



# **Medicaid EHR Incentive Program**

## **Eligible Provider Meaningful Use Attestation Manual**

**Program Year 2015**



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# 1 Program Overview

## 1.1 Introduction

The Kentucky Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) as they adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) of certified EHR technology. The purpose of this document is to provide instructions for providers to complete attestation for the Kentucky Medicaid EHR Incentive Program using the KYSLR system.

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>
- 42 CFR Parts 412 and 495 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program - Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule located at <http://chfs.ky.gov/NR/rdonlyres/9C13A6FE-199F-44F6-8C78-402E3BBCECE/0/ModandStage3FinalRule.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 1.1 located at <http://chfs.ky.gov/dms/EHR.htm>
- Kentucky Medicaid EHR Application Portal located at <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at <http://healthit.gov/>
- Kentucky Health Information Exchange located at <http://khie.ky.gov/Pages/index.aspx>

Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky providers. The RECs provide a full range of assistance related to EHR selection and training are listed below:

- Northeast Kentucky Area  
NorthEast Kentucky Regional Information Organization (NeKY RHIO)  
Website: <http://www.nekyrhio.org/>  
Phone: 855-385-2089  
E-mail: [admin@nekyrhio.org](mailto:admin@nekyrhio.org)
- Remaining Areas of Kentucky  
Kentucky Regional Extension Center  
Website: <http://kentuckyrec.com/>  
Phone: 888-KY-REC-EHR or 859-323-3090  
E-mail: [kyrec@uky.edu](mailto:kyrec@uky.edu)

## 1.2 Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to EPs, EEs and CAHs, participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage providers to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.gov>.

Goals for the national program include: 1) Improve the quality, safety, and efficiency of care while reducing disparities 2) Engage patients and families in their care 3) Promote public and population health 4) Improve care coordination and 5) Promote the privacy and security of patient information. Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) works closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Providers are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs to guide users on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

## 1.3 Overview of Changes for Program Year 2015

On October 16, 2015, CMS released a Final Rule that specifies criteria for participating in the Medicare and Medicaid EHR Incentive Programs for 2015 through 2017 (Modified Stage 2) as well as Stage 3 in 2018 and beyond. The EHR Incentive Programs in 2015 through 2017 (Modified Stage 2) reflect changes to the objectives and measures of Stages 1 and 2 to align with Stage 3, which focuses on the advanced use of EHRs. The changes also aim to reduce the complexity of the program and work toward a shift to a single set of sustainable objectives and measures in 2018. Redundant, duplicative, or topped out measures have been removed.

Starting in 2015, all providers will be required to attest to a single set of objectives and measures. Since this change may occur after providers have already started to work toward meaningful use in 2015, there are alternate exclusions and specifications within individual objectives for providers who were previously scheduled to be in Stage 1 of the EHR Incentive Programs.

In response to public comments, two patient engagement objectives that involve patient action have also been modified for 2015 through 2017. The public health reporting objectives have been consolidated into one objective with measure options, which aligns with the structure of Stage 3.

#### CMS Key Concepts for the EHR Incentive Programs in 2015 through 2017 (Modified Stage 2)

- Restructured Stage 1 and Stage 2 objectives and measures to align with Stage 3: 10 objectives for EPs, including one consolidated public health reporting objective with 3 measure options.
- Starting in 2015, the EHR reporting period aligns with the calendar year for all providers.
- Changed the EHR reporting period in 2015 to 90 days to accommodate modifications to meaningful use.
- EHR technology must be certified to the 2014 Edition.
- Modified Stage 2 patient engagement objectives that require “patient action”.
- Streamlined the program by removing redundant, duplicative, and topped out measures.
- CQM reporting remains as previously finalized.

To allow CMS and providers time to implement these modifications, the EHR reporting period in 2015 is any continuous 90 day period within the calendar year. All providers will have until May 31, 2016 to attest for program year 2015.

## 2 Eligibility

While providers could begin the program in Calendar Year (CY) 2011, they must begin the program no later than CY 2016.

The first tier of provider eligibility for the program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store **does not** correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following providers are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Physicians = Any provider who has a Provider Type 64 and Specialty other than 345 (Pediatrics)
- Physician Assistants (practicing in a FQHC [Provider Type 31 and Specialty 80] or RHC [Provider Type 35] led by a Physician Assistant) = Any provider with a Provider Type 95 and Specialty other than 959 (PA Group). A FQHC or RHC is considered to be PA led in the following instances:
  - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
  - The PA is the clinical or medical director at a clinical site of the practice

- The PA is the owner of the RHC
- Pediatricians = Any provider with a Provider Type 64 and Specialty 345
- Nurse Practitioners = Any provider with a Provider Type 78 and not Specialty 095 (CNM) or 789 (Nurse Practitioner Group)
- CNMs = Any provider with a Provider Type 78 and Specialty 095
- Dentists = Any provider with a Provider Type 60 (Individual)
- Optometrists = Any provider with a Provider Type 77
- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children’s Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

## 2.1 Additional Requirements

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, not be hospital-based and must:

1. Meet one of the following patient volume criteria:
  - a. Have a minimum of 30 percent patient volume attributable to individuals receiving TXIX and/or TXXI-CHIP (but not separate CHIPS) Medicaid services; **or**
  - b. Have a minimum 20 percent patient volume attributable to individuals receiving TXIX and/or TXXI-CHIP (but not separate CHIPS) Medicaid services, **and** be a pediatrician; **or**
  - c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.
2. Have no sanctions and/or exclusions.

An individual EP may choose to receive the incentive directly or assign it to a Medicaid contracted clinic or group to which the provider is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the NLR and must match a TIN linked to the individual provider in DMS’s system. If there is no contract on file with KY Medicaid, the system will not be available to a provider for attestation until a contract has been approved by DMS.

