Achieving Meaningful Use 2015–17 with OfficeMate/ExamWRITER

November 2016
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Getting Started

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NOTE

Download OfficeMate/ExamWRITER 12.0.3 SP4 or later to ensure accurate reporting of Modified Stage 2 criteria.

OfficeMate/ExamWRITER 11.1 has achieved ONC HIT 2014 Edition Complete EHR certification, which designates that the software is capable of supporting eligible providers with meeting the Stage 1 and Stage 2 meaningful use measures required to qualify for funding under the American Recovery and Reinvestment Act (ARRA). OfficeMate/ExamWRITER 11.1 was certified by ICSA Labs, an Office of the National Coordinator-Authorized Certification Body (ONC-ATCB), and is compliant in accordance with applicable criteria adopted by the Secretary of Health and Human Services (HHS).

The EHR Incentive Program requires eligible providers to integrate meaningful use of certified EHR technologies into their practices in stages. Each stage requires providers to meet specific measures and attest to their completion. Typically, you must complete two years of Stage 1 before you can begin Stage 2.

However, CMS has modified the EHR Incentive Programs for the 2015, 2016, and 2017 reporting years. To simplify the program, CMS is requiring all participants to report on a modified version of Stage 2. To help providers adapt to this change, CMS also made the following modifications to the program:

- All providers will attest to a 90-day reporting period in 2015.
- Providers who were scheduled to report on Stage 1 criteria may take additional qualified exemptions in 2015.
- Providers who are participating for the first time in 2016 will attest to a 90-day reporting period in 2016.
Refer to the following sections for an overview of the Modified Stage 2 requirements:

- **Objectives**, 4
- **Alternatives**, 4
- **Exclusions**, 4
- **Further Information**, 5
- **ePrescribing, Drug-Drug, Drug-Allergy, and Drug Formulary Checks**, 5

### Objectives

Like the previous stages, the Modified Stage 2 is broken down into objectives. These objectives are categorized as core, public health, and clinical quality measures. You’ll notice that there are fewer objectives than previous stages. There are fewer objectives because CMS removed several redundant objectives and objective that have been widely adopted by the industry as best practice.

You must complete 9 objectives, 1 public health objective, and 9 clinical quality measures. The following table displays how the Modified Stage 2 objectives correlate to what were previously called measures in the prior stages.

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Modified Stage 2 (2015-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 core measures</td>
<td>17 core measures</td>
<td><strong>9 objectives</strong></td>
</tr>
<tr>
<td>5 menu measures</td>
<td>3 menu measures</td>
<td><strong>1 public health objective</strong></td>
</tr>
<tr>
<td>6–9 clinical quality measures</td>
<td>9 clinical quality measures</td>
<td><strong>9 clinical quality measures</strong></td>
</tr>
</tbody>
</table>

If a measure specifies that you need to demonstrate more than a specific percentage (e.g., 50%), you must exceed that percentage (e.g., 51%) to fulfill the measure.

### Alternatives

Alternative measures apply only to providers who were scheduled to attest to Stage 1 in 2015. Refer to the individual measure descriptions in this guide for information about these alternative measures. After 2015, all providers must attest to the Modified Stage 2 objectives.

### Exclusions

You may satisfy objectives that are outside of your scope of practice by claiming an eligible exclusion. The exclusion is considered the same as having fulfilled the measure. Eligible exclusions are described in the details of each measure in this guide.
Within the public health objective, you claim an exclusion from certain measures that are outside of your scope of practice; however, you must first select measures that you can fulfill without exclusion. Only after you have exhausted all attainable measures, can you satisfy the public health objective by exclusion.

Further Information

This document helps you understand the objectives and clinical quality measures required in 2015, 2016, and 2017. It also shows you how to achieve meaningful use and avoid Medicare and Medicaid payment adjustments through the functions in OfficeMate/ExamWRITER. For more detailed information about the EHR Incentive Program's objectives, and for information about registering for the program and submitting attestation documents, go to www.cms.gov/EHRIncentivePrograms.

ePrescribing, Drug-Drug, Drug-Allergy, and Drug Formulary Checks

If you are using an ePrescribing system to meet CPOE, drug-drug and drug-allergy interaction check, and drug formulary check requirements and to generate and transmit permissible prescriptions electronically, it must be a “qualified” eRx system. There are two types of systems: a system for eRx only (standalone) and an electronic health record with eRx functionality (ExamWRITER ePrescribing Interface). Regardless of the type of system that you use, to be considered “qualified” it must be based on all of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PBMs), if available.
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts (defined below).
- Providing information related to lower cost, therapeutically appropriate alternatives (if any). (The availability of an eRx system to receive tiered formulary information, if available, will meet this requirement.)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

Eyefinity highly recommends that you use the ExamWRITER ePrescribing Interface as your qualified ePrescribing system because it is an integrated solution between ExamWRITER and DrFirst. If you use a system other than DrFirst, you will not be able to report your ePrescribing system use from within OfficeMate/ExamWRITER, you will have to manually calculate your meaningful use percentages and attest to them, and you will also have to rerecord prescriptions that you recorded in ExamWRITER in the standalone system. For more information about the ExamWRITER ePrescribing Interface, go to http://www.officemate.net/examwriter_va_erx.aspx or call the Sales team at 800.269.3666.
Beginning Meaningful Use

Use the following table to determine what stage you should complete and the length of your attention period for a given year. Follow the column that represents your adoption year (the year in which you started meaningful use).

The table below pertains to the Medicare EHR Incentive Program. If you are participating in the Medicaid program, visit the CMS website for more information: http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html.

<table>
<thead>
<tr>
<th>Attestation Year</th>
<th>2011 Adoption</th>
<th>2012 Adoption</th>
<th>2013 Adoption</th>
<th>2014 Adoption</th>
<th>2015 Adoption</th>
<th>2016 Adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Modified Stage 2 90 days</td>
<td>Modified Stage 2 90 days</td>
<td>Modified Stage 2 90 days</td>
<td>Modified Stage 2 90 days</td>
<td>Modified Stage 2 90 days</td>
<td>—</td>
</tr>
<tr>
<td>2016</td>
<td>Modified Stage 2 Full year</td>
<td>Modified Stage 2 Full year</td>
<td>Modified Stage 2 Full year</td>
<td>Modified Stage 2 Full year</td>
<td>Modified Stage 2 Full year</td>
<td>Modified Stage 2 90 days</td>
</tr>
<tr>
<td>2017</td>
<td>Modified Stage 3 or Stage 2 or Stage 3 or Stage 3</td>
<td>Stage 3 or Stage 3 or Stage 3 or Stage 3</td>
<td>Stage 3 or Stage 3 or Stage 3 or Stage 3</td>
<td>Stage 3 or Stage 3 or Stage 3 or Stage 3</td>
<td>Stage 3 or Stage 3 or Stage 3 or Stage 3</td>
<td>Modified Stage 2 or Stage 3 or Stage 3 or Stage 3</td>
</tr>
<tr>
<td>2018</td>
<td>Stage 3 Full year</td>
<td>Stage 3 Full year</td>
<td>Stage 3 Full year</td>
<td>Stage 3 Full year</td>
<td>Stage 3 Full year</td>
<td>Stage 3 Full year</td>
</tr>
</tbody>
</table>

1 If you were scheduled to attest to Stage 1 in 2015, you may attest to alternate exclusions and specifications for certain objectives and measures in 2015 only. After 2015, all providers must attest to the Modified Stage 2 objectives.

Registering for the Medicare and Medicaid EHR Incentive Programs

You registered for the EHR Incentive Program before you began meaningful use. You do not need to register again in subsequent years.

If you’re participating in meaningful use for the first time, go to the Registration and Attestation EHR Incentives Programs page on the CMS Web site: https://ehrincentives.cms.gov/hitech/login.action.

Finding the Office-Mate/ExamWRITER Certification Number

Participation in the EHR Incentive Programs requires that you demonstrate meaningful use with a certified EHR. EHRs are rigorously tested by a certifying body to ensure providers are able to fulfill the meaningful use objectives with the software. When an EHR passes, CMS issues a certification number for each version of the EHR that meets the certification criteria.

To learn more about locating your EHR Certification Number go to http://www.officemate.net/omkb/article.aspx?id=24494
OfficeMate/ExamWRITER features comprehensive and easy-to-understand reports to help you keep track of your meaningful use. The CMS Meaningful Use Reporting window helps you see where you have met meaningful use requirements and where you may need to focus more attention.

The CMS Meaningful Use Reporting window helps ensure you qualify for the incentive payments. You must meet all of the core objectives, the public health objective, and nine clinical quality measures.

Gathering Information from ExamWRITER

1. From the ExamWRITER main window, click the Reports menu and select Stage 2 2015 CMS Meaningful Use Reporting.

2. Select a line from the Meaningful Use Criteria. The description appears in the right column.

3. Select a date range from the Reporting From Date and Reporting Through Date fields.

4. Select a provider from the Provider drop-down menu.

5. Click Calculate Percentage to populate the Calculated Values fields. The calculated values are displayed in the Numerator, Denominator, and Percentage fields.

6. Click Generate MU Report to generate the Meaningful Use report. The report, an XML-based file, is placed in your DATA\eDocuments folder.

**NOTE** Download OfficeMate/ExamWRITER 12.0.3 SP4 or later to ensure accurate reporting of Modified Stage 2 criteria.

**NOTE** To access your Stage 1 - 2011 Edition, Stage 1 - 2014 Edition, and Stage 2 - 2014 Edition meaningful use reports for historical or auditing purposes, from the OfficeMate or ExamWRITER main window, click the Reports menu, select CMS Meaningful Use Reporting - Hx, and then select the appropriate stage and edition.
Attesting to Meaningful Use


For information about your EHR certification number, go to “Finding the OfficeMate/ExamWRITER Certification Number” on page 6.
CMS has published a list of supporting documents that they recommend collecting for Stage 2 audits. To read more, go to http://go.cms.gov/1xG8tXb.

If you have questions about your meaningful use audit that are not addressed in this document, email meaningfuluse@eyefinity.com.

Providing Proof of Possession

The auditor will ask you for proof that you were a licensed user of the certified EHR during your attestation. You will need to provide three items to prove possession:

- Your ExamWRITER license agreement
- The invoice from your ExamWRITER purchase(s)
- A screenshot of the About window showing your practice name and the ExamWRITER version. Take this screenshot during your attestation period.

Since the EHR incentive programs are government-funded initiatives, audits are an important part of abating fraud and waste in the program. The Centers for Medicare and Medicaid Services is spot checking meaningful use attestations, and they have hired a firm to conduct routine audits. An audit may occur prior to or after the incentive payment is made.

