Qualifying for Medicare Incentive Payments with Crystal Practice Management

Version 4.1.25

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General Information

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Program provides incentive payments to optometrists who are Medicare providers as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology.

To be eligible to apply to receive the payments in 2015, the optometrist must:

1. Use a certified EHR system (such as Crystal Practice management software) for 90 days;
2. Report meaningful use measures for the 90 days or full calendar year the software is used; and
3. Apply for the incentive payment.

The certified version of Crystal Practice Management software provides optometrists with everything they need to qualify for the EHR Incentive Program but it is up to the individual optometrist to report the meaningful use measures and apply for the incentive payment.

Links to External Guides

These guides will take the optometrist step by step through the process of reporting and applying for incentive payments.

Registration User Guide:
http://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf
Attestation User Guide:
http://www.cms.gov/EHRIncentivePrograms/downloads/EP_Attestation_User_Guide.pdf

Video on Registration and Attestation:
http://www.youtube.com/user/CMSHHSgov?feature=mhum#p/u/0/sKngNjd8Iuc

Meaningful Use Attestation Calculator: http://www.cms.gov/apps/ehr/

Crystal Certification Information

The following information is used during the attestation phase:

CMS EHR Certification ID:	A014E01NBBU2EAP
Certifying ATCB:	Drummond Group Inc.
CHPL Product Number:	02072014-2156-1
Classification:	Complete EHR
Practice Setting:	Ambulatory
Additional Software Required*:	Allscripts eRx, Email software

*2 additional requirements for Complete EHR Ambulatory certification are the use of All Scripts Platinum Account e-prescribing and any email software. If you do not already have a Platinum account you can register within Crystal PM in the Admin->E-Prescribe section.

OBTAINING MEANINGFUL USE WITH CRYSTAL PRACTICE MANAGEMENT SOFTWARE

The Centers for Medicare and Medicaid Services (CMS) established the criteria with which optometrists must comply to qualify for incentive payments available through the American Recovery and Reinvestment Act. Optometrists must use Electronic Health Records (EHRs) in a "meaningful" way to qualify for incentive payments. CMS established 22 "meaningful use" objectives, which were divided into a "core" group of 13 requirements that must be met, plus an additional 9 "menu" requirements, of which 5 must be met.

The following definitions and acronyms are used:

Active Medication Allergy List: A list of medications to which a given patient has known allergies.

Active Medication List: A list of medications that a given patient is currently taking.

Allergy: An exaggerated immune response or reaction to substances that are generally not harmful.

Appropriate Technical Capabilities: A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified HER technology or outside systems and programs that support the privacy and security of certified EHR technology.

ARRA: The American Recovery and Reinvestment Act of 2009

Business Days: Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Clinical Decision Support: HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Clinical Summary: An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered

	during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.
CPOE:	Computerized Provider Order Entry
Diagnostic Test Results:	All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.
Different Legal Entities:	A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.
Distinct Certified EHR Technology:	Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.
EHR:	Electronic Health Records
EP:	Eligible Providers (includes O.D.s)
Exchange:	Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the eligible professional must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or

	other vendor-specific alternative methods for exchanging clinical information.
Medication Reconciliation:	The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.
Office Visit:	Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.
Patient Authorized Entities:	Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.
Patient-Specific Education Resources:	Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.
Permissible Prescriptions:	Permissible prescriptions refer to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. Any prescription not subject to these restrictions is permissible.
Prescription:	The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.
Problem List:	A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

Public Health Agency:	An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.
Relevant Encounter:	An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so.
Specific Conditions:	Those conditions listed in the active patient problem list.
Transition of Care:	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Unique Patients:	Patients seen multiple times during EHR reporting periods are only counted once
Up-to-date:	The term ‘‘up-to-date’’ means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.

What are the requirements for Stage 1 of Meaningful Use (2011 and 2012)?

Meaningful use includes both a core set and a menu set of objectives that are specific to eligible professionals or eligible hospitals and CAHs.

- For eligible professionals, there are a total of 22 meaningful use objectives. To qualify for an incentive payment, 18 of these 22 objectives must be met.
  - There are 13 required core objectives.
  - The remaining 5 objectives may be chosen from the list of 9 menu set objectives.

Eligible Professional Core Set Measures

(1) 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.

