospitals to promote the adoption and meaningful use of interoperable health information technology and qualified electronic health records (EHR).

The Medical Assistance Provider Incentive Repository (MAPIR) is a Web-based program administered by state Medicaid programs that allows Eligible Professionals and Eligible Hospitals to apply for incentive payments to help defray the costs of a certified EHR system.

Per the final federal rule, Eligible Professionals under the Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a Federally Qualified Health Center or Rural Health Center that is led by a physician assistant

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an Eligible Professional must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume, and is a pediatrician
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

Note: Children’s Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.

To apply for the Medicaid EHR Incentive Payment Program, Eligible Professionals must first register at the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (R&A). Once registered they can submit an application and attest online using MAPIR.

This manual provides step-by-step directions for using MAPIR and submitting your application to the Medicaid EHR Incentive Payment Program.
Before You Begin

There are several pre-requisites to applying for state Medicaid EHR Incentive payments using MAPIR.

1. Complete your CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A) registration.

2. Identify one individual from your organization who will be responsible for completing the MAPIR application and attestation information. This person can also serve as a contact point for state Medicaid communications.

3. Gather the necessary information to facilitate the completion of the application and attestation process.

Complete your R&A registration.

You must register at the R&A before accessing MAPIR. If you access MAPIR and have not completed this registration, you will receive the following screen.

Please access the federal Web site below for instructions on how to do this or to register:

For general information regarding the Incentive Payment Program:
http://www.cms.gov/EHRIncentivePrograms

To register:
https://ehrincentives.cms.gov/hitech/login.action

You will not be able to start your MAPIR application process unless you have successfully completed this federal registration process. When MAPIR has received and matched your provider information, you will receive an email to begin the MAPIR application process. Please allow at least two days from the time you complete your federal registration before accessing MAPIR due to the necessary exchange of data between these two systems.
Identify one individual to complete the MAPIR application.

MAPIR is accessed via the secure provider portal by selecting the “EHR Incentive Program” hyperlink on the State of Rhode Island DHS/OHHS website [http://www.dhs.ri.gov/](http://www.dhs.ri.gov/) and selecting the “MAPIR Login Click Here” hyperlink present at the bottom of the “Electronic Health Records (EHR) Incentive Program” Page or by using this URL [https://www.dhs.ri.gov/secure/logonMAPIR.do](https://www.dhs.ri.gov/secure/logonMAPIR.do) for accessing directly.

Once an individual has started the MAPIR application process with their Internet/portal account, they cannot switch to another account during that program year. MAPIR will allow the user to save the information entered and return later to complete an application; however, only the same individual’s Internet/portal account will be permitted access to the application once it has been started.

Gather the necessary information to facilitate the completion of the required data.

MAPIR will request specific information when you begin the application process. To facilitate the completion of the application, it is recommended that you review the guidelines defined by the State of Rhode Island DHS/OHHS on their website [http://www.dhs.ri.gov/](http://www.dhs.ri.gov/) by selecting the hyperlink for EHR Incentive Program or you can directly access the information through the following URL “[http://www.dhs.ri.gov/DefaultPermissions/ElectronicHealthRecordsIncentiveProgram/tabid/997/Default.aspx](http://www.dhs.ri.gov/DefaultPermissions/ElectronicHealthRecordsIncentiveProgram/tabid/997/Default.aspx)” to understand what information will be required. At a minimum, you should have the following information available:

- Information submitted to the R&A
- Medicaid Patient Volume and associated timeframes
- The CMS EHR Certification ID that you obtained from the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL) Web site ([http://onc-chpl.force.com/ehrcert](http://onc-chpl.force.com/ehrcert)).
Using MAPIR

MAPIR uses a tab arrangement to guide you through the application. You must complete the tabs in the order presented. You can return to previous tabs to review the information or make modifications until you submit the application. You cannot proceed without completing the next tab in the application progression, with the exception of the Get Started and Review tabs which you can access anytime.

**Once you submit your application, you can no longer modify the data.** It will only be viewable through the Review tab. Also, the tab arrangement will change after submission to allow you to view status information.

As you proceed through the application process, you will see your identifying information such as Name, National Provider Identifier (NPI), Tax Identification Number (TIN), Payment Year, and Program year at the top of most screens. This is information provided by the R&A.

A **Print** link is displayed in the upper right-hand corner of most screens to allow you to print information entered. You can also use your Internet browser print function to print screen shots at any time within the application.

There is a **Contact Us** link with contact instructions should you have questions regarding MAPIR or the Medicaid Incentive Payment Program.

Most MAPIR screens display an **Exit** link that closes the MAPIR application window. If you modify any data in MAPIR without saving, you will be asked to confirm if the application should be closed (as shown to the right).

You should use the **Save & Continue** button on the screen before exiting or data entered on that screen will be lost.

The **Previous** button always displays the previous MAPIR application window without saving any changes to the application.

The **Reset** button will restore all unsaved data entry fields to their original values.

The **Clear All** button will remove standard activity selections for the screen in which you are working.

A (*) red asterisk indicates a required field. Help icons, located next to certain fields, display help content specific to the associated field when you hover the mouse over the icon.

*Note: Use the MAPIR Navigation buttons in MAPIR to move to the next and previous screens. Do not use the browser buttons as this could result in unexpected results.*

As you complete your incentive application you may receive validation messages requiring you to correct the data you entered. These messages will appear above the navigation button. See the Additional User Information section for more information.
Many MAPIR screens contain help icons to give the provider additional details about the information being requested. Moving your cursor over the will reveal additional text providing more details.
Step 1 – Getting Started

Log in to the State of Rhode Island DHS/OHHS and locate the MAPIR link.

Click the link to access the MAPIR screen.

The screen on the following page is the Medicaid EHR Incentive Program Participation Dashboard. This is the first screen you will access to begin the MAPIR application process.

This screen displays your incentive applications. Incentive applications are listed for all 6 years. Only the incentive applications that you are eligible to apply for are enabled.

The Status will vary, depending on your progress with the incentive application. The first time you access the system the status should be Not Started. From this screen you can choose to edit and view incentive applications in an Incomplete or Not Started status. You can only view incentive applications that are in a Completed, Denied, or Expired status.

Also from this screen, you can choose to abort an incentive application that is in an Incomplete status. When you click Abort on an incentive application, all progress will be eliminated for the incentive application.

When an incentive application has been completed the payment process, the status will change to Completed.

Select an application and click Continue.
Step 1 – Getting Started

Note: A state may allow a grace period which extends the specific Payment Year for a configured length of time. If two applications are showing for the same Payment Year, but different Program Years, one of your incentive applications is in the grace period. In this situation, the following message will display at the bottom of the screen.

You are in the grace period for program year <Year> which began on <Date> and ends on <Date>. The grace period extends the amount of time to submit an application for the previous program year. You have the option to choose the previous program year or the current program year.

You may only submit an application for one Program Year so once you select the application, the row for the application for the other Program Year will no longer display. If the incentive application is not completed by the end of the grace period, the status of the application will change to Expired and you will no longer have the option to submit the incentive application for that Program Year.
The following screen will display with the information for the incentive application you selected.

A status of *Not Registered at R&A* indicates that you have not registered at the R&A, or the information provided during the R&A registration process does not match that on file with the State of Rhode Island Medicaid Program. If you feel this status is not correct you can click the Contact Us link in the upper right for information on contacting the state Medicaid program office. A status of *Not Started* indicates that the R&A and state MMIS information have been matched and you can begin the application process.

*For more information on statuses, refer to the Additional User Information section later in this guide.*

Click **Get Started** to access the **Get Started** screen or **Exit** to close the program.

If you selected an incentive application that you are not associated with, you will receive a message indicating a different Internet/Portal account has already started the Rhode Island Medicaid EHR Incentive Payment Program application process and that the same Internet/Portal account must be used to access the application for this Provider ID. If you are the new user for the provider and want to access the previous applications, you will need to contact the Rhode Island DHS/OHHS or Customer Service Help Desk at (407)784-8100 for local and long distance calls or 1-800-964-6211 for in-state toll calls for assistance.
Step 1 – Getting Started

Click **Confirm** to associate the current Internet/portal account with this incentive application.

The **Get Started** screen contains information that includes your Name and Applicant NPI. Also included is the current status of your incentive application. Click **Continue** to proceed to the **R&A/Contact Info** section.
Step 2 – Confirm R&A and Contact Info

When you completed the R&A registration, your registration information was sent to the State of Rhode Island Medicaid program. This section will ask you to confirm the information sent by the R&A and matched with the State of Rhode Island Medicaid program information. It is important to review this information carefully. The R&A information can only be changed at the R&A but Contact Information can be changed at any time prior to application submission.

The initial R&A/Contact Info screen contains information about this section.

Click Begin to access the R&A/Contact Info screen to confirm information and to enter your contact information.

In this section, you will verify that you registered with CMS and the information you provided will be displayed for verification.

Please note the following:

- You will need to verify the accuracy of information derived from the CMS Registration & Attestation System (referred to in this system as the NLR).
- If there are errors or discrepancies in the information, you will need to return to the NLR to update any required information prior to resuming the application process.
- The following link will take you to the NLR to correct any errors noted: https://ehrincentives.cms.gov/hitech/login.action

See the Using MAPIR section of this guide for information on using the Print, Contact Us, and Exit links.

Check your information carefully to ensure all of it is accurate.

Compare the R&A Registration ID you received when you registered with the R&A with the R&A Registration ID that is displayed.

After reviewing the information click Yes or No.

Click Save & Continue to review your selection, or click Previous to go back. Click Reset to restore this panel back to the starting point or last saved data. The Reset button will not reset R&A information. If the R&A information is not correct, you will need to return to the R&A to correct it.
Step 2 – Confirm R&A and Contact Info

Enter a **Contact Name** and **Contact Phone**.
Enter a **Contact Email Address** twice for verification.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.
<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Medicaid Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant NPI</td>
<td>999999999999</td>
</tr>
<tr>
<td>Personal TIN/SSN</td>
<td>999999999999</td>
</tr>
<tr>
<td>Payee TIN</td>
<td>999999999999</td>
</tr>
<tr>
<td>Program Year</td>
<td>2011</td>
</tr>
<tr>
<td>Payment Year</td>
<td>1</td>
</tr>
</tbody>
</table>

**Contact Information**

Please enter your contact information. All email correspondence will go to the email address entered below. The email address, if any, entered at the R&A will be used as secondary email address. If an email address was entered at the R&A, all email correspondence will go to both email addresses.

When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel back to the starting point.

(*) Red asterisk indicates a required field.

- **Contact Name**: Dr. Medicaid Provider
- **Contact Phone**: 999 - 999 - 9999
- **Contact Email Address**: Professional@provider.com

Previous  Reset  Save & Continue
Step 2 – Confirm R&A and Contact Info

This screen confirms you successfully completed the **R&A/Contact Info** section.

Note the check box located in the **R&A/Contact Info** tab. You can return to this section to update the Contact Information at any time prior to submitting your application.

Click **Continue** to proceed to the **Eligibility** section.
Step 3 – Eligibility

The Eligibility section will ask questions to allow the State of Rhode Island Medicaid program to make a determination regarding your eligibility for the Medicaid EHR Incentive Payment Program. You will also enter your required CMS EHR Certification ID.

The initial Eligibility screen contains information about this section. Click Begin to proceed to the Eligibility Questions (Part 1 of 3).

In this section, you will provide basic information to confirm your eligibility for the EHR Incentive Program.

To be eligible, you will need to indicate that:

- You are a Rhode Island Medicaid provider in good standing
- You are not collecting Medicare incentive payments
- You are not a hospital-based provider (and therefore ineligible)
- You have no current Medicare or Medicaid sanctions in any state
- Your practice is HIPAA-compliant
- You are licensed in all states in which you practice

You will also need to provide:

- The CMS EHR Certification number which has been assigned to your organization
- Your provider type (only certain provider types are eligible)

Begin
Step 3 – Eligibility

Select **Yes** or **No** to the eligibility questions.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or the last saved data.
This screen will ask questions to determine your eligibility for the EHR Medicaid Incentive Payment Program. Please select your provider type from the list and answer the questions.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.
Step 3 – Eligibility

This Eligibility screen asks for information about your **CMS EHR Certification ID**. Enter the 15-character **CMS EHR Certification ID**.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

The system will perform an online validation of the CMS EHR Certification ID you entered.

* **A CMS EHR Certification ID can be obtained from the ONC Certified Health IT Product List (CHPL) website** (http://onc-chpl.force.com/ehrcert)
This screen confirms you successfully entered your CMS EHR Certification ID.

Click **Save & Continue** to proceed, **Previous** to go back.

This screen confirms you successfully completed the **Eligibility** section.

Note the check box in the **Eligibility** tab.

Click **Continue** to proceed to the **Patient Volumes** section.
Step 4 - Patient Volumes

The Patient Volumes section gathers information about your practice type, practice locations, the 90 day period you intend to use for reporting the patient volumes, and the patient volumes themselves. Additionally, you will be asked about how you utilize your certified EHR technology.

There are three parts to Patient Volumes:

Part 1 of 3 contains two questions which will determine the method you use for entering patient volumes in Part 3 of 3.

Part 2 of 3 establishes the 90 day period for reporting patient volumes.

Part 3 of 3 contains screens to add new locations for reporting Medicaid Patient Volumes, selecting at least one location for Utilizing Certified EHR Technology, and entering patient volumes for the chosen reporting period.
The initial **Patient Volumes** screen contains information about this section. Click **Begin** to proceed to the **Patient Volume Practice Type (Part 1 of 3)** screen.

---

In this section, you will provide information that will determine whether you meet minimum Medicaid patient volume (defined as encounters/patient visits).

You will need to select any 90-day period from the prior calendar year (days must be consecutive) and provide your Medicaid patient encounters during that period.

To qualify for the EHR Incentive Program:

- Providers with the following provider types will need to demonstrate at least **30%** Medicaid patient volume. Eligible provider types include:
  - Physician
  - Nurse Practitioner
  - Nurse Midwife
  - Dentist
  - Physician Assistant (if you practice in an FQHC that is staffed by a Physician Assistant)
- Pediatricians will need to demonstrate at least **20%** Medicaid patient volume. Patient volumes for pediatricians will need to be adjusted/reduced using the county-level adjustment percentage that has been defined for CHIP enrollments (enhancements).

In the first step, you will indicate whether you practice predominantly in a Federally Qualified Health Center (FQHC) and/or in a Rural Health Clinic (RHC). Your eligibility criteria may be impacted if you do practice in either or both of these settings.

To qualify for the EHR Incentive Program under FQHC guidelines, you will need to:

- Practice at least **50%** in an FQHC
- Have at least **30%** Medicaid patient encounter volume, which is comprised of a combination of Medicaid, CHIP, and Needy individual encounters.

Excluding Children’s Health Insurance Program (CHIP) Activity:

If your individual or group practice provides care to children between the age of 0 - 18, you will need to apply a County CHIP Patient Volume reduction to your total Medicaid encounters based on your facility or practice location. Each Rhode Island county location reduction percentage must be applied as follows:

- **Bristol** - 12.3%,
- **Kent** - 13.1%,
- **Newport** - 11.4%,
- **Providence** - 10.0%,
- **Washington** - 11.3%.

For example, if you have determined that over a 90-day consecutive period in the previous calendar year your practice in Newport County had 1,245 Medicaid encounters, you will need to reduce the amount to 1,103 after applying the related County CHIP Patient Volume percentage reduction of 11.4%.

Sample calculation: 1,245 * (11.4%) = 1,103

---

**Begin**
Patient Volume Practice Type (Part 1 of 3)

Patient Volume Practice Type (Part 1 of 3) contains two questions about your practice type to determine the appropriate method for collecting patient volume information.

Select the appropriate answers using the buttons. Move your cursor over the ? to access additional information.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.
Patient Volume 90 Day Period (Part 2 of 3)

For all practice types MAPIR will ask you to enter the start date of the 90 day patient volume reporting period in which you will demonstrate the required Medicaid patient volume participation level.

Enter a Start Date or select one from the calendar icon located to the right of the Start Date field. Click Save & Continue to review your selection or click Previous to go back. Click Reset to restore this panel to the starting point or the last saved data.