While the mere thought of an audit is anxiety-inducing prospect, don’t panic. You are not alone in this. Eyefinity is here to help.

Read all of the information that the auditors sent you. As you review the items requested in the auditors’ spreadsheet, also review the different sections of this book. This book explains how to gather the items that the auditors frequently request. Pay particular attention to the Audit Advice sections included with each measure in this book.

It’s common for the auditors to contact you again with follow-up questions or to request additional items. This book will help you address and mitigate many of the common follow-up questions.

The advice in this document is based on experiences with audits during Stages 1 and 2. It is routinely reviewed and updated as the auditors ask new questions.

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Objective 2

Preparing for an Audit
Demonstrating the 80% of Unique Patients Requirement

Locating Your License Agreement and Invoices

Check your files for your ExamWRITER invoices and license agreements. Your invoice(s) may be filed with your tax documentation. If you need a copy of your license agreement or invoice(s) send an email to meaningfuluse@eyefinity.com with your practice information. Please allow 3–5 business days for us to process your request.

**NOTE** If you purchased ExamWRITER several years ago, your invoice may refer to it as OPIS.

Taking a Screenshot of the About Window

To document that you have installed a certified version of OfficeMate/ExamWRITER, perform the following steps:

1. Open OfficeMate or ExamWRITER.
2. Click Help and select About.
   - The About window displays the practice name, the version number, and the date the software was last installed.
3. Press the Print Scrn key.
4. Open a new Word document (or use another word processor or graphics program).
5. Hold the Ctrl key and press the V key.
   - A copy of the screen is pasted into your document.
6. Save the Word document with your other meaningful use documentation.

**NOTE** Ideally, you should take this screenshot during your attestation period so the installation date displayed predates your reporting period. If you didn’t take the screenshot during your attestation period, the auditor may ask you for a statement from Eyefinity regarding when you installed the certified version.

Demonstrating the 80% of Unique Patients Requirement

The auditor is trying to determine that 80% of the unique patients you saw during your attestation period were maintained within ExamWRITER. Obviously, ExamWRITER can’t generate a report that accounts for patients whose records are not maintained within the software (if there are any at all).

One solution might be comparing two reports, one listing appointments and the other listing exams:

- Appointment Schedule report (found in the OfficeMate Reports & Statements window). Select a provider and the dates of the attestation period.
- Exam Analysis report (found in OfficeMate Administration’s ExamWRITER reports). Select the same provider and the same dates for the attestation period.
Objective 2

Preparing for an Audit

Documenting Objectives

Dividing the number of exams by the number of appointments should give you the percentage.

This isn’t very reliable, however, if you schedule patients to pick up eyewear because there’s no corresponding exam. To get a more accurate snapshot, export the Appointment Schedule report to Excel and filter out the pick-up appointments.

The auditor has asked you to provide a report that substantiates the numerators, denominators, and percentages that you entered for each of the core and menu set measures. The auditor specifies that the report must include information that shows that the report was generated in ExamWRITER.

Unfortunately, what the auditor is asking for was not part of the final rule for meaningful use. While OfficeMate/ExamWRITER generates a report of your calculations, we didn’t want to include anything extra that might cause your attestation to fail. So, we didn’t include the reporting dates, the doctor’s name, or the ExamWRITER logo (all of which customers have reported the auditors have asked for).

Here’s how you can get around it:

1. Open OfficeMate Administration or ExamWRITER.
2. Click the Reports menu and select CMS Meaningful Use Reporting.
3. For each measure, perform the following steps:
   a. Calculate the measure for the attestation dates.
   b. Press Alt-Print Scrn to take a screenshot.
   c. Paste the screenshot in a Microsoft Word document or in another word processor.

Perform these steps for each of the core and menu measures to which you attested.

**NOTE**

Note that measures with simple Yes/No answers are not calculated. The auditor may ask you to substantiate those separately.

Documenting the Clinical Quality Measures

If the auditor asks you to provide a report that substantiates the numerators, denominators, and percentages that you entered for each of the clinical quality measures, perform the same steps that you did for “Documenting Objectives” on page 11. This time, go to the CMS Quality Reporting window.
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Documenting the Clinical Quality Measures
PART TWO
OBJECTIVES
Protect Electronic Health Information

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The objective of this measure is to protect electronic health information created or maintained by the certified EHR through the implementation of appropriate technical capabilities.

Objective

Conduct or review a security risk analysis in accordance with the requirements under 45 CFR §164.308(a) (1), including addressing the encryption/security of data stored in a certified EHR in accordance with requirements under 45 CFR §164.312 (a)(2)(iv) and 45 CFR §164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process for EPs.

Alternatives

No alternative.

Exclusions

No exclusion.

OfficeMate/ExamWRITER Instructions

OfficeMate/ExamWRITER received ONC-ATCB 2011/2012 certification as a Complete EHR by CCHIT and therefore contains the following features to protect your electronic health information. You may use some or all of these features as part of your comprehensive security plan.

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- Auditing in OfficeMate/ExamWRITER, 17
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Objective 1

Protect Electronic Health Information

OfficeMate/ExamWRITER Instructions

Setting Up Security in OfficeMate/ExamWRITER

If desired, set up security in OfficeMate/ExamWRITER by following the instructions below. For more detailed instructions, see the OfficeMate Administration User’s Guide.

1. In OfficeMate/ExamWRITER Administration, click Setup and select Security.
2. Click Role Maintenance and set up a new role or modify the name and description or copy an existing role. You can set up as many roles as desired.
3. Select a role on the left side of the window and define its details. The roles can be as broad or as limiting as you desire.
4. Click the Users tab and assign role to users. You can assign as many roles as desired to users. All users will initially be automatically assigned to a default administrator role, which allows them access to all products, modules, and tasks in all locations, until you modify their role assignments. To grant users read-only emergency access to ExamWRITER, select the Allow Emergency Access check box; users with emergency access must identify the emergency situation when logging into ExamWRITER and type their reason for using the emergency access login.
5. Click the Preferences tab and set up security preferences for your locations.
6. Click Secure Reports and restrict user access to reports.
7. Click Print to print the Security Roles Report that displays the roles that you set up.
8. Click Close.

Encrypting Data in OfficeMate/ExamWRITER

By default, OfficeMate/ExamWRITER encrypts patient and provider protected health information (PHI) in your database. If you need to disable or re-enable encryption, perform the following steps.

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Passwords are encrypted within the database regardless of whether the rest of the database is encrypted or not; this functionality requires no action on your part.</th>
</tr>
</thead>
</table>

1. Back up your data!
2. In OfficeMate/ExamWRITER Administration, click Setup and select Encrypt/Decrypt Database.
3. Click Generate Key.
4. Click Save Key.
5. Click Encrypt.
Objective 1

Protect Electronic Health Information

Responsible Role

Audit in OfficeMate/ExamWRITER

To view the activities of OfficeMate/ExamWRITER users in your practice, track changes made to a particular patient's record, and view changes made to a specific exam, follow the instructions below:

1. In OfficeMate/ExamWRITER Administration, click **Setup** and select **Audit Log Management**.
2. Select the **Event Types** check boxes, as needed.
3. Click **Save/Exit**.
4. In OfficeMate Administration, click **Setup** and select **Audit Log Review**.
5. Record search criteria in the top of the window and click **Search** to find logs that meet your search criteria. Click **Print** to print the audit log search results or double-click on a log to view more details about it. To verify the integrity of an audit log entry that you have opened, click **Validate**.

Encrypting Individual eDocuments in ExamWRITER

If desired, encrypt documents by following the instructions below:

1. Open the patient's Patient Information Center window in ExamWRITER.
2. Click the **eDocuments** tab.
3. Select a document that you have already created.
4. Select a location where you want to save the encrypted document in the **Save to** text box in the Encrypt Document box.
5. Type any encryption key in the **Encryption Key** text box.
6. Click **Encrypt**. The encrypted file is saved as an EXE file in the location that you selected and displayed in the Patient Electronic Documents table.

If desired, validate that no one has tampered with a file by following the instructions below:

1. In ExamWRITER, click **Tools** and select **Process Hash File**.
2. Click **Browse** next to the File name to Generate Hash text box and select the file that you want to check.
3. Type a hash file name in the **Hash File Name** text box or click **Browse** and navigate to and select an existing hash file.
4. Click **Generate Hash**.
5. Click **Exit**.
6. In ExamWRITER, click **Tools** and select **Process Hash File**.
7. Click **Browse** next to the File name to Generate Hash text box and select the file that you want to compare.
8. Click **Browse** next to the Hash File Name text box and navigate to and select an existing hash file with a hash value.
9. Click **Compare Hash**.

**Responsible Role**

Office Manager
Technician
Front Desk

Achieving Meaningful Use 2015–17 with OfficeMate/ExamWRITER
Audit Advice

Since this measure is not percentage based, it does not appear in the CMS Meaningful Use Reporting window. It requires only a Yes/No attestation.

Many providers find this measure to be the most difficult, and many Stage 1 audits revealed that this measure requires more attention than anticipated. Due to the scope of the measure, this audit advice is divided into sections.

- Security Risk Analysis, 18
- Encryption, 19

Security Risk Analysis

Document and date your security risk analysis each year.

You cannot fulfill this measure simply by turning a security feature on or off. Your practice must conduct, at least once per year, a comprehensive security risk analysis in accordance with the requirements under HIPAA (45 CFR §164.308(a)(1)) and correct identified security deficiencies.

OfficeMate/ExamWRITER includes some features, which you may choose to enable as part of your overall security plan, but you cannot stop there. Questions you would need to answer as part of a security audit include, but are not limited to:

- Does the practice have antivirus or antimalware software installed, enabled, and current on every computer and server? Are operating system security patches up-to-date and installed on every workstation and the server?
- Is the practice’s network protected by a firewall? How often are the settings verified?
- Are mobile phones, tablets, laptops, desktops, and other devices used to access and transmit PHI password protected and encrypted?
- How is PHI removed from mobile phones, tablets, laptops, desktops, and other devices—including printers and fax machines—before disposition?
- Where is PHI collected, stored, maintained, and transmitted? What are the potential security threats and how likely are those threats?
- Does the practice have business associate contracts with all vendors that outline who is responsible and how PHI is protected?
- Is everyone in the practice trained in HIPAA? How is that education kept current?
- Does the practice have written, up-to-date policies and procedures in place regarding protecting PHI?
- How is the practice prepared to protect and restore PHI in case of natural or man-made disaster?
- How are off-site backups protected?