**Note** also that some provider types who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the Kentucky Medicaid EHR Incentive Program. The following Table is a summary of qualifying provider types and minimum patient encounter volumes.

### Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC - 30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	

## 2.2 Out-of-State Providers

The Kentucky Medicaid EHR Incentive Program welcomes out-of-state providers to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

## 2.3 Establishing Patient Volume

An eligible provider must annually meet patient volume requirements to participate in Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (but not separate CHIPs). All providers should calculate patient volume based on TXIX - Medicaid and/or TXXI-CHIP and out-of-state Medicaid patients.

### 2.3.1 Patient Encounters Methodology

- To calculate TXIX-Medicaid and/or TXXI-CHIP patient volume, an EP must divide:
  - The total TXIX and/or TXXI-CHIP Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the prior calendar year or preceding 12 months from date of attestation; by
  - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in an FQHC/RHC – to calculate needy individual patient volume, an EP must divide:
  - The total needy individual patient encounters in any representative, continuous 90-day period in the prior calendar year or preceding 12 months from date of attestation; by
  - The total patient encounters in the same 90-day period.

**2.3.2 Eligible Professional DMS Encounter Definition**

For purposes of calculating EP patient volume, a DMS encounter is defined as any service rendered on any one day to an individual enrolled in a Medicaid program whether or not Medicaid had a financial interest in the services that were rendered.

**2.3.3 Definition of a Needy Individual Encounter**

For purposes of calculating patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.

**2.3.4 Group Practices**

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic/group practice’s patient volume is appropriate as a patient volume methodology calculation for the EP.
- There is an auditable data source to support the clinic’s/group practice’s patient volume determination.
- **All** EPs in the clinic/group practice must use the same methodology for the payment year.
- The clinic/group practice uses the entire practice or clinic’s patient volume and does not limit patient volume in any way; and if an EP works inside and outside of the clinic/practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP’s outside encounters.

**3 Payment Methodology**

The maximum incentive payment an EP could receive from Kentucky Medicaid equals \$63,750, over a period of six years, or \$42,500 for pediatricians with a 20-29 percent DMS patient volume as shown below.

<b>Provider</b>	<b>EP</b>	<b>EP-Pediatrician</b>
<b>Patient Volume</b>	<b>30 percent</b>	<b>20-29 percent</b>
<b>Year 1</b>	\$21,250	\$14,167
<b>Year 2</b>	\$8,500	\$5,667
<b>Year 3</b>	\$8,500	\$5,667
<b>Year 4</b>	\$8,500	\$5,667
<b>Year 5</b>	\$8,500	\$5,667
<b>Year 6</b>	\$8,500	\$5,665
<b>Total Incentive Payment</b>	\$63,750	\$42,500

Since pediatricians are qualified to participate in the Kentucky Medicaid EHR incentive program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate they meet the minimum 30 percent Medicaid patient volume requirements.

### 3.3 Payments

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) at the NLR. The TIN must be associated in the Kentucky MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to himself or herself (and not a group or clinic) will be required to provide DMS with updated information. Each EP must have a current DMS contract and be contracted for at least 90 days.

The Kentucky Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (**Medicare** requires providers to implement and meaningfully use certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that provider was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis. However, the last year that an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

In the event that DMS determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

## 4 Provider Registration

If this is your first year with the EHR Incentive program, providers are required to begin by registering at the NLR. CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. Providers must enter their name, NPI, business address, phone number, taxpayer ID number (TIN) of the entity receiving the payment while EOs and CAHs must also provide their CCN. EPs may choose to receive the incentive payment themselves or re-assign payment to a clinic or group to which they belong.

EPs must choose to participate in either the Medicare or Medicaid's incentive program. If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to apply for their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments **unless** information needs to be updated.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number is required to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the provider based on the specified TIN, the NLR will be notified by DMS that a payment has been made.

## 5 Attestation Process & Validation

DMS uses the secure KYSLR system to house the attestation system. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance is available by contacting the EHR Incentive Program at 502-564-0105 extension 2480.

### 5.1 Attestation

The following is a brief description of the information that a provider must report or attest to during the process:

1. After registering at the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/> the provider will receive an email at the email address provided upon registration, indicating they are eligible for the program.
2. The provider will log into the KYSLR <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx> using their NPI and CMS-assigned Registration Identifier.
3. The provider is asked to view the information displayed with the pre-populated data received from the NLR.

4. EPs will then enter two categories of data to complete the Eligibility Provider Details screen including: 1) patient volume characteristics, and 2) certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules).

The EP will be asked to attest to:

- Assigning the incentive payment to a specific TIN (only asked if applicable); provider and TIN to which the payment is assigned at the NLR will be displayed;
  - Not working as a hospital based professional (this will be verified by DMS through claims analysis);
  - Not applying for an incentive payment from another state or Medicare;
  - Not applying for an incentive payment under another DMS ID;
  - Meaningful Use of certified EHR technology; and
  - Complete objectives and clinical quality measures.
5. The providers are asked to electronically sign the attestation.
    - The provider or the agent/ staff member's initials are entered
    - The providers NPI

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the provider to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

The first year of the program is the only time a provider is allowed to attest to adopting, implementing or upgrading to certified EHR technology. However, attesting to AIU is not mandatory in the first year. If a provider chooses to attest as a Meaningful User the first year they may do so. All providers will be required to attest to meaningful use to receive incentive payments after attesting to the Adopt, Implement, or Upgrade for the first year.