Enter a Start Date or select one from the calendar icon located to the right of the Start Date field.
Review the **Start Date** and **End Date** information. The 90 Day **End Date** has been calculated for you. Click **Save & Continue** to continue, or click **Previous** to go back.
In order to meet the requirements of the Medicaid EHR Incentive Program you must provide information about your patient volumes. The information will be used to determine your eligibility for the incentive program. The responses to the questions for Practice Type (Part 1 of 3) on the first Patient Volume screen determine the questions you will be asked to complete and the information required. The information is summarized below:

1. Practice locations – MAPIR will present a list of practice locations that the State of Rhode Island DHS/OHHS has on record. If you have additional practice locations you have the option to add them. When all locations are added, you will enter the required information for all your practice locations.

2. Utilizing Certified EHR Technology – You must select the practice locations where you are utilizing certified EHR technology. At least one practice location must be selected.

3. Patient volume – You are required to enter the information for the patient volume 90 day period you entered.

Depending on your practice type you will be asked for different information related to patient volumes. Not all information you enter will be used in the patient volume percentage calculation. Information not used will be reviewed by the State of Rhode Island Medicaid program to assist with determining your eligibility. The specific formula for each practice type percentage calculation is listed within the section for that practice type.

The table below directs you to the page number in this guide to provide details for completing this section.

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>25</td>
</tr>
<tr>
<td>Group</td>
<td>31</td>
</tr>
<tr>
<td>FQHC/RHC* Individual</td>
<td>37</td>
</tr>
<tr>
<td>FQHC/RHC* Group</td>
<td>43</td>
</tr>
</tbody>
</table>

* Federally Qualified Health Center/Rural Health Clinic
Patient Volume – Individual

The following pages will show you how to apply for the EHR Incentive program as an Individual provider. If you are not applying as an Individual provider, refer to the table on page 24 for more information about your practice type.

Practice locations – MAPIR will present a list of locations that the State of Rhode Island Medicaid program office has on record. If you have additional locations, you can add them. Once all locations are added, you will enter the required Patient Volume information.

Add new locations by clicking **Add Location**.
If you clicked **Add Location** on the previous screen, you will see the following screen.
Enter the requested practice location information.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.
Step 4 - Patient Volumes

For each location, check whether you will report Medicaid Patient Volumes and whether you plan to Utilize Certified EHR Technology. You must select at least one location for meeting patient requirements and at least one location for utilizing certified EHR technology.

Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

*Note: The Edit and Delete options are not available for locations already on file.*

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
Click **Begin** to proceed to the screens where you will enter patient volumes.

---

In this section, you will provide information that will determine whether you meet minimum Medicaid patient volume (defined as encounters/patient visits).

You will need to provide your Medicaid patient encounters during that period. To qualify for the EHR Incentive:

- Providers with the following provider types will need to demonstrate at least 30% Medicaid patient volume. Eligible provider types include:
  - Physician
  - Nurse Practitioner
  - Nurse Midwife
  - Dentist
  - Physician Assistant (if you practice in a FQHC that is so led by a Physician Assistant)
- Pediatricians will need to demonstrate at least 20% Medicaid patient volume. Patient volumes for pediatricians will need to be adjusted/reduced using the county-level adjustment percentage that has been defined for CHIP enrollees (children).

**Excluding Children’s Health Insurance Plan (CHIP) Activity**

If your individual or group practice provides care to children between the age of 8 - 18, you will need to apply a County CHIP Patient Volume reduction to your total Medicaid encounters based on your facility or practice location. Each Rhode Island county location reduction percentage must be applied as follows: Bristol - 12.5%, Kent - 13.1%, Newport 11.4%, Providence - 10.6%, Washington - 11.3%.

For example, if you have determined that over a 90-day consecutive period in the previous calendar year your practice in Newport country had 1,245 Medicaid encounters, you will need to reduce the amount to 1,103 after applying the related County CHIP Patient Volume percentage reduction of 11.4%.

Sample calculation: $1,245 \times (\frac{11.4}{100}) = 1,103$
Medicaid Patient Volume Percentage Formula - Individual
(Medicaid Encounter Volume / Total Encounter Volume)

Enter patient volumes for each location listed on the screen.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

<table>
<thead>
<tr>
<th>Provider Id</th>
<th>Location Name</th>
<th>Address</th>
<th>Medicaid Only Encounter Volume (Total Numerator)</th>
<th>Medicaid Only Encounter Volume (In State Numerator)</th>
<th>Medicaid Encounte Volume (Total Numerator)</th>
<th>Total Encounter Volume (Denominator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999999</td>
<td>Doctor Office</td>
<td>123 East Street</td>
<td>800</td>
<td>1000</td>
<td></td>
<td>3300</td>
</tr>
<tr>
<td>N/A</td>
<td>New Location</td>
<td>123 Main Street</td>
<td>400</td>
<td>500</td>
<td></td>
<td>1500</td>
</tr>
</tbody>
</table>
This screen displays the locations where you are utilizing certified EHR technology, patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

Click **Save & Continue** to proceed or **Previous** to go back.

Proceed to page 50 of this guide to continue with the application.
Step 4 - Patient Volumes

MAPIR User Guide for Eligible Professionals

Patient Volume - Group
The following pages will show you how to apply for the EHR Incentive program as a Group provider. If you are not applying as a Group provider, refer to the table on page 24 for more information.

Practice locations – MAPIR will present a list of locations that the State of Rhode Island Medicaid program office has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information.

Review the listed locations. Add new locations by clicking Add Location.
If you clicked **Add Location** on the previous screen, you will see the following screen.
Enter the requested practice location information.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

![Patient Volume - Group (Part 3 of 3) form]

Please provide the information requested below to add a location to MAPIR *(for this Payment Incentive Application use only)*

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) Red asterisk indicates a required field.

- **Location Name**: New Location
- **Address Line 1**: 123 Main Street
- **City**: Anytown
- **State**: Alabama
- **Zip (5-4)**: 12345
For each location check whether you are **Utilizing Certified EHR Technology**.

Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
Click **Begin** to proceed to the screens where you will enter patient volumes.

This section is designated for program applicants who practice in a clinical group setting and who wish to calculate and attest to patient volume as a group.

The following guidelines apply for group-based applications:

- The Group NPI must be used to define the group
- All members of the group must apply in the same manner (i.e. as a group)
- The group method cannot be used in cases where one or more providers in the group see commercial, Medicare, or self-pay patients exclusively
- All providers included in the group must have Medicaid encounters in the selected 90-day period from the prior calendar year
- Medicaid patient encounter volume must equal at least 30% at an aggregate group level

**Excluding Children’s Health Insurance Plan (CHIP) Activity**

If your individual or group practice provides care to children between the age of 0-18, you will need to apply a County CHIP Patient Volume reduction to your total Medicaid encounters based on your facility or practice location. Each Rhode Island county location reduction percentage must be applied as follows: Bristol - 12.3%, Kent - 13.1%, Newport 11.4%, Providence - 13.0%, Washington - 11.3%.

For example, if you have determined that over a 90-day consecutive period in the previous calendar year your practice in Newport county had 1,245 Medicaid encounters, you will need to reduce the amount to 1,103 after applying the related County CHIP Patient Volume percentage reduction of 11.4%.

Sample calculation: \(1,245 \times (1 - 11.4\%) = 1,103\)
Medicaid Patient Volume Percentage Formula - Group

Medicaid Encounter Volumes
Divided by
Total Encounter Volume

Enter **Group Practice Provider IDs**. Please be sure to include all Medicaid Group Practice ID(s) associated with the group or organization. Group patient volume is determined by the entire group and cannot be split apart in any way. If you listed four **Group Practice Provider IDs** and the patient volume numbers at the bottom reflect more than the four IDs you listed, please check the box directly below the provider IDs.

Enter **Patient Volumes** for the locations.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.

---

**Medicaid Patient Volume Percentage Formula - Group**

**Medicaid Encounter Volumes**
Divided by
Total Encounter Volume

Enter **Group Practice Provider IDs**. Please be sure to include all Medicaid Group Practice ID(s) associated with the group or organization. Group patient volume is determined by the entire group and cannot be split apart in any way. If you listed four **Group Practice Provider IDs** and the patient volume numbers at the bottom reflect more than the four IDs you listed, please check the box directly below the provider IDs.

Enter **Patient Volumes** for the locations.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.
This screen displays the volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

Review the information for accuracy.

Note the Total % patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

Click Save & Continue to proceed or Previous to go back.

Proceed to page 50 of this guide to continue with the application.
Patient Volume – FQHC/RHC Individual

The following pages will show you how to apply for the EHR Incentive program as an FQHC/RHC Individual provider. If you are not applying as an FQHC/RHC Individual provider, refer to the table on page 24 for more information.

Practice locations – MAPIR will present a list of locations that the State of Rhode Island Medicaid program office has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information.

Review the listed locations. Add new locations by clicking Add Location.

![Patient Volume - FQHC/RHC Individual (Part 3 of 3)](image)

When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.

(*) Red asterisk indicates a required field.
If you clicked **Add Location** on the previous screen, you will see the following screen. Enter the requested practice location information.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
For each location, check whether you will report Medicaid Patient Volumes and whether you plan to Utilize Certified EHR Technology. You must select at least one location for meeting patient requirements and at least one location for utilizing certified EHR technology.

Click Edit to make changes to the added location or Delete to remove it from the list.

*Note: The Edit and Delete options are not available for locations already on file.*

Click Save & Continue to review your selection or click Previous to go back. Click Reset to restore this panel to the starting point or last saved data.
If you practice predominately in a Federally Qualified Health Center (FQHC) and/or in a Rural Health Clinic (RHC) and wish to register as an individual, this section will be used to calculate and attest to your patient encounter volume.

Requirements for qualification for the EHR Incentive Program under FQHC guidelines, as a group registrant, include:

- Practice at least 50% in an FQHC
- Have at least 30% Medicaid patient encounter volume, which is comprised of a combination of Medicaid, CHIP, and Newly Individual encounters
- Practice comprised of a combination of medium and low-income CHIP enrollees
- Must have Medicaid encounters in the selected 90-day period from the prior calendar year

Excluding Children’s Health Insurance Plan (CHIP) Activity
If your individual or group practice provides care to children between the ages of 0 - 18, you will need to apply a County/CHIP Patient Volume reduction to your total Medicaid encounters based on your facility or practice location. Each Rhode Island county location reduction percentage must be applied as follows: Bristol - 12.3%, Kent - 13.1%, Newport 11.4%, Providence - 10.0%, Washington - 11.3%.

For example, if you have determined that over a 90 day consecutive period in the previous calendar year your practice in Newport county had 1,245 Medicaid encounters, you will need to reduce the amount to 1,103 after applying the related County CHIP Patient Volume percentage reduction of 11.4%.

Sample calculation: 1,245 x (1 - 11.4%) = 1,103

Click Begin to proceed to the screens where you will enter patient volumes.
Step 4 - Patient Volumes

Medicaid Patient Volume Percentage Formula – FQHC/RHC Individual

Total Needy Encounter Volume

Divided by

Total Encounter Volume

Enter **Patient Volume** for the locations.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
This screen displays the locations you are utilizing certified EHR technology, patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

Click **Save & Continue** to proceed or **Previous** to go back.

Proceed to page 50 of this guide to continue with the application.

```
<table>
<thead>
<tr>
<th>Utilizing Certified EHR Technology?</th>
<th>Provider ID</th>
<th>Location Name</th>
<th>Address</th>
<th>Encounter Volumes</th>
<th>% Volume (Denominator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>999999999999</td>
<td>Doctor Office</td>
<td>123 First Street</td>
<td>Medicaid and chip Numerator: 800</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anytown, PA 12345-1234</td>
<td>Other Needy Numerator: 1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total Needy Numerator: 1800</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denominator: 3300</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>N/A</td>
<td>New Location</td>
<td>123 Main Street</td>
<td>Medicaid and chip Numerator: 400</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anytown, AL 12345</td>
<td>Other Needy Numerator: 500</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total Needy Numerator: 900</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Denominator: 1500</td>
<td></td>
</tr>
</tbody>
</table>
```

```
<table>
<thead>
<tr>
<th>Sum Medicaid and Chip Encounter Volume</th>
<th>Sum Other Needy Individual Encounter Volume</th>
<th>Sum Total Needy Encounter Volume</th>
<th>Denominator</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200</td>
<td>1500</td>
<td>2700</td>
<td>4800</td>
<td>56%</td>
</tr>
</tbody>
</table>
```
Patient Volume - FQHC/RHC Group

The following pages will show you how to apply for the EHR Incentive program as an FQHC/RHC Group provider. If you are not applying as an FQHC/RHC Group provider, refer to the table on page 24 for more information.

Practice locations – MAPIR will present a list of locations that the State of Rhode Island Medicaid program office has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information.

Review the listed locations. Add new locations by clicking **Add Location**.

---

### Patient Volume - FQHC/RHC Group (Part 3 of 3)

RI has the following information on the locations in which you practice.

If you wish to report patient volumes for a location or site that is not listed, click **Add Location**.

*You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.*

When ready click the **Save & Continue** button to review your selections, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(* Red asterisk indicates a required field.

<table>
<thead>
<tr>
<th>Utilizing Certified EHR Technology (Must Select One)</th>
<th>Provider ID</th>
<th>Location Name</th>
<th>Address</th>
<th>Available Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No</td>
<td>05, XXXX01, 005</td>
<td>RI PROVIDER CLINIC</td>
<td>XXX PROVIDER RD WARWICK RI 02895 - XXXX</td>
<td></td>
</tr>
</tbody>
</table>

Add Location | Refresh
If you clicked **Add Location** on the previous screen, you will see the following screen.
Enter the requested practice location information.
Click **Save & Continue** to proceed or **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
For each location, check whether you plan to utilize certified EHR technology. You must select at least one location for utilizing certified EHR technology.

Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
Click **Begin** to proceed to the screens where you will enter patient volumes.

If you practice predominately in a Federally Qualified Health Center (FQHC) and/or in a Rural Health Clinic (RHC) and wish to register as a group, this section will be used to calculate and attest to your patient encounter volume.

**Requirements for qualification for the EMR Incentive Program under FQHC guidelines, as a group registrant, include:**

- Practice at least 50% in an FQHC
- Have at least 30% Medicaid patient encounter volume, which is comprised of a combination of Medicaid, CHIP, and Needy Individual encounters
- Practice comprised of a combination of medium and low-income CHIP enrollees
- Group NPI must be used to define the group
- All members of the group must apply in the same manner (i.e. as a group)
- The group method cannot be used in cases where one or more providers in the group see commercial, Medicare, or self-pay patients exclusively
- All providers included in the group must have Medicaid encounters in the selected 90-day period from the prior calendar year
- Medicaid patient encounter volume must equal at least 30% at an aggregate group level

**Excluding Children’s Health Insurance Plan (CHIP) Activity**

If your individual or group practice provides care to children between the age of 0 – 18, you will need to apply a County CHIP Patient Volume reduction to your total Medicaid encounters based on your facility or practice location. Each Rhode Island county location reduction percentage must be applied as follows: Bristol - 12.5%, Kent - 13.1%, Newport 11.4%, Providence - 10.0%, Washington - 11.3%.

For example, if you have determined that over a 90-day consecutive period in the previous calendar year your practice in Newport county had 1,245 Medicaid encounters, you would need to reduce the amount to 1,103 after applying the related County CHIP Patient Volume percentage reduction of 11.4%.

Sample calculation: $1,245 \ast (\text{-11.4\%}) = 1,103$
Medicaid Patient Volume Percentage Formula – FQHC/RHC Group

Total Needy Encounter Volume
Divided by
Total Encounter Volume

Enter **Group Practice Provider IDs**. Please be sure to include all Medicaid Group Practice ID(s) associated with the group or organization. Group patient volume is determined by the entire group and cannot be split apart in any way. If you listed four **Group Practice Provider IDs** and the patient volume numbers at the bottom reflect more than the four IDs you listed, please check the box directly below the provider IDs.

Enter **Patient Volumes**.

Click **Save & Continue** to proceed or **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
This screen displays the locations where you are utilizing EHR technology, patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

Click **Save & Continue** to proceed or **Previous** to go back.
This screen confirms you successfully completed the **Patient Volume** section. Note the check box in the Patient Volume tab. Click **Continue** to proceed to the **Attestation** section.
Step 5 – Attestation

This section will ask you to provide information about your **EHR System Adoption Phase**. Adoption phases include **Adoption, Implementation, Upgrade, and Meaningful Use**. Based on the adoption phase you select, you may be asked to complete additional information about activities related to that phase.

For the first year of participation in the Medicaid EHR Incentive program, Eligible Professionals will have the option to attest to **Adoption, Implementation, Upgrade, or Meaningful Use**. After the first year of participation, the Eligible Professionals are required to attest to **Meaningful Use**.