Objective 1

Protect Electronic Health Information
Audit Advice

Encryption

Although encryption is not strictly required by 45 CFR §164.312 (a)(2)(iv), encryption is enabled by default in OfficeMate/ExamWRITER v11.1 and later. You may decrypt your OfficeMate/ExamWRITER database, provided you meet the following criteria:

- During your security risk analysis, you determine that encryption is not a reasonable and appropriate safeguard of the confidentiality, integrity, and availability of PHI;
- You document your security risk determination; and
- You implement an equivalent alternative measure that is reasonable and appropriate.

If you maintain PHI in other systems, you must also check the encryption settings in those systems.
<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Protect Electronic Health Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit Advice</td>
</tr>
</tbody>
</table>
Clinical Decision Support Rule

In this chapter:
- Objective, 21
- Alternatives, 21
- Exclusions, 22
- ExamWRITER Instructions, 22
- Responsible Role, 23
- Audit Advice, 23

The objective of this measure is to use clinical decision support to improve performance on high-priority health conditions.

Objective
You must satisfy both measure 1 and 2.

Measure 1: Clinical Decision Support
Implement five clinical decision support interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. If fewer than four CQMs relate to an EP’s scope of practice or patient population, the clinical decision support messages must be related to high-priority health conditions. CMS suggests that one of the five clinical support interventions be related to improving healthcare efficiency.

Measure 2: Drug Interaction Checks
Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Alternatives

Alternative Measure 1: Clinical Decision Support
If you were scheduled to attest to Stage 1 in 2015, you may implement one clinical decision support rule. After 2015, all providers must attest to the Modified Stage 2 objectives.
Exclusions

Exclusion for Measure 2: Drug Interaction Checks

You may claim an eligible exclusion from the drug-drug and drug-allergy interaction checking if you write fewer than 100 medication orders during your EHR reporting period. This eligible exclusion is available to all providers.

ExamWRITER Instructions

There are two parts to this measure: implementing clinical decision support and implementing drug-drug and drug-allergy interaction checks.

- Implementing Clinical Decision Support, 22
- Implementing Drug Interaction Checks, 22

Implementing Clinical Decision Support

By default, Eyefinity turned on five clinical decision support rules that are related to clinical quality measures:

- Age-related macular degeneration (ARMD)
- Diabetes and the eye
- High-risk medication
- Primary open angle glaucoma (POAG)
- Primary open angle glaucoma intraocular pressure (IOP) control

As long as you finalize five exams where one of these conditions is indicated, you’ll fulfill the measure. To create additional clinical decisions support rules, perform the following steps:

1. In ExamWRITER, click Tools and select Clinical Decision Support.
2. Click New to create a new condition.
3. Type a name in the Condition Name text box.
4. Record one or more criteria, such as a diagnosis code medication, medication allergy, blood pressure, or BMI.
5. Type a requirement in the Requirement text box, such as an action to take.
6. Type the name of a Source or a link to a website, and type any Source Notes (e.g., “See page 3”) as needed.
7. Click Save.

When you finalize an exam, if the criteria that you set up matches the patient’s problem list, medication list, demographics, or laboratory test results, you’ll receive a patient alert to take an action.

Implementing Drug Interaction Checks

When you use the ExamWRITER ePrescribing Interface, you automatically send patient medication allergy and medication history textual information (without codes) from ExamWRITER to the interface. When you prescribe a medication that interacts negatively with another medication or patient medication allergy, a warning message may appear. Drug-drug interaction and drug-allergy warnings may not appear, however, if the medication has a red triangle to the left of its
Objective 2

Clinical Decision Support Rule

Responsible Role

Doctor
Technician
Scribe

Audit Advice

Since this measure is not percentage based, it does not appear in the CMS Meaningful Use Reporting window. It requires only a Yes/No attestation.

The firm conducting the meaningful use audits has been known to ask for evidence documenting the presence of these features during the attestation period.

- Documenting Clinical Decision Support, 23
- Documenting Drug Interaction Checks, 24

Documenting Clinical Decision Support

To document that you invoked a clinical decision support rule, perform the following steps during your attestation period:

1. Close or finalize an exam that includes one of the clinical decision triggers.
2. Press the Print Scrn key.

**NOTE** Alternatively, take a screenshot of each of the enabled clinical decision support rules.

3. Open a new Word document (or use another word processor or graphics program).
4. Hold the Ctrl key and press the V key.
   A copy of the screen is pasted into your document.
5. Save the Word document with your other meaningful use documentation.

**NOTE**  
By default, Eyefinity turned on five clinical decision support rules that are related to clinical quality measures. You can add, edit, or delete clinical decision support rules, but ExamWRITER does not allow you disable clinical decision support altogether.  
Provide this document to the auditor if he or she asks for a statement to this effect.

---

**Documenting Drug Interaction Checks**

To document the presence of this feature, perform the following steps during your attestation period:

1. Open the ePrescribing interface window.
2. 
3. Click **Additional Options**.
4. Click **Preferences - Location**.
5. Press the **Print Scrn** key. Be sure to capture the drug-interaction settings at the bottom of the page.
6. Open a new Word document (or use another word processor or graphics program).
7. Hold the **Ctrl** key and press the **V** key.  
   A copy of the screen is pasted into your document. 
8. Save the Word document with your other meaningful use documentation.

If you are not using the ExamWRITER ePrescribing interface, ensure that you have a copy of the contract indicating that you had subscribed to a service prior to your attestation period.

**NOTE**  
ExamWRITER does not allow you to disable drug-drug or drug-allergy interaction checks as long as you are subscribed to the ePrescribing interface.  
Provide this document to the auditor if he or she asks for a statement to this effect.
Computerized Provider Order Entry

In this chapter:
- Objective, 25
- Alternatives, 26
- Exclusions, 27
- ExamWRITER Instructions, 27
- Responsible Role, 28
- Audit Advice, 28

The objective of this measure is to use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

**Objective**

You must satisfy all three measures.

**Measure 1: Medication Orders**

More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

<table>
<thead>
<tr>
<th>NOTES</th>
<th>Denominator: Number of medication orders created by the EP or during the EHR reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: The number of orders in the denominator recorded using CPOE.</td>
</tr>
<tr>
<td></td>
<td>Threshold: The resulting percentage must be more than 60 percent in order to meet this measure.</td>
</tr>
</tbody>
</table>
Objective 3

Computerized Provider Order Entry

Alternatives

Measure 2: Laboratory Orders

More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

NOTES
Denominator: Number of laboratory orders created by the EP during the EHR reporting period.

Numerator: The number of orders in the denominator recorded using CPOE.

Threshold: The resulting percentage must be more than 30 percent in order to meet this measure.

Measure 3: Radiology Orders

More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

NOTES
Denominator: Number of radiology orders created by the EP during the EHR reporting period.

Numerator: The number of orders in the denominator recorded using CPOE.

Threshold: The resulting percentage must be more than 30 percent to meet this measure.

Alternatives

If you were scheduled to attest to Stage 1 in 2015, you may attest to the following alternate and exclusions in 2015 only. After 2015, all providers must attest to the Modified Stage 2 objectives.

Alternative Measure 1: Medication Orders

If you were scheduled to attest to Stage 1 in 2015, you may attest to this alternate measure in 2015 only. More than 30% of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Alternate Exclusion for Measure 2: Laboratory Orders

If you were scheduled to attest to Stage 1 in 2015, you may claim an exclusion for measure 2 of the Stage 2 CPOE objective for an EHR reporting period in 2015.
Objective 3

Computerized Provider Order Entry

Exclusions

Alternate Exclusion for Measure 3: Radiology Orders

If you were scheduled to attest to Stage 1 in 2015, you may claim an exclusion for measure 3 of the Stage 2 CPOE objective for an EHR reporting period in 2015.

Exclusions

These eligible exclusions are available to all providers.

Exclusion for Measure 1: Medication Orders

You may claim an eligible exclusion if you write fewer than 100 permissible prescriptions during the EHR reporting period.

Exclusion for Measure 2: Laboratory Orders

You may claim an eligible exclusion if you write fewer than 100 laboratory orders during the EHR reporting period.

Exclusion for Measure 3: Radiology Orders

You may claim an eligible exclusion if you write fewer than 100 radiology orders during the EHR reporting period.

ExamWRITER Instructions

There are three parts to this measure: ordering medications, ordering laboratory tests, and ordering radiology tests.

• Ordering Medications, 27
• Ordering Lab and Radiology Tests, 28

Ordering Medications

1. Open a patient’s exam record in ExamWRITER.
2. Press F6 to open the Medication Order window.
3. If you are using the ExamWRITER ePrescribing Interface, follow the instructions below; otherwise, if you are using another ePrescribing service, go to step 4. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm.
   a. Click the eRX icon.
   b. Click the Pharmacy link to select the pharmacy where you want to send the patient’s medication order.
   c. Click Prescribe in the main navigation bar.
   d. Search for and select a medication.
   e. Select the appropriate option to send and print the order.
Objective 3

Computerized Provider Order Entry

Responsible Role

Doctor
Technician
Scribe

Audit Advice

Be sure to deselect the Entered Using CPOE check box if the order was handwritten.

Ordering Lab and Radiology Tests

1. Open a patient’s exam record in ExamWRITER.
2. Press F3 to open the Orders window.
3. Select the Laboratory or Radiology radio button.
4. Select orders in the box on the left of the Orders window.
5. Select appropriate dates from the Timeline drop-down boxes.
6. Select an action from the Action drop-down menu.
7. Select a recall from the OfficeMate Patient Recall drop-down menu.
8. If this lab or radiology entry is a duplicate of a handwritten order, deselect the Entered Using CPOE check box.
9. Click Save(s).
10. Click Process.

NOTE

Although it is not required to satisfy this measure, you may record a status for the tests at this point. The order status appears on the clinical summary. To record a status for the order, click Change Status, select a Status and a Date, and click Save.

4. If you are using the Medication Order window in ExamWRITER, follow the instructions below:
   a. Select or enter the medication information.
   b. If this medication entry is a duplicate of a handwritten order, deselect the Entered Using CPOE check box.
   c. Click Save Med. Order to add the medication order to the Current Therapeutic Rx table.
   d. Click Print w/Sig/Exit or Print no Sig/Exit to print the medication order and exit the window.
In this chapter:
- **Objective**, 29
- **Alternatives**, 29
- **Exclusions**, 30
- **ExamWRITER Instructions**, 30
- **Responsible Role**, 30
- **Audit Advice**, 30

The objective of this measure is to generate and transmit permissible prescriptions electronically (eRx).

**Objective**

More than 50% of all permissible prescriptions (or all prescriptions) written by the EP are queried for a drug formulary and transmitted electronically using a certified EHR.

**NOTES**

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

- **Numerator**: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using a certified EHR.

- **Threshold**: The resulting percentage must be more than 50 percent in order to meet this measure.

