Achieving Meaningful Use Stage 2 with AcuityLogic/ExamWRITER

October 2015
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PART ONE
STAGE 2 OVERVIEW
Getting Started

In this chapter:
- Understanding the Differences between Stage 1 and Stage 2, 3
- Beginning Stage 2, 5
- Registering for the Medicare and Medicaid EHR Incentive Programs, 6
- Finding the AcuityLogic/ExamWRITER Certification Number, 7
- Reporting Meaningful Use, 7
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OfficeMate/ExamWRITER v11.1 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 v11.1 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).

AcuityLogic version 3.3 has achieved ONC HIT 2014 Edition Modular 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 v11.1 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).

Understanding the Differences between Stage 1 and Stage 2

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. You must complete two years of Stage 1 before you can begin Stage 2.

Stage 2 is a graduation from Stage 1 and requires the use of additional functionality and additional reporting intended to lead to greater interoperability. Stage 2 builds on your knowledge of Stage 1. Refer to the following sections for an overview Stage 2:
- Measures, 4
- Exclusions, 4
- Further Information, 4
Chapter 1
Understanding the Differences between Stage 1 and Stage 2

Measures

There are many differences between Stage 1 and Stage 2, but there are also many similarities. Like Stage 1, Stage 2 is broken up into three types of measures:

- **Core measures.** There are 17 core set measures that must be completed to successfully attest to meaningful use. Many of these measures will be familiar to you from Stage 1, but they have higher thresholds.
- **Menu measures.** There are 6 menu set measures, of which you must satisfy 3. Many of the menu measures are new to Stage 2.
- **Clinical quality measures.** There are 64 clinical quality measures (CQMs), of which you must satisfy 9. There are only 9 CQMs applicable to eyecare, and only those measures are supported in AcuityLogic/ExamWRITER.

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.

Exclusions

You may satisfy some measures 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.

In reporting periods prior to 2014, you could select menu measures that fell outside of your scope of practice specifically to claim the exclusion and count the measures toward your requirement.

Starting in 2014, you can still claim an exclusion from certain measures that are outside of your scope of practice; however, you must first select menu measures that you can fulfill without exclusion. Only after you have exhausted all attainable menu measures, can you satisfy a menu measure by exclusion.

Further Information

This document helps you understand the core set, menu set, and clinical quality measures and exclusions in the EHR Incentive Program. It also shows you how to achieve meaningful use and be eligible for incentive money through the functions in AcuityLogic/ExamWRITER. For more detailed information about the EHR Incentive Program's measures, and for information about registering for the program and submitting attestation documents, go to www.cms.gov/EHRIncentivePrograms.
Beginning Stage 2

With the introduction of Stage 2 in 2014 and Stage 3 in 2017, determining which stage to implement and for how long can be a confusing task.

NOTE

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 AcuityLogic/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.
Use the table below to determine when you need to graduate to Stage 2 and Stage 3. 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.

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1 Only three months of meaningful use were required in 2014.

Registering for the Medicare and Medicaid EHR Incentive Programs

You registered for the EHR Incentive Program before you began Stage 1. You do not need to register again.

For more information about the registration and attestation process, go to the Registration and Attestation EHR Incentives Programs page on the CMS Web site: http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp.
An EHR Certification Number is not required when you initially register for Medicare and Medicaid EHR Incentive Program, but is required when you reach the attestation stage. You will need to look up this number each year that you attest.

1. Go to the Certified Health IT Product List: http://oncchpl.force.com/ehrcert
3. Click Ambulatory Practice Type.
4. Type OfficeMate in the Search for text box in the center of the page and click Search.
5. In the search result displaying your versions of OfficeMate/ExamWRITER, click Add to Cart.
6. Type AcuityLogic in the Search for text box in the center of the page and click Search.
7. In the search result displaying your version of AcuityLogic, click Add to Cart.
8. AcuityLogic/ExamWRITER are eligible to meet 100% of the criteria, but if you are using other components to meet portions of the criteria, search for those products and add them to your cart.

<table>
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<th>NOTES</th>
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<tr>
<td>• You do not need to add DrFirst as components in your cart. ONC already knows that you need to use those components with OfficeMate to achieve meaningful use.</td>
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<tr>
<td>• If you migrated from another certified EHR to AcuityLogic/ExamWRITER during your reporting period, or if you upgraded from one certified version of AcuityLogic/ExamWRITER to another (e.g., from v11.1 to v11.2), you will need to add both certified products to your cart.</td>
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9. Click View Cart.
10. Click the Get CMS EHR Certification ID button.
11. Write down or copy the EHR Certification Number that appears in bold in the middle of the page and return to the Medicare and Medicaid EHR Incentive Program to enter or paste the number in the registration or attestation pages.

Reporting Meaningful Use

AcuityLogic/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.
Chapter 1
Getting Started
Reporting Meaningful Use

The CMS Meaningful Use Reporting window in ExamWRITER and the Meaningful Use Reporting page in AcuityLogic helps ensure you qualify for the incentive payments. You must meet all of the core measures and three of the menu measures. A permissible exclusion can count as having met the objective; however, you are not permitted to count exclusions toward the minimum requirement of meeting three menu set measures if there are other menu set measures that you can meet.

Gathering Information from ExamWRITER

1. Select Reports from the main window toolbar, and then select CMS Meaningful Use Reporting.
2. Select a Meaningful Use Criteria line from the left column. 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.
Chapter 1

Getting Started

Reporting Meaningful Use

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

Gathering Information from AcuityLogic

1. Click **Correspondence** in the AcuityLogic BackOffice application and then select **Stage 2 Reporting [MU]**.

2. Select **Patient Reminders** from the **Meaningful Use Criteria** drop-down menu.

   The description appears in the window.

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 populate the Calculated Values fields. The calculated values are displayed in the Numerator, Denominator, and Percentage fields.
Chapter 1

Getting Started
Reporting Meaningful Use

Attesting to Meaningful Use


For information about your EHR certification number, go to “Finding the AcuityLogic/ExamWRITER Certification Number” on page 7.
Preparing for an Audit

In this chapter:
- Providing Proof of Possession, 11
- Demonstrating the 80% of Unique Patients Requirement, 12
- Documenting the Core and Menu Set Measures, 13
- Documenting the Clinical Quality Measures, 13

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

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 Stage 1. It is routinely reviewed and updated as the auditors ask new questions.

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.
Chapter 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.
Chapter 2
Preparing for an Audit
Documenting the Core and Menu Set Measures

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.

Documenting the Core and Menu Set Measures

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 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 the Core and Menu Set Measures” on page 13. This time, go to the CMS Quality Reporting window.
Documenting the Clinical Quality Measures
PART TWO
CORE MEASURES
CPOE for Medication, Laboratory, and Radiology Orders

In this chapter:
- Measure, 17
- Exclusion, 17
- Differences from Stage 1, 17
- ExamWRITER Instructions, 17
- Responsible Role, 18
- Audit Advice, 19

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.

Measure

More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion

You may be eligible to claim an eligible exclusion from this measure if you write fewer than 100 medication, radiology, or laboratory orders during your EHR reporting period.

Differences from Stage 1

When compared to Stage 1 core set measure 1, this measure raises the percentage of CPOE for medication orders from 30 to 60% and adds the requirement for lab and radiology orders.

ExamWRITER Instructions

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

- Ordering Medications, 17
- Ordering Lab and Radiology Tests, 18

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,
CPOE for Medication, Laboratory, and Radiology Orders

Responsible Role

Doctor

Technician

Scribe


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. 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.