This initial Attestation screen provides information about this section.

Click **Begin** to continue to the **Attestation** section.
Attestation Phase (Part 1 of 3)

The Attestation Phase (Part 1 of 3) screen asks for the EHR System Adoption Phase. The screen shown below is the Attestation Phase (Part 1 of 3) screen you will see if it is your first year participating (Payment Year 1).

If it is not your first year participating (Payment Year 2 or beyond), turn to page 62 of this guide.

After making your selection, the next screen you see will depend on the phase you selected.

Click Save & Continue to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point or last saved data.

For Adoption continue to page 53 of this guide.

For Implementation turn to page 54 of this guide.
For **Upgrade** turn to page 58 of this guide.

For **Meaningful Use** turn to page 62 of this guide.
Adoption Phase

For Adoption select the Adoption button. Click Save & Continue to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point or last saved data.

Proceed to page 200 of this guide.
Implementation Phase (Part 2 of 3)

For **Implementation** select the Implementation button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
Select your **Implementation Activity** by selecting the **Planned** or **Complete** button. Click **Other** to add any additional **Implementation Activities** you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data. This is an example of a completed screen.
This screen shows an example of entering activities other than what was in the Implementation Activity listing.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.

Review the **Implementation Activity** you selected.

Click **Save & Continue** to continue, or click **Previous** to go back.

Proceed to page 200 in this guide to continue.
### Attestation Phase (Part 2 of 3)

Please review the list of the activities where you have planned or completed an implementation.

When ready click the **Save & Continue** button to continue, or click **Previous** to go back.

<table>
<thead>
<tr>
<th>Implementation Activity</th>
<th>Planned</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workflow Analysis</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Workflow Redesign</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Hardware Installation</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Peripherals Installation</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Uploading Patient Data</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>(Other) Reviewed EHR Certification Information</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>

[Previous] [Save & Continue]
Upgrade Phase (Part 2 of 3)

For Upgrade select the Upgrade button.

Click Save & Continue to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point or last saved data.
Select your **Upgrade Activities** by selecting the **Planned** or **Complete** button for each activity.

Click **Other** to add any additional **Upgrade Activities** you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.
This screen shows an example of entering activities other than what was in the Upgrade Activity listing. Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.

Review the **Upgrade Activities** you selected.

Click **Save & Continue** to continue, or click **Previous** to go back.

Proceed to page 200 in this guide to continue.
Attestation Phase (Part 2 of 3)

Please review the list of activities where you have planned or completed an upgrade.

When ready click the Save & Continue button to continue, or click Previous to go back.

<table>
<thead>
<tr>
<th>Upgrade Activity</th>
<th>Planned</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upgrading Software Version</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Clinical Decision Support</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>(Other) Reviewed EHR Certification Information</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>
**Meaningful Use Phase**

For **Meaningful Use** select the Meaningful Use button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
Select a 90-day period or a full year period for reporting **Meaningful Use of certified EHR technology**.

If you selected Meaningful Use in the Attestation Phase for Payment Year 1, your only option on this screen for Payment Year 2 and beyond will be the Meaningful Use (Full Year).

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.
Depending on the selection made on the previous screen, the Attestation EHR Reporting Period (Part 1 of 3) screen will display with the 90-day period or the full year period. The example below displays the 90-day period.

Enter a **Start Date** or use the calendar located to the right of the Start Date field.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.
This screen displays an example of a **Start Date** of January 1, 2012 and a system-calculated **End Date** of March 30, 2012.

Click **Save & Continue** to review your selection, or click **Previous** to go back.
Attestation Meaningful Use Measures

The screen on the following page displays the Measures Topic List. The Attestation Meaningful Use Measures are divided into six distinct topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, Alternate Core Clinical Quality Measures, and Additional Clinical Quality Measures.

You may select any of the six topics and complete them in any order. You are not required to complete any of the Alternate Core Clinical Quality Measures unless you have entered a zero denominator for one or more Core Clinical Quality Measures.

While it is not required that you begin each topic in the order shown on the screen, this user guide will follow the order in which the topics are listed.

Click **Begin** to start a topic.
Attestation Meaningful Use Measures

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Medicaid Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant NPI</td>
<td>9999999999999</td>
</tr>
<tr>
<td>Personal TIN/SSN</td>
<td>9999999999999</td>
</tr>
<tr>
<td>Payee TIN</td>
<td>9999999999999</td>
</tr>
<tr>
<td>Payment Year</td>
<td>1</td>
</tr>
<tr>
<td>Program Year</td>
<td>2012</td>
</tr>
</tbody>
</table>

Attestation Meaningful Use Measures

The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.

**Note:** The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.

Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.

<table>
<thead>
<tr>
<th>Completed?</th>
<th>Topics</th>
<th>Progress</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Requirements</td>
<td></td>
<td>Begin</td>
</tr>
<tr>
<td></td>
<td>Core Measures</td>
<td></td>
<td>Begin</td>
</tr>
<tr>
<td></td>
<td>Menu Measures</td>
<td></td>
<td>Begin</td>
</tr>
</tbody>
</table>

You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all three of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.

<table>
<thead>
<tr>
<th>Core Clinical Quality Measures</th>
<th>Begin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Core Clinical Quality Measures</td>
<td>Begin</td>
</tr>
</tbody>
</table>

In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.

<table>
<thead>
<tr>
<th>Additional Clinical Quality Measures</th>
<th>Begin</th>
</tr>
</thead>
</table>

**Note:**
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
**Meaningful Use General Requirements**

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator entered. The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the Edit button to further edit the topic, click Clear All to clear all topic information you entered, or click Begin to start the next topic.

Attestation Meaningful Use Measures

The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.

Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality has a denominator of zero.

Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return. Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.

You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.

In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.

Note: When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Meaningful Use Core Measures

This screen provides information about the Meaningful Use Core Measures. Click **Begin** to continue to the Meaningful Use Core Measure List Table.

As part of the meaningful use attestation, Eligible Professionals (EPs) are required to complete **15 Core Measures**. Certain objectives do provide **exclusions**. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation.

**HELPFUL HINTS:**

1. The Core Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%.
5. Results are only displayed in whole numbers.
6. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 80%, a result of 80.1% will pass but a result of exactly 80.0% would not pass.
7. After completing all 15 measures, you will receive a green checkmark indicating the section is complete.
8. The green checkmark does not mean you passed or failed the 15 measures.
9. Evaluation of MU measures is made after the application is electronically signed.
10. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.

**Instructions:** Users must adequately answer each measure they intend to meet by either correctly filling in the numerator and denominator values, or choosing an exclusion if you meet the requirements for that exclusion. Two types of percentage based measures are included in demonstrating Meaningful Use. With this, there are two different types of denominators:

1. Denominator is all patients seen during the EHR reporting period. The denominator is all patients regardless of whether their records are kept using a certified EHR technology.
2. Denominator is actions or subsets of patients seen during the EHR reporting period whose records are kept using certified EHR technology.
The screen on the following page displays the Meaningful Use Core Measure List Table. The first time a topic is accessed you will see an **Edit** option for each measure.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return to Main** to return to the Measures Topic List.
### Meaningful Use Core Measures

To edit information, select the "EDIT" button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the "Return to Main" button to access the main attestation topic list.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Objective</th>
<th>Entered</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPCMU01</td>
<td>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.</td>
<td>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.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU02</td>
<td>Implement drug-drug and drug-allergy interaction checks.</td>
<td>The EP has enabled this functionality for the entire EHR reporting period.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU03</td>
<td>Maintain an up-to-date problem list of current and active diagnoses.</td>
<td>More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU04</td>
<td>Generate and transmit permissible prescriptions electronically (eRx).</td>
<td>More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU05</td>
<td>Maintain active medication list.</td>
<td>More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU06</td>
<td>Maintain active medication allergy list.</td>
<td>More than 80% of all unique patients seen by the EP have an active medication allergy list recorded as structured data.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU07</td>
<td>Record all of the following demographics: Preferred language, Gender, Race, Ethnicity, Date of birth.</td>
<td>More than 10% of all unique patients seen by the EP have demographics recorded as structured data.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU08</td>
<td>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.</td>
<td>More than 10% of all unique patients age 2 and over seen by the EP have height, weight and blood pressure recorded as structured data.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU09</td>
<td>Record smoking status for patients 13 years old or older.</td>
<td>More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU10</td>
<td>Report ambulatory clinical quality measures.</td>
<td>Successfully report ambulatory clinical quality measures as required.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU11</td>
<td>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.</td>
<td>Implement one clinical decision support rule.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU12</td>
<td>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.</td>
<td>More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU13</td>
<td>Provide clinical summaries for patients for each office visit.</td>
<td>Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU14</td>
<td>Capability to exchange key clinical information (for example, problem list, medication lists, allergies, diagnostic test results), among providers of care and patient authorized entities electronically.</td>
<td>Performed at least one test of the certified EHR technology's capacity to electronically exchange key clinical information.</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPCMU15</td>
<td>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.</td>
<td>Conduct or review a security risk analysis per 45 CFR 164.308 (e) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.</td>
<td>EDIT</td>
</tr>
</tbody>
</table>
Core Measure 1 (Measure Code EPCMU01)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the next page.

If the exclusion does not apply to you, answer the Patient Records question, select No to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.

![Core Measure 1 (Measure Code EPCMU01) Interface](image-url)

Click HERE to review CMS Guidelines for this measure.

When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.

(*) 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 seen by the EP 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 patient records maintained using certified EHR technology.

EXCLUSION: Based on ALL patient records: 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

If the exclusion does not apply please 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: 65 * Denominator: 100
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
After you enter information for a measure and click **Save & Continue**, you will be returned to the Meaningful Use Core Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below (please note that the entire screen is not displayed in this example).

You can continue to edit the measures at any point prior to submitting the application.

Click **Edit** for the next measure.
Core Measure 2 (Measure Code EPCMU02)

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Core Measure 3 (Measure Code EPCMU03)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

![Core Measure 3 Form](image-url)
Core Measure 4 (Measure Code EPCMU04)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the next page.

If the exclusion does not apply to you, answer the Patient Records question, select No to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select Yes to the exclusion, and do not enter a numerator and denominator.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
Core Measure 5 (Measure Code EPCMU05)

Enter information in all required fields.
The denominator entered must be greater than or equal to the numerator. The numerator and
denominator entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this
panel to the starting point.

![Attestation Meaningful Use Measures](image)

**Objective:** Maintain active medication list.

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

Complete the following information:

- **Numerator** = Number of patients in the denominator who have a medication (or an indication that the patient is
  not currently prescribed any medication) recorded as structured data.
- **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.

\[ \text{Numerator} = 85 \quad \text{Denominator} = 100 \]
Core Measure 6 (Measure Code EPCMU06)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

(1) Red asterisk indicates a required field.