**Alternatives**

If you were scheduled to attest to Stage 1 in 2015, you may attest to the following alternate measure in 2015 only: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using a certified EHR. After 2015, all providers must attest to the Modified Stage 2 objectives.
Objective 4: ePrescribing (eRx) Exclusions

You may claim an eligible exclusion if you meet the following criteria:

• You write fewer than 100 permissible prescriptions during the EHR reporting period; or
• You do not have a pharmacy within your organization and there are no pharmacies that accept electronic prescriptions within 10 miles of your practice location at the start of your EHR reporting period.

This eligible exclusion is available to all providers.

ExamWRITER Instructions

To generate and transmit prescriptions electronically, follow the instructions below and use the ExamWRITER ePrescribing Interface. The interface conducts drug formulary checks on medications that you select and displays formulary warnings in blue text.

For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm.

1. Open a patient's exam record in ExamWRITER.
2. Press F6 to open the Medication Order window.
3. Click the eRX icon.
4. Click the Pharmacy link to select the pharmacy where you want to send the patient's medication order.
5. Click Prescribe in the main navigation bar.
6. Search for and select a medication.
7. Select the appropriate option to send and print the medication order.

Responsible Role

Doctor
Technician

Audit Advice

The firm conducting the meaningful use audits has been known to ask for screenshots documenting the presence of drug formulary checking during the attestation period. To document the presence of this feature, perform the following steps during your attestation period:

1. Open the ePrescribing interface window and display a drug formulary check.
2. Press the Print Scrn key.
3. Open a new Word document (or use another word processor or graphics program).
4. Hold the Ctrl key and press the V key.
   A copy of the screen is pasted into your document.
5. Save the Word document with your other meaningful use documentation.
In this chapter:

- Objective, 31
- Alternatives, 31
- Exclusions, 31
- ExamWRITER Instructions, 32
- Responsible Role, 32

Formerly known as Summary of Care. The objective of this measure is to provide a summary of care record for each transition of care or referral when you transition your patient to another setting of care or provider of care or when you refer your patient to another provider.

**Objective**

The EP who transitions or refers their patient to another setting of care or provider of care (1) uses a certified EHR to create a summary of care record and (2) electronically transmits such summary to a receiving provider for more than 10% of transitions of care and referrals.

<table>
<thead>
<tr>
<th>NOTES</th>
<th>Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using a certified EHR and is exchanged electronically.</td>
</tr>
<tr>
<td></td>
<td>Threshold: The percentage must be more than 10 percent in order to meet this measure.</td>
</tr>
</tbody>
</table>

**Alternatives**

If you were scheduled to attest to Stage 1 in 2015, you may claim an exclusion because there was no equivalent for Stage 1. After 2015, all providers must attest to the Modified Stage 2 objective.

**Exclusions**

You may claim an eligible exclusion if you transfer patients to another setting or refer patients to another provider fewer than 100 times during the EHR reporting period. This eligible exclusion is available to all providers.
This objective of this measure is to encourage you to generate and send a summary of care for your outbound referrals. You should, whenever possible, transmit the summary of care electronically via secure messaging.

**NOTE**

Start asking your fellow providers for their direct addresses so you can achieve the 10% threshold early in your reporting period. The direct address may also be known as a secure messaging address or HISP address.

1. Within the patient's exam, click **Patient Hx**.
   The patient's Patient Information Center window opens.
2. On the **Exam Hx** tab, click **New Referral**.
3. Select the **Referring Provider**, **Refer to Provider**, **Reason**, **SNOMED**, **Referral Date**, and **Expected Return Date** and click **Save**.
4. Click **Create CDA Transition of Care** and click **Exit**.

![Image of Patient Referral window](image)

5. Click the **eDocuments** tab, select the **CDA Export - Transition of Care** from the list of eDocuments.
6. Select the **Provider** radio button and click **Secure Send**.
   The Secure Message window opens.
7. Type the provider's direct mail address or select it from the drop-down menu, type a **Subject**, type a message, and click **Send**.
   Your message and the patient's CDA are sent securely.

**Responsible Role**

- Doctor
- Technician
- Scribe
Patient-Specific Education Resources

In this chapter:

- Objective, 33
- Alternatives, 33
- Exclusions, 33
- ExamWRITER Instructions, 34
- Responsible Role, 34

The objective of this measure is to use clinically relevant information from a certified EHR to identify patient-specific education resources and provide those resources to the patient.

Objective

Patient-specific education resources identified by the certified EHR are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.

<table>
<thead>
<tr>
<th>NOTES</th>
<th>Denominator: Number of unique patients with office visits seen by the EP during the EHR reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: Number of patients in the denominator who were provided patient-specific education resources identified by the certified EHR.</td>
</tr>
<tr>
<td></td>
<td>Threshold: The resulting percentage must be more than 10 percent to meet this measure.</td>
</tr>
</tbody>
</table>

Alternatives

If you were scheduled to attest to Stage 1 in 2015, you may claim an eligible exclusion if you did not intend to select Patient Specific Education as one of your menu measures for Stage 1 in 2015.

After 2015, all providers must attest to the Modified Stage 2 objective.

Exclusions

You may claim an eligible exclusion if you have no office visits during the EHR reporting period. This eligible exclusion is available to all providers.
Objective 6: Patient-Specific Education Resources

**ExamWRITER Instructions**
Send clinical summaries to patients directly from ExamWRITER to the secure messaging portal. Patients are notified by email when there are new records available for them to view. When patients log into the portal, they will have the option to view and download their latest clinical summary or send it to another provider, like their primary care physician.

**Responsible Role**
- Doctor
- Technician
- Scribe
Medication Reconciliation

In this chapter:
• Objective, 35
• Alternatives, 35
• Exclusions, 35
• OfficeMate/ExamWRITER Instructions, 35
• Responsible Role, 36

The objective of this measure is to perform a medication reconciliation when you receive a patient from another setting of care or provider of care or when you believe an encounter is relevant.

Objective
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.

<table>
<thead>
<tr>
<th>NOTES</th>
<th>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.</td>
</tr>
<tr>
<td></td>
<td>Threshold: The resulting percentage must be more than 50 percent to meet this measure.</td>
</tr>
</tbody>
</table>

Alternatives
If you were scheduled to attest to Stage 1 in 2015, you may claim an eligible exclusion if you did not intend to select Medication Reconciliation as one of your menu measures for Stage 1 in 2015.

After 2015, all providers must attest to the Modified Stage 2 objective.

Exclusions
You may claim an eligible exclusion if you received no transitions of care during the EHR reporting period. This eligible exclusion is available to all providers.

OfficeMate/ExamWRITER Instructions
1. Open a patient’s exam record in ExamWRITER.
2. Click the Patient Hx - ROS tab.
3. Click the Patient History category bar.
Objective 7: Medication Reconciliation

**Responsible Role**

4. Select the **Reviewed [MU]** check box.
   OR
   Select the **Medications - Systemic/Ocular/Allergies [MU]** or **Allergens - Non Medication** check box and click **Transition of Care Medication Reconciliation [MU]**.

5. Click **Process** or **Save/Exit**.

6. Open a patient’s Patient Information Center in ExamWRITER or Patient Demographics window in OfficeMate.

7. Select the **Professional [MU]** radio button next to **Referred By**.

8. Click the button next to **Referred Name** and find and select a referring professional.

9. Click **OK** or **Save**.

**Responsible Role**

- Doctor
- Technician
- Scribe
In this chapter:
- Objective, 37
- Alternatives, 38
- Exclusions, 38
- ExamWRITER Instructions, 39
- Responsible Role, 42
- Audit Advice, 42

The objective of this measure is to provide patients the ability to view online, download, and transmit their health information within four business days of the information being available to the EP.

Objective
You must satisfy both measure 1 and 2.

Measure 1: Timely Access
More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within four business days after the information is available to the EP) online access to their health information, subject to the EP’s discretion to withhold certain information.

The following information must be made available online unless the information is not available in the certified EHR; is restricted from disclosure due to any federal, state, or local law regarding the privacy of a person’s health information, including variations due to the age of the patient; or the provider believes that substantial harm may arise from disclosing particular health information in this manner:

- Patient name
- Provider’s name and office contact information
- Current and past problem list
- Procedures
- Laboratory test results
- Current medication list and medication history
- Current medication allergy list and medication allergy history
- Vital signs (height, weight, blood pressure, BMI, growth charts)
- Smoking status
Objective 8

Patient Electronic Access

Alternatives

- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider of record

**NOTES**

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

**Numerator:** The number of patients in the denominator who have timely (within four business days after the information is available to the EP) online access to their health information.

**Threshold:** The resulting percentage must be more than 50 percent to meet this measure.

**Measure 2: Patient Action**

At least one patient seen by EP during EHR reporting period (or their authorized representative) views, downloads, or transmits his or her health information to a third party.

**Alternatives**

If you were scheduled to attest to Stage 1 in 2015, you may claim the following exclusion in 2015 only. After 2015, all providers must attest to the Modified Stage 2 objectives.

**Alternate Exclusion for Measure 2: Patient Action**

If you were scheduled to attest to Stage 1 in 2015, you may claim an exclusion from Measure 2 because there was no equivalent for Stage 1. After 2015, all providers must attest to the Modified Stage 2 objective.

**Exclusions**

You may claim an eligible exclusion if you meet the following criteria:

- You neither order nor create any of the information listed for inclusion as part of the measures; or
- You conduct 50 percent or more of your patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

This eligible exclusion is available to all providers.
Send clinical summaries to patients directly from ExamWRITER to the secure messaging portal. Patients are notified by email when there are new records available for them to view. When patients log into the portal, they will have the option to view and download their latest clinical summary or send it to another provider, like their primary care physician.

**ExamWRITER Instructions**

Perform the following steps within four business days:

- **Creating Clinical Summary Documents, 39**
- **Sending the Clinical Summaries to Patients, 41**

### NOTES

- Encourage patients to view or download their clinical summaries to satisfy the second measure of this objective.
- Encourage patients to send you a message through the patient portal acknowledging receipt of their clinical summaries to satisfy the Secure Messaging objective.

**NOTE**

For more information on setting up the secure messaging portal for your practice, refer to the *OfficeMate Administration User’s Guide*.

### Creating Clinical Summary Documents

1. Open the patient’s exam.
2. Click **Patient Hx**.
3. Click the **Demographics** tab and verify the patient’s **Name, Date of Birth**, and **E-Mail Address**.
4. Click the **eDocuments** tab.
5. Select the **Clinical Summary (open exam)** radio button.
6. Select the **Patient Requested** check box.
7. Click **Create CDA**.

The Edit Clinical Summary window opens. The Original Document section reflects all of the data in the clinical summary that is capable of being shared with the patient. The Final Document section reflects only the data that you have selected to share with the patient. By default, all of the data is selected.
8. To exclude certain data, deselect the appropriate check boxes in the **Original Document** section.