(2) Implement drug-drug and drug-allergy interaction checks.

(3) Maintain an up-to-date problem list of current and active diagnoses.

(4) Generate and transmit permissible prescriptions electronically (eRx).

(5) Maintain active medication list.

(6) Maintain active medication allergy list.

(7) Record all of the following demographics:
(A) Preferred language.
(B) Gender.
(C) Race.
(D) Ethnicity.
(E) Date of birth.

(8) Record and chart changes in the following vital signs:
(A) Height.
(B) Weight.
(C) Blood pressure.
(D) Calculate and display body mass index (BMI).
(E) Plot and display growth charts for children 2–20 years, including BMI.

(9) Record smoking status for patients 13 years old or older.

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

(11) Provide patients the ability to view online, download and transmit their health information (including diagnostics test results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the eligible professional.

(12) Provide Clinical Summaries for patients for each office visit.

(13) Protect electronic health information created or maintained by the certified EHR

Eligible Professional Menu Set Measures

(1) Implement drug formulary checks.

(2) Incorporate clinical lab-test results into EHR as structured data.

(3) Generate patient lists by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

(4) Send patient reminders per patient preference for preventive/follow-up care.

(5) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

(6) 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.

(7) 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 summary care record for each transition of care or referral.

(8) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

(9) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

Core Measure 1 of 13 - CPOE for Medication Order

Objective	Use 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 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Exclusion	Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period is excluded from this requirement.
Crystal PM Direction	Medications entered in the DrugRx tab in the Medical Records, or entered on the Allscripts website, will automatically qualify for this measure.

Attestation Requirements

- DENOMINATOR: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator that have at least one medication order entered using CPOE.
- EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 30 percent in order for an EP to meet this measure.

Additional Information on Core Measure 1:

- The optometrist is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that the CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order.
- Electronic transmittal of the medication order to the pharmacy, laboratory, or diagnostic imaging center is not a requirement for meeting the measure of this objective. However, a separate objective (Core Measure 4) addresses the electronic transmittal of prescriptions and is a requirement for optometrists to meet Meaningful Use.

Core Measure 2 of 13 - Drug Interaction Checks

Objective	Implement drug-drug and drug-allergy interaction checks.
Measure	The EP has enabled this functionality for the entire EHR reporting period.
Exclusion	No exclusion.
Crystal PM Direction	The Allscripts website is loaded with common Drug-Drug, and Drug-Allergy, interactions, so by placing drug orders within their site you are preforming drug-drug and drug-allergy interactions. To manually add your own interactions with Crystal PM To set up drug-drug interactions: 1) Navigate to Admin -> Defaults 2) Select DrugRx Defaults from the drop-down box 3) Select the Drug-Drug Warnings tab 4) Click the Add Item button to add a pair of drugs that you would like to mark as having an unwanted interaction. Drug Allergy checks are done automatically based on the allergy list specified for the patient in the ARRA tab of the Medical Records.

Attestation Requirements

YES / NO Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

Core Measure 3 of 13 - Maintain Problem List	
Objective	Maintain an up-to-date problem list of current and active diagnoses.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion	No exclusion.
Crystal PM Directions	Crystal automatically tracks diagnoses for users that include the Diagnosis field type in their Medical Records. To add a Diagnosis field: 1) Click on Records and select any patient. 2) Select EHR from the main menu at the top of the window, and select Edit Medical Records. 3) A new window will appear displaying the current medical record fields. You can add a new field by clicking the Add New Field button, or you can highlight an existing field and edit the details in the section on the right of the window. 4) Select Diagnosis from the Type drop-down box. 5) Diagnosis fields come in pairs, one for the ICD-9 code, and one for the description. Each field of the pair should have the same number listed in the Diagnosis Number input to link them together. 6) If the Diagnosis Number is less than 100 then any diagnosis code entered in that field will automatically be added to the routing slip; Diagnosis Numbers over 100 will not be added to the routing slip.

Attestation Requirements

- **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR**: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information on Core Measure 3:

- The Medicare and Medicaid EHR Incentive Programs do not specify the use of ICD-9 or SNOMED-CT® in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 or SNOMED-CT® for the entry of structured data for this measure and made this a requirement for EHR technology to be certified. Therefore, EPs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® as a basis for the entry of structured data into certified EHR technology in order to meet the measure for this objective.
- For patients with no current or active diagnoses, an entry must still be made to the problem list indicating that no problems are known.