**Objective:** Maintain active medication allergy list.

**Measure:** More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. 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 : 185  Denominator : 220
```
Core Measure 7 (Measure Code EPCMU07)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Core Measure 8 (Measure Code EPCMU08)

Enter information in all required fields.

If either of the exclusions applies to you, refer to the screen on the next page.

If the exclusions do not apply to you, answer the Patient Records question, select No to the exclusions, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
If either of the exclusions apply to you, answer the Patient Records question, select **Yes** to the exclusion(s), and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Core Measure 9 (Measure Code EPCMU09)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the next page.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

---

**Objective:** Record 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.

- **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 patient records maintained using certified EHR technology.

**EXCLUSION:** Based on all patient records: An EP who sees no patients 12 years or older 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

If the exclusion does not apply please 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**: 45  
**Denominator**: 81
If the exclusion applies to you, answer the Patient Records question, select Yes to the exclusion, and do not enter a numerator and denominator.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
Core Measure 10 (Measure Code EPCMU10)

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

---

**Objective:** Report ambulatory clinical quality measures.

**Measure:** Successfully report ambulatory clinical quality measures as required.

**I will submit Clinical Quality Measures.**

- Yes  
- No

---
Core Measure 11 (Measure Code EPCMU11)

Enter information in all required fields.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.

Name: [Medicaid Provider]
Applicant NPI: 929999999
Personal TIN/SSN: 929999999
Payee TIN: 929999999
Payment Year: 1
Program Year: 2012

Attestation Meaningful Use Measures

Core Measure 11

(1) Click HERE to review CMS Guidelines for this measure.

When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.

(*) Red asterisk indicates a required field.

Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to 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 to that rule?

☐ Yes ☐ No
Core Measure 12 (Measure Code EPCMU12)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

If the exclusion does not apply to you, answer the Patient Records question, select No to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Core Measure 13 (Measure Code EPCMU13)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

If the exclusion does not apply to you, answer the Patient Records question, select No to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Core Measure 14 (Measure Code EPCMU14)

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Core Measure 15 (Measure Code EPCMU15)

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

---

**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**

---

(\*) Red asterisk indicates a required field.
Once you attested to all the measures for this topic, click **Return to Main** to return to the Measures Topic List.
If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.

---

### Attestation Meaningful Use Measures

The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.

**Note:** The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.

Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.

<table>
<thead>
<tr>
<th>Completed?</th>
<th>Topics</th>
<th>Progress</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>General Requirements</td>
<td>2/2</td>
<td>![EDIT] Clear All</td>
</tr>
<tr>
<td>✓</td>
<td>Core Measures</td>
<td>15/15</td>
<td>![EDIT] Clear All</td>
</tr>
</tbody>
</table>

**Menu Measures**

You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.

- ![Core Clinical Quality Measures](Begin)
- ![Alternate Core Clinical Quality Measures](Begin)

In addition you are required to select (2) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.

- ![Additional Clinical Quality Measures](Begin)

**Note:**

When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Meaningful Use Menu Measures

This initial screen provides information about the Menu Measures. Click **Begin** to continue to the Meaningful Use Menu Measures Selection screen.

---

**Meaningful Use Menu Measures**

As part of the meaningful use attestation process, Eligible Professionals are required to complete a minimum of five out of ten Menu Set Measures. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. The EP must be able to meet at least one public health measure. If an EP can attest to one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.

**HELPFUL HINTS**

1. The Menu Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%.
5. Results are only displayed in whole numbers.
6. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 80%, a result of 80.1% will pass but a result of exactly 80.0% would not pass.
7. After completing a minimum of five measures, you will receive a green checkmark indicating the section is complete.
8. The green checkmark does not mean you passed or failed the minimum of five measures.
9. Evaluation of MU measures is made after the application is electronically signed.
10. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.

For Menu Set Measures nine & ten (Public Health Measures), not all of the information entered into these measures will be displayed on the MU Menu Measures Worksheet Screen. Also for these two measures, when you select them, they will be at the top of the list, but when you are completing and reviewing all the measures completed, they move to the bottom of the list.

---

**Begin**
From the Meaningful Use Menu Measures Selection screen displayed on the following page, choose five Meaningful Use Menu Measures to attest to. One measure must be from the public health list (first two measures listed on the top half of the screen). The remainder of the measures can be any combination from the remaining public health list measures or from the additional Meaningful Use Menu Measures listed. In the example shown on the following page, one public health measure and four measures from the additional Meaningful Use Measures listed are selected.

If a measure is selected and information is entered for that measure, unselecting the measure will clear all information previously entered.

Click **Save & Continue** to proceed, or click **Return to Main** to go back. Click **Reset** to restore this panel to the starting point.
Attestation Meaningful Use Measures

Instructions:
Eligible Professionals must report on a minimum of five (5) Meaningful Use Menu Measures. EPMMU09 and EPMMU10 are the Public Health measures. Eligible Professionals are required to attest to at least one (1) Public Health measure and four (4) other Menu measures, or attest to two (2) Public Health measures and three (3) other Menu measures. If an Eligible Professional can be excluded from both Public Health measures, the Eligible Professional must claim an exclusion from only one (1) Public Health measure and report on four (4) additional Menu measures. Please refer to the tab introduction (splash page) for state specific information.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion is applied.

When ready click the Save & Continue button to review your selection, or click Return to Main to go back. Click Reset to restore this panel to the starting point.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Objective</th>
<th>Public Health Measure</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPMMU09</td>
<td>Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.</td>
<td>Performed at least one test of certified EHR technology's capability 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).</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU10</td>
<td>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.</td>
<td>Performed at least one test of certified EHR technology's capability 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).</td>
<td>✔</td>
</tr>
</tbody>
</table>

You must submit additional menu measure objectives until a minimum 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.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Objective</th>
<th>Measure</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPMMU01</td>
<td>Implement drug formulary checks.</td>
<td>The EP has enabled the functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU02</td>
<td>Incorporate clinic lab test results into EHR as structured data.</td>
<td>More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU03</td>
<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.</td>
<td>Generate at least one report listing patients of the EP with a specific condition.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU04</td>
<td>Send reminders to patients per patient preference for preventive/follow up care.</td>
<td>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.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU05</td>
<td>Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within four business days of the information being available to the EP.</td>
<td>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.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU06</td>
<td>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</td>
<td>More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU07</td>
<td>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.</td>
<td>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.</td>
<td>✔</td>
</tr>
<tr>
<td>EPMMU08</td>
<td>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.</td>
<td>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.</td>
<td>✔</td>
</tr>
</tbody>
</table>
The five measures you selected to attest to will display on the Meaningful Use Menu Measure Worksheet. The example below displays the five measures selected on the previous screen example.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return to Selection List** to return to the Meaningful Use Menu Measures Selection screen.

The 10 available Meaningful Use Menu Measures are described in this user guide. Only those that you selected will apply to you.
Menu Measure 1 (Measure Code EPMMU01)

Enter information in all required fields.
If the exclusion applies to you, see the screen on the following page.
If the exclusion does not apply to you, select No to the exclusion and answer the question. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

---

**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 - Based on All patient records:** 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

If the exclusion does not apply please 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
If the exclusion applies to you, select **Yes** to the exclusion.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.
Menu Measure 2 (Measure Code EPMMU02)

Enter information in all required fields.

If the exclusion applies to you, see the screen on the following page.

If the exclusion does not apply to you, select No to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
If the exclusion applies to you, select **Yes** to the exclusion and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Menu Measure 3 (Measure Code EPMMU03)

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

Name: Dr. Medicaid Provider

<table>
<thead>
<tr>
<th>Personal TIN/SSN</th>
<th>999999999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Year</td>
<td>1</td>
</tr>
</tbody>
</table>

Click **HERE** for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) 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 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 maintained using certified EHR technology.
- This data was extracted only from patient 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
Menu Measure 4 (Measure Code EPMMU04)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select Yes to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Menu Measure 5 (Measure Code EPMMU05)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

If the exclusion does not apply to you, answer the Patient Records question, select No to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Menu Measure 6 (Measure Code EPMMU06)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

---

**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 the 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:** 21

**Denominator:** 122
Menu Measure 7 (Measure Code EPMMU07)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

If the exclusion does not apply to you, answer the Patient Records question, select No to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Menu Measure 8 (Measure Code EPMMU08)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.
Menu Measure 9 (Measure Code EPMMU09)

Enter information in all required fields.
If Exclusion 1 and/or Exclusion 2 apply to you, refer to the second screen for this Menu Measure.
If Exclusion 1 and 2 do not apply to you, select No to the exclusions and answer the EHR technology question. If you answered yes to the EHR Technology question, complete the Additional Information section of the screen. In the example below, the exclusion does not apply.
Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
Menu Measure 9

(*) 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 EP submits such information have the capacity to receive the information electronically).

EXCLUSION 1 - Based on ALL patient records: An EP who 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 - Based on ALL patient records: 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

Note: If you would like to upload additional information that you feel justifies this exclusion, please use the upload file function found on the "Submit" tab.

If the exclusions do not apply please answer the following question:

*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 (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)? 
☐ Yes ☐ No

Additional Information:

* Enter the name of the immunization registry used: Immunization Reg

IF you performed at least one test of EHR submission of electronic data to immunization registries:

Was the test successful? 
☐ Yes ☐ No

If the test was successful, please enter the date and time of the test:

Date (MM/DD/YY) 02/15/12

Time (HH:MM AM/PM) 12:15 PM (Example: 02:15 PM)

If you answered Yes to 'Was the test successful', you must answer the following:

Was a follow up submission done? ☐ Yes ☐ No
If Exclusion 1 and/or Exclusion 2 apply to you select Yes and do not answer the EHR technology question. Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
Menu Measure 10 (Measure Code EPMMU10)

Enter information in all required fields.

If Exclusion 1 and/or Exclusion 2 apply to you, refer to the second screen for this Menu Measure.

If Exclusion 1 and 2 do not apply to you, select No to the exclusions and answer the EHR technology question. If you answered yes to the EHR Technology question, complete the Additional Information section of the screen. In the example below, the exclusion does not apply.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore this panel to the starting point.
Attestation Meaningful Use Measures

Menu Measure 10

Click HERE for additional information on completing this measure.

When ready, click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.

(*) 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 an EP submits such information have the capacity to receive the information electronically).

EXCLUSION 1 - Based on ALL patient records: If an EP 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 - Based on ALL patient records: 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

Note: It is advised that you upload an electronic copy of the letter that was received from the public health agency stating why they are not capable of data submission. If you would like to upload additional information that you feel justifies this exclusion, please use the upload file function found on the "Submit" tab.

If the exclusions do not apply please complete the following information:

*Did you perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)?

[ ] Yes  [ ] No

Additional Information:

*Enter the name of the syndromic surveillance agency: Syndromic Surveillance

If you performed at least one test of EHR submission of electronic data to public health agencies:

Was the test successful?

[ ] Yes  [ ] No

If the test was successful, please enter the date and time of the test:

Date (MM/DD/YYYY) 02/19/12

Time (HH:MM AM/PM) 12:30 PM (Example: 00:15 PM)

If you answered Yes to 'Was the test successful', you must answer the following:

Was a follow up submission done?  [ ] Yes  [ ] No
If Exclusion 1 and/or Exclusion 2 apply to you, select Yes and do not answer the EHR technology question.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

![Image of user guide interface](image_url)

<table>
<thead>
<tr>
<th>Name</th>
<th>Applicant NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9999999999</td>
</tr>
<tr>
<td>Personal TIN/SSN</td>
<td>Payee TIN</td>
</tr>
<tr>
<td>999999999</td>
<td>9999999999</td>
</tr>
<tr>
<td>Payment Year</td>
<td>Program Year</td>
</tr>
<tr>
<td>1</td>
<td>2012</td>
</tr>
</tbody>
</table>

**Attestation Meaningful Use Measures**

**Menu Measure 10**

![Click HERE for additional information on completing this measure.](image_url)

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) 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 an EP submits such information have the capacity to receive the information electronically).

**EXCLUSION 1 - Based on ALL patient records:** If an EP 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 - Based on ALL patient records:** 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

**Note:** It is advised that you upload an electronic copy of the letter that was received from the public health agency stating why they are not capable of data submission. If you would like to upload additional information that you feel justifies this exclusion, please use the upload file function found on the "Submit" tab.

**Additional Information:**

* Enter the name of the syndromic surveillance agency:

**If you performed at least one test of EHR submission of electronic data to public health agencies:**

Was the test successful?

- [ ] Yes  [ ] No

If the test was successful, please enter the date and time of the test:

**Date (MM/DD/YY)**

**Time (HH:MM AM/PM)** 

(Example: 09:15 PM)

If you answered Yes to "Was the test successful," you must answer the following:

Was a follow up submission done?

- [ ] Yes  [ ] No
Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Menu Measure Selection screen.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Objective</th>
<th>Measure</th>
<th>Entered</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPMMU01</td>
<td>Implement drug formulary checks.</td>
<td>The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.</td>
<td>Yes</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPMMU03</td>
<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.</td>
<td>Generate at least one report listing patients of the EP with a specific condition.</td>
<td>Yes</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPMMU06</td>
<td>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</td>
<td>More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.</td>
<td>Numerator= 21 Denominator= 122</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPMMU08</td>
<td>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care.</td>
<td>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for each transition of care or referral.</td>
<td>Numerator= 93 Denominator= 153</td>
<td>EDIT</td>
</tr>
<tr>
<td>EPMMU09</td>
<td>Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.</td>
<td>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).</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Click **Return to Main** to return to the Measure Topic List.

## Attestation Meaningful Use Measures

**Instructions:**

Eligible Professionals must report on a minimum of five (5) Meaningful Use Menu Measures. EPMUJ09 and EPMUJ10 are the Public Health measures. Eligible Professionals are required to attest to at least one (1) Public Health measure and four (4) other Menu measures, or attest to two (2) Public Health measures and three (3) other menu measures. If an Eligible Professional can be excluded from both Public Health measures, the Eligible Professional must claim an exclusion from only one (1) Public Health measure and report on four (4) additional menu measures. Please refer to the tab introduction (splash page) for state specific information.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion is applied.

---

### Measure Number | Objective | Public Health Measure | Select
--- | --- | --- | ---
EPMUJ09 | 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 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). |  
EPMUJ10 | 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). |  

---

You must submit additional menu measure objectives until a minimum 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.

### Measure Number | Objective | Measure | Select
--- | --- | --- | ---
EPMUJ01 | Implement drug formulary checks. | The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period. |  
EPMUJ02 | Incorporate clinic lab test results into EHR as structured data. | More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. |  
EPMUJ03 | 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. |  
EPMUJ04 | Send reminders to patients per patient preference for preventive/follow up care. | More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. |  
EPMUJ05 | Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP. | At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. |  
EPMUJ06 | 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. |  
EPMUJ07 | 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. |  
EPMUJ08 | 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. | 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. |  
If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.
Meaningful Use Core Clinical Quality Measures

This initial screen provides information about the Meaningful Use Core Clinical Quality Measures. Click **Begin** to continue to the Meaningful Use Core Clinical Quality Measure Worklist Table.
The screen on the following page displays the Meaningful Use Core Clinical Quality Measure Worklist Table. You must complete all measures.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for the measure or click **Return to Main** to return to the Measures Topic List.
Core Clinical Quality Measure NQF 0013

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Numerator: 55  Denominator: 100

(*) 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 0013

Title: Hypertension: Blood Pressure Measurement.
Description: Percentage of patient visits for patients aged 10 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Core Clinical Quality Measure Worklist Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.
Core Clinical Quality Measure NQF 0028-PQRI 114

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Click **HERE** for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) 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 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.

Complete the following information. All data entered must be a positive whole number:

**Numerator:** 16  
**Denominator:** 32

**b. Tobacco Cessation Intervention**
**Description:** Percentage of patients aged 18 years and older indentified 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. All data entered must be a positive whole number:

**Numerator:** 8  
**Denominator:** 16

Click **Save & Continue**.
Core Clinical Quality Measure NQF 0421-PQRI 128

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Core Clinical Quality Measure NQF 0421-PQRI 128**

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
The following screen displays the Meaningful Use Core Clinical Quality Measures Worklist Table with data entered for every measure.

Click **Return to Main** to return to the Measures Topic List.
If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Progress</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Requirements</td>
<td>2/2</td>
<td><strong>EDIT</strong></td>
</tr>
<tr>
<td>Core Measures</td>
<td>15/15</td>
<td><strong>EDIT</strong></td>
</tr>
<tr>
<td>Menu Measures</td>
<td>5/5</td>
<td><strong>EDIT</strong></td>
</tr>
<tr>
<td>Core Clinical Quality Measures</td>
<td>3/3</td>
<td><strong>EDIT</strong></td>
</tr>
<tr>
<td>Alternate Core Clinical Quality Measures</td>
<td></td>
<td><strong>Begin</strong></td>
</tr>
</tbody>
</table>

You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.

In addition you are required to select (2) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.

**Note:** When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Meaningful Use Alternate Core Clinical Quality Measures

This initial screen provides information about the Alternate Core Clinical Quality Measures. Click Begin to continue to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

---

Meaningful Use Alternate Core Clinical Quality Measures

As part of the Meaningful Use attestation, Eligible Professionals (EPs) are required to complete six Clinical Quality Measures (three Core or Alternate Core measures and three Additional). The EP must report results for up to three Alternate Core Measures if the EP reports a zero for the Core Measure denominator.

The data for these measures must be obtained directly from the certified EHR system. If a Clinical Quality Measure does not apply to the EP, the EP would not have any eligible patients or actions for the Alternate Measure denominator. The following screen will allow you to attest to the Alternate Core Clinical Quality Measures.

HELPFUL HINTS

1. The Clinical Quality Measures can be completed in any order by selecting the ‘Begin’ button.
2. For Clinical Quality Measures with multiple numerators and denominators, all fields must be completed for the Clinical Quality Measure to be validated. A provider may enter a zero if it is applicable to the measure.
3. You may review the completed measures by selecting the ‘Edit’ button.
4. After completing the required number of Core Clinical Quality Measures, a green checkmark is displayed indicating the section is complete.
6. Exclusions related to the Clinical Quality Measures must be whole numbers. If you do not have an exclusion, enter a zero. All fields need to be completed in order to continue to the next measure.

Begin
The following screen displays the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

You are only required to answer an Alternate Core Clinical Quality Measure if you entered a zero in a denominator field for a Core Clinical Quality Measure.

If you only enter zeros in the denominator fields for the Alternate Core Clinical Quality Measures, then you must attest to all three Alternate Core Clinical Quality measures to show that you were not able to attest to any of the Alternate Core Clinical Quality Measures with a value greater than zero in the denominator field.

Click on the checkbox next to the measure(s) you want to attest to. Click **Save & Continue** to proceed to the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table where you can review your selections. Click **Reset** to restore this panel to the starting point or last saved data. Click **Return to Main** to return to the Measures Topic List.
The 3 available Alternate Core Clinical Quality Measures are described in this user guide. Only those that you selected will apply to you.

The screen on the following page displays the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table which lists the measures you chose to attest to on the previous screen.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for the measure or click **Return to Selection List** to return to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.
Alternate Core Clinical Quality Measure NQF 0024

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.
Alternate Core Clinical Quality Measure NQF 0041-PQRI 110

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Attestation Meaningful Use Measures**

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) Red asterisk indicates a required field.

**NQF 0041-PQRI 110**

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

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

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 86
- **Denominator:** 100
- **Exclusion:** 24
Alternate Core Clinical Quality Measure NQF 0038

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

(*) Red asterisk indicates a required field.

**NQF 0038**

**Title:** Childhood Immunization Status.

**Description:** 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 (Var); 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. All data entered must be a positive whole number:

- **Numerator 1:** 25
  - **Denominator:** 100

- **Numerator 2:** 35
  - **Denominator:** 100

- **Numerator 3:** 45
  - **Denominator:** 100

- **Numerator 4:** 55
  - **Denominator:** 100

- **Numerator 5:** 65
  - **Denominator:** 100

- **Numerator 6:** 75
  - **Denominator:** 100

- **Numerator 7:** 95
  - **Denominator:** 100

- **Numerator 8:** 95
  - **Denominator:** 100

- **Numerator 9:** 90
  - **Denominator:** 100

- **Numerator 10:** 80
  - **Denominator:** 100

- **Numerator 11:** 70
  - **Denominator:** 100

- **Numerator 12:** 60
  - **Denominator:** 100
Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Population Criteria 1</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024 - Height Assessment and Counseling for Children and Adolescents.</td>
<td>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.</td>
<td>Numerator = 50; Denominator = 100</td>
<td>EDIT</td>
</tr>
<tr>
<td>NQF 0041-PQRI 110 - Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.</td>
<td>Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).</td>
<td>Numerator = 86; Denominator = 100; Exclusion = 24</td>
<td>EDIT</td>
</tr>
<tr>
<td>NQF 0038 - Childhood Immunization Status.</td>
<td>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 (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two of 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.</td>
<td>Numerator values vary; Denominator = 100</td>
<td>EDIT</td>
</tr>
</tbody>
</table>
Click **Return to Main** to return to the Measure Topic List.

### Attestation Meaningful Use Measures

**Instructions:**
You have entered a denominator of zero for one or more of your Core Clinical Quality Measures. You must submit one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero Denominator.

**Please select the Alternate Core Clinical Quality Measure(s) from the list below.**

Please Note: Unchecking an Alternate Core Clinical Quality Measure will result in the loss of any data entered for that measure. 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.

When ready click the **Save & Continue** button to review your selection, or click **Return to Main** to go back. 
Click **Reset** to restore this panel to the starting point.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Title</th>
<th>Description</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Children and Adolescents.</td>
<td>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.</td>
<td>✔️</td>
</tr>
<tr>
<td>NQF 0041-PQRI 110</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.</td>
<td>Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).</td>
<td>✔️</td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status.</td>
<td>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 hepatitits B (hep B); 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.</td>
<td>✔️</td>
</tr>
</tbody>
</table>
If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.
Meaningful Use Additional Clinical Quality Measures

This initial screen provides information about the Additional Clinical Quality Measures. Click **Begin** to continue to the Meaningful Use Additional Clinical Quality Measures Selection screen.

**HELPFUL HINTS**

1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. For Clinical Quality Measures with multiple numerators and denominators, all fields must be completed for the Clinical Quality Measure to be validated. A provider may enter a zero if it is applicable to the measure.
3. You may review the completed measures by selecting the 'Edit' button.
4. After completing the required number of Core Clinical Quality Measures, a green checkmark is displayed indicating the section is complete.
5. More information about the Clinical Quality Measures is available at: [https://www.cms.gov/apps/ama/license-qa/QualityMeasures/](https://www.cms.gov/apps/ama/license-qa/QualityMeasures/). Please review this page, and accept the terms. You will then be able to access all of the Clinical Quality Measures. Exclusions related to the Clinical Quality Measures must be whole numbers. If you do not have an exclusion, enter a zero. All fields need to be completed in order to continue to the next measure.
The screens on the following pages display the Meaningful Use Additional Clinical Quality Measures Selection screen.

You are required to answer three Additional Clinical Quality Measures. There are a total of 38 Additional Clinical Quality Measures to choose from.

The 38 available Additional Core Clinical Quality Measures are described in this user guide. Only those that you selected will apply to you.

Click on the checkbox next to the measures you want to attest to, click **Save & Continue** to review your selections, or click **Reset** to restore this panel to the starting point or last saved data.
### Meaningful Use Additional Clinical Quality Measures Selection screen (Part 1 of 3)

<table>
<thead>
<tr>
<th>Measure#</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0059-PQRI 1</td>
<td>Diabetes: Hemoglobin A1c Poor Control.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.</td>
</tr>
<tr>
<td>NQF 0064-PQRI 2</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management and Control.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100mg/dl.</td>
</tr>
<tr>
<td>NQF 0061-PQRI 3</td>
<td>Diabetes: Blood Pressure Management.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.</td>
</tr>
<tr>
<td>NQF 0081-PQRI 5</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF less than 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
</tr>
<tr>
<td>NQF 0070-PQRI 7</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD patients with prior Myocardial Infarction (MI).</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.</td>
</tr>
<tr>
<td>NQF 0043-PQRI 111</td>
<td>Pneumonia Vaccination Status for Older Adults.</td>
<td>Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.</td>
</tr>
<tr>
<td>NQF 0031-PQRI 112</td>
<td>Breast Cancer Screening.</td>
<td>Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.</td>
</tr>
<tr>
<td>NQF 0034-PQRI 113</td>
<td>Colorectal Cancer Screening.</td>
<td>Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.</td>
</tr>
<tr>
<td>NQF 0067-PQRI 6</td>
<td>Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.</td>
</tr>
<tr>
<td>NQF 0083-PQRI 8</td>
<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF less than 40%) who were prescribed beta-blocker therapy.</td>
</tr>
<tr>
<td>NQF 0105</td>
<td>Anti-depressant medication management; (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment.</td>
<td>Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.</td>
</tr>
<tr>
<td>NQF 0086-PQRI 12</td>
<td>Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0088-PQRI 18</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.</td>
<td>Percentage of patients aged 18 years and older with 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.</td>
</tr>
<tr>
<td>NQF 0089-PQRI 10</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.</td>
<td>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 at least once within 12 months.</td>
</tr>
<tr>
<td>NQF 0047-PQRI 53</td>
<td>Asthma Pharmacologic Therapy.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 002-PQRI 66</td>
<td>Appropriate Testing for Children with Pharyngitis.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0387-PQRI 71</td>
<td>Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.</td>
<td>Percentage of female patients aged 18 years and older with stage IIA through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.</td>
</tr>
<tr>
<td>NQF 0385-PQRI 72</td>
<td>Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.</td>
<td>Percentage of patients aged 18 years and older with stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.</td>
</tr>
<tr>
<td>NQF 0389-PQRI 102</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0327-PQRI 115</td>
<td>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.</td>
<td>Percentage of patients 18-75 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.</td>
</tr>
<tr>
<td>NQF 0055-PQRI 117</td>
<td>Diabetes: Eye Exam.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.</td>
</tr>
<tr>
<td>NQF 0062-PQRI 119</td>
<td>Diabetes: Urine Screening.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0056-PQRI 162</td>
<td>Diabetes: Foot Exam.</td>
<td>The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).</td>
</tr>
<tr>
<td>NQF 0074-PQRI 197</td>
<td>Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).</td>
</tr>
<tr>
<td>NQF 0084-PQRI 200</td>
<td>Heart Failure (HF): Warfarin Therapy patients with Atrial Fibrillation.</td>
<td>Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.</td>
</tr>
<tr>
<td>NQF 0073-PQRI 201</td>
<td>Ischemic Vascular Disease (IVD): Blood Pressure Management.</td>
<td>Percentage of patients 18 years of age or older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (less than 140/90 mmHg).</td>
</tr>
<tr>
<td>NQF 0068-PQRI 204</td>
<td>Ischemic Vascular Disease (IVD): Use of aspirin or another antithrombotic.</td>
<td>Percentage of patients 18 years of age or older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass (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.</td>
</tr>
<tr>
<td>NQF 0004</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement.</td>
<td>Percentage of adolescent and adult patients with a new episode of alcohol and other drug (OUD) dependence who initiated treatment through an inpatient OUD 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 OUD diagnosis within 30 days of the initiation visit.</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NQF 0001-PQRI 64</td>
<td>Asthma Assessment.</td>
<td>Percentage of patient 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.</td>
</tr>
<tr>
<td>NQF 0012</td>
<td>Prenatal Care: Screening for Human Immunodeficiency Virus (HIV).</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0014</td>
<td>Prenatal Care: Anti-D Immune Globulin.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0018</td>
<td>Controlling High Blood Pressure.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0032</td>
<td>Cervical Cancer Screening.</td>
<td>Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.</td>
</tr>
<tr>
<td>NQF 0033</td>
<td>Chlamydia Screening for women.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0036</td>
<td>Use of Appropriate Medications for Asthma.</td>
<td>Percentage of patients 5-50 years of age who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. Report three age strataficiations (5-11 years, 12-50 years, and total).</td>
</tr>
<tr>
<td>NQF 0052</td>
<td>Low Back Pain: Use of Imaging Studies.</td>
<td>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.</td>
</tr>
<tr>
<td>NQF 0075</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.</td>
<td>Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal angioplasty (PTCA) from January 1-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 less than 100 mg/dL.</td>
</tr>
<tr>
<td>NQF 0575</td>
<td>Diabetes: Hemoglobin A1c (less than 8.0%).</td>
<td>The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c less than 8.0%.</td>
</tr>
</tbody>
</table>
The following screen displays the Meaningful Use Additional Clinical Quality Measure Worklist Table with the Additional Clinical Quality Measures you selected to attest to.

Click **Edit** to enter or edit information for a measure or click **Return to Selection List** to return to the Meaningful Use Additional Clinical Quality Measures Selection screen.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.
Additional Clinical Quality Measure NQF 0059-PQRI 1

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**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 greater than 9.0%.

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 38
- **Denominator:** 76
- **Exclusion:** 2

---

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.
After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Core Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.
Additional Clinical Quality Measure NQF 0064-PQRI 2

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
Additional Clinical Quality Measure NQF 0061-PQRI 3

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
**Additional Clinical Quality Measure NQF 0081-PQRI 5**

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Attestation Meaningful Use Measures**

**Additional Clinical Quality Measure**

Click **HERE** for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) 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 aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF less than 40%) who were prescribed ACE inhibitor or ARB therapy.

Complete the following information. All data entered must be a positive whole number:

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th><strong>Denominator</strong></th>
<th><strong>Exclusion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>25</td>
<td>2</td>
</tr>
</tbody>
</table>

---

June 25, 2012 153
Additional Clinical Quality Measure NQF 0070-PQRI 7

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Additional Clinical Quality Measure NQF 0070-PQRI 7](image)

(*) Red asterisk indicates a required field.

**NQF 0070-PQRI 7**

**Title:** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD patients with prior Myocardial Infarction (MI).

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

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 16
- **Denominator:** 29
- **Exclusion:** 3

Click **Save & Continue** to proceed.
Additional Clinical Quality Measure NQF 0043-PQRI 111

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

(* 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. All data entered must be a positive whole number:

- **Numerator**: 24
- **Denominator**: 89

Save & Continue
Additional Clinical Quality Measure NQF 0031-PQRI 112

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Attestation Meaningful Use Measures](image-url)

(*) 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. All data entered must be a positive whole number:

- **Numerator:** 100
- **Denominator:** 120
Additional Clinical Quality Measure NQF 0034-PQRI 113

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
Additional Clinical Quality Measure NQF 0067-PQRI 6

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Attestation Meaningful Use Measures](image)

(* 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. All data entered must be a positive whole number:

- **Numerator:** 23
- **Denominator:** 45
- **Exclusion:** 5
Additional Clinical Quality Measure NQF 0083-PQRI 8

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Omit information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 12
- **Denominator:** 24
- **Exclusion:** 2
Additional Clinical Quality Measure NQF 0105

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Numerator 1**: 23  **Denominator**: 50

**Numerator 2**: 27  **Denominator**: 50
Additional Clinical Quality Measure NQF 0086-PQRI 12

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Additional Clinical Quality Measure 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. All data entered must be a positive whole number:

- **Numerator:** 10
- **Denominator:** 120
- **Exclusion:** 1
Additional Clinical Quality Measure NQF 0088-PQRI 18

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Image of Attestation Meaningful Use Measures]

- **Numerator**: 15
- **Denominator**: 120
- **Exclusion**: 2
Additional Clinical Quality Measure NQF 0089-PQRI 19

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Numerator:** 14  
**Denominator:** 120  
**Exclusion:** 1
Additional Clinical Quality Measure NQF 0047-PQRI 53

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Numerator:** 65

**Denominator:** 200

**Exclusion:** 5
Additional Clinical Quality Measure NQF 0002-PQRI 66

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Numerator**: 15  
**Denominator**: 100

---

Additional Clinical Quality Measure 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. All data entered must be a positive whole number:

**Numerator**: 15  
**Denominator**: 100
**Additional Clinical Quality Measure NQF 0387-PQRI 71**

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Additional Clinical Quality Measure NQF 0387-PQRI 71**

**Title:** Oncology Breast Cancer: Hormonal Therapy for Stage I-III Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.

**Description:** Percentage of female patients aged 18 years and older with Stage I through III, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 16
- **Denominator:** 50
- **Exclusion:** 3

---
**Additional Clinical Quality Measure NQF 0385-PQRI 72**

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

Enter the following information:

- **Numerator**: 32
- **Denominator**: 56
- **Exclusion**: 0
Additional Clinical Quality Measure NQF 0389-PQRI 102

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Attestation Meaningful Use Measures](image)

Click Here for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) 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. All data entered must be a positive whole number:

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>33</td>
<td>45</td>
<td>1</td>
</tr>
</tbody>
</table>
Additional Clinical Quality Measure NQF 0027-PQRI 115

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click Save & Continue to review your selection, click Previous to go back, or click Reset to restore the panel to the starting point.

(1) Red asterisk indicates a required field.

NQF 0027-PQRI 115


Description: 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.

Complete the following information. All data entered must be a positive whole number:

\[ \text{Numerator} 1: 78 \quad \text{Denominator}: 76 \]

\[ \text{Numerator} 2: 75 \quad \text{Denominator}: 78 \]
Additional Clinical Quality Measure NQF 0055-PQRI 117

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Screenshot of the Additional Clinical Quality Measure NQF 0055-PQRI 117 page]

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

Complete the following information. All data entered must be a positive whole number:

- **Numerator**: 50
- **Denominator**: 78
- **Exclusion**: 3
Additional Clinical Quality Measure NQF 0062-PQRI 119

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

(*) Red asterisk indicates a required field.

**NQF 0062-PQRI 119**

**Title:** Diabetes: Urine Screening.

**Description:** 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.

Complete the following information. All data entered must be a positive whole number:

- Numerator: 46
- Denominator: 78
- Exclusion: 5
Additional Clinical Quality Measure NQF 0056-PQRI 163

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Additional Clinical Quality Measure](image)

**Numerator**: 58  
**Denominator**: 78  
**Exclusion**: 3
Additional Clinical Quality Measure NQF 0074-PQRI 197

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