## **5.2 Incentive Payments**

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and verification by DMS, an incentive payment can be approved. Providers will be notified of approval for payment by email to the email address submitted with registration. Please be sure the email address provided is current.

## **5.3 Program Integrity**

DMS has a contract with the Office of Inspector General (OIG) to perform audits and investigations of potential Medicaid fraud and/or abuse; therefore OIG A&I will conduct post payment incentive money audits. The audits conducted will investigate for all things attested; including, but not limited to the certified EHR technology component, percentage of Medicaid

population treated, Medicaid eligibility, etc. Any documentation to which an EP or EH attests, including future meaningful use, will be audited. All reviews will ensure that no duplication of payment occurred within the commonwealth system. The OIG A&I will submit reports on audit findings and recommendations to the DMS Division of Program Integrity. All documentation supporting the attestation is to be retained for six years.

#### **5.4 Administrative Audits/Appeals**

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. In accordance with 907 KAR 6:005 Section 13, to appeal the provider must request a dispute resolution meeting. The request shall be in writing and mailed to and received by the department within 30 calendar days of the date the notice was received. The request must clearly identify each specific issue and dispute, and clearly state the basis on which the department's decision on each issue is believed to be erroneous. The provider shall also state the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf. Any supporting documentation to the appeal should be included with the request. The address to send the request is below:

Division of Program Integrity  
ATTN: EHR Appeal  
Department for Medicaid Services  
275 E. Main Street, 6E-A  
Frankfort, KY 40621

## **6 Getting Started**

EPs are required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation (more details follow in this manual).

After registering with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/> the provider should receive an email including a summary of the registration information. The information includes the NPI and registration ID. Please keep this information for login to the Kentucky EHR Incentive Program attestation website (KYSLR) and in case of potential future edits for the NLR.

Please allow 48 hours after registration to log into the KYSLR.

The provider begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx>.

## 6.1 Sign-in

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

Release: 01.46.00.04  
KY Agencies | KY Services

► CMS EHR Site | KY Medicaid EHR Site | Send E-mail

### KY Medicaid EHR Incentive Program

In order to receive EHR incentive payments from Kentucky Medicaid, you first have to register at the [CMS Web Site](#). After about 24 hours of successfully registering at the CMS level you should be able to complete your application on this site.

Please enter your NPI

Please enter the CMS assigned Registration Identifier

The provider enters the NPI and CMS assigned Registration Identifier that was returned by the NLR.

If the data submitted by the provider matches the data received from the NLR, the Home Screen will display. If the provider entry does not match, an error message with instructions will be returned.

## 6.2 Home Screen

The Home screen provides announcements, information about the provider's current KY attestation review as well as provides navigation for the provider to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment. This is also where the provider selects the Program year they are attesting and selects the status of their EHR; Adopt, Implement, Upgrade or Meaningful User.


**Cabinet for Health and Family Services**  
 KY Medicaid EHR Incentive Program
 

 Release: 01.58.02.00  
 Test User | 2111111111 | Logout | KY Agencies | KY Services

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KY Medicaid EHR Site
Send E-mail

- Home
- Reports
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- Additional Resources
  - KY Medicaid EHR Site
  - CMS EHR Site
  - User Manuals
    - Provider User Manual
    - EP Meaningful Use Manual
    - EH Meaningful Use Manual

### Home (Year 2 Attestation)

**Announcements And Messages**

No Announcements and Messages !

**Issues/Concerns**

Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses received from the DMS.  
[Click Here](#)

**Provider Information**

You are currently enrolled in KY's EHR Incentive Program.  
 Payment Year '2' is your current year attestation.  
**The current status of your application for the year 2 payment is 'AWAITING PROVIDER ATTESTATION'.**

**Stage of Meaningful Use**

1st Year	2011	2015	2016	2017	2018	2019
2011	AIU 1	MU Mod Stage 2 w/alt. avail (90 Days)	MU Mod Stage 2 w/alt. avail (365 Days)	MU Mod Stage 2 or Stage 3 (365 Days)	MU Stage 3 (365 Days)	MU Stage 3 (365 Days)

**Provider Status Flow**

CMS Registration

→

Preliminary Verification

→

Provider Attestation

Completed
In Process

**Provider Attestation Details**

**For which Program Year are you applying? Indicate the status of your EHR:**

2015

Meaningful User

Save Attestation Details

**Provider Attestation Navigation**

Payment Year	Status	AttestationID	Action
1	Paid	KY0001221	<a href="#">View</a>
2	Attest_inProcess	-	<a href="#">Begin/Modify Attestation</a>

There are seven sections to the Home page listed below:

- Announcements and Messages – Displays messages or announcements for the provider.
- Issues/Concerns – Provides a link for the provider to submit a new issue or view a response to an issue.
- Provider Information – Provides a high-level status for the provider including the current payment year and the current status for the payment year.
- Stage of Meaningful Use – Supplies the stage of Meaningful Use the provider will need to attest to according to the program year.
- Provider Status Flow – Displays a diagram showing the provider’s current year’s attestation. If the provider has been found not eligible for any reason, specific reasons for that finding is shown in this section.
- Provider Attestation Details – Provider selects the Program Year and the status of their EHR. The selections available for EHR status are:
  - (A) Adopt - Acquire, purchase, or secure access to CEHRT;
  - (I) Implement - Install or commence utilization of CEHRT capable of meeting meaningful use requirements;
  - (U) Upgrade - Expand the available functionality of CEHRT capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to CEHRT per the ONC EHR certification criteria;
  - (MU) Meaningful User – currently meaningfully using CEHRT and are prepared to attest to Meaningful Use and Clinical Quality Measures.
- Provider Attestation Navigation – Lists the provider’s attestations by payment year and provides the navigation actions available for each year. These options may include:
  - View for a previously paid attestation;
  - View Attestation for a completed attestation;
  - Begin/Modify for a new or not yet completed attestation.