**NOTE** You may also deselect the check boxes in the Final Document section, but if you need to reselect them, you will need to select the check boxes in the Original Document section.

9. Once you have selected only the data that you want to send the patient, click **Save**.

10. Click **OK** to dismiss the success message.

The Patient Electronic Documents list refreshes and displays the clinical summary document that you created at the top.

### Sending the Clinical Summaries to Patients

1. Click **Show eDocs**.

2. Select the clinical summary from the **Patient Electronic Documents** list.

3. Select **Patient** from the **Send To** radio buttons.
Objective 8

Patient Electronic Access

Responsible Role

4. Click **Secure Send**.

5. Click **OK** to dismiss the message confirmation.

   The patient will receive an email explaining that new records are available from your practice. If the patient has not logged into the secure messaging portal before, he or she will receive a second email explaining how to log in for the first time.

6. Encourage the patient to log into the portal, review the clinical summary, and send you a message through the portal.

Responsible Role

Doctor

Technician

Scribe

Audit Advice

If you plan to claim an eligible exclusion due to lack of broadband availability in the county you serve, document the lack of broadband access at the beginning of your attestation period. Go to the National Broadband Map website, and search for the county in which more than 50% of your patient encounters take place. If the map indicates that fewer than 50% of the housing units in the county have access to internet speeds of at least 4 mbps, you may claim the eligible exclusion. Print the web page for your records. You can access the National Broadband Map online at [http://www.broadbandmap.gov](http://www.broadbandmap.gov).
Use Secure Messaging

In this chapter:
- Objective, 43
- Alternatives, 44
- Exclusions, 44
- ExamWRITER Instructions, 45
- Responsible Role, 45
- Audit Advice, 45

The objective of this measure is to use secure electronic messaging to communicate with patients on relevant health information.

Objective

The objective requirements increase each year:
- 2015: Secure messaging enabled
- 2016: Send a secure message to at least one patient during the reporting period
- 2017: Send secure messages to at least 5% of the patients seen during the reporting period.

2015

The capability for patients to send and receive a secure electronic message with the provider was fully enabled.
Objective 9

Use Secure Messaging

Alternatives

2016

For at least one patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of the certified EHR to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

<table>
<thead>
<tr>
<th>NOTES</th>
<th>Denominator: Number of unique patients seen by the EP during the EHR reporting period.</th>
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<tbody>
<tr>
<td></td>
<td>Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).</td>
</tr>
<tr>
<td></td>
<td>Threshold: The numerator and denominator must be reported, and the numerator must be equal to or greater than 1.</td>
</tr>
</tbody>
</table>

2017

For more than 5% of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of certified EHR to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative) during the EHR reporting period.

<table>
<thead>
<tr>
<th>NOTES</th>
<th>Denominator: Number of unique patients seen by the EP during the EHR reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).</td>
</tr>
<tr>
<td></td>
<td>Threshold: The resulting percentage must be more than 5%.</td>
</tr>
</tbody>
</table>

Alternatives

If you were scheduled to attest to Stage 1 in 2015, you may claim an exclusion because there was no equivalent for Stage 1. After 2015, all providers must attest to the Modified Stage 2 objective.

Exclusions

You may claim an eligible exclusion if you meet the following criteria:

- You have no office visits during the EHR reporting period; or
- You conduct 50 percent or more of your patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

This eligible exclusion is available to all providers.
Objective 9

ExamWRITER Instructions

This objective simply requires that you enable patients to communicate with you through secure messaging and that you exchange at least one message during the reporting period. This feature is enabled through the secure messaging portal. For instructions on using the secure messaging portal, go to “Patient Electronic Access” on page 37.

Send a secure message to a patient (or a patient-authorized representative):

To send a message to the Patient Portal:

1. Open the provider portal and log in as the provider who saw the patient.

2. Click Compose.

3. Select or search for a patient.

4. Select Send to Portal and click OK.

5. Compose the Subject and Message.

6. Add attachments as needed.

7. Click Send.

Encourage your patients to log into the patient portal and send you a message. To download a flier to give to your patients, go to http://www.eyefinity.com/resource-center/meaningfuluse/meaningful-use-resources.html.

Responsible Role

Doctor
Technician
Front Desk

Audit Advice

Take a screenshot of the secure messaging portal enabled at the beginning of your attestation period. This will require an administrator to log in. Since this objective no longer measures how many messages you and your patients exchange, the auditors are likely to ask for proof that patient's had the ability to send you secure message.

If you plan to claim an eligible exclusion due to lack of broadband availability in the county you serve, document the lack of broadband access at the beginning of your attestation period. Go to the National Broadband Map website, and search for the county in which more than 50% of your patient encounters take place. If the
Objective 9  Use Secure Messaging
Audit Advice

map indicates that fewer than 50% of the housing units in the county have access to internet speeds of at least 4mbps, you may claim the eligible exclusion. Print the web page for your records. You can access the National Broadband Map online at http://www.broadbandmap.gov.
The objective of this measure is to submit electronic data to health registries except where prohibited, and in accordance with applicable law and practice.

Objective

You must report two of the following measures.

**NOTE**

In Stage 1 and 2, CMS used the term “ongoing submission” to describe registry interactions. This term has been replaced with “active engagement.” CMS defines active engagement as completing one of the following.

**Completed Registration to Submit Data.** The EP has registered to submit data with the public health agency (PHA) or, where applicable, the clinical data registry (CDR) to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP, eligible hospital, or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers who have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

**Testing and Validation.** The EP is in the process of testing and validating electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

**Production.** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.
Objective 10

Public Health

Alternatives

Measure 1: Immunization Registry Reporting

The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system.

Measure 2: Syndromic Surveillance Reporting

The EP is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs.

Measure 3: Specialized Registry Reporting

The EP is in active engagement to submit data to a specialized registry.

Alternatives

If you were scheduled to attest to Stage 1 in 2015, you may attest to one public health measure in 2015 only. After 2015, all providers must attest to two public health measures.

Exclusions

These eligible exclusions are available to all providers.

Exclusion for Measure 1: Immunization Registry Reporting

You may claim an eligible exclusion from immunization registry reporting if you meet any of the following criteria:

• You do not administer any immunizations to any of the populations for which data is collected by you jurisdiction’s immunization registry or immunization information system during the EHR reporting period; or
• You operate in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the certified EHR definition at the start of your EHR reporting period; or
• You operate in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from you at the start of the EHR reporting period.

Exclusion for Measure 2: Syndromic Surveillance Reporting

You may claim an eligible exclusion from syndromic surveillance reporting if you meet any of the following criteria:

• You do not treat or diagnose or directly treat any disease or condition associated with a syndromic surveillance system in your jurisdiction; or
• You operate in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific
standards required to meet the certified EHR definition at the start of the EHR reporting period; or

• You operate in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from you at the start of the EHR reporting period.

**Exclusion for Measure 3: Specialized Registry Reporting**

You may claim an eligible exclusion from case reporting if you meet any of the following criteria:

• You do not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in your jurisdiction during the EHR reporting period; or

• You operate in a jurisdiction for which no specialized registry is capable of receiving electronic registry transactions in the specific standards required to meet the certified EHR definition at the start of your EHR reporting period; or

• You operate in a jurisdiction where no specialized registry for which you’re eligible has declared readiness to receive electronic registry transactions at the start of the EHR reporting period.

This section is broken down by measure:

- **Measure 1: Immunization Registry Reporting, 49**
- **Measure 2: Syndromic Surveillance Reporting, 50**
- **Measure 3: Specialized Registry Reporting, 50**

**Measure 1: Immunization Registry Reporting**

If you administer immunizations, you can fulfill this measure in ExamWRITER. There are two parts to fulfilling this measure: recording the immunizations you administer and reporting the data to a local immunization registry.

- **Recording Patient Immunizations, 49**
- **Reporting Data to Immunization Registries, 49**

**Recording Patient Immunizations**

1. Open the patient’s Patient Information Center window in ExamWRITER.
2. Click **Immunization**.
3. Record vaccines that the patient has previously received and then click **Save**.
4. Click **Exit**.

**Reporting Data to Immunization Registries**

1. In OfficeMate/ExamWRITER Administration, click **Reports** from the main window toolbar.
2. Select **Immunization Registry**.
Objective 10
Public Health

Responsible Role

3. Record the sending and receiving facility information, the receiving application, and the reporting date range.
4. Click **Generate HL7 V2.3.1 Immunization Files**.
5. Send the immunization files in the DATA\eDocuments\ImmunizationRegistry folder to the specified receiving facility. The file names follow the format: VXU_V04_231_Patient ID_date

Measure 2: Syndromic Surveillance Reporting

1. In OfficeMate/ExamWRITER Administration, click **Reports** from the main window toolbar.
2. Select **Public Health Surveillance**.
3. Record the sending and receiving facility information, receiving application, reporting date range, and ICD-9 code being reported.
4. Click **Generate HL7 V2.3.1 Public Health Files**.
5. Send the public health files in the DATA\eDocuments\PublicHealth folder to the specified receiving facility. The file names follow the format: ADT_A28_231_Patient ID_date

Measure 3: Specialized Registry Reporting

At the time of this publication, CMS is developing the criteria for this measure.

Responsible Role

Doctor
Technician
Front Desk

Audit Advice

Since this measure is not percentage based, it does not appear in the CMS Meaningful Use Reporting window. It requires only a Yes/No attestation.

If you receive any confirmation for your submission, be it an email or a web page displaying a confirmation message, print it and save it with your other meaningful use documentation.
PART THREE
CLINICAL QUALITY MEASURES
Getting Started with Clinical Quality Measures

In this chapter:
- Minimum Requirements, 53
- Relationship with PQRS, 54
- Differences from 2011 Edition, 54
- Coding for CMS Quality Measures, 55
- Automating PQRS Codes, 55
- Reporting CMS Quality Measures, 56

For more information on CQMs, see the “Clinical Quality Measures (CQMs) 2014 Edition” series of recorded video tutorial.

This chapter explains the general requirements of the clinical quality measures (CQMs), how they relate to the Physician Quality Reporting System (PQRS), how to set up ExamWRITER to calculate your CQMs, and how to report CQMs. The following chapter explains the specific requirements for the supported CQMs.

NOTE
The 2014 Edition CQMs are calculated on a similar window as the 2011 Edition measures. The 2011 measure calculations are still available for historical purposes; however, all providers must attest to the 2014 Edition quality measures.