```
Name Dr. Medicate Provider
Personal TIN/SSN 999999999
Payment Year 1

Applicant NPI 999999999
Payee TIN 999999999
Program Year 2012

Attestation Meaningful Use Measures

Additional Clinical Quality Measure

Click HERE for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) 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 ACC/AMA guidelines).

Complete the following information. All data entered must be a positive whole number:

```
  Numerator: 32  Denominator: 46  Exclusion: 10
```

Prevous  Reset  Save & Continue
Additional Clinical Quality Measure NQF 0084-PQRI 200

Enter information in all required fields. The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Medicaid Provider</th>
<th>Applicant NPI</th>
<th>Payee TIN</th>
<th>Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>9999999999</td>
<td>9999999909</td>
<td>2012</td>
</tr>
</tbody>
</table>

**Personal TIN/SSN**: 999999999

**Payment Year**: 1

---

**Attestation Meaningful Use Measures**

<table>
<thead>
<tr>
<th>Additional Clinical Quality Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0084-PQRI 200</td>
</tr>
</tbody>
</table>

(*) Red asterisk indicates a required field.

**Title**: Heart Failure (HF): Warfarin Therapy patients with Atrial Fibrillation.

**Description**: Percentage of all 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. All data entered must be a positive whole number:

- **Numerator**: 17
- **Denominator**: 23
- **Exclusion**: 3
**Additional Clinical Quality Measure NQF 0073-PQRI 201**

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**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 alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 - November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (less than 140/90 mmHg).

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 27
- **Denominator:** 54
Additional Clinical Quality Measure NQF 0068-PQRI 204

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Numerator:** 65  
**Denominator:** 78
Additional Clinical Quality Measure NQF 0004

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

**Name**: Dr. Medicaid Provider

**Applicant NPI**: 099999999

**Personal TIN/SSN**: 999999999

**Payment Year**: 1

**Program Year**: 2012

The numerator and denominator entries must be positive whole numbers.

Click **Here** for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(**) Red asterisk indicates a required field.

**NQF 0004**

**Title**: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement.

**Description**: 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 initiation visit.

Complete the following information. All data entered must be a positive whole number:

<table>
<thead>
<tr>
<th>Population Criteria 1:</th>
<th>Numerator 1: 24</th>
<th>Denominator: 65</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator 2: 23</td>
<td>Denominator: 65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population Criteria 2:</th>
<th>Numerator 1: 29</th>
<th>Denominator: 38</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator 2: 25</td>
<td>Denominator: 38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population Criteria 3:</th>
<th>Numerator 1: 40</th>
<th>Denominator: 47</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator 2: 20</td>
<td>Denominator: 47</td>
</tr>
</tbody>
</table>
Additional Clinical Quality Measure NQF 0001-PQRI 64

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
Additional Clinical Quality Measure NQF 0012

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**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. All data entered must be a positive whole number:

- **Numerator**: 90
- **Denominator**: 100
- **Exclusion**: 10
Additional Clinical Quality Measure NQF 0014

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**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. All data entered must be a positive whole number:

- **Numerator:** 30
- **Denominator:** 60
- **Exclusion:** 10

---
Additional Clinical Quality Measure NQF 0018

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
Additional Clinical Quality Measure NQF 0032

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

**Additional Clinical Quality Measure**

**NQF 0032**

**Title:** Cervical Cancer Screening.

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

Complete the following information. All data entered must be a positive whole number:

- **Numerator:** 115
- **Denominator:** 120
Additional Clinical Quality Measure NQF 0033

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.
Additional Clinical Quality Measure NQF 0036

Enter information in all required fields.
The numerator, denominator, and exclusion entries must be positive whole numbers.
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Click HERE for additional information on completing this measure.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(*) Red asterisk indicates a required field.

NQF 0036

**Title:** Use of Appropriate Medications for Asthma.

**Description:** Percentage of patients 5-50 years of age 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. All data entered must be a positive whole number:

<table>
<thead>
<tr>
<th>Population Criteria 1</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>60</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population Criteria 2</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40</td>
<td>50</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population Criteria 3</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55</td>
<td>65</td>
<td>10</td>
</tr>
</tbody>
</table>
Additional Clinical Quality Measure NQF 0052

Enter information in all required fields.
The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

![Image of user interface for Additional Clinical Quality Measure NQF 0052]
Additional Clinical Quality Measure NQF 0075

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

---

Complete the following information. All data entered must be a positive whole number:

- **Numerator 1**: 25  
  **Denominator**: 50
- **Numerator 2**: 20  
  **Denominator**: 50
Additional Clinical Quality Measure NQF 0575

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

(*) Red asterisk indicates a required field.