## **6.3 Registration Data Screen**

### **6.3.1 Provider CMS Registration Data**

The data displayed in the Provider CMS Registration Data section is view only. If any of this data is incorrect, the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected.

The fields from the CMS registration are listed below:

- **Applicant National Provider Identifier (NPI)** – This is the eligible provider’s individual NPI. The NPI registered at CMS should be the same individual NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – This is the eligible providers Tax Identification Number. This TIN should be the same TIN that is listed for the provider in MMIS.
- **Payee National Provider Identifier (NPI)** – This is the eligible provider’s payee NPI given during the CMS registration. The Payee NPI should be enrolled in KY Medicaid and listed as a payee with whom the individual provider is a member.
- **Payee TIN** – The tax identification number associated with the payee NPI. This was the tax id given during registration that will have the tax liability of the incentive payment. The Payee TIN should match the FEIN or SSN listed for the payee NPI within KY Medicaid.
- **Program Option** – This program option was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.
- **Medicaid State** – This is the State that was selected during the provider’s registration.

- **Provider Type** – This is the provider type that was given during the registration at CMS. This type will be validated with your type of license.
- **Participation year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system-generated emails on updates for the provider’s attestation and communication from the EHR review staff. **Note:** It is very important that this email address be accurate and up-to-date.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

### 6.3.2 Provider Medicaid Attestation Data

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. If the Provider needs their paper check mailed to an address other than the one registered with CMS in the screen above, this is where it can be noted. Once the attestation is submitted by the provider, the data will become view only. These data fields are described below:

- **Medicaid ID** - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers. **This Medicaid Number will be used for your incentive payments.**
- **Mailing Address** - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence. This change will only be used for mailing the provider’s incentive payment. This will not change the address listed with CMS.
- **Medicaid Provider Type** - Please select the provider type from the list. This type should match the type of provider listed under your KY Medicaid enrollment and your type of license.
- **Were you assisted by a Regional Extension Center in Kentucky** - Response to this question is required. If the response is yes, then please type the name of the person who assisted you during the attestation process.

## 6.4 Provider Eligibility Details Screen

EPs must enter two categories of information to complete the Eligibility Provider Details screen including Eligibility Details and Service Locations. Within the Eligibility Details section the provider will enter data for Patient Volume and EHR Details.

### 6.4.1 Eligibility Details

Eligibility details section allows the provider to view or enter information depending on the source of the information and the status of the attestation. Information in this section includes patient volume and information about EHR use.

KY Medicaid EHR Site    Send E-mail

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Home

Reports

View All Payment Years

Issues/Concerns

Appeals

Additional Resources

KY Medicaid EHR Site

CMS EHR Site

User Manuals

Provider User Manual

EP Meaningful Use Manual

EH Meaningful Use Manual

### Provider Eligibility Details (Year 2 Attestation)

Eligibility Details:

To request a KCHIP report, please complete questions 1-5, click Save Data For KCHIP button, then click Reports link in the navigation menu.

All \* fields are required fields.

<b>Patient Volume:</b>	1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:	<input type="text" value="No"/>
	2. If yes, please enter the NPI of the clinic or group:	<input type="text" value=""/>
	3. For which program year are you applying?	* <input type="text" value="2015"/>
	4. What is the time frame used for patient volume calculation?	* <input type="text" value="Prior Calendar Year"/>
	5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage:	* <input type="text" value="1/1/2014"/> <small>(mm/dd/yy)</small>
<a href="#" style="background-color: #4CAF50; color: white; padding: 5px 15px; border-radius: 3px;">Save Data For KCHIP</a>		
	6. Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.):	* <input type="text" value="80"/>
	7. Total patient encounters during this period:	* <input type="text" value="100"/>
	8. Medicaid patient volume percentage:	<b>80.00%</b>
<b>EHR Details:</b>	9. Enter the CMS EHR Certification ID of your EHR:	* <input type="text" value="1314E01QPVP1EAN"/> <a href="#">What is this?</a>
	10. Indicate the status of your EHR:	* <input checked="" type="radio"/> Meaningful User

#### Patient Volume

1. Indicate if patient volume was calculated at a clinic or practice level for all eligible professionals.
  - If submitting at the clinic or practice levels, **all** EPs from the clinic or practice must

- also submit their volume at the clinic or practice level for the same program year.
2. If submitting at the clinic or practice level, enter the NPI of the clinic or group.
  3. Select the program year for attestation.
    - This should be the current year or the prior year, if the current date is on or before May 31.
  4. Select the time frame used for patient volume calculation.
    - From the dropdown menu select either the “Prior Calendar Year” or “Preceding 12 Months” of the date of attestation.
  5. Select the starting date of the 90-day period to calculate the Medicaid encounter volume percentage. Enter as mm/dd/yy.
    - This date should be a continuous 90-day period.
  6. Enter Medicaid patient encounters during this period.
  7. Enter Total patient encounters during this period.
  8. Medicaid patient volume percentage is auto-calculated based on the volume numbers entered and is displayed as a percentage with two decimal points.
    - Volume thresholds are calculated using the EP’s total number of Medicaid member encounters for the 90-day period as the numerator and *all* patient encounters for the same EP over the same 90-day period as the denominator.

#### EHR Details

9. The CMS EHR Certification ID is displayed from your selection made on the Home screen
10. The status of your EHR is display only from your selection made on the Home screen.