Minimum Requirements

You must report on nine clinical quality measures that cover at least three National Quality Strategy domains. ExamWRITER supports only those measures that apply to eyecare. For a complete explanation of these measures, go to “Fulfilling Clinical Quality Measures” on page 57.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Title</th>
<th>Quality Strategy Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0018</td>
<td>Controlling High Blood Pressure</td>
<td>Clinical Processes/Effectiveness</td>
</tr>
<tr>
<td>CMS 165</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS 236</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQF 0022</td>
<td>Use of High-Risk Medications in the Elderly</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>CMS 156</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS 238</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS 138</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS 226</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NQF 0055</td>
<td>Diabetes: Eye Exam</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS 131</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PQRS 117</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Getting Started with Clinical Quality Measures

Relationship with PQRS

Unlike the meaningful use measures, you do not need to meet a minimum threshold to fulfill the individual CQMs. In other words, you can report CQMs with low or zero percentages.

Some CQMs may also be used to satisfy Physician Quality Reporting System (PQRS) measures. The two programs, however, do not align exactly. For PQRS requirements, refer to the "Participating in the Physician Quality Reporting System" document.

Differences from 2011 Edition

All providers must attest to the 2014 Edition quality measures regardless of which stage of meaningful use they are fulfilling. While some of the clinical quality measures are the same as they were in previous editions, most of them are new.

You must report 9 of 64 approved 2014 Edition CQMs. Unlike the 2011 Edition, there is no required core set but rather, you must report on nine clinical quality measures that cover at least three National Quality Strategy domains.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Title</th>
<th>Quality Strategy Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0086 CMS 143 PQRS 12</td>
<td>Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0088 CMS 167 PQRS 18</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0089 CMS 142 PQRS 19</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0419 CMS 68 PQRS 130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>NQF 421 CMS 69 PQRS 128</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>NQF 0564 CMS 132 PQRS 192</td>
<td>Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>NQF 0565 CMS 133 PQRS 191</td>
<td>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS 50 PQRS 374</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Care Coordination</td>
</tr>
</tbody>
</table>
In order for ExamWRITER to correctly calculate CQM values, you must select the correct patient information, diagnosis codes, and procedure codes during an exam. Unless otherwise noted, all exams must have occurred within the past 12 months in order to be included in the calculation of CMS quality measure metrics.

Prior to coding exams for CQMs, you must enable autocoding. Always review the codes in the Diagnosis/Procedure Coding window and manually add codes and modifiers if necessary. You must deselect diagnoses that copy forward from prior exams if the diagnosis is no longer applicable; otherwise, those diagnoses will affect the denominators that are reported.

Automating PQRS Codes

Prior to coding exams for CQMs, you must enable autocoding.

This procedure tells you how to set up autocoding for PQRS codes. After you set up autocoding, all PQRS codes related to procedures and observations you select in ExamWRITER automatically populate in the Diagnosis/Procedure Coding window.

For more information on setting up automatic coding, see the “Auto PQRS” recorded video tutorial.

1. From the OfficeMate Administration main window, click Setup.
2. Select Insurance Setup.
   The Insurance Billing Initial Setup window opens.
3. Select an insurance carrier from the Carrier drop-down menu.
4. Click the Preferences tab.
5. Select the Yes radio button for the Automate PQRS setting to automatically apply PQRS codes on exams in ExamWRITER for patients who use the selected insurance carrier as their primary insurance carrier.
6. Click Save to save your changes.
Reporting CMS Quality Measures

The CMS Quality Reporting window calculates the numerator, denominator, exclusions, percentage, and reporting rate for quality measures. Use, use the percentages displayed in the window during your attestation to report your CQMs manually. The actual value of the percentage reported will not affect the incentive dollars for the EHR incentive program.

To display your CQM percentages, perform the following steps:

1. Select Reports from the main window toolbar, and then select CMS Quality Reporting 2014 Edition.
2. Select a measure from the Reporting Criteria list.
3. Select a date range from the Reporting From Date and Reporting Through Date fields.
4. Select a provider from the Provider drop-down menu.
5. Click Calculate to display your CQM metrics.
   The CMS Quality Reporting 2014 Edition window displays the numerator, denominator, and percentage for that quality measure.
6. Make a note of the information displayed.
7. Repeat steps 2–6 for each measure you’re reporting.
8. Enter the calculated numbers in the EHR Registration and Attestation System.

**NOTE** Eyefinity recommends closing OfficeMate/ExamWRITER on all workstations and performing these steps on the OfficeMate server.

**NOTE** You must report nine CQMs.

Reporting CQM Data Electronically

The CMS Quality Reporting window creates quality reporting data architecture (QRDA) documents in XML format that you can upload to a qualified registry and satisfy your CQM requirement for meaningful use.

To create the files you need to report your CQM data, perform the following steps:

1. Select Reports from the main window toolbar, and then select CMS Quality Reporting 2014 Edition.
2. Select the extent of reporting criteria that you want to view.
3. Select a date range from the Reporting From Date and Reporting Through Date fields.
4. Select a provider from the Provider drop-down menu.
5. Click Create QRDA Documents to generate the data files.
   An XML-based data file is created in the DATA\eDocuments folder. The file begins with the letters QRDA and has today’s date.
7. Follow the instructions given by the registry to upload your QRDA files.
Fulfilling Clinical Quality Measures

In this chapter:

• Controlling High Blood Pressure, 58
• Use of High-Risk Medications in the Elderly, 60
• Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, 61
• Diabetes: Eye Exam, 63
• Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, 65
• Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy, 67
• Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, 69
• Documentation of Current Medications in the Medical Record, 71
• Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up, 73
• Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures, 75
• Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery, 80
• Closing the Referral Loop: Receipt of Specialist Report, 86

For more information on CQMs, see the “Clinical Quality Measures (CQMs) 2014 Edition” series of recorded video tutorial.

This chapter explains which CMS clinical quality measures (CQMs) ExamWRITER tracks and how the numerator and denominator are calculated for each measure. These instructions are not intended to give you clinical advice on coding your exams, but rather describe how they are counted toward CQMs.
Fulfilling Clinical Quality Measures
Controlling High Blood Pressure

Unless otherwise noted, all exams must have occurred within the past 12 months in order to be included in the calculation of CMS quality measure metrics. Always review the codes in the Diagnosis/Procedure Coding window and manually add codes and modifiers if necessary. You must deselect diagnoses that copy forward from prior exams if the diagnosis is no longer applicable; otherwise, those diagnoses will affect the denominators that are reported.

<table>
<thead>
<tr>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Due to the nature of ExamWRITER’s autocoding feature, Level II CPT codes (PQRS codes) are required to complete some CQMs. ExamWRITER translates Level II CPT codes to the appropriate codes required for CMS reporting behind the scenes.</td>
</tr>
<tr>
<td>• For full lists of CPT, ICD, HCPCS, LOINC, RxNorm, SNOMED codes required by each CQM, go to <a href="http://bit.ly/ew2014cqm">http://bit.ly/ew2014cqm</a>. The lists are extensive and should only be used if you believe your CQMs are not calculating correctly.</td>
</tr>
</tbody>
</table>

Controlling High Blood Pressure

This section includes the following topics:

• Measure, 58
• Denominator, 58
• Numerator, 59
• Exclusions, 59
• Differences from Previous Editions, 59
• ExamWRITER Instructions, 59
• Audit Advice, 59

Measure

Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90mmHg) during the measurement period. This measure falls under the domain of Clinical Processes/Effectiveness.

Denominator

Patients aged 18 to 85 years

AND who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period:

I10
**Numerator**

Patients who are included in the denominator AND whose most recent blood pressure is adequately controlled during the measurement period:

- Diastolic blood pressure less than 90 mmHg
- Systolic blood pressure less than 140 mmHg

**Exclusions**

No exclusion.

**Differences from Previous Editions**

This measure is new to the 2014 Edition.

**ExamWRITER Instructions**

Screen the patient for high blood pressure:

1. In a patient’s exam record in ExamWRITER, record the office visit (992xx).
2. Click the **Exam - Special Tests** tab.
3. Click the yellow **Vital Signs** button.
4. Click your cursor in the **Blood Pressure** box, record the patient’s **Systolic**, **Diastolic**, and **Pulse** in the Blood Pressure/Pulse window, and click **Save/ Exit**.
5. Record a diagnosis that indicates essential hypertension.
6. When the patient returns to your practice, record the office visit and blood pressure once again. A BP less than 140/90mmHg will count toward the numerator.

**Audit Advice**

By recording blood pressure for any of your patients, the auditors may interpret that as conceding the measurement is within the scope of your practice, and therefore, ineligible for the exclusion. If you claim an exclusion and are later audited, you may need to explain any blood pressure measurements that you recorded during your reporting period.

The calculator includes historical data. If your practice used to record blood pressure, that information still resides in your patient records and is picked up by the calculator. If you are audited, you may be asked to provide a letter stating that you used to collect blood pressure, but you no longer do so because it is irrelevant to your scope of practice.
Use of High-Risk Medications in the Elderly

This section includes the following topics:

- Measure, 60
- Denominator, 60
- Numerator, 60
- Exclusions, 61
- Differences from Previous Editions, 61
- ExamWRITER Instructions, 61

**Measure**

Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported:

- Percentage of patients who were ordered at least one high-risk medication
- Percentage of patients who were ordered at least two different high-risk medications

This measure falls under the domain of Patient Safety.

**Denominator**

Patients aged 66 years or older AND who had a visit during the measurement period.

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397, G0438, G0439

**Numerator**

Patients who are included in the denominator AND who have an order for (a) at least one high-risk medication or (b) at least two different high-risk medications during the measurement period.

**Exclusions**

No exclusion.
Differences from Previous Editions

This measure is new to the 2014 Edition.

ExamWRITER Instructions

Order high-risk medications:

1. In a patient's exam record in ExamWRITER, record the office visit (992xx).
2. Press F6 to open the Medication Order window.
3. If you are using the ExamWRITER ePrescribing Interface, follow the instructions below; otherwise, go to step 4. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm.
   a. Click the eRX icon.
   b. Click the Pharmacy link to select the pharmacy where you want to send the patient's medication order.
   c. Click Prescribe in the main navigation bar.
   d. Search for and select a medication.
   e. Select the appropriate option to send and print the order.
4. If you are using the Medication Order window in ExamWRITER, follow the instructions below:
   a. Click Save Med. Order to add the medication order to the Current Therapeutic Rx table.
   b. Click Print w/Sig/Exit or Print no Sig/Exit to print the medication order and exit the window.

Patients with high-risk medication orders will count toward the numerator. To review CMS' extensive list of high-risk medications, go to http://bit.ly/hi-risk-med.

This section includes the following topics:

- Measure, 62
- Denominator, 62
- Numerator, 62
- Exclusions, 63
- Differences from Previous Editions, 63
- ExamWRITER Instructions, 63
Fulfilling Clinical Quality Measures
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user. This measure falls under the domain of Population/Public Health.