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.
Audit Advice

Be sure to deselect the **Entered Using CPOE** check box if the order was handwritten.
Core Measure 1
CPOE for Medication, Laboratory, and Radiology Orders
Audit Advice
ePrescribing (eRx)

In this chapter:
- Measure, 21
- Exclusion, 21
- Differences from Stage 1, 21
- ExamWRITER Instructions, 21
- Responsible Role, 22
- Audit Advice, 22

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

Measure

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.

Exclusion

If you meet one or more of the following criteria, you may claim an eligible exclusion from this measure:
- 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.

Differences from Stage 1

When compared to Stage 1 core set measure 4 and menu set measure 1, this measure raises the percentage of electronic prescriptions from 40 to 50% and requires drug-formulary checking.

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.
Core Measure 2  ePrescribing (eRx)

Responsibility Role

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

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.
Record Demographics

In this chapter:

- Measure, 23
- Exclusion, 23
- Differences from Stage 1, 23
- AcuityLogic/ExamWRITER Instructions, 23
- Responsible Role, 24

The objective of this measure is to record the following demographics:

- Preferred language
- Sex
- Race
- Ethnicity
- Date of birth

Measure

More than 80% of all unique patients seen by the EP have demographics recorded as structured data.

Exclusion

No exclusion.

Differences from Stage 1

When compared to Stage 1 core set measure 7, this measure raises the percentage of patients with recorded demographics from 50 to 80%.

AcuityLogic/ExamWRITER Instructions

Verify each patient’s demographics information when the patient schedules an appointment and when the patient checks out to ensure a 100% satisfaction rate for this measure.

1. Open the patient’s profile in the AcuityLogic POS application.
2. Select the patient’s gender from the Gender drop-down menu.
3. Type the patient’s date of birth in the Birth Date text box.
4. Click Other Information.
5. Select the patient’s ethnicity from the Ethnicity drop-down menu.
Core Measure 3

Record Demographics

Responsible Role

6. Select the patient’s race from the **Race** drop-down menu.

7. Select the patient’s preferred language from the **Preferred Language** drop-down menu.

8. Click **Save**.

9. Click **Return**.

**NOTE**: Select “Decline to State” only if the patient refuses to disclose his or her race or ethnicity.

Responsible Role

Front Desk
Record Vital Signs

In this chapter:

- Measure, 25
- Exclusion, 25
- Differences from Stage 1, 26
- ExamWRITER Instructions, 26
- Responsible Role, 26
- Audit Advice, 26

The objective of this measure is to record and chart changes in the following vital signs:

- Record height/length and weight (no age limit)
- Record blood pressure (ages 3 and over)
- Calculate and display body mass index (BMI)
- Plot and display growth charts for patients 0–20 years, including BMI

Measure

More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.

Exclusion

If you meet one or more of the following criteria, you may claim an eligible exclusion from this measure:

- If you see no patients 3 years or older, you are excluded from recording blood pressure;
- If you believe that all three vital signs of height/length, weight, and blood pressure have no relevance to your scope of practice, you are excluded from recording them;
- If you believe that height/length and weight are relevant to your scope of practice, but blood pressure is not, you are excluded from recording blood pressure; or
- If you believe that blood pressure is relevant to your scope of practice, but height/length and weight are not, you are excluded from recording height/length and weight.
Core Measure 4 | Record Vital Signs

Differences from Stage 1

When compared to Stage 1 core set measure 8, this measure raises the percentage of vital sign recordings from 50 to 80%. This measure also raises the age threshold from 2 to 3 years (same as 2013) and allows an exclusion from height and weight only; blood pressure only; or all three, height weight, and blood pressure, if they are not applicable to the EP’s scope of practice (same as 2013).

ExamWRITER Instructions

1. Open a patient’s exam record in ExamWRITER.
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 weight in the Weight window, and click Save/Exit.
6. Click your cursor in the Blood Pressure box, record the patient’s blood pressure in the Blood Pressure/Pulse window, and click Save/Exit.
   The BMI is automatically calculated for you next to the BMI box.
7. Click the Growth Chart buttons to view height, weight, and BMI growth charts for children 3–20 years.

If you believe that height and weight or blood pressure (or all three) are not relevant to your scope of practice, do not record the items from which you are claiming an exclusion.

Responsible Role

Doctor
Technician

Audit Advice

If you believe certain vital signs are not relevant to your scope of practice, you may claim an eligible exclusion from

- height and weight;
- blood pressure; or
- height, weight, and blood pressure.

By recording the vital signs 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 vital signs that you recorded during your reporting period.

The calculator includes historical data. If your practice used to record vital signs, 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 vital signs but you no longer do so because vital signs are irrelevant to your scope of practice.
Record Smoking Status

In this chapter:
- Measure, 27
- Exclusion, 27
- Differences from Stage 1, 27
- ExamWRITER Instructions, 27
- Responsible Role, 28

The objective of this measure is to record smoking status for patients 13 years old or older.

**Measure**

More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

**Exclusion**

You may be eligible to claim an eligible exclusion from this measure if you neither see nor admit any patients 13 years old or older.

**Differences from Stage 1**

When compared to Stage 1 core set measure 9, this measure raises the percentage of smoking status recordings from 50 to 80%. This measure also removes the requirement to report PQRS codes in favor of reporting SNOMED codes for the following conditions:

- Current every day smoker (449868002)
- Current some day smoker (428041000124106)
- Former smoker (8517006)
- Never smoker (266919005)
- Smoker, current status unknown (77176002)
- Unknown if ever smoked (266927001)
- Heavy tobacco smoker (428071000124103)
- Light tobacco smoker (428061000124105)

**ExamWRITER Instructions**

1. Ensure that you have services linked to the 4004F and 1036F CPT codes in the ExamWRITER Products window.
2. Open a patient's exam record in ExamWRITER.
3. Click the Patient Hx - ROS tab.
4. Click the Patient History category bar.


6. If the patient does not smoke, drink, or take narcotics or reports no history of STDs or blood transfusions, check the box at the top of the window and skip to step 8.
   Otherwise, select the Tobacco Use radio button that corresponds to the patient’s use.

7. If the patient is a smoker, you must select either the Counseling Intervention Recommended or Pharmaceutical Intervention Recommended check box and select a Patient Counseling radio button.

8. Click Process.
In this chapter:
- Measure, 29
- Exclusion, 29
- Differences from Stage 1, 30
- ExamWRITER Instructions, 30
- Responsible Role, 31
- Audit Advice, 31

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

**Measure**

You must satisfy both measure 1 and 2.

**Measure 1**

Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. If fewer than four clinical quality measures relate to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

**Measure 2**

Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

**Exclusion**

The following exclusions correspond to the measures listed above.

**Measure 1**

No exclusion.
Measure 2

You may be eligible to 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.

Differences from Stage 1

When compared to Stage 1 core set measures 2 and 11, this measure raises the requirement from 1 clinical decision support rule to 5 and specifies that the clinical decision support must be related to clinical quality measures or high priority health conditions.

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, 30
- Implementing Drug Interaction Checks, 31

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 name; these triangles indicate that the medication was entered by hand, rather than selected from a list, was transferred with a code that the ExamWRITER ePrescribing Interface did not recognize, or was transferred as textual information from ExamWRITER to the interface.

To receive more conclusive warning messages, click Manage Medications and reselect the patient's other medications or medication allergies from the medication list. For more information about using the ExamWRITER ePrescribing Interface, view the ExamWRITER ePrescribing Help at http://www.officemate.net/WebHelp/ExamWRITER_ePrescribing_Help.htm.

If you are not using the ExamWRITER ePrescribing interface, then you must use a third-party ePrescribing or interaction check service that is certified and capable of generating a report of your meaningful use. Third-party services do not integrate with ExamWRITER. If you use another ePrescribing service, you will need to enter the patient medication and allergy information twice: once in ExamWRITER and once in the third-party service.