#### 6.4.2 Service Locations

In the Service location section, enter information about the service locations equipped with a certified EHR. Practice/Locations equipped with CEHRT can qualify for meaningful use in the following ways:

- The CEHRT is permanently installed at the practice location.
- The CEHRT can be brought to the practice/location on a portable computing device.
- The CEHRT can be accessed remotely using computing devices at the practice/location.

Service Locations

The practice/location equipped with Certified EHR Technology (CEHRT) can be met in 3 ways:

1. CEHRT is permanently installed at the practice location
2. The CEHRT can be brought to the practice/location on a portable computing device
3. The CEHRT can be accessed remotely using computing devices at the practice/location

---

\*Do you have multiple service locations?  Yes  No

---

\*Enter the total number of locations:

---

\*Enter the total number of locations with certified EHR Technology:

---

\* Indicate below the service location(s) associated with this attestation that have Certified EHR Technology:

To complete this section, perform the following steps:

- Select Yes or No to indicate if there are multiple locations.
  - If Yes is selected, enter the total number of locations and the number of locations with a certified EHR.
    - A new section will open for entering an address. After entering the address, click on the Add button.
  - If No is selected, the total number of locations and locations with EHR technology will automatically populate with a 1.
- Enter the single service location address by clicking on the **Enter Service Location Address** button.

\* Indicate below the service location(s) associated with this attestation that have Certified EHR Technology:

Address1:

Address 2:

City:

State:

Zip Code:

ZipCode Extension:

**Add**

Previous
Next
Save
Cancel

- Enter the Service location address information in the fields, then click the Add button.

\* Indicate below the service location(s) associated with this attestation that have Certified EHR Technology:

Edit	Address Line 1	Address Line 2	City	State	Zip Code	Zip Code Extension	Delete
<a href="#">Modify</a>	12 Millcreek Park		Frankfort	KY	40601		<a href="#">Delete</a>
	<input type="text"/>	<b>ADD</b>					

Previous
Next
Save
Cancel

Once the address is added into the table, it can be modified or deleted, and more Service locations can be added.

- To edit or update a Service location, click the Modify link.
- To remove a Service location, click the Delete link.

- To add a new Service location, enter address information in to the fields and click the ADD button.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

#### 6.4.2 Requesting KCHIP Report Data

On the 'Provider Eligibility Details' page, complete questions 1 -5, and click the 'Save Data for KCHIP' button. Please note: This process is only available while the attestation is in an 'Attest in Process' status, which enables the provider to 'Begin or Modify' the attestation. Once the provider has clicked the 'Submit' button to submit the attestation for review, the attestation will have to be reopened to have access to this function. So it is very important this step is completed before you submit your attestation for review.

**Provider Eligibility Details (Year 2 Attestation)**

Eligibility Details:

To request a KCHIP report, please complete questions 1-5, click Save Data For KCHIP button, then click Reports link in the navigation menu.

All fields are required fields.

**Patient Volume:**

1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:
2. If yes, please enter the NPI of the clinic or group:
3. For which program year are you applying?
4. What is the time frame used for patient volume calculation?
5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage:

The KCHIP data report will take approximately 2 -3 hours to complete. Once the report is ready to be viewed, an email will be sent to the email address on file within the attestation. This email address can be verified on the 'Registration Data' screen of the attestation. If this email address is not correct, please go to the CMS Registration website to update this information. Email is our main form of communication with providers, so please take a moment to verify this information. Also, please be aware this update takes 24 hours to complete.

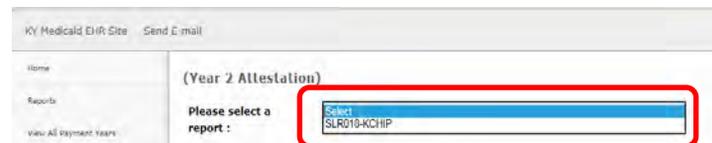
Once you have received email notification that your KCHIP data is ready to be viewed, you will need to sign back into the attestation and click on the 'Reports' link located within the menu options located on the left hand side of the 'Home' screen and complete the following steps:



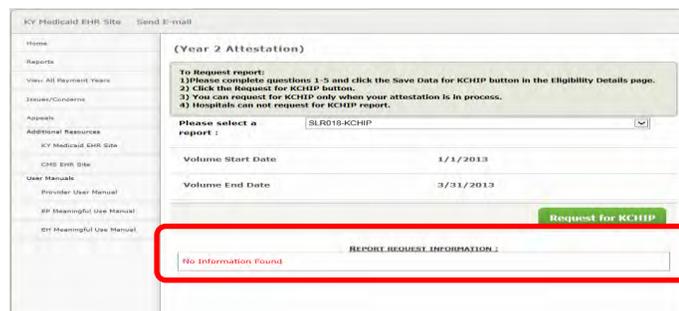
Step 1: Click the down arrow to select a report.



Step 2: Select 'SLR018-KCHIP'.



Step 3: Scroll toward the bottom of the page and locate the 'Report Request Information' heading. If KCHIP data was found, there would be a button option to 'Select' below the 'Report Requested Information' heading displayed in a table.



If KCHIP data is returned, you will need to total the number of encounters displayed, then subtract this total from the numerator value of your 90 day patient volume data which is your total 'Medicaid Encounters'. This adjusted total is what will be reported on line 6 on the 'Eligibility Details' page of the attestation. If 'No Information Found' is displayed, you would

report your total Medicaid patients as you have calculated with no adjustments to line 6 on the 'Eligibility Details' page of the attestation and continue the completion of your attestation for review.

Eligibility Details:

To request a KCHIP report, please complete questions 1-5, click Save Data For KCHIP button, then click Reports link in the navigation menu.

All \* fields are required fields.