**NQF 0575**

**Title:** Diabetes: Hemoglobin A1c (less than 8.0%).

**Description:** The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c less than 8.0%.

Complete the following information. All data entered must be a positive whole number:

- Numerator: 50
- Denominator: 67
- Exclusion: 3
Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Additional Clinical Quality Measures Selection screen.
Click **Return to Main** to return to the Measure Topic List. (Only the top and bottom sections of the Meaningful Use Additional Clinical Quality Measures Selection screen are displayed below.)

### Attestation Meaningful Use Measures

**Instructions:**
Select three (3) Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you select the **Save & Continue** button below.

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Title</th>
<th>Description</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0059-PQRI 1</td>
<td>Diabetes: Hemoglobin A1c Poor Control.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.</td>
<td>✔</td>
</tr>
<tr>
<td>NQF 0064-PQRI 2</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management and Control.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100mg/dl.</td>
<td>✔</td>
</tr>
<tr>
<td>NQF 0061-PQRI 3</td>
<td>Diabetes: Blood Pressure Management.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.</td>
<td>✔</td>
</tr>
<tr>
<td>NQF 0061-PQRI 5</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF less than 40%) who were prescribed ACE inhibitor or ARB therapy.</td>
<td>✔</td>
</tr>
<tr>
<td>NQF 0075</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.</td>
<td>Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal angioplasty (PTCA) from January 1-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 less than 100 mg/dl.</td>
<td>✔</td>
</tr>
<tr>
<td>NQF 0575</td>
<td>Diabetes: Hemoglobin A1c (less than 8.0%).</td>
<td>The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c less than 6.0%.</td>
<td>✔</td>
</tr>
</tbody>
</table>
If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

The screen on the following page displays the Measures Topic List with all six meaningful use measure topics marked complete. Click **Save & Continue** to view a summary of the Meaningful Use Measures you attested to.
### Attestation Meaningful Use Measures

The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.

**Note:** The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.

Available actions for a topic will be determined by current progress level. To start a topic select the **Begin** button. To modify a topic where entries have been made select the **EDIT** button for a topic to modify any previously entered information. Select **Previous** to return.

<table>
<thead>
<tr>
<th>Completed?</th>
<th>Topics</th>
<th>Progress</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>General Requirements</td>
<td>2/2</td>
<td><strong>EDIT</strong> Clear All</td>
</tr>
<tr>
<td>✔</td>
<td>Core Measures</td>
<td>15/15</td>
<td><strong>EDIT</strong> Clear All</td>
</tr>
<tr>
<td>✔</td>
<td>Menu Measures</td>
<td>5/5</td>
<td><strong>EDIT</strong> Clear All</td>
</tr>
</tbody>
</table>

You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.

| ✔         | Core Clinical Quality Measures       | 3/3      | **EDIT** Clear All |
| ✔         | Alternate Core Clinical Quality Measures | 3/3  | **EDIT** Clear All |

In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.

| ✔         | Additional Clinical Quality Measures | 3/3      | **EDIT** Clear All |

**Note:**
When all topics are marked as completed, select the **Save & Continue** button to complete the attestation process.
Meaningful Use Measures Summary

This screen displays a summary of all entered meaningful use attestation information.

Review the information for each measure. If further edits are necessary, click Previous to return to the Measures Topic List where you can choose a topic to edit.

If the information on the summary is correct, click Save & Continue to proceed to Part 3 of 3 of the Attestation Phase.

### Attestation Meaningful Use Measures

The Meaningful Use Measures you have attested to are depicted below. Please review the current information to verify what you have entered is correct.

#### Meaningful Use General Requirements Review

<table>
<thead>
<tr>
<th>Question</th>
<th>Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized.</td>
<td>Numerator = 600  Denominator = 1000  Percentage = 60%</td>
</tr>
<tr>
<td>Please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.</td>
<td>Numerator = 850  Denominator = 1000  Percentage = 85%</td>
</tr>
</tbody>
</table>

#### Meaningful Use Core Measure Review

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Objective</th>
<th>Measure</th>
<th>Entered</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPCMU01</td>
<td>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.</td>
<td>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.</td>
<td>Numerator = 65  Denominator = 100  Percentage = 65%</td>
<td>Patient Records = All</td>
</tr>
<tr>
<td>EPCMU02</td>
<td>Implement drug-drug and drug-allergy interaction checks.</td>
<td>The EP has enabled this functionality for the entire EHR reporting period.</td>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| EPCMU03 | Maintain an up-to-date problem list of current and active diagnoses. | More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data. | Numerator = 115 
Denominator = 150 
Percentage = 76% | N/A |
| EPCMU04 | Generate and transmit permissible prescriptions electronically (eRx). | More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. | Numerator = 95 
Denominator = 200 
Percentage = 47% | Patient Records = All |
| EPCMU05 | Maintain active medication list. | More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. | Numerator = 85 
Denominator = 100 
Percentage = 85% | N/A |
| EPCMU06 | Maintain active medication allergy list. | More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. | Numerator = 115 
Denominator = 220 
Percentage = 52% | N/A |
| EPCMU07 | Record all of the following demographics: | More than 50% of all unique patients seen by the EP have demographics recorded as structured data. | Numerator = 51 
Denominator = 99 
Percentage = 52% | N/A |
| EPCMU08 | Record and chart changes in vital signs: | More than 50% of all unique patients age 2 and over seen by the EP have height, weight and blood pressure recorded as structure data. | Numerator = 69 
Denominator = 130 
Percentage = 54% | Patient Records = All |
| EPCMU09 | Record smoking status for patients 13 years old or older. | More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. | Numerator = 42 
Denominator = 81 
Percentage = 52% | Patient Records = Only EHR |
| EPCMU10 | Report ambulatory clinical quality measures. | Successfully report ambulatory clinical quality measures as required. | Yes | N/A |
| EPCMU11 | Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule. | Implement one clinical decision support rule. | Yes | N/A |
| EPCMU12 | Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request. | More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days. | Numerator = 61 
Denominator = 105 
Percentage = 58% | Patient Records = All |
This is screen 3 of 6 of the Meaningful Use Measures Summary.

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Objective</th>
<th>Measure</th>
<th>Entered</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPMU02</td>
<td>Incorporate clinic lab test results into EHR as structured data.</td>
<td>More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.</td>
<td>Numerator = 40 Denominator = 63 Percentage = 63%</td>
<td>N/A</td>
</tr>
<tr>
<td>EPMU04</td>
<td>Send reminders to patients per patient preference for preventive/follow up care.</td>
<td>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.</td>
<td>Excluded</td>
<td>Patient Records = All</td>
</tr>
<tr>
<td>EPMU05</td>
<td>Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.</td>
<td>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.</td>
<td>Numerator = 14 Denominator = 100 Percentage = 14%</td>
<td>Patient Records = Only EHR</td>
</tr>
</tbody>
</table>
### Meaningful Use Measures Summary

**EPMMU07**
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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>54</td>
<td>100</td>
<td>54%</td>
</tr>
</tbody>
</table>

**EPMMU10**
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).

- Yes

**Additional Information**

**EPMMU10**
Syndromic Surveillance Agency: Syndromic Surveillance
Test Successful: Yes
Test Date & Time: 02/19/12 12:30 PM
Follow Up Submission: Yes

### Meaningful Use Core Clinical Quality Measure Review

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Title</th>
<th>Description</th>
<th>Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0013</td>
<td>Hypertension: Blood Pressure Measurement.</td>
<td>Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.</td>
<td>Numerator = 55 Denominator = 100</td>
</tr>
</tbody>
</table>
| NQF 0028-PQRI 114 | Preventive Care and Screening Measure Pair. | a. Tobacco Use Assessment Description: 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. Tobacco Cessation Intervention Description: 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. | a. Numerator = 16 Denominator = 32 b. Numerator = 8 Denominator = 16 |
This is screen 5 of 6 of the Meaningful Use Measures Summary.

### Meaningful Use Alternate Clinical Quality Measure Review

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Title</th>
<th>Description</th>
<th>Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Children and Adolescents.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>NQF 0041-PQRI 110</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.</td>
<td>Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).</td>
<td></td>
</tr>
</tbody>
</table>

### Population Criteria 1
- Numerator = 35
- Denominator = 80
- Exclusion = 10

### Population Criteria 2
- Numerator = 20
- Denominator = 0
- Exclusion = 5

### Population Criteria 3
- Numerator = 178
- Denominator = 200
- Exclusion = 100
This is screen 6 of 6 of the Meaningful Use Measures Summary.

### Meaningful Use Additional Clinical Quality Measure Review

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Title</th>
<th>Description</th>
<th>Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0059-PQRI 1</td>
<td>Diabetes: Hemoglobin A1c Poor Control.</td>
<td>Percentage of patients 10-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.</td>
<td>Numerator = 30 Denominator = 76 Exclusion = 2</td>
</tr>
<tr>
<td>NQF 0064-PQRI 2</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management and Control.</td>
<td>Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100mg/dl.</td>
<td>Numerator1 = 39 Denominator = 76 Exclusion = 0 Numerator2 = 32 Denominator = 60</td>
</tr>
<tr>
<td>NQF 0061-PQRI 3</td>
<td>Diabetes: Blood Pressure Management.</td>
<td>Percentage of patients 10-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.</td>
<td>Numerator = 39 Denominator = 78 Exclusion = 7</td>
</tr>
</tbody>
</table>
Attestation Phase (Part 3 of 3)

Part 3 of 3 of the Attestation Phase contains a question regarding assignment of your incentive payment and confirmation of the address to which the incentive payment will be sent.

Click Yes to confirm you are receiving this payment as the payee indicated or you are assigning this payment voluntarily to the payee and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.

Click the Payment Address from the list below to be used for your Incentive Payment.

Click Save & Continue to review your selections, or click Previous to go back. Click Reset to restore this panel to the starting point or last saved data.
This screen confirms you successfully completed the **Attestation** section.

Note the check box in the Attestation tab.

Click **Continue** to proceed to the **Review** tab.
Step 6 – Review Application

The Review section allows you to review all information you entered into your application. If you find errors you can click the associated tab and proceed to correct the information. Once you have corrected the information you can click the Review tab to return to this section. From this screen you can print a printer-friendly copy of your application for review.

Please review all information carefully before proceeding to the Submit section. After you have submitted your application you will not have the opportunity to change it.

Click Print to generate a printer-friendly version of this information.

When you have reviewed all information click the Submit tab to proceed.
This is screen 1 of 3 of the Review tab display.

The **Review** panel displays the information you have entered to date for your application. Select **Print** to generate a printer friendly version of this information. Select **Continue** to return to the last page saved. If all tabs have been completed and you are ready to continue to the Submit Tab, please click on the **Submit** Tab itself to finish the application process.

### Incomplete

#### R&A Verification

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Medicaid Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant NPI</td>
<td>99999999999</td>
</tr>
<tr>
<td>Payee NPI</td>
<td>99999999999</td>
</tr>
<tr>
<td>Payee TIN</td>
<td>90090909099</td>
</tr>
<tr>
<td>Program Year</td>
<td>2012</td>
</tr>
<tr>
<td>Payment Year</td>
<td>1</td>
</tr>
<tr>
<td>Personal TIN/SSN</td>
<td>09999999999</td>
</tr>
<tr>
<td>Business Address</td>
<td>123 First Street, Anytown, PA 12345-1234</td>
</tr>
<tr>
<td>Business Phone</td>
<td>999-999-9999</td>
</tr>
<tr>
<td>Incentive Program</td>
<td>MEDICAID</td>
</tr>
<tr>
<td>Eligible Professional Type</td>
<td>Physician</td>
</tr>
<tr>
<td>R&amp;A Registration ID</td>
<td>90090909090</td>
</tr>
<tr>
<td>R&amp;A Registration Email</td>
<td><a href="mailto:Provideremail@provider.com">Provideremail@provider.com</a></td>
</tr>
<tr>
<td>CMS EHR Certification Number</td>
<td>9999999999999999</td>
</tr>
<tr>
<td>Is this information accurate?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
This is screen 2 of 3 of the Review tab display.

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Name</strong></td>
</tr>
<tr>
<td><strong>Contact Phone</strong></td>
</tr>
<tr>
<td><strong>Contact Email Address</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility Questions (Part 1 of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you a hospital-based eligible professional?</td>
</tr>
<tr>
<td>I confirm that I waive my right to a Medicare Electronic Health Record Incentive Payment for this payment year and am only accepting Medicaid Electronic Health Record Incentive Payments from Colorado.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility Questions (Part 2 of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of provider are you?</td>
</tr>
<tr>
<td>Do you have any current sanctions or pending sanctions with Medicare or Medicaid in any state?</td>
</tr>
<tr>
<td>Are you currently in compliance with all parts of the HIPAA regulations?</td>
</tr>
<tr>
<td>Are you licensed in all states in which you practice?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility Questions (Part 3 of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS EHR Certification ID:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Volume Practice Type (Part 1 of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you practice predominantly at an FQHC/RHC (over 50% of your total patient encounters occur over a 6 month period in an FQHC/RHC)?</td>
</tr>
<tr>
<td>Please indicate if you are submitting volumes for:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Volume 90 Day Period (Part 2 of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start Date:</strong></td>
</tr>
<tr>
<td><strong>End Date:</strong></td>
</tr>
</tbody>
</table>
This is screen 3 of 3 of the Review tab display.

Patient Volume Individual (Part 3 of 3)

<table>
<thead>
<tr>
<th>Utilizing Certified EHR Technology?</th>
<th>Provider ID</th>
<th>Location Name</th>
<th>Address</th>
<th>Encounter Volumes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>99999999999999</td>
<td>Doctor Office</td>
<td>123 First Street, Anytown, PA 12345-1234</td>
<td>Medicaid Only In State: Total Medicaid: Denominator:</td>
<td>0 / NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sum Medicaid Only In State Encounter Volume (Numerator)</th>
<th>Sum Medicaid Encounter Volume (Numerator)</th>
<th>Total Encounter (Denominator)</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Attestation Phase (Part 1 of 3)

EHR System Adoption Phase: Meaningful Use

Attestation EHR Reporting Period (Part 1 of 3)

Start Date: Jan 01, 2012
End Date: Mar 30, 2012

Attestation Meaningful Use Measures

Attestation Meaningful Use Measures may be accessed by selecting the link below: Meaningful Use Measures

Attestation Phase (Part 3 of 3)

Based on the information received from the R&A, you requested to assign your incentive payment to the entity above (Payee TIN). Please confirm that you are receiving that payment as the payee indicated above or you are assigning this payment voluntarily to the payee above and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.

You have selected the mailing address below to be used for your Incentive Payment, if you are approved for payment.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Location Name</th>
<th>Address</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999999999999</td>
<td>Doctor Office</td>
<td>1224 First Street, Anytown, PA 12345-1234</td>
<td>Service Location Address: 2525 9th Ave</td>
</tr>
</tbody>
</table>

Continue
Step 7 – Submit Your Application

The final submission of your application involves the following steps:

Review and Check Errors - The system will check your application for errors. If errors are present you will have the opportunity to go back to the tab where the error occurred and correct it. If you do not want to correct the errors you can still submit your application; however, the errors may affect your eligibility and payment amount.

File Upload – You will have the opportunity to upload PDF files with documentation supporting your application. This optional information could include additional information on patient volumes, locations, or your certified EHR system.

Preparer Information - Providers attesting to the EHR Incentive program have two options for completing the electronic signature portion of the application. The provider can perform the submission process, or the provider can designate a preparer to complete the application. If a preparer is completing the application they will navigate through screens to collect the additional required information from the preparer. The provider associated with this application is still responsible for the accuracy of the information provided and attested to.

The initial Submit screen contains information about this section.

Click Begin to continue to the submission process.
This screen lists the current status of your application and any error messages identified by the system. You can correct these errors or leave them as is. You can submit this application with errors; however, errors may impact your eligibility and incentive payment amount.

To correct errors:

Click **Review** to be taken to the section in error and correct the information. To return to this section at any time click the **Submit** tab.

Click **Save & Continue** to continue with the application submission.
To upload files click **Browse** to navigate to the file you wish to upload.