- An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances.

- The initial diagnosis can be recorded in lay terms and later converted to standard structured data or can be initially entered using standard structured data.

Core Measure 4 of 13 - e-Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically (eRx).
Measure	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
Crystal PM Directions	1. Open desired patient's Medical Records page. 2. Click Drug Rx tab. 3. Click E-Prescribe button. Fill out Drug Rx and select pharmacy on All Scripts – for more information visit www.allscripts.com.

Attestation Requirements

- DENOMINATOR: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.

- NUMERATOR: Number of prescriptions in the denominator generated and transmitted electronically.

- EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

Additional Information on Core Measure 4:

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the measure.

- Instances where patients specifically request a paper prescription may not be excluded from the measure.

- The determination of whether a prescription is a ''permissible prescription'' for purposes of this measure should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010.

- EPs cannot receive incentive payments for e-prescribing under both the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Medicare EHR Incentive Program for the same year.

- Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.

- Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology. For more information, refer to ONC's FAQ at http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_22/21286.

- EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.

- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur constructively if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.

Core Measure 5 of 13 - Active Medication List

Objective	Maintain active medication list.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Exclusion	No exclusion.
Crystal PM Directions	Medications entered in the DrugRx tab of the Medical Records will be tracked by Crystal automatically. If patient does not have any medications check the 'No current Medications' box on the ARRA tab.

Attestation Requirements

•DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

•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.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information on Core Measure 5:

- For patients with no active medications, an entry must still be made to the active medication list indicating that there are no active medications.
- An EP is not required to update this list at every contact with the patient. The EP can then use his or her clinical judgment to decide when additional updating is required.

Core Measure 6 of 13 - Medication Allergy List	
Objective	Maintain active medication allergy list.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Exclusion	No exclusion.
Crystal PM Directions	The medication allergies are stored in the ARRA tab of the Medical Records. Click on the Add Allergy button to select a drug that the patient has an allergy to. Users can also add a Drug Allergy field to their medical records and that field will synchronize with the Allergy list. To add allergies to this second list you can add a Button field. Then click Add Command->Command->Pre-Loaded Application->Allergy Add. If the patient does not have any known allergies click the 'No know drug allergies' box.

Attestation Requirements

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

- 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.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information on Core Measure 6:

- For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies.

- An EP is not required to update this list at every contact with the patient. The measure ensures that the EP has not ignored having a medication allergy list for patients seen during the EHR reporting period and that at least one piece of information on medication allergies is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances at hand.

Core Measure 7 of 13 - Record Demographics

Objective	Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth
Measure	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
Exclusion	No exclusion.
Crystal PM Directions	All of the required demographics can be entered in the ARRA tab of the Medical Records.

Attestation Requirements

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

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

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Core Measure 7:

- Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr).

- If a patient declines to provide all or part of the demographic information, or if capturing a patient's ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. In regards to patients who do not know their ethnicity, EPs should treat these patients the same way as patients who decline to provide race or ethnicity— identify in the patient record that the patient declined to provide this information.

- EPs are not required to communicate with the patient in his or her preferred language in order to meet the measure of this objective.

Core Measure 8 of 13 - Record Vital Signs	
Objective	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI
Measure	For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.
Exclusion	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. Blood Pressure may solely be excluded if the EP believes that it has no relevance to their scope of practice. The EP may solely exclude height/weight if they believe that it has no relevance to their scope of practice.
Crystal PM Directions	All vital signs can be recorded in the ARRA tab in the Medical Records. You may also exclude height/weight or blood pressure. Please review the Crystal PM Meaningful Use Report to see the updated vital sign measures.

Attestation Requirements

- DENOMINATOR: Number of unique patients age 2 or over seen by the EP during the EHR reporting period.

- NUMERATOR: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.

- EXCLUSION: An EP who sees no patients 2 years or older would be excluded from this requirement. Additionally, an EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Core Measure 8:

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

- The only information required to be inputted by the provider is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.

- Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated

- Height, weight, and blood pressure can get into the patient's medical record as structured data in a number of ways. Some examples include entry by the EP, entry by someone on the EP's staff, transfer of the information electronically or otherwise from another provider or entered directly by the patient through a portal or other means.