**Patient Volume:**

1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:

2. If yes, please enter the NPI of the clinic or group:

3. For which program year are you applying?

4. What is the time frame used for patient volume calculation?

5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage:  (mm/dd/yy)

6. Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.):

7. Total patient encounters during this period:

8. Medicaid patient volume percentage: **66.67%**

**EHR Details:**

9. Enter the CMS EHR Certification ID of your EHR:  [What is this?](#)

10. Indicate the status of your EHR:  Adopt/Implement/Upgrade  Meaningful User

## 6.5 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EPs who have selected to attest for Meaningful Use will be directed to the Meaningful Use Questionnaire screen. Here, the provider will enter the Meaningful Use reporting period. For Program year 2015 the meaningful use reporting period must be a 90 day consecutive period within the current calendar year.

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### Meaningful Use Questionnaire (Year 1 Attestation)

Meaningful Use Questionnaire

**Please provide the EHR reporting period associated with this attestation:**

\*EHR Reporting Period Start Date:  (mm/dd/yy)

\*EHR Reporting Period End Date:  (mm/dd/yy)

\*Enter the percentage of unique patients who have structured data recorded your certified EHR technology as of the reporting period above:

**Previous**    **Next**    **Save**    **Cancel**

Enter responses for the following:

- Enter EHR Reporting Period Start Date
  - This is the starting date of the reporting period for the Meaningful Use data.
- Enter EHR Reporting Period End Date
  - This is the end date of the reporting period for the Meaningful Use data.
- Enter percentage of unique patients who have structured data recorded in the certified EHR technology as of the reporting period above.
  - This can be calculated by dividing the number of patients with structured data in your Certified EHR by the total number of patients seen at service location(s) with Certified EHR Technology. Multiply by 100 to obtain the percentage. The amount of patients with structured data stored in your EHR should be at least 80%.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 7 Requirements for Meaningful Use Measures

Providers who are demonstrating Meaningful Use for the Kentucky Medicaid EHR program will submit and attest to the same Meaningful Use measures and Clinical Quality Measures as put forth by Medicare.

Medicaid providers who are demonstrating Meaningful Use need to meet the following requirements:

- Medicaid provider eligibility requirements;
- Medicaid volume requirements;
- For Program Year 2015, Providers must select an EHR MU reporting period that is any continuous 90-day period within the current calendar year. Providers have until May 31, 2016 to attest that EHR MU reporting period;
- For providers who work at multiple locations, 50% or more of patient encounters must occur at the location equipped with EHR certified technology;
- 80% of unique patients must have structured data recorded in the CEHRT;
- Must meet 10 meaningful use objectives;
- Must submit 9 Clinical Quality Measures across 3 domains.

The system is designed to display the alternate objectives, exclusions and specifications accordingly for those providers who are scheduled to attest to Stage 1 and for those attesting to Modified Stage 2 requirements.

Providers will be directed through the 10 MU Objectives listed below. The Clinical Quality Measures will not be available for attestation until the MU Objectives have been completed.

- Meaningful Use Objectives
  1. Protect Patient Health Information
  2. Clinical Decision Support
  3. Computerized Provider Order Entry
  4. Electronic Prescribing
  5. Health Information Exchange
  6. Patient Specific Education
  7. Medication Reconciliation
  8. Patient Electronic Access
  9. Secure Electronic Messaging
  10. Public Health
    - Immunization Registry Reporting
    - Syndromic Surveillance Reporting
    - Specialized Registry Reporting
- Clinical Quality Measures

For additional information on Meaningful Use Measures, please see the following CMS Web site below:

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

## 7.1 Meaningful Use Menu Screen

The menu screen will only allow the user to select a group of measures as they are available. For example, once the Meaningful Use Core Objectives are completed, the Public Health Objectives will be active to select.



**Meaningful Use Core Objectives Link**-Takes the EP to the first screen of the Meaningful Use Core Objectives.

**Public Health Objectives Link**-Takes the EP to the first screen of the Public Health Objectives. This link is only active after the MU Core Objectives are completed.

**Clinical Quality Measures Submission Link**-Takes the EP to the first screen of the Clinical Quality Measures. This link is only active after the Public Health Objectives are completed.

If the EP does not wish to click the links for attestation, buttons at the bottom of the screen are available for navigation.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.

## 7.2 Meaningful Use Core Objectives - Scheduled for Stage 1

### 7.2.1 MU Core Objective 1 - Protect Patient Health Information

**OBJECTIVE:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

KY Medicaid EHR Site    Send E-mail

Home  
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Meaningful Use Questionnaire  
Meaningful Use Menu Options  
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Meaningful Use Public Health Objectives  
Clinical Quality Measures Submission  
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Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

Release: 01.58.05.00  
Gem Eye | 8800880088 | Logout | KY Agencies | KY Services

### Meaningful Use Core Objectives (Year 1 Attestation)

#### EP Objective 1 - Protect Patient Health Information

(\*) Red asterisk indicates a required field.

**Objective:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure:** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT 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 EP's risk management process.

Complete the following information:

\*Have you conducted or reviewed a security risk analysis in accordance with the requirements?

Yes  No

Previous    Next    Save    Cancel

In order for EPs to meet the objectives, they must be able to satisfy the measure.

To satisfy the Measure, select a response to the question.