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, 31
- Documenting Drug Interaction Checks, 32

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.
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 | 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 and display a drug-drug–drug-allergy interaction 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.

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.
Patient Electronic Access

In this chapter:
- Measure, 33
- Exclusion, 34
- Differences from Stage 1, 34
- ExamWRITER Instructions, 35
- Responsible Role, 38

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.

Measure

You must satisfy both measure 1 and 2.

Measure 1

More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.

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
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
Core Measure 7 - Patient Electronic Access

Exclusion

- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider of record

Measure 2

More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.

Exclusion

If you meet one or more of the following criteria, you may claim an eligible exclusion from this measure:

- If you neither order nor create any of the information listed for inclusion as part of both measures, except for patient's name and provider's name and office contact information, you may exclude both measures; or
- If you conduct 50% or more of your patient encounters in a county that does not have 50% or more of its housing units with 3 Mbps broadband availability according to the latest information available from the FCC on the first day of your EHR reporting period, you may exclude only the second measure.

Differences from Stage 1

When compared to Stage 1 core set measure 12 and menu set measure 5, this measure makes the following changes:

- Removes the Stage 1 qualification of "patients who request" in favor of all unique patients.
- Removes the exclusion of having no requests.
- Raises the Stage 1 threshold from at least 10% to more than 50% of all unique patients.
- Adds the requirement that at 5% of patients must view their health information, effectively requiring EPs to encourage them to do so.
- Adds an exclusion that accounts for the available bandwidth of the county.
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.

**NOTES**

- Although core measure 7 allows you four days to grant patients electronic access, you can satisfy part of core measure 7 and core measures 8 and 13 by sending the clinical summary *within one business day*.
- Encourage patients to view or download their clinical summaries to satisfy the second part of core measure 7.
- Encourage patients to send you a message through the patient portal acknowledging receipt of their clinical summaries to satisfy core measure 17.
- Clinical summaries printed from the Print icon in the exam or from the Exam Finalization window are not counted in your Stage 2 reporting.

Perform the following steps within one business day to satisfy core measures 7, 8, and 13:

- Creating Clinical Summary Documents, 35
- Sending the Clinical Summaries to Patients, 37

**NOTE**

For more information on setting up the secure messaging portal for your practice, refer to the *AcuityLogic 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.
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
Clinical Summaries

In this chapter:

- Measure, 39
- Exclusion, 39
- Differences from Stage 1, 39
- ExamWRITER Instructions, 39
- Responsible Role, 40

The objective of this measure is to provide clinical summaries for patients for each office visit.

**Measure**

Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50% of office visits.

**Exclusion**

You may be eligible to claim an eligible exclusion from this measure if you have no office visits during your EHR reporting period.

**Differences from Stage 1**

When compared to Stage 1 core set measure 13, this measure reduces the number of business days from 3 to 1.

**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.

Perform the steps listed for core measure 7 within one business day to satisfy core measures 7, 8, and 13. For more information go to “Patient Electronic Access” on page 33.

The patient portal displays only finalized exams.

**NOTE**

For more information on setting up the secure messaging portal for your practice, refer to the *AcuityLogic Administration User’s Guide*. 
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<thead>
<tr>
<th>Core Measure 8</th>
<th>Clinical Summaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Role</td>
<td>Doctor</td>
</tr>
<tr>
<td></td>
<td>Technician</td>
</tr>
<tr>
<td></td>
<td>Scribe</td>
</tr>
</tbody>
</table>
Protect Electronic Health Information

In this chapter:

- Measure, 41
- Exclusion, 41
- Differences from Stage 1, 41
- AcuityLogic/ExamWRITER Instructions, 41
- Responsible Role, 45
- Audit Advice, 46

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.

**Measure**

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.

**Exclusion**

No exclusion.

**Differences from Stage 1**

When compared to Stage 1 core set measure 15, there are no substantive changes; although special emphasis is placed on encryption and security.

**AcuityLogic/ExamWRITER Instructions**

AcuityLogic/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.

- Setting Up Security in OfficeMate/ExamWRITER, 42
- Setting Up Security in AcuityLogic, 42
- Encrypting Data in OfficeMate/ExamWRITER, 43
- Encrypting Data in AcuityLogic, 43
- Auditing in OfficeMate/ExamWRITER, 44
- Auditing in AcuityLogic, 44
- Encrypting Individual eDocuments in ExamWRITER, 45
- Encrypting Documents in AcuityLogic, 45

**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**.

**Setting Up Security in AcuityLogic**

If desired, set up security in AcuityLogic by following the instructions below.

1. In the AcuityLogic Admin application, click **Company** and select **Security**.
2. Click **Roles** and modify the access, active/inactive status, and name of an existing role. To edit an existing role, click **Edit**. Note that if you select the **Full Access** check box next to a role, all other access options selected for the role will be overridden and users will have full access to the role (but not the application).
3. Click **Access by Option** or **Access by Role** to add options to roles or roles to options.
4. Click **Return**.
5. To grant users read-only emergency access to the AcuityLogic POS application, click **Company**, select **Company Setup**, and follow the additional instructions below:
   a. Click **Employees**.
   b. Select an employee.
   c. Select the **Emergency Access** check box.
   d. Click **Save**.

Users with emergency access must select the **Emergency Access** check box when logging into the AcuityLogic POS application and type their reason for using the emergency access login in order to gain read-only access.

### 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**.

### Encrypting Data in AcuityLogic

If desired, encrypt patient and provider protected health information (PHI) in your AcuityLogic database by following the instructions below. Note that 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.

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Do not encrypt your database if you are using a third-party patient engagement platform to schedule appointments or send reminders. The patient engagement platform will not be able to read the encrypted database.</th>
</tr>
</thead>
</table>

1. In the AcuityLogic Admin application, click **Company** and select **Company Setup**.
2. Select a company.
3. Select the **General Encryption** check box in the Additional Attributes box.
Core Measure 9

Protect Electronic Health Information

AcuityLogic/ExamWRITER Instructions

4. Click **Save**.

**Auditing 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**.

**Auditing in AcuityLogic**

If desired, view the activities of AcuityLogic 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 the AcuityLogic Admin application, click **Company** and select **Company Setup**.
2. Select the company.
3. Select a level of auditing from the **Audit Logging** drop-down menu:
   - **Profile Only**. Only changes to patient profile information will be recorded in the Audit Log Report (AL101). This is the default option.
   - **Detail**. Create, edit, view, delete, print, and encryption and audit log enabling/disabling actions will all be recorded in the Audit Log Report (AL101). Due to the amount of information being logged, you may notice some impact to system performance when Audit Logging is set to Detail.
4. Select the **Initial Authentication** check box in the Additional Attributes box and click **Save**.
5. In the AcuityLogic BackOffice application, click **Miscellaneous** and select **Miscellaneous Reports**.
6. Click **Audit Log Report (AL101)** and complete the instructions below:
   a. Record search criteria in the top of the window, select an action from the **Action** drop-down menu, and click **Search** to find logs that meet your search criteria.
   b. Click **Export to PDF** or **Export to Excel** to export and print the audit log search results.
   c. 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.
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.

Encrypting Documents in AcuityLogic

If desired, encrypt text documents in AcuityLogic by following the instructions below:

1. In the AcuityLogic Admin application, click Tools, select Encryption, and select Encrypt and Transmit.
2. Click Browse and navigate to and select a text (.txt) file.
3. Type any password in the Password text box.
4. If you are transmitting the file via FTP only, select the FTP only check box.
5. Click Encrypt and Protect, Download File, Send via FTPS, or Send via SFTP.
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, 46
- Encryption, 47

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.

AcuityLogic/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?