*Note: Only files that are in portable data format (PDF) and a maximum of 2 megabytes (MB) in size are acceptable documentation to upload.*

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr. Medicaid Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant NPI</td>
<td>9999999999</td>
</tr>
<tr>
<td>Payee TIN</td>
<td>9999999999</td>
</tr>
<tr>
<td>Program Year</td>
<td>2011</td>
</tr>
</tbody>
</table>

**Application Submission (Part 1 of 2)**

You will now be asked to **upload** any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

To upload a file, type the full path or click the **Browse...** button.

All files must be in **PDF** format, and must be no larger than **2 MB** in size.

File Location: [Browse...](#)

[Upload File]

[Previous]  [Reset]  [Save & Continue]
The **Choose file** dialog box will display.

Navigate to the file you want to upload and select **Open**.
Check the file name in the file name box.

Click **Upload File** to begin the file upload process.

---

**Application Submission (Part 1 of 2)**

You will now be asked to **upload** any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

To upload a file, type the full path or click the **Browse...** button.

All files must be in **PDF** format, and must be no larger than **2 MB** in size.

File Location: C:\Documents and Settings\Username\MAPIRFileUpload.pdf

**Upload File**

**Previous** **Reset** **Save & Continue**
Note the “File has been successfully uploaded.” message. Review the uploaded file list in the Uploaded Files box.

If you have more than one file to upload, repeat the steps to select and upload a file as many times as necessary.

All of the files you uploaded will be listed in the **Uploaded Files** section of the screen.

To view the uploaded file click **View** in the Available Actions column.

To delete an uploaded file click **Delete** in the Available Actions column.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.
Select the check box to acknowledge that you have reviewed all of your information.

Select the **Provider** or **Preparer** button, as appropriate.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.

---

<table>
<thead>
<tr>
<th>Name</th>
<th>Applicant NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Medicaid Provider</td>
<td>9999999999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal TIN/SSN</th>
<th>Payee TIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>9999999999</td>
<td>9999999999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2011</td>
</tr>
</tbody>
</table>

---

**Application Submission (Part 1 of 2)**

Please answer the following questions.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

(+) Red asterisk indicates a required field.

- By checking the box, you are indicating that you have reviewed all information that has been entered into MAPIR (as displayed on the **Review** panel).

- Indicate if you are completing this application as the actual provider, or as a preparer on behalf of the provider:
  - **Provider**
  - **Preparer**

---

Previous | Reset | Save & Continue
This screen depicts Provider selection.
Click Save & Continue to review your selection, or click Previous to go back. Click Reset to restore the panel to the starting point or last saved data.
This screen depicts the Provider signature screen.

Enter your **Provider Initials, NPI, and Personal TIN.**

Click **Sign Electronically** to proceed.

Click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
This screen depicts the signature screen for a Preparer on behalf of the provider.

As the preparer of this application on behalf of the provider, please attest to the accuracy of all information entered.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.
As the preparer of this application on behalf of the provider, please attest to the accuracy of all information entered.

Enter your **Preparer Name** and **Preparer Relationship** to the provider.

Click **Sign Electronically** to review your selection, or click **Previous** to return. Click **Reset** to restore this panel to the starting point or last saved data.
After electronically signing the application, MAPIR determines if the Meaningful Use attestation data you attested to is accepted or rejected. If your Meaningful Use attestation data is rejected, the following screen will display.

If your Meaningful Use attestation data is accepted, this screen will not display. Proceed to the following page.

Click on the **Meaningful Use Measures** link to review the Meaningful Use attestation data that you entered as well as the acceptance or rejection outcome for each measure. Click on the **Attestation** tab to return to the Meaningful Use Attestation where you can revise the Meaningful Use attestation data.

Please note that you may be subject to an audit after frequent attempts at correcting failed measures. Also note that while you have the option to continue with your submission by clicking **Save & Continue**, if you do not meet the mandatory requirements, you will not receive an incentive payment.

Click **Previous** to go back, click the **Save & Continue** to proceed with the submission of your application.
This is an example of an incentive payment chart for a **non Pediatric Professional**.

No information is required on this screen.

The incentive payment chart example for Pediatricians is shown on the next page.

*Note: This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click Exit, and return at any time to complete the submission process.*

Click **Submit Application** to continue.
This is an example of an incentive payment chart for a Pediatric Professional.

No information is required on this screen.

Note: This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click Exit, and return at any time to complete the submission process.

Click Submit Application.
The check indicates your application has been successfully submitted. Click **OK**.

![Application Submitted Successful]

Your application has been successfully submitted and will be processed within 15-20 business days.

You will receive an email message when processing has been completed.
When your application has been successfully submitted, you will see the application status of Submitted. You can click the Review Application tab to review your application; however, you will not be able to make changes.

Click **Exit** to exit MAPIR.

This screen shows that your MAPIR session has ended. You should now close your browser window.
Post Submission Activities

This section contains information about post application submission activities. At any time you can check the status of your application by logging into the State of Rhode Island Medicaid portal. Once you have successfully completed the application submission process you will receive an email confirming your submission has been received. You may also receive email updates as your application is processed.

When you log in to MAPIR after submitting your application you will see the Medicaid EHR Incentive Program Participation Dashboard.

Notice that the Status of your application is Submitted. You can only view an application in a Submitted status. The next payment year application will be enabled when you become eligible to apply. For status information, please see the Status Definition table in the Post Submission Activities section of this manual.
The screen below shows an application in a status of Completed.

You can click the **Submission Outcome** tab to view the results of submitting your application.
The following table lists some of the statuses your application may go through.

<table>
<thead>
<tr>
<th>Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Registered at R&amp;A</td>
<td>MAPIR has not received a matching registration from both the R&amp;A and the state MMIS.</td>
</tr>
<tr>
<td>Incomplete</td>
<td>The application is in a working status but has not been submitted and may still be updated by the provider.</td>
</tr>
<tr>
<td>Submitted</td>
<td>The application has been submitted. The application is locked to prevent editing and no further changes can be made.</td>
</tr>
<tr>
<td>Payment Approved</td>
<td>A determination has been made that the application has been approved for payment.</td>
</tr>
<tr>
<td>Payment Disbursed</td>
<td>The financial payment data has been received by MAPIR and will appear on your remittance advice.</td>
</tr>
<tr>
<td>Partial Recoupment Received</td>
<td>An adjustment has been requested and the total amount has not been recouped.</td>
</tr>
<tr>
<td>Partial Remittance Received</td>
<td>An adjustment has been processed and a partial recoupment has been made and will appear on your remittance advice.</td>
</tr>
<tr>
<td>Aborted</td>
<td>When in this status, all progress has been eliminated for the incentive application and the application can no longer be modified or submitted.</td>
</tr>
<tr>
<td>Appeal Initiated</td>
<td>An appeal has been lodged with the proper state authority by the provider.</td>
</tr>
<tr>
<td>Appeal Approved</td>
<td>The appeal has been approved.</td>
</tr>
<tr>
<td>Appeal Denied</td>
<td>The appeal has been denied.</td>
</tr>
<tr>
<td>Denied</td>
<td>A determination has been made that the provider does not qualify for an incentive payment based on one or more of the eligibility rules.</td>
</tr>
<tr>
<td>Completed</td>
<td>The application has run a full standard process and completed successfully with a payment to the provider.</td>
</tr>
<tr>
<td>Cancelled</td>
<td>An application has been set to “Cancelled” status only when R&amp;A communicates a registration cancellation to MAPIR. MAPIR cancels both the registration and any associated application.</td>
</tr>
<tr>
<td>Future</td>
<td>This is a status that will be displayed against any application to indicate the number of future applications that the provider can apply for within the EHR Incentive Program.</td>
</tr>
<tr>
<td>Not Eligible</td>
<td>This is a status that will be displayed against any application whenever the provider has exceeded the limits of the program timeframe.</td>
</tr>
<tr>
<td>Not Started</td>
<td>This is a status that will be displayed against any application whenever the provider has not started an application but MAPIR received an R&amp;A registration and has been matched to an MMIS provider.</td>
</tr>
<tr>
<td>Expired</td>
<td>An application is set to an “Expired” status when an application in an “Incomplete” status has not been submitted within the allowable grace period for a program year or when an authorized admin user changes an application to this status after the end of the grace period. Once an application is in an Expired status, the status cannot be changed and it is only viewable to the provider.</td>
</tr>
</tbody>
</table>
Additional User Information

This section contains an explanation of informational messages, system error messages, and validation messages you may receive.

**Start Over and Delete All Progress** - If you would like to start your application over from the beginning you can click the Get Started tab. Click the *here* link on the screen to start over from the beginning. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

---

![Image of the screen with the Get Started tab and the model of steps to complete.

**Welcome to the State of Rhode Island Medical Assistance Provider Incentive Repository (MAPIR) System!**

In order to become eligible for the EHR Incentive Program, you will need to complete the following six steps:

- **NLK & Contact Information** – Verify data from your CMS registration file
- **Eligibility** – Verify demographics and provider information
- **Patient Volume** – Verify your patient volume and practice category
- **Attestation** – Attest that you have adopted, implemented, or upgraded to a certified EHR system
- **Review** – Verify all information prior to submission
- **Submit** – Submit your EHR Incentive registration

**Navigation Keys:**

- **Save and Continue** - At the bottom of each screen, it is important that you utilize the Save & Continue button. This allows you to come back to your records after leaving a MAPIR session in the event you are unable to complete the entire registration at one time.
- **Previous** - Allows you to move to the previous screen
- **Reset** - Allows you to reset the values within the screen you are currently on
- **Print** - You can print as part of the review of saved data (multiple tabs) and the check error review
This screen will confirm your selection to start the application over and delete all information saved to date. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

Click **Confirm** to Start Over and Delete All Progress.

If you clicked **Confirm** you will receive the following confirmation message. Click **OK** to continue.
**Contact Us** – Clicking on the Contact Us link in the upper right corner of most screens within MAPIR will display the following State of Rhode Island Medicaid program contact information.

![Contact Us Information](image)

**MAPIR Error Message** – This screen will appear when a MAPIR error has occurred. Follow all instructions on the screen. Click **Exit** to exit MAPIR.

![MAPIR Error Message](image)
Validation Messages – The following is an example of the validation message – **You have entered an invalid CMS Certification ID.** Check and reenter your CMS EHR Certification ID. The Validation Messages Table lists validation messages you may receive while using MAPIR.

![Validation Messages Table](image)

- **You have entered an invalid CMS EHR Certification ID.**
  - Previous
  - Reset
  - Save & Continue
## Validation Messages Table

<table>
<thead>
<tr>
<th>Validation Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please enter all required information.</td>
</tr>
<tr>
<td>You must provide all required information in order to proceed.</td>
</tr>
<tr>
<td>Please correct the information at the Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System (R&amp;A).</td>
</tr>
<tr>
<td>The date that you have specified is invalid, or occurs prior to the program eligibility.</td>
</tr>
<tr>
<td>The date that you have specified is invalid.</td>
</tr>
<tr>
<td>The phone number that you entered is invalid.</td>
</tr>
<tr>
<td>The phone number must be numeric.</td>
</tr>
<tr>
<td>The email that you entered is invalid.</td>
</tr>
<tr>
<td>As a Hospital based physician, you are not eligible to participate.</td>
</tr>
<tr>
<td>You must participate in the Medicaid incentive program in order to qualify.</td>
</tr>
<tr>
<td>You must select at least one type of provider.</td>
</tr>
<tr>
<td>You must select at least one location in order to proceed.</td>
</tr>
<tr>
<td>The ZIP Code that you entered is invalid.</td>
</tr>
<tr>
<td>You must select at least one activity in order to proceed.</td>
</tr>
<tr>
<td>You must define all added 'Other' activities.</td>
</tr>
<tr>
<td>Amount must be numeric.</td>
</tr>
<tr>
<td>You must indicate whether you are completing this application as the actual provider or a preparer.</td>
</tr>
<tr>
<td>You must verify that you have reviewed all information entered into MAPIR.</td>
</tr>
<tr>
<td>Please confirm. You must not have any current sanctions or pending sanctions with Medicare or Medicaid in order to qualify.</td>
</tr>
<tr>
<td>You did not meet the criteria to receive the incentive payment.</td>
</tr>
<tr>
<td>All data must be numeric.</td>
</tr>
<tr>
<td>You must enter all requested information in order to submit the application.</td>
</tr>
<tr>
<td>The email address you have entered does not match.</td>
</tr>
<tr>
<td>You have entered an invalid CMS EHR Certification ID.</td>
</tr>
<tr>
<td>You must be licensed in the state(s) in which you practice.</td>
</tr>
<tr>
<td>You must select Yes or No to utilizing certified EHR technology in this location.</td>
</tr>
<tr>
<td>You have entered a duplicate Group Practice Provider ID.</td>
</tr>
<tr>
<td>You must select a Payment Address in order to proceed.</td>
</tr>
<tr>
<td>You must enter the email address a second time.</td>
</tr>
<tr>
<td>You must be in compliance with HIPAA regulations.</td>
</tr>
<tr>
<td>All amounts must be between 0 and 999,999,999,999,999.</td>
</tr>
<tr>
<td>You must answer Yes to utilizing certified EHR technology in at least one location in order to proceed.</td>
</tr>
<tr>
<td>You must exit MAPIR and return, in order to access a different program year incentive application.</td>
</tr>
<tr>
<td>You must choose an application</td>
</tr>
<tr>
<td>The amounts entered are invalid.</td>
</tr>
</tbody>
</table>
# Hover Bubble Definitions

<THE FOLLOWING IS A LIST THE HOVER BUBBLES IN MAPIR. THIS LIST SHOULD BE REPLACED BY STATES WITH AN UPDATED LIST THAT INCLUDE THAT STATE’S CUSTOMIZED HOVER BUBBLES.>