- If No is selected, upon navigation, a message will pop up stating that the entry for the measure does not meet the threshold to qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

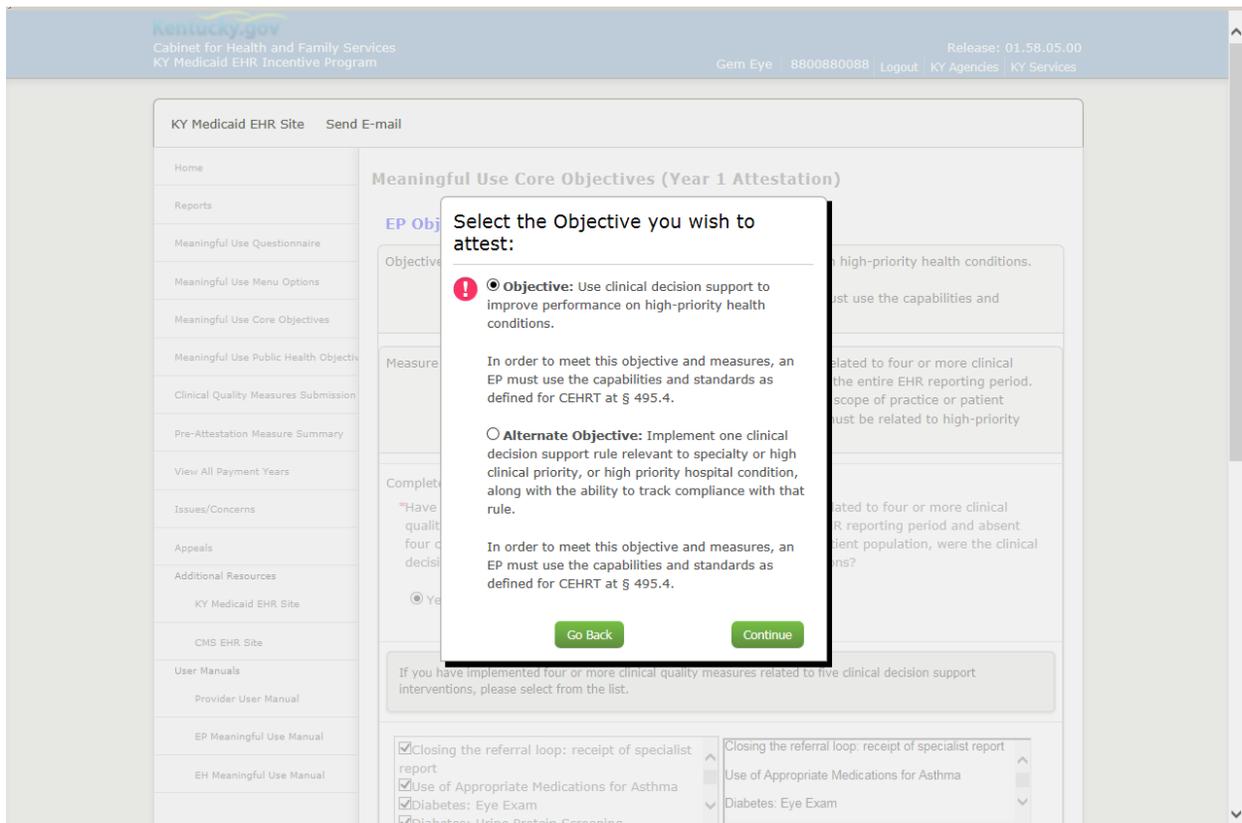
- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.2 MU Core Objective 2 Selection - Clinical Decision Support

**OBJECTIVE:** Use clinical decision support to improve performance on high-priority health conditions.

**ALTERNATE OBJECTIVE:** Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.



Select the Objective being reported.

- Click **Continue** to move on to the Measure details.
- Click **Go Back** to return to the previous screen.

### 7.2.3 MU Core Objective 2 – Clinical Decision Support

**OBJECTIVE:** Use clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

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---

**Meaningful Use Core Objectives (Year 1 Attestation)**

**EP Objective 2 - Clinical Decision Support**

**Objective:**    Use clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

---

**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. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

---

Complete the following information:

\*Have you implemented 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 and absent four clinical quality measures related to your scope of practice or patient population, were the clinical decision support interventions related to high-priority health conditions?

Yes    No

---

If you have implemented four or more clinical quality measures related to five clinical decision support interventions, please select from the list.

<input checked="" type="checkbox"/> Closing the referral loop: receipt of specialist report	<input type="checkbox"/> Closing the referral loop: receipt of specialist report
<input checked="" type="checkbox"/> Use of Appropriate Medications for Asthma	<input type="checkbox"/> Use of Appropriate Medications for Asthma
<input checked="" type="checkbox"/> Diabetes: Eye Exam	<input type="checkbox"/> Diabetes: Eye Exam
<input checked="" type="checkbox"/> Diabetes: Urine Protein Screening	

---

**Measure 2:**    The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

---

**EXCLUSION:**    Any EP who writes fewer than 100 medication orders during the EHR reporting period.

\*Does this exclusion apply to you?

Yes    No

---

Complete the following information:

\*Has the EP enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period?

Yes    No

---

**Previous**   **Next**   **Save**   **Cancel**

In order for EPs to meet the objective, they must satisfy both of the following measures through a combination of selecting yes to the measures or claiming the exclusion.

To satisfy Measure 1, respond to the question.

- If Yes is selected, choose the five clinical decision support interventions implemented related to four or more clinical quality measures.
- If No is selected, upon navigation, a message will pop up stating the entry for the Measure does not qualify for an incentive payment.

To satisfy Measure 2, respond to the Exclusion.