Encryption

Although encryption is not strictly required by 45 CFR §164.312 (a)(2)(iv), encryption is enabled by default in AcuityLogic/ExamWRITER v11.1 and later. You may decrypt your AcuityLogic/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.
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Clinical Lab Test Results

In this chapter:
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- Exclusion, 49
- Differences from Stage 1, 49
- ExamWRITER Instructions, 49
- Responsible Role, 52

The objective of this measure is to incorporate clinical lab-test results into a certified EHR as structured data.

Measure

More than 55% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in the certified EHR as structured data.

Exclusion

You may be eligible to claim an eligible exclusion from this measure if you order no lab tests where results are either in a positive/negative affirmation or numeric format during your EHR reporting period.

Differences from Stage 1

When compared to Stage 1 menu set measure 2, this measure raises the percentage of lab results entered into the EHR from 40 to 55%.

ExamWRITER Instructions

Fulfilling this measure is a two-step process. First, you must record the lab order within the exam (this counts toward the denominator). Second, once you have the lab results, you must import the electronic file into ExamWRITER or enter the lab results manually (this counts toward the numerator).

- Ordering Lab Tests, 49
- Importing an Electronic Lab Results File, 50
- Recording Lab Results Manually, 51

Ordering Lab Tests

1. Open a patient's exam record in ExamWRITER.
2. Click the Surgery - Plan - Mgmt tab.
3. Click the Patient Management category bar.
4. Select **Current and Future Orders**.
5. Click **Process**.
6. Select the **Laboratory** radio button.
7. Select the specific orders type in the box on the left of the Orders window.
8. Select appropriate **Eye, Timeline**, and **Action** information as needed.
9. Click **Save(s)**.
10. Click **Process**.

### Importing an Electronic Lab Results File

You can import lab results that you receive electronically in the HL7 format.

1. Click the **Patient Hx** icon.
2. Click the **eDocuments** tab.
3. Click **Import Lab Results**.
4. Browse for the HL7 lab results file and click **Open**.
   
   The Importing Patient Match window opens and displays the name, date of birth, and gender of patient you have open in ExamWRITER and of the patient listed in the lab results file.

5. Verify that you are importing the correct patient’s lab results.
   - Click **Import** if the patient matches.
   - Click **Select Another File** if the patient does not match.
   
   ExamWRITER displays the contents of the lab results file for your review.
6. Click **Import**.
7. On the Patient Information window, click **Enter Lab Results**.
8. Double-click the lab results listed under **Lab Order Results**.
9. Select the **Order Link** by clicking the ellipsis (…) and selecting the exam where the lab tests were ordered.

**NOTE**

If you edit the order after linking it, you must return to this step and relink the order.

10. Click **Save**.
Recording Lab Results Manually

There are two main steps required to record lab results. First, create the lab test report. Second, record the individual elements within that test.

1. Perform the following steps to record the lab report:
   a. Click the **Patient Hx** icon.
   b. Click **Enter Lab Results**.
   c. Click **New** in the middle of the window.
   d. Select the **Test Name**.
      
      **NOTE** Press F12 to create a new test name.
   e. Select the **Test Type** and **Code Type** from the drop-down menus and enter the **Code**.
   f. Select the **Order Link** by clicking the ellipsis (…) and selecting the exam where the lab tests were ordered.
   g. Record the lab details in the appropriate fields.
2. For each element reported on the lab result, perform the following steps:
   a. Click **New** at the bottom of the window.
   b. At minimum, type the **Element**, **Result Value**, and **UOM** (unit of measure).
   c. Select a **Test Date**.
   d. Click **Save** at the bottom of the window.

3. Click **Save** in the middle of the window.

**Responsible Role**

Doctor

Technician

Front Desk
In this chapter:

- Measure, 53
- Exclusion, 53
- Differences from Stage 1, 53
- ExamWRITER Instructions, 53
- Responsible Role, 54
- Audit Advice, 54

The objective of this measure is to generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

**Measure**

Generate at least one report listing patients of the EP with a specific condition.

**Exclusion**

No exclusion.

**Differences from Stage 1**

When compared to Stage 1 menu set measure 3, this measure changes nothing.

**ExamWRITER Instructions**

1. In ExamWRITER, click **Tools** and select **Patient Search**.
2. Select your search criteria.
3. Click **Search**. A list of patients matching your criteria displays.

4. Click **Print** to print the list and document your use of the patient list.

**Responsible Role**
- Doctor
- Office Manager

**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 auditor may ask you to document your patient search. To document that you used this feature, perform the following steps during your reporting period:

1. Open the Patient Search window and search for patients as described above.
2. Click **Print**.
3. Save the Word document with your other meaningful use documentation.

**NOTE**
The patient report functionality is always present in ExamWRITER. There is no way to disable this functionality.
Preventive Care

In this chapter:

- Measure, 55
- Exclusion, 55
- Differences from Stage 1, 55
- AcuityLogic/ExamWRITER Instructions, 56
- Responsible Role, 58

The objective of this measure is to use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

**Measure**

*More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.*

**Exclusion**

You may be eligible to claim an eligible exclusion from this measure if you have had no office visits in the 24 months before your EHR reporting period.

**Differences from Stage 1**

When compared to Stage 1 menu set measure 4, this measure removes the limitation of patient ages. This measure now includes patients who were seen twice within the 24 months prior to the reporting period. This measure also reduces the percentage of reminders from 20 to 10% of unique patients.
Incorporating recalls into your workflow is an easy and effective way to remind patients to return for regular exams or follow up on specific conditions. The following sections describe how to set up recalls and send patient reminders.

- Creating Recall Letters and Postcards, 56
- Creating Recall Schedules, 56
- Assigning Recall Dates, 57
- Printing Recall Correspondence, 57

**NOTES**

- The denominator counts all patients who were seen twice within the last two years. The numerator counts only those patients included in the denominator for whom a recall was generated.
- The patient counts in the numerator and denominator of the provider selected on the patient’s Demographics tab, regardless of whether that provider saw the patient for both visits.

**Creating Recall Letters and Postcards**

Create recall letters and postcards in AcuityLogic by following the instructions below:

1. In the AcuityLogic Admin application, click **Company** and select **Recall Setup**.
2. Click **Compose Letter**.
3. To edit an existing recall document, select the letter’s template from the Default or User Defined templates folder on the left side of the window. To create a new recall document, click **Add Template**.
4. Type a name for the template in the **Template Name** text box.
5. Select a print format for the template from the **Print Formats** drop-down menu.
6. Select **Recall** from the **Template Category** drop-down menu.
7. Type the recall document in the word processing area.
8. Double-click or drag and drop merge fields from the Patient, Insurance, Subscriber, and Office merge fields folders on the right side of the window into the document in the word processing area.
9. Click **Save**.

**Creating Recall Schedules**

Create recall schedules in AcuityLogic by following the instructions below:

1. In the AcuityLogic Admin application, click **Company** and select **Recall Setup**.
2. Click **Recall Types**.
3. Click **Add Recall Type**.
4. Type the name of the new recall type in the **Description** text box.
5. Type the number of months until the patient will be recalled in the **Months** text box.

6. Click **Save**.

7. Click **Schedule** next to the new recall type.

8. Click **Add Recall Schedule**.

9. Type the number of periods in the **Number of Periods** text box, select the period (months or weeks) from the drop-down menu, and select when you want the recall to be scheduled from the **When** drop-down menu. For example, if you want the recall to be scheduled one week before the recall date, type 1 in the Number of Periods text box, select Week(s) from the drop-down menu, and select Before from the When drop-down menu.

10. Select the letter or postcard that you want to print for the recall from the **Print Letters/Post Cards** drop-down menu.