Core Measure 9 of 13 - Record Smoking Status	
Objective	Record smoking status for patients 13 years old or older.
Measure	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion	Any EP who sees no patients 13 years or older.
Crystal PM Directions	Smoking status can be recorded in the ARRA tab of the Medical Records.

Attestation Requirements

- DENOMINATOR: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator with smoking status recorded as structured data.
- EXCLUSION: An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Core Measure 9:

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- This is a check of the medical record for patients 13 years old or older. If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.

Core Measure 10 of 13 - Clinical Decision Support Rule	
Objective	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
Measure	Implement one clinical decision support rule.
Exclusion	No exclusion.
Crystal PM Directions	Crystal implements a check on the cup-to-disc ratio field located in the ARRA tab. If the value entered is greater than 0.4, the user is prompted to test for glaucoma.

Attestation Requirements

Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.

Additional Information on Core Measure 11:

- CMS will not issue additional guidance on the selection of appropriate clinical decision support rules for Stage 1 Meaningful Use. This determination is best left to the EP taking into account their workflow, patient population, and quality improvement efforts.

- Drug-drug and drug-allergy interaction alerts cannot be used to meet the meaningful use objective for implementing one clinical decision support rule. EPs must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks.

Core Measure 11 of 13 - Electronic Copy of Health Information	
Objective	Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the eligible professional. (including diagnostic test results, problem list, medication lists, medication allergies)
Measure	More than 50 percent of all patients must be provided an uploaded electronic copy of their health record.
Exclusion	Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information."
Crystal PM Directions	In the ARRA tab of the Medical Records there is a button labeled Upload Medical Record. Select the Upload Medical Record button then assign a username/password. Next select the Add Access button to upload the medical record to the online portal.

Attestation Requirements

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have timely (within 4 business after the information is available to the EP) online access to their health information to view, download, and transmit to a third party.
- EXCLUSION: An EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information."

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Core Measure 12:

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

- When responding to patient requests for information, the EP should accommodate patient requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524, Access of individuals to protected health information. HIPAA contains requirements for providing patients copies of their health information.

- Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP

- An EP may withhold information from the electronic copy of a patient's health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.

- An EP should provide a patient with all of the health information they have available electronically, subject to withholding as described in the HIPAA Privacy Rule, as specified at in 45 CFR 164.524. Form and format should be human readable and comply with the HIPAA Privacy

Rule, as specified at 45 CFR 164.524(c). The media could be any electronic form such as patient portal, PHR, CD, USB fob, etc. EPs are expected to make reasonable accommodations for patient preference as outlined in 45 CFR 164.522(b). The charging of fees for this information is governed by the HIPAA Privacy Rule at 45 CFR 164.524(c)(4) (which only permits HIPAA covered entities to charge an individual a reasonable, cost-based fee for a copy of the individual's health information).

- If provision of the copy involves the mailing of physical electronic media, then it would need to be mailed by at least the third business day following the request of the patient or their agents.

- Third-Party Requests: Only specific third-party requests for information are included in the denominator. Providing the copy to a family member or patient's authorized representative consistent with federal and state law may substitute for a disclosure of the information to the patient and count in the numerator. A request from the same would count in the denominator. All other third-party requests are not included in the numerator or the denominator.

Core Measure 12 of 13 - Clinical Summaries	
Objective	Provide clinical summaries for patients for each office visit.
Measure	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion	Any EP who has no office visits during the EHR reporting period.
Crystal PM Directions	In the ARRA tab of the Medical Records, there is a checkbox that allows the user to indicate that the patient has received a clinical summary for the office visit in question. Crystal provides a default Clinical Summary by clicking the Print Clinical Summary button in the ARRA tab. Once printed, the clinical summary checkbox will automatically be checked. Users can also send or print a custom Letter or Word document, and in that case the box would need to be checked manually.

Attestation Requirements

- DENOMINATOR: Number of office visits by the EP during the EHR reporting period.
- NUMERATOR: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.
- EXCLUSION: EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Core Measure 13:

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- The provision of the clinical summary is limited to the information contained within certified EHR technology.
- The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request.
- If an EP believes that substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information from the clinical summary.
- Providers should not charge patients a fee to provide this information.

- When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit.