<table>
<thead>
<tr>
<th>Screen/Panel Name</th>
<th>Item Name/Verbiage</th>
<th>Response</th>
<th>Mouse Over/Hover Bubble Verbiage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Questions (Part 1 of 3)</td>
<td>Are you a Hospital based physician?</td>
<td>Yes/No</td>
<td>A Hospital based Eligible Professional (EP) such as a pathologist, anesthesiologist, or emergency physician, who furnishes 90 percent or more of his or her covered professional services in a hospital setting (Inpatient - Place of Service 21 or Emergency Room - Place of Service 23).</td>
</tr>
<tr>
<td>Eligibility Questions (Part 1 of 3)</td>
<td>I confirm I waive my right to a Medicare Electronic Health Record Incentive Payment for this payment year and am only accepting Medicaid Electronic Health Record Incentive Payments from &lt;state&gt;. (This is a disposition question that can be set to Pend, Deny or No Action)</td>
<td>Yes/No</td>
<td>An Eligible Professional may only receive payment from either Medicare or Medicaid in a payment year, but not both. The state will validate Medicaid selection with CMS prior to payment issuance.</td>
</tr>
<tr>
<td>Eligibility Questions (Part 2 of 3)</td>
<td>What type of Provider are you? (Select One)</td>
<td>Radio Button</td>
<td>Eligibility for the Medicaid EHR Incentive Program is based on your provider type and specialty on file with the State’s MMIS.</td>
</tr>
<tr>
<td>Eligibility Questions (Part 2 of 3)</td>
<td>Do you have any current sanctions or pending sanctions with Medicare or Medicaid in &lt;state&gt;?</td>
<td>Yes/No</td>
<td>The temporary or permanent barring of a person or other entity from participation in the Medicare or State Medicaid health care program and that services furnished or ordered by that person are not paid for under either program. See 42 CFR Ch. IV § 402.3 Definitions in the current edition.</td>
</tr>
<tr>
<td>Eligibility Questions (Part 2 of 3)</td>
<td>Are you currently in compliance with all parts HIPAA regulations?</td>
<td>Yes/No</td>
<td>All providers must be in compliance with the current Health Information Portability and Accountability Act (HIPAA) regulations. Current regulations can be reviewed at <a href="http://www.hhs.gov">http://www.hhs.gov</a></td>
</tr>
<tr>
<td>Eligibility Questions (Part 2 of 3)</td>
<td>Are you licensed in all states in which you practice?</td>
<td>Yes/No</td>
<td>Eligible Professionals must meet the state law licensure requirements of the state that is issuing the EHR incentive payment.</td>
</tr>
<tr>
<td>Patient Volume Practice Type (Part 1 of 3)</td>
<td>Do you practice predominantly at an FQHC/RHC (over 50% of your patient encounters occur over a 6 month period in an FQHC/RHC)?</td>
<td>Yes/No</td>
<td>Practices predominantly means an Eligible Professional for whom the clinical location(s) for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent calendar year occurs at a federally qualified health center or rural health clinic.</td>
</tr>
<tr>
<td>Patient Volume Practice Type (Part 1 of 3)</td>
<td>Please indicate if you are submitting volumes for: (Select one) --- Individual Practitioner</td>
<td>Radio Button</td>
<td>Individual Practitioners count his or her own Medicaid and non-Medicaid patient encounters only.</td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Patient Volume Practice Type (Part 1 of 3)</td>
<td>Please indicate if you are submitting volumes for: (Select one) --- Group/Clinic</td>
<td>Radio Button</td>
<td>Group/Clinic selection requires all Eligible Professionals to use the entire group practice or clinic's Medicaid and non-Medicaid patient encounters.</td>
</tr>
<tr>
<td>Patient Volume Practice Type (Part 1 of 3)</td>
<td>Please indicate if you are submitting volumes for: (Select one) --- Individual Practitioner's Panel</td>
<td>Radio Button</td>
<td>A Practitioner's Panel is calculated on and consists of Medicaid enrollees assigned to the Eligible Professional through a Medicaid panel plus any unduplicated Medicaid encounters.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Medicaid Patient Volume (Must Select at Least One)</td>
<td>Check Box</td>
<td>Medicaid patient volume consists of encounters for individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period selected.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Utilizing Certified EHR Technology? (Must Select at Least One)</td>
<td>Yes/No</td>
<td>Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at <a href="http://healthit.hhs.gov/chpl">http://healthit.hhs.gov/chpl</a></td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display Field</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Enterable</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Location Name</td>
<td>Enterable</td>
<td>Enter the legal entity name for the location being added</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Address Line 1</td>
<td>Enterable</td>
<td>Enter the location's street address. Example: 55 Main Street This cannot be a Post Office Box number.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Available Actions</td>
<td>Buttons</td>
<td>Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display Field</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual (Part 3 of 3)</td>
<td>Medicaid &amp; CHIP Encounter Volume (Numerator)</td>
<td>Enterable</td>
<td>The number of encounters provided to individuals enrolled in CHIP (Title XXI) and Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period for each location listed.</td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------</td>
<td>----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual</td>
<td>Other Needy Individual Encounter Volume</td>
<td>Enterable</td>
<td>Enter the number of encounters for the continuous 90-day period selected for each location below where the services furnished at either no cost or reduced cost based on a sliding scale as determined by the individual's ability to pay or furnished as uncompensated care.</td>
</tr>
<tr>
<td>(Part 3 of 3)</td>
<td>(Numerator)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual</td>
<td>Total Needy Encounter Volume</td>
<td>Enterable</td>
<td>Enter the sum of the Medicaid &amp; CHIP Encounter Volume plus the Other Needy Individual Encounter Volume.</td>
</tr>
<tr>
<td>(Part 3 of 3)</td>
<td>(Total Numerator)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Individual</td>
<td>Total Encounter Volume</td>
<td>Enterable</td>
<td>Enter the total number of encounters (all States) for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.</td>
</tr>
<tr>
<td>(Part 3 of 3)</td>
<td>(Denominator)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Medicaid Patient Volume</td>
<td>Checkbox</td>
<td>Medicaid patient volume consists of encounters for individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period selected.</td>
</tr>
<tr>
<td></td>
<td>(Must Select at Least One)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Utilizing Certified EHR Technology?</td>
<td>Yes/No</td>
<td>Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at <a href="http://healthit.hhs.gov/chpl">http://healthit.hhs.gov/chpl</a></td>
</tr>
<tr>
<td></td>
<td>(Must Select at Least One)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display</td>
<td>Configurable by State</td>
</tr>
<tr>
<td></td>
<td>Display Field</td>
<td>Field</td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Enterable</td>
<td>Configurable by State</td>
</tr>
<tr>
<td></td>
<td>Enterable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Location Name</td>
<td>Enterable</td>
<td>Enter the legal entity name for the location being added.</td>
</tr>
<tr>
<td></td>
<td>Enterable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Address Line 1</td>
<td>Enterable</td>
<td>Enter the service location's street address. Example: 55 Main Street. This cannot be a Post Office Box number.</td>
</tr>
<tr>
<td></td>
<td>Enterable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Available Actions</td>
<td>Buttons</td>
<td>Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.</td>
</tr>
<tr>
<td></td>
<td>Buttons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display</td>
<td>Configurable by State</td>
</tr>
<tr>
<td></td>
<td>Display Field</td>
<td>Field</td>
<td></td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Medicaid Only Encounter Volumes <em>(In State Numerator)</em></td>
<td>Enterable</td>
<td>Encounters for individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period. In-State= the State to which you are applying for an incentive payment.</td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Medicaid Encounter Volumes <em>(Total Numerator)</em></td>
<td>Enterable</td>
<td>Total Numerator includes services to all in-state &amp; out-of-state individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period selected.</td>
</tr>
<tr>
<td>Patient Volume - Individual (Part 3 of 3)</td>
<td>Total Encounter Volume <em>(Denominator)</em></td>
<td>Enterable</td>
<td>Enter the total number of encounters for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.</td>
</tr>
<tr>
<td>Patient Volume - Individual Practitioner's Panel (Part 3 of 3)</td>
<td>Medicaid Patient Volume <em>(Must Select at Least One)</em></td>
<td>Checkbox</td>
<td>Select the checkbox(es) for the location(s) where the Eligible Professional is reporting Medicaid patient volume for the continuous 90-day period selected.</td>
</tr>
<tr>
<td>Patient Volume - Individual Practitioner's Panel (Part 3 of 3)</td>
<td>Utilizing Certified EHR Technology? <em>(Must Select at Least One)</em></td>
<td>Yes/No</td>
<td>Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at <a href="http://healthit.hhs.gov/chpl">http://healthit.hhs.gov/chpl</a></td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner's Panel (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display Field</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner's Panel (Part 3 of 3)</td>
<td>Available Actions</td>
<td>Buttons</td>
<td>Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.</td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner's Panel (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display Field</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner's Panel (Part 3 of 3)</td>
<td>Total Medicaid Patients on the Individual Practitioners Panel <em>(Numerator)</em></td>
<td>Enterable</td>
<td>See Instructions for #1 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the State Medicaid Health Information Technology Program Office (SMHPO) for assistance.</td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner Panel (Part 3 of 3)</td>
<td>Unduplicated Medicaid Only Encounter Volume <em>(Numerator)</em></td>
<td>Enterable</td>
<td>See Instructions for #2 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the State Medicaid Health Information Technology Program Office (SMHPO) for assistance.</td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner Panel (Part 3 of 3)</td>
<td>Total Patient Panel Encounters <em>(Denominator)</em></td>
<td>Enterable</td>
<td>See Instructions for #3 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the State Medicaid Health Information Technology Program Office (SMHPO) for assistance.</td>
</tr>
<tr>
<td>Patent Volume - Individual Practitioner Panel (Part 3 of 3)</td>
<td>Total Unduplicated Encounter Volume <em>(Denominator)</em></td>
<td>Enterable</td>
<td>See Instructions for #4 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the State Medicaid Health Information Technology Program Office (SMHPO) for assistance.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Group (Part 3 of 3)</td>
<td>Utilizing Certified EHR Technology? <em>(Must Select at Least One)</em></td>
<td>Yes/No</td>
<td>Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at <a href="http://healthit.hhs.gov/chpl">http://healthit.hhs.gov/chpl</a></td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Group (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display Field</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Group (Part 3 of 3)</td>
<td>Medicaid &amp; CHIP Encounter Volume <em>(Numerator)</em></td>
<td>Enterable</td>
<td>Encounters provided to individuals enrolled in CHIP (Title XXI) and Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period selected.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Group (Part 3 of 3)</td>
<td>Other Needy Individual Encounter Volume <em>(Numerator)</em></td>
<td>Enterable</td>
<td>Enter the number of encounters provided over the continuous 90-day period selected for each location where the services furnished at either no cost or reduced cost based on a sliding scale as determined by the individual's ability to pay, or furnished as uncompensated care.</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Group (Part 3 of 3)</td>
<td>Total Needy Encounter Volume <em>(Numerator)</em></td>
<td>Enterable</td>
<td>Enter the sum of the Medicaid &amp; CHIP Encounter Volume plus the Other Needy Individual Encounter Volume</td>
</tr>
<tr>
<td>Patient Volume - FQHC/RHC Group (Part 3 of 3)</td>
<td>Total Encounter Volume <em>(Denominator)</em></td>
<td>Enterable</td>
<td>Enter the total number of encounters (all States) for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.</td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------</td>
<td>----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Patient Volume - Group (Part 3 of 3)</td>
<td>Utilizing Certified EHR Technology? (Must Select at Least One)</td>
<td>Yes/No</td>
<td>Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at <a href="http://healthit.hhs.gov/chpl">http://healthit.hhs.gov/chpl</a></td>
</tr>
<tr>
<td>Patient Volume - Group (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display Field</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patient Volume - Group (Part 3 of 3)</td>
<td>Medicaid Only Encounter Volumes (In State Numerator)</td>
<td>Enterable</td>
<td>Encounters for individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period. In-State= the State to which you are applying for an incentive payment.</td>
</tr>
<tr>
<td>Patient Volume - Group (Part 3 of 3)</td>
<td>Medicaid Encounter Volumes (Total Numerator)</td>
<td>Enterable</td>
<td>Total Numerator includes services to all in-state &amp; out-of-state individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period selected.</td>
</tr>
<tr>
<td>Patient Volume - Group (Part 3 of 3)</td>
<td>Total Encounter Volume (Denominator)</td>
<td>Enterable</td>
<td>Enter the total number of encounters for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Adoption:</td>
<td>Radio Button</td>
<td>Eligible Professional must have purchased a certified EHR technology. Accepted documentation includes executed vendor contracts and receipts indicating a certified EHR product(s) that correlate with the CMS certification number.</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Implementation:</td>
<td>Radio Button</td>
<td>Eligible Professional must have installed and be using certified EHR technology in their clinical practice. In addition to the accepted documentation for adoption, proof could also include staff training contracts/logs, data sharing agreements, and user license agreements.</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Upgrade:</td>
<td>Radio Button</td>
<td>Eligible Professional must have expanded the functionality of their certified EHR with enhancements to facilitate meaningful use. Accepted documentation includes executed contracts and receipts indicating the upgrade.</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Meaningful Use:</td>
<td>Radio Button</td>
<td>EPs will have the option to attest to 90 days from the current calendar year or a full year of Meaningful Use. The reporting period for the full year attestation will be the entire calendar year</td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Attestation Phase (Part 3 of 3)</td>
<td>Based on the information received from the R&amp;A you requested to assign your incentive payment to the entity above (Payee TIN). Please confirm that you are assigning this payment voluntarily and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.</td>
<td>Yes/No</td>
<td>EPs may reassign their incentive payment to an entity with which they have a valid contractual arrangement; this includes the ability to bill for the EP’s services or a standard employment contract. The EP will select one TIN to receive any applicable Medicaid EHR incentive payment through the R&amp;A.</td>
</tr>
<tr>
<td>Application Submission (Part 2 of 2)</td>
<td>Preparer Relationship:</td>
<td>Enterable</td>
<td>Enter the relationship the Preparer has with the Eligible Professional.</td>
</tr>
<tr>
<td>FQHC/RHC Group (Part 3 of 3)</td>
<td>FQHC/RHC Group Practice Provider ID</td>
<td>Enterable</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Attestation Phase (Part 3 of 3)</td>
<td>Additional Information</td>
<td>Display</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>Patient Volume – FQHC/RHC Group (Part 3 of 3)</td>
<td>Available Actions</td>
<td>Buttons</td>
<td>Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.</td>
</tr>
<tr>
<td>Patient Volume – Group (Part 3 of 3)</td>
<td>Available Actions</td>
<td>Buttons</td>
<td>Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.</td>
</tr>
<tr>
<td>Patient Volume – Group (Part 3 of 3)</td>
<td>Please indicate in the box(es) provided, the Group Practice Provider ID(s) you will use to report patient volume requirements.</td>
<td>Enterable</td>
<td>This is the NPI number of the group practices used to report patient volume.</td>
</tr>
<tr>
<td>Patient Volume – Group (Part 3 of 3)</td>
<td>Medicaid Only Encounter Volumes (In State Numerator)</td>
<td>Enterable</td>
<td></td>
</tr>
<tr>
<td>Attestation Phase (Part 3 of 3)</td>
<td>Provider ID</td>
<td>Display</td>
<td>Configurable by State</td>
</tr>
<tr>
<td>MAPIR Dashboard</td>
<td>Status</td>
<td>Display</td>
<td>Status of the incentive application.</td>
</tr>
<tr>
<td>MAPIR Dashboard</td>
<td>Payment Year</td>
<td>Display</td>
<td>The payment year is designated as a sequential number starting with payment year 1 up to the maximum number of payments for the program.</td>
</tr>
<tr>
<td>MAPIR Dashboard</td>
<td>Program Year</td>
<td>Display</td>
<td>The 4 digit year within which a provider attests to data for eligibility for a payment. For an EP this is the Calendar year (January thru December). For an EH it is the Federal Fiscal Year (October thru September). Valid Program Years are 2011-2021.</td>
</tr>
<tr>
<td>MAPIR Dashboard</td>
<td>Payment Amount</td>
<td>Display</td>
<td>The incentive amount that was paid for a particular application for the specified program and payment year. This includes initial and all adjustment amounts.</td>
</tr>
<tr>
<td>Screen/Panel Name</td>
<td>Item Name/Verbiage</td>
<td>Response</td>
<td>Mouse Over/Hover Bubble Verbiage</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Meaningful Use – 90 Days</td>
<td>Radio</td>
<td>You may apply using the Meaningful Use 90 day if you have been utilizing EHR technology for a continuous 90 day period within the current Federal Fiscal year, and if you have not attested to 90 days of Meaningful Use in a previous program year.</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Meaningful Use – Full Year</td>
<td>Radio</td>
<td>You must apply using the Meaningful Use Full Year if you have attested to 90 days of Meaningful Use in the previous program year, and you must be utilizing EHR technology for the entire current Federal Fiscal year.</td>
</tr>
<tr>
<td>Attestation Phase (Part 1 of 3)</td>
<td>Meaningful Use – Full Year</td>
<td>Radio</td>
<td>For EPs demonstrating they are meaningful EHR users for the first time after receiving a payment for A, I or U, you will utilize a continuous 90-day period within the calendar year for MU attestation.</td>
</tr>
<tr>
<td>Attestation Meaningful Use Measures</td>
<td>Meaningful Use – Full Year</td>
<td>Radio</td>
<td>For EPs demonstrating they are meaningful EHR users after attesting to 90 days MU for the previous payment, the EHR reporting period is the full calendar year.</td>
</tr>
<tr>
<td>EP MU General Requirements</td>
<td>Encounter Volumes</td>
<td>Enterable</td>
<td>Numerator – Enter only patient encounters where a medical treatment is provided and/or evaluation and management services are provided in location(s) with federally certified EHRs.</td>
</tr>
<tr>
<td>EP MU General Requirements</td>
<td>Encounter Volumes</td>
<td>Enterable</td>
<td>Denominator – Enter all patient encounters where a medical treatment is provided and/or evaluation and management services are provided in location(s) with or without federally certified EHRs.</td>
</tr>
<tr>
<td>EP MU General Requirements</td>
<td>Unique Patients</td>
<td>Enterable</td>
<td>Numerator – Enter the number of unique patients during the reporting period seen by an EP that have their data in a certified EHR. If a patient is seen by an EP more than once during the reporting period, they can only be counted once.</td>
</tr>
<tr>
<td>EP MU General Requirements</td>
<td>Unique Patients</td>
<td>Enterable</td>
<td>Denominator – Enter all unique patients seen by an EP during the reporting period. If a patient is seen by an EP more than once during the reporting period, they can only be counted once.</td>
</tr>
</tbody>
</table>
Acronyms and Terms

CHIP – Children’s Health Insurance Program
CHPL – ONC Certified Healthcare IT Product List
CMS – Center for Medicare and Medicaid Services
EH – Eligible Hospital
EHR – Electronic Health Record
EP – Eligible Professional
FQHC/RHC – Federally Qualified Health Center/Rural Health Clinic
MAPIR – Medical Assistance Provider Incentive Repository
NPI – National Provider Identifier
ONC – Office of the National Coordinator for Health Information Technology
R&A – CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System
TIN – Taxpayer Identification Number