11. Click **Save**.

### Assigning Recall Dates

Assign recall dates to patients in AcuityLogic by following the instructions below:

1. Open the patient's profile in the AcuityLogic POS application.

2. Select the patient's communication preference from the **Communication Preference** drop-down menu.

3. Click the **Recall** tab.

4. Click **Add Recall**.

5. Select a recall type from the **Recall Type** drop-down menu.

6. Type the number of months until the patient will be recalled in the **Months To Recall** text box.

7. Select the next recall date from the **Next Recall** calendar.

8. Click **Save**.

### Printing Recall Correspondence

Print recall correspondence in AcuityLogic by following the instructions below.

1. In the AcuityLogic BackOffice application, click **Correspondence** and select **Recall**.

2. Click **New Recall**.

3. Select **Schedule Recall** from the **Recall Category** drop-down menu.

4. Type the recall category name in the **Description** text box.

5. Select dates from the **Recall From** and **Recall To** calendars.

6. Click the green check mark to save the recall.

7. Click **Parameters** next to the recall that you scheduled.

8. Click the pencil (**Edit**) in the Actions column.

9. Select a recall type from the **Recall Type** drop-down menu.

10. Click **Save**.
Core Measure 12  Preventive Care

Responsible Role

11. Click **Return**.
12. Click **Run** next to the recall that you scheduled and selected.
13. Click the printer to begin printing the recall correspondences.

Responsible Role

Office Manager
Front Desk
Patient-Specific Education Resources

In this chapter:
- Measure, 59
- Exclusion, 59
- Differences from Stage 1, 59
- ExamWRITER Instructions, 59
- Responsible Role, 59

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.

**Measure**

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.

**Exclusion**

You may be eligible to claim an eligible exclusion from this measure if you have no office visits during your EHR reporting period.

**Differences from Stage 1**

When compared to Stage 1 menu set measure 6, this measure added the exclusion of any EP who has no office visits during the reporting period.

**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.

Perform the steps listed for core measure 7 within one business day to satisfy core measures 7, 8, and 13. For more information go to “Patient Electronic Access” on page 33.

**Responsible Role**

Doctor

Technician

Scribe
<table>
<thead>
<tr>
<th>Core Measure 13</th>
<th>Patient-Specific Education Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Responsible Role</td>
</tr>
</tbody>
</table>
Medication Reconciliation

In this chapter:
- Measure, 61
- Exclusion, 61
- Differences from Stage 1, 61
- ExamWRITER Instructions, 61
- Responsible Role, 62

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.

**Measure**

The EP who performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.

**Exclusion**

You may be eligible to claim an eligible exclusion from this measure if you were not the recipient of any transitions of care during your EHR reporting period.

**Differences from Stage 1**

When compared to Stage 1 menu set measure 7, this measure changes nothing.

**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.
   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.
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.
### Core Measure 14

**Medication Reconciliation**

**Responsible Role**

<table>
<thead>
<tr>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
</tr>
<tr>
<td>Technician</td>
</tr>
<tr>
<td>Scribe</td>
</tr>
</tbody>
</table>
Summary of Care

In this chapter:
- Measure, 63
- Exclusion, 64
- Differences from Stage 1, 64
- ExamWRITER Instructions, 64
- Using the NIST EHR Randomizer Tool, 65
- Responsible Role, 67

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.

Measure

You must satisfy both measures 1 and 2 and one option from measure 3.

Measure 1

Provide a summary of care record for more than 50% of transitions of care and referrals.

Measure 2

Provide a summary of care record for more than 10% of such transitions and referrals using one of the following methods:
- Electronically transmitted using certified EHR to a recipient; or
- Electronically transmitted through exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.

Measure 3

An EP must satisfy one of the following criteria:
- (a) Conduct one or more successful electronic exchanges of a summary of care document, which is counted in measure 2, with a recipient who has a
Achieving Meaningful Use Stage 2 with AcuityLogic/ExamWRITER

Core Measure 15

Summary of Care

Exclusion

certified EHR that was developed and designed by a different EHR developer than the sender's certified EHR.

• (b) Conduct one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Exclusion

You may be eligible to claim an eligible exclusion from all three parts of this measure if you transfer a patient to another setting or refer a patient to another provider fewer than 100 times during your EHR reporting period.

Differences from Stage 1

When compared to Stage 1 menu set measure 9, this measure effects the following changes:

• Raises the exclusion threshold from zero transitions to fewer than 100.
• Adds the requirement to transmit a summary of care for 10% of referrals from the EHR via secured messaging directly to the receiving provider or from the EHR through a NwHIN portal.
• Adds the requirement to successfully exchange a summary of care with a provider who uses a different certified EHR or with CMS' designated test EHR.

ExamWRITER Instructions

This objective of this measure is to encourage you to generate and send a summary of care for more than half of your outbound referrals. You should, whenever possible, transmit the summary of care electronically via secure messaging. This electronic transmission will help you meet all three parts of this measure. You may print the summary of care, but this method only helps you meet the first part of this measure.

<table>
<thead>
<tr>
<th>NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start asking your fellow providers for their direct addresses so you can achieve that 10% threshold early in your reporting period. The direct address may also be known as a secure messaging address or HISP address.</td>
</tr>
</tbody>
</table>

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**.

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.

---

**NOTES**

- Measure 1: You may print the CDA and fax it. Printing the CDA counts toward the 50% required by Measure 1.
- Measure 2: Use Secure Send as directed above to meet the 10% required by Measure 2.
- Measure 3: Conduct a test by sending a CDA to a provider who uses a certified EHR developed by a vendor other than Eyefinity. If you don’t know any providers who use a non-Eyefinity certified EHR, use the NIST EHR Randomizer Tool to locate a provider with whom to conduct a test. For more information, go to “Using the NIST EHR Randomizer Tool” on page 65.

---

**Using the NIST EHR Randomizer Tool**

Measure 3 requires that you electronically exchange at least one CDA with a provider who uses a certified EHR that is developed by a different EHR vendor. If you don’t know any providers who use a non-Eyefinity certified EHR, use the NIST EHR Randomizer Tool to locate a provider with whom to conduct a test.
Core Measure 15
Summary of Care
Using the NIST EHR Randomizer Tool

1. Create an account for the EHR Randomizer on the NIST site: https://ehr-randomizer.nist.gov/ehr-randomizer-app/#/registration.

2. Once you have created your account, log into the EHR Randomizer.

3. Click My CEHRTs.

4. Create a profile for ExamWRITER.
   - **CEHRT Label** can be anything you choose.
   - **Direct Email Address** is the secure messaging address that you setup in the Secure Messaging Portal Setup window.
   - **Developer** is Eyefinity.
   - **Direct Trust Membership** must be set to Yes.

5. Click Save.

6. Click My Matches.
7. Click **Request New Match**.

8. Follow the instructions you receive to exchange a CDA with another provider.

**NOTE**
The instructions state that you must download and install a "trust anchor." This step is not necessary. Our secure messages already contain the trust information that’s required.

**Responsible Role**
- Doctor
- Technician
- Scribe

**Audit Advice**
Keep any communication related to Measure 3, conducting a test electronic exchange. If you conduct the electronic exchange with a close colleague, ask for an email confirming a successful exchange. If you conduct the exchange with a provider you located through the NIST EHR Randomizer Tool, save the email confirming a successful exchange.
Immunization Registries Data Submission

In this chapter:
- Measure, 69
- Exclusion, 69
- Differences from Stage 1, 69
- AcuityLogic/ExamWRITER Instructions, 70
- Responsible Role, 70
- Audit Advice, 70

The objective of this measure is to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure

Successful ongoing submission of electronic immunization data from a certified EHR to an immunization registry or immunization information system for the entire EHR reporting period.