- The EP must include all of the items listed under "Clinical Summary" in the above "Definition of Terms" section that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of these fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):

    - Problem List
    - Diagnostic Test Results
    - Medication List
    - Medication Allergy List

Core Measure 13 of 13 - Protect Electronic Health Information	
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 in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion	No exclusion.
Crystal PM Directions	The EP must complete a Security Risk Analysis during the reporting period. Please contact Crystal PM for instructions on how to complete this document.

Attestation Requirements

Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

Additional Information

- EPs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.

- A security update would be required if any security deficiencies were identified during the risk analysis. A security update could be updated software for certified EHR technology to be implemented as soon as available, changes in workflow processes or storage methods, or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.

Menu Measure 1 of 9-Drug Formulary Checks	
Objective	Implement drug formulary checks.
Measure	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
Crystal PM Directions	Drug formulary checks are implemented in the AllScripts Platinum package. Please see www.allscripts.com for details.

Attestation Requirements

YES / NO / EXCLUSION Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure. An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

Additional Information on Menu Measure 1:

- At a minimum an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.

Menu Measure 2 of 9-Clinical Lab Test Results	
Objective	Incorporate clinical lab test results into EHR as structured data.
Measure	More than 40 percent 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.
Exclusion	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
Crystal PM Directions	To add a lab test result for a Patient. 1) Load the Patient in the Medical Records Tab. 2) Under the Top Menu Item select EHR->External Data 3) Summary Form ->Add Diag Tests 4) Complete the form.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

• DENOMINATOR: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
• NUMERATOR: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
• EXCLUSION: If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

Additional Information on Menu Measure 2:

- The provider is permitted, but not required, to limit the measure of this objective to labs ordered for those patients whose records are maintained using certified EHR technology.
- Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
- Lab results are not limited to any specific type of laboratory or to any specific type of lab test.

- The Medicare and Medicaid EHR Incentive Programs do not specify the use of code set standards in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory, for the entry of structured data for this measure and made this a requirement for EHR technology to be certified.

Menu Measure 3 of 9-Patient Lists	
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.
Exclusion	No exclusion.
Crystal PM Directions	The Correspondence Report in Crystal satisfies the requirement for this measure. To access this report: 1) Click Reports on the main menu. 2) Select Correspondence Report from the drop-down menu. 3) Select the criteria for the patient list you want to generate. The More button in the upper-right will enable extra criteria. 4) Export the Correspondence Report to a CSV file and insert a header that includes the report was run from Crystal PM, the date and diagnosis selected.

Attestation Requirements

YES / NO Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Additional Information on Menu Measure 3:

- This objective does not dictate the report(s) which must be generated. An EP is best positioned to determine which reports are most useful to their care efforts.
- The report generated could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP.
- The report generated is required to include only patients whose records are maintained using certified EHR technology.

Menu Measure 4 of 9-Patient Reminders	
Objective	Send reminders to patients per patient preference for preventive/follow-up care.
Measure	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
Crystal PM Directions	The Correspondence Report and the Recall Report in Crystal will satisfy this requirement. When a list of patients is brought up in either report, there is a checkbox at the bottom of the report window that allows the user to specify that the list is for sending reminders to the patients. The measure will be stored when the list is printed, labels are printed, or patients are sent emails.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

• DENOMINATOR: Number of unique patients 65 years old or older or 5 years older or younger.
• NUMERATOR: Number of patients in the denominator who were sent the appropriate reminder.
• EXCLUSION: If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 20 percent in order for an EP to meet this measure.

Additional Information on Menu Measure 4:

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- EPs meet the aspect of ‘‘per patient preference’’ of this objective if they are accommodating reasonable requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), which is the guidance established for accommodating patient requests.
- EP has the discretion to determine the frequency, means of transmission, and form of the reminder limited only by the requirements the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), and any other applicable federal, state or local regulations that apply to them.