Denominator

Patients aged 18 years or older

AND one of these exams within 24 months:
99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429

OR two or more of these exams within 24 months (may have two of the same exam):
90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Numerator

Patients who are included in the denominator

AND tobacco users with a social history recorded with one of the following SNOMED codes:
77176002, 160603005, 266919005, 449868002, 428041000124106, 428061000124105, 428071000124104

AND have a CPT code of 1036F or 4004F

OR are not tobacco users with a social history recorded in any exam within 24 months of any exams that were performed during the reporting period with one of the following SNOMED codes:
8517006, 266919005

Exclusions

No exclusion.

Differences from Previous Editions

All smokers are counted in one calculation and restrictions. Several code choices have been added, including light and heavy smoker
ExamWRITER Instructions

Screen the patient for tobacco use:

1. In a patient’s exam record in ExamWRITER, record the office visit (99201).
2. Click the Patient Hx - ROS tab.
3. Click the Patient History category bar.
5. Record the patient’s tobacco use status using the check box at the top of the Social History window or the radio buttons in the Tobacco Use [MU] box.
6. If the patient is a tobacco user, you must select the patient’s tobacco use and either the Counseling Intervention Recommended or Pharmaceutical Intervention Recommended check box.
7. If you counseled the patient, select the amount of time from the Patient Counseling radio buttons.
8. Click Process.

Diabetes: Eye Exam

This section includes the following topics:

- Measure, 64
- Denominator, 64
- Numerator, 64
- Exclusions, 65
- Differences from Previous Editions, 65
- ExamWRITER Instructions, 65

Measure

Percentage of patients 18 to 75 years of age with diabetes who had a retinal or dilated eye exam by an eyecare professional during the reporting period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the reporting period. This measure falls under the domain of Clinical Process/ Effectiveness.

NOTE

Review the specifications, listed below, for this measure. 92xxx codes will not count toward this measure; only the 992xx and 993xx codes listed count.
**Fulfilling Clinical Quality Measures**

**Diabetes: Eye Exam**

**Denominator**

Patients aged 18 to 75

AND one of these exams within the reporting period:

- 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385, 99386, 99387, 99395, 99396, 99397

AND are diagnosed with type 1 or type 2 diabetes:


**Numerator**

Patients who are included in the denominator

AND have at least one exam during the reporting period that has one of the following procedure codes:

- 2022F, 2024F, 2026F, 3072F

**Exclusions**

No exclusion.

**Differences from Previous Editions**

This measure is new to the 2014 Edition.

**ExamWRITER Instructions**

Screen the patient for diabetes:

1. In a patient's exam record in ExamWRITER, record the office visit (992xx).
2. Click the **Exam - Special Tests** tab.
3. Click the Examination category bar.
4. Select the Retina - Vascular check box and click Process.
5. On the Retina/Vascular window, select the check boxes that correspond to the patient's condition, select an eye, and click Process:
   - DFE performed (Diabetic Patient)
6. On the Impression/Retna-Vascular window, select the check boxes that correspond to the patient's condition and click Process:
   - DM, Type I w/ Complications
   - Diabetes, Type II w/ Complications
   - Low Risk Retinopathy

This section includes the following topics:
- Measure, 66
- Denominator, 66
- Numerator, 66
- Exclusions, 66
- Differences from Previous Editions, 66
- ExamWRITER Instructions, 67

**Measure**

Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during two or more office visits within 12 months. This measure falls under the domain of Clinical Process/Effectiveness.

**NOTE**

Although the description provided by CMS, indicated one or more office visits, the specification CMS published under CMS143v2 requires two or more office visits.

**Denominator**

Patients aged 18 years or older
AND two or more of these exams (may have two of the same exam):

92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305,
Fulfilling Clinical Quality Measures
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

99306, 99307, 99308, 99309, 99310, 99324, 99326, 99327, 99328, 99334, 99335, 99336, 99337

AND is diagnosed with POAG:

Numerator
This level II procedure code:
2027F

Exclusions
This level II procedure code and modifier:
2027F with 1P

Differences from Previous Editions
No changes from previous editions.

ExamWRITER Instructions
Evaluate the optic nerve head:
1. In a patient’s exam record in ExamWRITER, record the office visit (920xx).
2. Click the Exam - Special Tests tab.
3. Click the Examination category bar.
4. Select the Glaucoma or Glaucoma Suspect check box, select an eye, and click Process.
5. Select the appropriate check boxes on the Evaluation, Impression, and Treatment windows.
6. If you only selected the Glaucoma Suspect check box in step 4, you may also need to document the optic nerve in order for 2027F to autocode:
   a. In the Examination window, select the Optic Nerve check box, select an eye, and click Process.
   b. Select the OPTIC NERVE, Impression, and Treatment check boxes, select an eye, click Process, and document the conditions appropriately in each window.
7. Record a CD Ratio in the Examination category.
### Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

This section includes the following topics:
- **Measure**, 67
- **Denominator**, 68
- **Numerator**, 68
- **Exclusions**, 68
- **Differences from Previous Editions**, 68
- **ExamWRITER Instructions**, 69

### Measure

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months. This measure falls under the domain of Clinical Process/Effectiveness.

### Denominator

Patient aged 18 years or older

AND is diagnosed with diabetic retinopathy:


AND two or more of these exams (may have two of the same exam):

- 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

### Numerator

This LOINC:

- 32451-7

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### Table

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Exclusions

Any of the following SNOMED codes indicating why the macular exam was not performed:

Medical reason: 161590003, 183932001, 183964008, 183966005, 216952002, 266721009, 269191009, 274512008, 31438003, 35688006, 371133007, 397745006, 407563006, 410534003, 410536001, 416098002, 416406003, 428119001, 445536004, 59037007, 62014003, 79899007

OR

Patient reason 105480006, 160932005, 160934006, 182890002, 182895007, 182897004, 182900006, 182902003, 183944003, 183945002, 184081006, 185479006, 185481008, 224187001, 225928004, 258147002, 266710000, 266966009, 275694009, 275936005, 281399006, 310343007, 373787003, 385648002, 406149000, 408367005, 413310006, 413311005, 413312003, 416432009, 423656007, 424739004, 443390004, 5015009

Differences from Previous Editions

No changes from previous editions.

ExamWRITER Instructions

Examine the macula and fundus:

1. In a patient's exam record in ExamWRITER, record the office visit (920xx or 992xx).
2. Click the Exam - Special Tests tab.
3. Click the Examination category bar.
4. Select the Retina - Vascular check box, select an eye, and click Process.
5. On the Retina/Vascular window, select the check boxes that correspond to the patient's condition and click Process:
   - DEF performed (Diabetic Patient)
   - Macular edema WNI or Edema
   - Macular elevation
6. On the Impressions window, select the check boxes that correspond to the patient's condition, select an eye, and click Process:
   - Indicate diabetes if applicable.
   - Select one of the options under Retinopathy, Background
   - Select a severity from the fourth column even if indicated in the retinopathy selection.
7. On the Treatment window, indicate whether dilation was performed or not.
8. Select PCP report (for NQF 0089) and click Process.
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

This section includes the following topics:

- Measure, 70
- Denominator, 70
- Numerator, 70
- Exclusions, 70
- Differences from Previous Editions, 70
- ExamWRITER Instructions, 71

Measure

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months. This measure falls under the domain of Clinical Process/Effectiveness.

Denominator

Patient aged 18 years or older

AND is diagnosed with diabetic retinopathy:


AND two or more of these exams (may have two of the same exam):

92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Numerator

Must have the following CPT II and G-codes:

- 5010F and G8397
Fulfilling Clinical Quality Measures

Documentation of Current Medications in the Medical Record

Exclusions

This level II procedure code and modifier:

- 5010F with 1P
- OR
- 5010F with 2P

Differences from Previous Editions

No changes from previous editions.

ExamWRITER Instructions

Send a letter to the provider about macular or fundus exam findings:

1. Follow the instructions for “Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy” on page 67.
2. In the TREATMENT RETINA - VASCULAR window, Select the Diabetes Managing Provider Report (5010F) check box and one of the following check boxes:
   - Document Dilation and DR & ME: Dilation performed with retinopathy and macular edema report (G8397)
   - Document No Dilated Exam: Dilated macular or fundus exam not performed (G8398)
3. Click Process.
4. Click the Print icon in the ExamWRITER chart window.
5. Select Auto Letter [MU, QRM] from the drop-down menu and print a letter to the patient’s primary care physician.

NOTE

The autoletter must be printed the same day as the exam.

This section includes the following topics:

- Measure, 71
- Denominator, 72
- Numerator, 72
- Exclusions, 72
- Differences from Previous Editions, 72
- ExamWRITER Instructions, 72
Fulfilling Clinical Quality Measures

Documentation of Current Medications in the Medical Record

Measure

Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements, and must contain the medications’ name, dosage, frequency, and route of administration. This measure falls under the domain of Patient Safety.

Denominator

Patients aged 18 years or older

AND one of these exams:

90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92543, 92544, 92545, 92547, 92548, 92557, 92558, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99338, 99339, 99340, 99341, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Numerator

Patients who are included in the denominator

AND has at least one exam during the reporting period (920xx or 992xx)

AND has one of the following codes:

G8427, G8428, G8430

NOTE

The following codes denotes the completeness of the current medication list:

- **G8427.** The documented medication information is current, accurate, and complete.
- **G8428.** The current medications are not documented, no reason given.
- **G8430.** The patient is not eligible for medication documentation.

Exclusions

No exclusion.

Differences from Previous Editions

This measure is new to the 2014 Edition.
ExamWRITER Instructions

Document G8427 or G8428:
1. In a patient’s exam record in ExamWRITER, record the office visit (92002).
2. Click the Patient Hx - ROS tab.
3. Click the Patient History category bar.
5. Select the Systemic or Ocular radio button to record history associated with those areas.
6. Double-click the medication name in the table at the top of the window.
7. Type the dosage, strength, and route in the Notes column.
8. Select the Verified Medications or Meds listed, not verified radio button.

NOTE If you don’t see these radio buttons, auto-PQRS is not enabled for the patient’s insurance carrier.

9. Click Save.

Or document G8430:
1. In a patient’s exam record in ExamWRITER, click the Patient Hx - ROS tab.
2. Click the Patient History category bar.
4. Select Patient is Ineligible for Medication Assessment and click Process.

This section includes the following topics:

- Measure, 73
- Denominator, 74
- Numerator, 74
- Exclusions, 75
- Differences from Previous Editions, 75
- ExamWRITER Instructions, 75

NQF 0421
CMS 69
PQRS 128
Measure

Percentage of patients with a documented BMI during the encounter or during the previous six months, and when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Two age groups are reported:

a. Percentage of patients 18–64 years of age with a measured BMI ≤ 18.5 and > 25 kg/m²
b. Percentage of patients 65 years of age and older with a measured BMI ≤ 23 and > 30 kg/m²

This measure falls under the domain of Population/Public Health.