Exclusion

If you meet one or more of the following criteria, you may claim an eligible exclusion from this measure:

- You do not administer any of the immunizations to any of the populations for which data is collected by your jurisdiction’s immunization registry or immunization information system during your EHR reporting period;
- You operate in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for certified EHR at the start of your EHR reporting period;
- You operate in a jurisdiction where no immunization registry or immunization information system provides timely information on the capability to receive immunization data; or
- You operate in a jurisdiction for which no immunization registry or immunization information system—that is capable of accepting the specific standards required by a certified EHR—can enroll additional EPs at the start of your EHR reporting period.

Differences from Stage 1

When compared to Stage 1 menu set measure 9, this measure removes the one test limitation and requires continual submissions. Additionally, this measure qualifies the exclusions with more detail.
Core Measure 16

Immunization Registries Data Submission

AcuityLogic/ExamWRITER Instructions

Most eyecare professionals claim an exclusion for this measure because they do not administer immunizations. 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, 70
- Reporting Data to Immunization Registries, 70

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 ExamWRITER Administration, click Reports from the main window toolbar.
2. Select Immunization Registry.
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

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.
Use Secure Messaging

In this chapter:

- Measure, 71
- Exclusion, 71
- Differences from Stage 1, 71
- ExamWRITER Instructions, 71
- Responsible Role, 72

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

Measure

A secure message was sent using the electronic messaging function of certified EHR by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Exclusion

If you meet one or more of the following criteria, you may claim an eligible exclusion from this measure:

- You have no office visits during the EHR reporting period; or
- You conduct 50% or more of your patient encounters in a county that does not have 50% or more of its housing units with 3 Mbps broadband availability according to the latest information available from the FCC on the first day of your EHR reporting period.

Differences from Stage 1

This measure is new to Stage 2.

ExamWRITER Instructions

Core measure 17 measures patients’ communications with you through the secure messaging portal. It is imperative that you encourage your patients to log into the patient portal and send you a message. Since you are sending clinical summaries to your patients to fulfill core measures 7, 8, and 13, ask them to send you a message acknowledging receipt.

To download a flier to give to your patients, go to http://www.eyefinity.com/resource-center/meaningfulUse/meaningful-use-resources.html.
<table>
<thead>
<tr>
<th>Core Measure 17</th>
<th>Use Secure Messaging</th>
<th>Responsible Role</th>
</tr>
</thead>
</table>

**Responsible Role**

- Doctor
- Technician
- Front Desk
PART THREE
MENU MEASURES
Syndromic Surveillance Data Submission

In this chapter:
- Measure, 75
- Exclusion, 75
- Differences from Stage 1, 75
- ExamWRITER Instructions, 76
- Responsible Role, 76
- Audit Advice, 76

The objective of this measure is to demonstrate the capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure
Successful ongoing submission of electronic syndromic surveillance data from a certified EHR to a public health agency for the entire EHR reporting period.

Exclusion
If you meet one or more of the following criteria, you may be excluded from this objective:
- You are not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period;
- You operate in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by the certified EHR at the start of your EHR reporting period;
- You operate in a jurisdiction where no public health agency provides timely information on the capability to receive syndromic surveillance data; or
- You operate in a jurisdiction for which no public health agency—that is capable of accepting the specific standards required by the certified EHR at the start of your EHR reporting period—can enroll additional EPs.

Differences from Stage 1
When compared to Stage 1 menu set measure 10, this measure removes the one test limitation and requires continual submissions. Additionally, this measure qualifies the exclusions with more detail.
**ExmWRITER Instructions**

1. In AcuityLogic/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

**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.
Electronic Notes

In this chapter:

- Measure, 77
- Exclusion, 77
- Differences from Stage 1, 77
- ExamWRITER Instructions, 78
- Responsible Role, 78

The objective of this measure is to record electronic notes in patient records.

**Measure**

Enter at least one electronic progress note created, edited, and signed by an EP for more than 30% of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.

**Exclusion**

No exclusion.

**Differences from Stage 1**

This measure is new to Stage 2.
Menu Measure 2

Electronic Notes

ExamWRITER Instructions

1. Open the patient's exam.
2. Click Notes.
   The Notes Menu window opens.

3. Select a Note Category.
4. Type the note text.

5. Click Save/Exit.

NOTE: Add commonly written notes to your exam templates to avoid having to type the same note for repeat conditions.

Responsible Role

Doctor
Scribe
Technician
In this chapter:

- Measure, 79
- Exclusion, 79
- Differences from Stage 1, 79
- ExamWRITER Instructions, 79
- Responsible Role, 82

The objective of this measure is to ensure that imaging results consisting of the image itself and any explanation or other accompanying information are accessible through a certified EHR.

**Measure**

*More than* 10% of all tests where the result is one or more images ordered by the EP during the EHR reporting period are accessible through a certified EHR.

**Exclusion**

Any EP who orders fewer than 100 tests where the result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period.

**Differences from Stage 1**

This measure is new to Stage 2.

**ExamWRITER Instructions**

Fulfilling this measure is a two-step process. First, you must record the image order within the exam (this counts toward the denominator). Second, once you have the image results, you must attached the image and enter the lab results (this counts toward the numerator).

- Ordering Imaging Tests, 80
- Recording Imaging Results, 81

**NOTE**

If you desire to include other types of imaging services that do not rely on electronic product radiation you may do so as long as the policy is consistent across all patients and for the entire EHR reporting period.
Menu Measure 3

Ordering Imaging Tests

1. Open a patient’s exam record in ExamWRITER.
2. Click the Surgery - Plan - Mgmt tab.
3. Click the Patient Management category bar.
4. Select Current and Future Orders.
5. Click Process.
6. Select the Radiology radio button.
7. Select a radiology or imaging test from the list on the left.

8. Select Schedule from the Action drop-down menu.
9. Select today’s date from the Action date field.
10. Click Save(s).
11. Click Process.

NOTES
- ExamWRITER counts only those orders where the Radiology radio button is selected.
- If you wish to count other images, select the Radiology radio button, click in the Search text box, and press F12 to add additional image types.
Recording Imaging Results

There are two main steps required to record imaging results. First, create the lab test report. Second, record the individual elements within that test.

1. Perform the following steps to record the lab report:
   a. Click the **Patient Hx** icon.
   b. Click **Enter Lab Results**.
   c. Click **New** in the middle of the window.
   d. Select the **Test Name**.
   e. Select **Imaging** from the **Test Type** drop-down menu.
   f. Select a **Code Type** from the drop-down menu and enter the **Code**.
   g. Select the **Order Link** by clicking the ellipses (...) and selecting the exam where the lab tests were ordered.

   **NOTE** If you edit the order after linking it, you must return to this step and relink the order.
2. For each element reported on the lab result, perform the following steps:
   a. Click New at the bottom of the window.
   b. At minimum, type the Element, Result Value, and UOM (unit of measure).
   c. Select a Test Date.
   d. Click Save at the bottom of the window.

3. Click Save in the middle of the window.

Responsible Role

- Doctor
- Technician
- Front Desk
Family Health History

In this chapter:
- Measure, 83
- Exclusion, 83
- Differences from Stage 1, 83
- ExamWRITER Instructions, 83
- Responsible Role, 84

The objective of this measure is to record patient family health history as structured data.

**Measure**

More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

**Exclusion**

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

**Differences from Stage 1**

This measure is new to Stage 2.

**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.
5. Select the SNOMED, Ocular, or Systemic radio button depending upon the coding you want to use.
6. Select the appropriate text in the box on the left of the window.
7. Select a first-degree family member from the Family Member(s) box.
   
   **NOTE** The first-degree, or immediate, family members are listed in the left column. They include mother, father, sister, brother, daughter, and son.
8. If necessary, select an eye from the Eye drop-down menu.
9. Select dates from the **Timeline** drop-down menus.

10. Click **Save Item**.

11. Repeat steps 7–10, as necessary, until all family history information is saved in the table at the bottom of the window.