Menu Measure 5 of 9-Patient-specific Education Resources	
Objective	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
Exclusion	No exclusion.
Crystal PM Directions	2 Methods Method 1: Generate a list of Patients which require a patient specific resource. Example Diagnosed with Glaucoma. 1) Click on Reports Page 2) Select Correspondence Report and click More on the right side. 3) Search for specific Diagnosis Code [e.g. 365.11], medication or allergy. This can be used to send an MS Word Mail Merge, an Email, or clicking Assign Online Document. The measure will only be automatically recorded if the patients in the list are assigned an online document. Otherwise the checkbox in the ARRA tab must be checked manually. Patient can be given a paper resource as long as the checkbox is marked in the ARRA tab. Method 2: Modify Diagnosis Codes to prompt for Education Resources 1) Go To Admin->Diag Codes 2) Double Click on Specific Code 3) Add Alert with a check in the checkbox 'Check provided education resource' This will prompt you to provide the educational resource anytime you assign this Diagnosis code to a patient.

Attestation Requirements
NUMERATOR / DENOMINATOR

• DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
• NUMERATOR: Number of patients in the denominator who are provided patient-specific education resources.

The resulting percentage (Numerator ÷ Denominator) must be more than 10 percent in order for an EP to meet this measure.

Additional Information on Menu Measure 6:

- Certified EHR technology is certified to use (1) the patient's problem list, (2) medication list, or (3) laboratory test results to identify the patient-specific educational resources.

These or additional elements can be used in the identification of educational resources that are specific to the patients needs.

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

Menu Measure 6 of 9-Medication Reconciliation	
Objective	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
Measure	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion	An EP who was not the recipient of any transitions of care during the EHR reporting period.
Crystal PM Directions	Two checkbox fields in the ARRA tab of the Medical Records satisfy this requirement. The first is the Patient Transferred In/Referred to This Provider checkbox to indicate the patient was transfer into the user's office. The second is the Medication Reconciliation Performed checkbox which indicates the doctor has added any relevant medications from the referring provider to the patient's records.

Attestation Requirements
NUMERATOR / DENOMINATOR / EXCLUSION

• DENOMINATOR: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
• NUMERATOR: Number of transitions of care in the denominator where medication reconciliation was performed.
• EXCLUSION: If an EP was not on the receiving end of any transition of care during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Menu Measure 7:

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.

Menu Measure 7 of 9-Transition of Care Summary	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measure	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Exclusion	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
Crystal PM Directions	In the ARRA tab of the Medical Records, there is a field labeled Patient Transferred Out/ Referred to Other Provider to indicate whether the patient was referred to another provider. Crystal automatically tracks when a Continuity of Care Record (CCR) is generated for each patient. To generate a CCR: 1) Navigate to the Patient page for the chosen patient. 2) Click on the Files tab. 3) Click on the Continuity of Care Record button. 4) Click Save Continuity of Care Record to store the file on your PC.

Attestation Requirements
NUMERATOR / DENOMINATOR / EXCLUSION

• DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
• NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
• EXCLUSION: If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information on Menu Measure 8:

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- The transferring party must provide the summary care record to the receiving party.
- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so.

- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care.

Menu Measure 8 of 9-Immunization Registries Data Submission	
Objective	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to 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 has the capacity to receive the information electronically).
Exclusion	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
Crystal PM Directions	To generate Immunization Registry. 1) Load the Patient in the Medical Records Tab. 2) Under the Top Menu Item select EHR->External Data 3) Summary Form ->Immunization Complete the form.

Attestation Requirements
YES / NO / EXCLUSION

Additional Information on Menu Measure 9:

- The test to meet the measure of this objective must involve the actual submission of information to a registry or immunization information system, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- An unsuccessful test to submit electronic data to immunization registries or immunization information systems will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- The transmission of immunization information must use the standards at 45 CFR 170.302(k).

Menu Measure 9 of 9-Syndromic Surveillance Data Submission	
Objective	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to 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 has the capacity to receive the information electronically).
Exclusion	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.
Crystal PM Directions	To Nodify CDC for a Patient. 1) Load the Patient in the Medical Records Tab. 2) Under the Top Menu Item select EHR->External Data 3) Summary Form ->Notify CDC Complete the form.

Attestation Requirements
YES / NO / EXCLUSION

Additional Information on Menu Measure 10:

- The test to meet the measure of this objective must involve the actual submission of electronic syndromic surveillance data to public health agencies, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of electronic syndromic surveillance data is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- An unsuccessful test to submit electronic syndromic surveillance data to public health agencies will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- EPs must test their ability to submit electronic syndromic surveillance data to public health agencies at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Each payment year requires it own unique test.

- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.

- The transmission of syndromic surveillance information must us