Denominator

Patients who had a visit during the measurement period:

90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

AND fall under one of the following age groups:

a. Age 18–64 years
b. Age 65 years and older

BUT NOT encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.

Numerator

**Group A:** Patients 18–64 years of age

AND a measured BMI within normal parameters (between 18.5 and 25 kg/m²)

OR a measured BMI outside normal parameters (below 18.5 or higher than 25 kg/m²)

AND counseling coded with the following diagnosis code:

Z71.3

OR the following procedure codes:

43644, 43645, 43770, 43771, 43772, 43773, 43842, 43843, 43845, 43846, 43847, 43848, 97804, 98960, 99078

OR the following SNOMED codes:

30459008, 307818003, 361231003, 370847001, 386291006, 386292004, 386373004, 386463000, 386464006, 410177006, 413315001, 418995006, 424753004, 429095004, 443288003
Fulfilling Clinical Quality Measures
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

OR

**Group B:** Patients 65 years of age and older
AND a measured BMI within normal parameters (between 23 and 30 kg/m²)
OR a measured BMI outside normal parameters (below 23 and higher than 30 kg/m²)
AND counseling coded with the following diagnosis code:
Z71.3
OR the following procedure codes:
43644, 43645, 43770, 43771, 43773, 43774, 43842, 43843, 43845,
43846, 43847, 43848, 97804, 98960, 99078
OR the following SNOMED codes
304549008, 307818003, 361231003, 370847001, 386291006, 386292004,
386373004, 386463000, 386464006, 410177006, 413315001, 418995006,
424753004, 429095004, 443288003

**Exclusions**

No exclusion.

**Differences from Previous Editions**

This measure is new to the 2014 Edition.

**ExamWRITER Instructions**

Screen the patient for BMI:

1. In a patient's exam record in ExamWRITER, record the office visit (990xx or 992xx).
2. Click the Exam - Special Tests tab.
3. Click the yellow Vital Signs button.
4. Click your cursor in the Height (inches) box, record the patient's height in the Height window, and click Save/Exit.
5. Click your cursor in the Weight (pounds) box, record the patient's height in the Weight window, and click Save/Exit.
6. If the patient's BMI is outside the normal range for his or her age group, Record a procedure that indicates weight counseling.
Fulfilling Clinical Quality Measures

Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

This section includes the following topics:

- Measure, 76
- Denominator, 76
- Numerator, 79
- Exclusions, 79
- Differences from Previous Editions, 79
- ExamWRITER Instructions, 80

Measure

Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence. This measure falls under the domain of Patient Safety.

Denominator

All patients aged 18 years and older who had cataract surgery and no significant preoperative ocular conditions impacting the surgical complication rate.

66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

BUT NOT any of the following active diagnoses before the cataract surgery:

Acute and Subacute Iridocyclitis


Adhesions and Disruptions of Iris and Ciliary Body


Anomalies of Puillary Function

H57.03

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Fulfilling Clinical Quality Measures

Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Aphakia and other Disorders of Lens

H27.10, H27.111, H27.112, H27.113, H27.119, H27.121, H27.122, H27.123, H27.129, H27.131, H27.132, H27.133, H27.139

Burn Confined to Eye and Adnexa


Cataract Secondary to Ocular Disorders


Cataract, Congenital

Q12.0

Cataract, Mature or Hypermature

H26.9

Cataract, Posterior Polar

Q12.0

Central Corneal Ulcer


Certain Types of Iridocyclitis


Chronic Iridocyclitis

A18.54, H20.10, H20.11, H20.12, H20.13, H20.9

Cloudy Cornea

H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829

Corneal Edema


Corneal Opacity and other Disorders of Cornea

H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9

Cysts of Iris, Ciliary Body, and Anterior Chamber


Enophthalmos

H05.401, H05.402, H05.403, H05.409, H05.411, H05.412, H05.413, H05.419, H05.421, H05.422, H05.423, H05.429
Fulfilling Clinical Quality Measures

Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Glaucoma


Hereditary Corneal Dystrophies


High Hyperopia

- H52.00, H52.01, H52.02, H52.03

Hypotony of Eye

- H44.40, H44.411, H44.412, H44.413, H44.419, H44.421, H44.422, H44.423, H44.429, H44.431, H44.432, H44.433, H44.439, H44.441, H44.442, H44.443, H44.449

Injury to Optic Nerve and Pathways

Fulfilling Clinical Quality Measures
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional
Open Wound of Eyeball
S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA,
S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA,
S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA,
S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Pathologic Myopia
H44.20, H44.21, H44.22, H44.23, H44.30
Posterior Lenticous
Q12.2, Q12.4, Q12.8
Pseudoexfoliation Syndrome
H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420,
H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431,
H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492,
H40.1493, H40.1494
Retrolental Fibroplasias
H35.171, H35.172, H35.173, H35.179
Senile Cataract
H25.89
Traumatic Cataract
H26.133, H26.139
Uveitis
H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133,
H44.139
Vascular Disorders of Iris and Ciliary Body
NOR an active medication with any of the following RxNorm codes:
197625, 197626, 197627, 197628, 198141, 199799, 260376, 312481,
312482, 312483, 312593, 312594, 313215, 313217, 313219, 636360,
636361, 861132, 861402, 863669, 996097, 1088455, 1100691
Numerator
Patients who had one or more specified operative procedures for any of the
following major complications within 30 days following cataract surgery: retained
nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal
detachment, or wound dehiscence:
65235, 65900, 65920, 65930, 66250, 67005, 67010, 67015, 67025, 67028,
67030, 67031, 67036, 67039, 67041, 67042, 67043, 67101, 67105, 67107,
67108, 67110, 67112, 67141, 67145, 67250, 67255
Fulfilling Clinical Quality Measures
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Exclusions
No exclusion.

Differences from Previous Editions
This measure is new to the 2014 Edition.

ExamWRITER Instructions
1. In a patient's exam record in ExamWRITER, click the Surgery - Plan - Mgmt tab.
2. Click the Surgery category bar.
3. On the Surgery window, select the check boxes that correspond to the patient's condition and click Process:
   - Cataract - 6698x
   - IOL, secondary - 6698x
4. Select the appropriate procedures and click Process.
5. If the patient returns within 30 days, record a second surgical procedure (for example, foreign body removal).

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This section includes the following topics:
- Measure, 80
- Denominator, 80
- Numerator, 85
- Exclusions, 85
- Differences from Previous Editions, 86
- ExamWRITER Instructions, 86

Measure
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery. This measure falls under the domain of Clinical Process/Effectiveness.
Fulfilling Clinical Quality Measures
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Denominator

All patients aged 18 years and older who had cataract surgery that was performed during the reporting period, but at least 90 days before the end of the reporting period.

66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

BUT NOT any of the following active diagnoses before the cataract surgery:

- Acute and Subacute Iridocyclitis

- Amblyopia

- Burn Confined to Eye and Adnexa

- Cataract Secondary to Ocular Disorders

- Central Corneal Ulcer

- Certain Types of Iridocyclitis

- Chorioretinal Scars

- Choroidal Degenerations
  - H35.33

- Choroidal Detachment

- Chronic Iridocyclitis
  - A18.54, H20.10, H20.11, H20.12, H20.13, H20.9

- Cloudy Cornea
  - H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Fulfilling Clinical Quality Measures
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Corneal Edema

Corneal Opacity and other Disorders of Cornea
H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9

Degeneration of Macula and Posterior Pole

Degenerative Disorders of Globe
H44.20, H44.21, H44.22, H44.23, H44.311, H44.312, H44.313, H44.319, H44.321, H44.322, H44.323, H44.329, H44.391, H44.392, H44.393, H44.399

Diabetic Macular Edema

Diabetic Retinopathy

Disorders of Optic Chiasm
H47.41, H47.42, H47.43, H47.49

Disorders of Visual Cortex
H47.611, H47.612, H47.619

Disseminated Chorioretinitis and Disseminated Retinochoroiditis

Focal Chorioretinitis and Focal Retinochoroiditis

Glaucoma
H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211,
Fulfilling Clinical Quality Measures
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery


Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes

H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

Hereditary Choroidal Dystrophies

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Hereditary Corneal Dystrophies

Fulfilling Clinical Quality Measures
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

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**Numerator**

Patients with a physical exam finding best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery from the denominator.
Fulfilling Clinical Quality Measures
Closing the Referral Loop: Receipt of Specialist Report

Exclusions
No exclusion.

Differences from Previous Editions
This measure is new to the 2014 Edition.

ExamWRITER Instructions
1. In a patient's exam record in ExamWRITER, click the Surgery - Plan - Mgmt tab.
2. Click the Surgery category bar.
3. On the Surgery window, select the check boxes that correspond to the patient's condition and click Process:
   - Cataract - 6698x)
   - IOL, secondary - 6698x
4. Select the appropriate procedures and click Process.
5. If the patient returns within 90 days, record a second exam.
6. If the patient's visual acuity is 20/40 or better, manually code 4175F

Closing the Referral Loop: Receipt of Specialist Report

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Measure
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred. This measure falls under the domain of Care Coordination.

Denominator
Number of patients, regardless of age, who had a visit during the reporting period and were referred to another provider.
Fulfilling Clinical Quality Measures
Closing the Referral Loop: Receipt of Specialist Report

Numerator
Number of patients who were referred to another provider and for whom a report was received from the referred provider.

Exclusions
No exclusion.

Differences from Previous Editions
This measure is new to the 2014 Edition.

ExamWRITER Instructions
Record the referral to another provider:
1. In a patient’s exam record in ExamWRITER, record the office visit (92xxx or 99xxx).
2. Click Patient Hx.
3. Click the Exam Hx tab and click New Referral.
4. Select the Referring Provider, Refer to Provider, Reason, SNOMED, Referral Date, and Expected Return Date and click Save.
5. Click Create CDA Transition of Care and click Exit.

When the patient returns, attach the report received from the referred provider:
1. Open the patient’s exam.
2. Click Patient Hx.
3. Click the eDocuments tab.
4. Click Show eDocs.
5. Click Add.
6. Select Receipt of Specialist Report from the Document Type drop-down menu.
7. Scan the physical report or browse for an electronic file received from the referred provider.
8. Click **Save/Exit**.

| NOTE | Attaching the report with ECR Vault does not advance the numerator at this time. You must attach it using eDocs. |
Fulfilling Clinical Quality Measures
Closing the Referral Loop: Receipt of Specialist Report
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