**Responsible Role**

Doctor

Technician
Report Cancer Cases

In this chapter:
- Measure, 85
- Exclusion, 85
- Differences from Stage 1, 85
- ExamWRITER Instructions, 86
- Responsible Role, 86
- Audit Advice, 86

The objective of this measure is to demonstrate the capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

Measure
Successful ongoing submission of cancer case information from a certified EHR to a public health central cancer registry for the entire EHR reporting period.

Exclusion
If you meet one or more of the following criteria, you may be excluded from this objective:
- You do not diagnose or directly treat cancer;
- You operate in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required by your certified EHR at the beginning of your EHR reporting period;
- You operate in a jurisdiction where no public health agency provides information in a timely manner on the capability to receive electronic cancer case information; or
- You operate in a jurisdiction for which no public health agency—that is capable of receiving electronic cancer case information in the specific standards required by your certified EHR at the beginning of your EHR reporting period—can enroll additional EPs.

Differences from Stage 1
This measure is new to Stage 2.
<table>
<thead>
<tr>
<th><strong>Menu Measure 5</strong></th>
<th><strong>Report Cancer Cases</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ExamWRITER Instructions</strong></td>
<td>Since this measure does not apply to eyecare, you cannot complete this measure. You may claim an eligible exclusion from this measure if you have exhausted all attainable menu measures.</td>
</tr>
<tr>
<td><strong>Responsible Role</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Audit Advice</strong></td>
<td>The auditor may ask you to sign a written statement attesting to the fact that reporting cancer cases falls outside of your scope of practice.</td>
</tr>
</tbody>
</table>
Report Specific Cases

In this chapter:
• Measure, 87
• Exclusion, 87
• Differences from Stage 1, 88
• ExamWRITER Instructions, 88
• Responsible Role, 88
• Audit Advice, 88

The objective of this measure is to demonstrate the capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

**Measure**
Successful ongoing submission of specific case information from certified EHR to a specialized registry for the entire EHR reporting period.

**Exclusion**
If you meet one or more of the following criteria, you may be excluded from this objective:

• You do not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which you are eligible, or the public health agencies in your jurisdiction;

• You operate in a jurisdiction for which no specialized registry—sponsored by a public health agency or by a national specialty society for which you are eligible—is capable of receiving electronic specific case information in the specific standards required by your certified EHR at the beginning of your EHR reporting period;

• You operate in a jurisdiction where no public health agency or national specialty society for which you are eligible provides information in a timely manner on the capability to receive information into their specialized registries; or

• You operate in a jurisdiction for which no specialized registry—sponsored by a public health agency or by a national specialty society for which you are eligible that is capable of receiving electronic specific case information in the specific standards required by your certified EHR at the beginning of your EHR reporting period—can enroll additional EPs.
<table>
<thead>
<tr>
<th>Menu Measure 6</th>
<th>Report Specific Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences from Stage 1</td>
<td>This measure is new to Stage 2.</td>
</tr>
<tr>
<td>ExamWRITER Instructions</td>
<td>Since this measure does not apply to eyecare, you cannot complete this measure. You may claim an eligible exclusion from this measure if you have exhausted all attainable menu measures.</td>
</tr>
<tr>
<td>Responsible Role</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Audit Advice</td>
<td>The auditor may ask you to sign a written statement attesting to the fact that reporting specific cases falls outside of your scope of practice.</td>
</tr>
</tbody>
</table>
PART FOUR
CLINICAL QUALITY MEASURES
Getting Started with the 2014 Edition Clinical Quality Measures

In this chapter:
- Minimum Requirements, 91
- Differences from 2011 Edition, 92
- Coding for CMS Quality Measures, 93
- Automating PQRS Codes, 93
- Reporting CMS Quality Measures, 94

This chapter explains the general requirements of the 2014 Edition 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.

The 2014 Edition CQMs are required for both Stage 1 and Stage 2 meaningful use beginning in 2014.

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 regardless of which stage of meaningful use they are fulfilling.

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 97.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Title</th>
<th>Quality Strategy Domain</th>
</tr>
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## 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.

### Measures

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You may use the clinical quality measures to satisfy the Physician Quality Reporting System (PQRS) requirements for 2014.

Unlike the core and menu set 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; however at least one CQM must have a nonzero numerator and denominator to count for PQRS.
If this is your first year attesting to meaningful use, you may enter your CQM numerators and denominators manually into the EHR Registration and Attestation System. If you are beyond your first year of meaningful use, you will no longer manually enter your clinical quality information when you attest to meaningful use. Instead, you will submit your clinical quality information electronically through a qualified registry like QualityNet.

**Coding for CMS Quality Measures**

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.

1. From the AcuityLogic 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.
Chapter 1

Getting Started with the 2014 Edition Clinical Quality Measures

Reporting CQMs

Reporting CQMs is the last critical step in quality reporting. This section explains how to report or attest to CQMs:

- Determining How to Report CQMs, 94
- Reporting CQM Data Manually, 94
- Reporting CQM Data Electronically, 95

Determining How to Report CQMs

Reporting clinical quality measures helps your practice meet meaningful use criteria. How you report CQMs depends on whether this is your first year demonstrating meaningful use:

- If this is your first year demonstrating meaningful use, you may attest to your CQM data manually through the EHR Registration and Attestation System or submit your CQM data to a registry electronically.

To avoid a Medicare payment adjustment in 2015, you must begin your reporting period no later than July 1 and attest no later than October 1, 2014.

- If you have previously demonstrated meaningful use, you must report your CQM data to a registry electronically.

NOTES

- In 2014, you may submit CQM data for a single calendar quarter provided that quarter aligns with your meaningful use reporting dates.
- Although the reporting period for meaningful use in 2014 is one calendar quarter, you will need to report CQM data for the entire year to also qualify for PQRS.

Reporting CQM Data Manually

The CMS Quality Reporting window calculates the numerator, denominator, exclusions, percentage, and reporting rate for quality measures. If this is your first year demonstrating meaningful 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.
Chapter 1

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.

   **NOTE** You must report nine CQMs.
8. Enter the calculated numbers in the **EHR Registration and Attestation System**.

**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. If you have previously demonstrated meaningful use, you must report your CQM data to a registry electronically.

To create the files you need to upload 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.
6. Locate a qualified registry like **QualityNet**.
7. Follow the instructions given by the registry to upload your QRDA files.
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.

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.

**NOTES**

- 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.

- For full lists of CPT, ICD, HCPCS, LOINC, RxNorm, SNOMED codes required by each CQM, go to [http://bit.ly/ew2014cqm](http://bit.ly/ew2014cqm). The lists are extensive and should only be used if you believe your CQMs are not calculating correctly.
Controlling High Blood Pressure

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:

- 401.0, 401.1, 401.9

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.
Chapter 2

Fulfilling Clinical Quality Measures

NQF 0022

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.

NQF 0022

This section includes the following topics:

- Use of High-Risk Medications in the Elderly, 99
- Denominator, 100
- Numerator, 100
- Exclusions, 100
- Differences from Previous Editions, 100
- ExamWRITER Instructions, 100

Use of High-Risk Medications in the Elderly

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

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

This measure falls under the domain of Patient Safety.
Chapter 2

Fulfilling Clinical Quality Measures

NQF 0022

Denominator

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

99201, 99202, 99203, 99204, 99205, 99212, 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.
Chapter 2

Fulfilling Clinical Quality Measures

NQF 0028

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.


NQF 0028

This section includes the following topics:
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, 101
- Denominator, 101
- Numerator, 101
- Exclusions, 102
- Differences from Previous Editions, 102
- ExamWRITER Instructions, 102

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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 are 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

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.

**Denominator**

Patients aged 18 to 75

AND one of these exams within the reporting 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

AND are diagnosed with type 1 or type 2 diabetes:

AND are diagnosed with any of the following codes:

250, 250.0, 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

**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.
Chapter 2
Fulfilling Clinical Quality Measures

NQF 0086

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/Retinal-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

NQF 0086

This section includes the following topics:

- Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation, 104
- Denominator, 104
- Numerator, 105
- Exclusions, 105
- Differences from Previous Editions, 105
- ExamWRITER Instructions, 105

Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

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

AND one of these diagnosis codes:
365.10, 365.11, 365.12, 365.15

**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.
Chapter 2
Fulfilling Clinical Quality Measures

NQF 0088

This section includes the following topics:

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy, 106
- Denominator, 106
- Numerator, 106
- Exclusions, 106
- Differences from Previous Editions, 107
- ExamWRITER Instructions, 107

Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

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 one of these diagnosis codes:
362.01, 362.02, 362.03, 362.04, 362.05, 362.06
AND two or more of these exams (may have two of the same exam):
92002, 92004, 92012, 92014, 99201, 99202, 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 level II procedure code:
2021F

Exclusions

This level II procedure code and modifier:
2021F with 1P
OR
2021F with 2P
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.

NQF 0089

This section includes the following topics:

- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, 108
- Denominator, 108
- Numerator, 108
- Exclusions, 108
- Differences from Previous Editions, 108
- ExamWRITER Instructions, 109
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

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 one of these active diagnosis codes:

362.01, 362.02, 362.03, 362.04, 362.05, 362.06

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

AND level II procedure code:

2021F

Numerator

This level II procedure code:

5010F

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 “NQF 0088” on page 106.
2. In the TREATMENT RETINA - VASCULAR window, select the **PCP report** check box, select an eye, and click **Process**.
3. Click the **Print** icon in the ExamWRITER chart window.
4. 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.

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**NQF 0419**

This section includes the following topics:

- Documentation of Current Medications in the Medical Record, 109
- Denominator, 109
- Numerator, 110
- Exclusions, 110
- Differences from Previous Editions, 110
- ExamWRITER Instructions, 110

**Documentation of Current Medications in the Medical Record**

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, 92507, 92508, 92526, 92541, 92543, 92544, 92545, 92547, 92548, 92557, 92558, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 96153, 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, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
Chapter 2
Fulfilling Clinical Quality Measures
NQF 0419

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

<table>
<thead>
<tr>
<th>NOTE</th>
<th>The following codes denotes the completeness of the current medication list:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <strong>G8427.</strong> The documented medication information is current, accurate, and complete.</td>
</tr>
<tr>
<td></td>
<td>• <strong>G8428.</strong> The current medications are not documented, no reason given.</td>
</tr>
<tr>
<td></td>
<td>• <strong>G8430.</strong> The patient is not eligible for medication documentation.</td>
</tr>
</tbody>
</table>

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.
9. Click Save.

| NOTE | If you don’t see these radio buttons, auto-PQRS is not enabled for the patient’s insurance carrier. |
Chapter 2

Fulfilling Clinical Quality Measures

NQF 0421

This section includes the following topics:

- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up, 111
- Denominator, 111
- Numerator, 112
- Exclusions, 112
- Differences from Previous Editions, 112
- ExamWRITER Instructions, 113
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Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

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, 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 a procedure code:

43644, 43645, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845, 43846, 43847, 43848, 97804, 98960, 99078

OR the following SNOMED codes

443288003 386464006, 304549006, 307818003, 361231003, 370847001, 386291006, 386292004, 386373004, 386463000, 386464006, 410177006, 413315001, 418995006, 424753004, 429095004, 443288003

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 a procedure code:

43644, 43645, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845, 43846, 43847, 43848, 97804, 98960, 99078

OR the following SNOMED codes

443288003 386464006, 304549006, 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.
Chapter 2

Fulfilling Clinical Quality Measures

NQF 0564

Exa mWRITER 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.

Audit Advice

By recording height and weight for any of your patients, the auditors may interpret that as conceding these measurements are 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 height and weight measurements that you recorded during your reporting period.

The calculator includes historical data. If your practice used to record height and weight, 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 height and weight, but you no longer do so because vital signs are irrelevant to your scope of practice.

NQF 0564

This section includes the following topics:

• Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures, 114
• Denominator, 114
• Numerator, 114
• Exclusions, 115
• Differences from Previous Editions, 115
• ExamWRITER Instructions, 115
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

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:


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
Chapter 2

Fulfilling Clinical Quality Measures

NQF 0565

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).

NQF 0565
This section includes the following topics:
• Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery, 115
• Denominator, 116
• Numerator, 116
• Exclusions, 116
• Differences from Previous Editions, 117
• ExamWRITER Instructions, 117

Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
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.
Chapter 2  Fulfilling Clinical Quality Measures
NQF 0565

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:

360.00, 360.01, 360.02, 360.03, 360.04, 360.11, 360.12, 360.12,
360.13, 360.14, 360.19, 360.20, 360.20, 360.21, 360.21, 360.23, 360.24,
360.29, 361.00, 361.01, 361.02, 361.03, 361.04, 361.05, 361.06, 361.07,
362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 362.12, 362.16,
362.18, 362.20, 362.21, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27,
362.31, 362.32, 362.35, 362.36, 362.41, 362.42, 362.43, 362.50, 362.51,
362.52, 362.53, 362.54, 362.55, 362.56, 362.57, 362.70, 362.71, 362.72,
362.73, 362.74, 362.75, 362.76, 362.81, 362.82, 362.83, 362.84, 362.85,
362.89, 363.00, 363.01, 363.03, 363.04, 363.05, 363.06, 363.07, 363.08,
363.10, 363.11, 363.12, 363.13, 363.14, 363.15, 363.20, 363.21, 363.22,
363.30, 363.31, 363.32, 363.33, 363.35, 363.43, 363.50, 363.51, 363.52,
363.53, 363.54, 363.55, 363.56, 363.57, 363.61, 363.62, 363.63, 363.72,
364.00, 364.01, 364.02, 364.03, 364.04, 364.05, 364.06, 364.10, 364.11,
364.21, 364.22, 364.23, 364.24, 365.9, 365.10, 365.11, 365.12, 365.13,
365.61, 365.61, 365.62, 365.62, 365.63, 365.63, 365.64, 365.65, 365.65,
365.65, 365.81, 365.81, 365.82, 365.82, 365.83, 365.83, 365.89, 365.89,
366.32, 366.33, 368.01, 368.02, 368.03, 368.03, 368.41, 369.00, 369.01, 369.02,
369.03, 369.04, 369.05, 369.06, 369.07, 369.08, 369.10, 369.11, 369.12,
369.13, 369.14, 369.15, 369.16, 369.17, 369.18, 370.03, 371.00, 371.01,
371.02, 371.03, 371.03, 371.04, 371.04, 371.20, 371.21, 371.22, 371.23,
371.43, 371.44, 371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56,
371.57, 371.58, 371.60, 371.61, 371.62, 371.70, 371.71, 371.72, 371.73,
377.32, 377.33, 377.34, 377.39, 377.41, 377.51, 377.52, 377.53, 377.54,
377.75, 379.04, 379.05, 379.06, 379.07, 379.09, 379.11, 379.12, 379.51,
871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3, 940.0,
940.1, 940.2, 940.3, 940.4, 940.5, 940.9, 950.0, 950.1, 950.2, 950.3, 950.9

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.

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

This section includes the following topics:
- Closing the Referral Loop: Receipt of Specialist Report, 117
- Denominator, 117
- Numerator, 117
- Exclusions, 117
- Differences from Previous Editions, 118
- ExamWRITER Instructions, 118

Closing the Referral Loop: Receipt of Specialist Report

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.

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 (992xx).
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.
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