- If No is selected, respond to the question for Measure 2.
  - If No is selected in response to the question for measure 2, upon navigation, a message will pop up stating the entry for Measure 2 does not qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.4 MU Core Objective 2 – Clinical Decision Support Alternate

**ALTERNATE OBJECTIVE:** Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows the KY Medicaid EHR Site interface. At the top, there is a navigation bar with the Kentucky.gov logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', and user information including 'Gem Eye | 8800880088 | Logout | KY Agencies | KY Services'. The main content area is titled 'Meaningful Use Core Objectives (Year 1 Attestation)'. Underneath, 'EP Objective 2 - Clinical Decision Support' is highlighted. The objective text reads: 'Alternate Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule. In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.' Below this, 'Measure 1: Implement one clinical decision support rule.' is listed. A section titled 'Complete the following information:' contains a question: '\*Has the EP implemented one clinical decision support rule?' with radio buttons for 'Yes' (selected) and 'No'. At the bottom, there is a text input field with the placeholder text '\*Please enter the clinical decision support rule implemented.' and the word 'testing' entered in the field.

The screenshot shows a web-based interface for entering data for Measure 2. On the left is a navigation menu with links for 'CMS EHR Site', 'User Manuals', 'Provider User Manual', 'EP Meaningful Use Manual', and 'EH Meaningful Use Manual'. The main content area displays the following information:

**Measure 2:** The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

**EXCLUSION:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.  
 \*Does this exclusion apply to you?  
 Yes  No

**Complete the following information:**  
 \*Has the EP enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period?  
 Yes  No

At the bottom of the form are four green buttons: 'Previous', 'Next', 'Save', and 'Cancel'.

In order for EPs to meet the objective, they must satisfy both of the following measures through a combination of selecting yes to the measures or claiming the exclusion.

To satisfy Measure 1, respond to the question.

- If Yes is selected, enter the name of the clinical decision support rule implemented.
- If No is selected, upon navigation, a message will pop up stating the entry for the Measure does not qualify for an incentive payment.

To satisfy Measure 2, respond to the Exclusion.

- If No is selected, respond to the question for Measure 2.
  - If No is selected in response to the question for measure 2, upon navigation, a message will pop up stating the entry for the Measure does not qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.5 MU Core Objective 3 Selection – Computerized Provider Order Entry

**OBJECTIVE:** Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows the KY Medicaid EHR Site interface. A modal dialog box is displayed in the center, containing the following text:

There are three measures applicable to this objective. Measure 1 has an alternate measure. Please select below for measure 1.

**Objective:**  
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure 1:** More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**Alternate Measure 1:** More than 30% of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

At the bottom of the dialog box are two buttons: "Go Back" and "Continue".

**MEASURE 1:** More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**ALTERNATE MEASURE 1:** More than 30% of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Select the Measure being reported to.

- Click **Continue** to move on to the Measure details.
- Click **Go Back** to return to the previous screen.

## 7.2.6 MU Core Objective 3 – Computerized Provider Order Entry

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  - EH Meaningful Use Manual

### Meaningful Use Core Objectives (Year 1 Attestation)

#### EP Objective 3 - Computerized Provider Order Entry

**Objective:** Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure 1:** More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**\*PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

**\* Does this exclusion apply to you?**

Yes  No

Complete the following information:

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

**Denominator =**                      Number of medication orders created by the EP during the EHR reporting period.

**\*Numerator :**                          **\*Denominator :**

**Measure 2:** More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**ALTERNATE EXCLUSION**    Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

**\*Does this exclusion apply to you?**

Yes  No

**\*PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

**\* Does this exclusion apply to you?**

Yes  No

Complete the following information:

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

**Denominator** = Number of laboratory orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

---

Measure 3: More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

---

**ALTERNATE EXCLUSION** Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

\*Does this exclusion apply to you?

Yes  No

---

\***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

---

**EXCLUSION:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

\* Does this exclusion apply to you?

Yes  No

Complete the following information:

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

**Denominator** = Number of radiology orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

To satisfy Measure 1, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

To satisfy Measure 2, respond to the Alternate Exclusion.

- If No is selected, make two selections.
- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 3, respond to the Alternate Exclusion.

- If No is selected, make two selections.
- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.7 MU Core Objective 3 – Computerized Provider Order Entry Alternate

The screenshot shows a web application interface for the KY Medicaid EHR Site. The header includes the Kentucky.gov logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', and a release date of 01.58.05.00. A navigation menu on the left lists various options like Home, Reports, and Questionnaires. The main content area is titled 'Meaningful Use Core Objectives (Year 1 Attestation)' and focuses on 'EP Objective 3 - Computerized Provider Order Entry'. It contains an objective description, a measure requirement (30% of medication orders using CPOE), a selection for data source (ALL records or certified EHR), and an exclusion section with a 'Yes/No' question.

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    Provider User Manual

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    EH Meaningful Use Manual

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**Meaningful Use Core Objectives (Year 1 Attestation)**

**EP Objective 3 - Computerized Provider Order Entry**

**Objective:** Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

---

**Measure 1:** More than 30% of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

---

**\*PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

---

**EXCLUSION:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

\* Does this exclusion apply to you?

Yes  No

Complete the following information:

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

**Denominator** = Number of medication orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

Measure 2: More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**ALTERNATE EXCLUSION** Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

\*Does this exclusion apply to you?

Yes  No

\*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.  
 This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

\* Does this exclusion apply to you?

Yes  No

Complete the following information:

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

**Denominator** = Number of laboratory orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

Measure 3: More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**ALTERNATE EXCLUSION** Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

\*Does this exclusion apply to you?

Yes  No

\*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.  
 This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

\* Does this exclusion apply to you?

Yes  No

Complete the following information:

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

**Denominator** = Number of radiology orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

[Previous](#) [Next](#) [Save](#) [Cancel](#)

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

To satisfy Measure 1, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 2, respond to the Alternate Exclusion.

- If No is selected, make two selections.
- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 3, respond to the Alternate Exclusion.

- If No is selected, make two selections.
- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

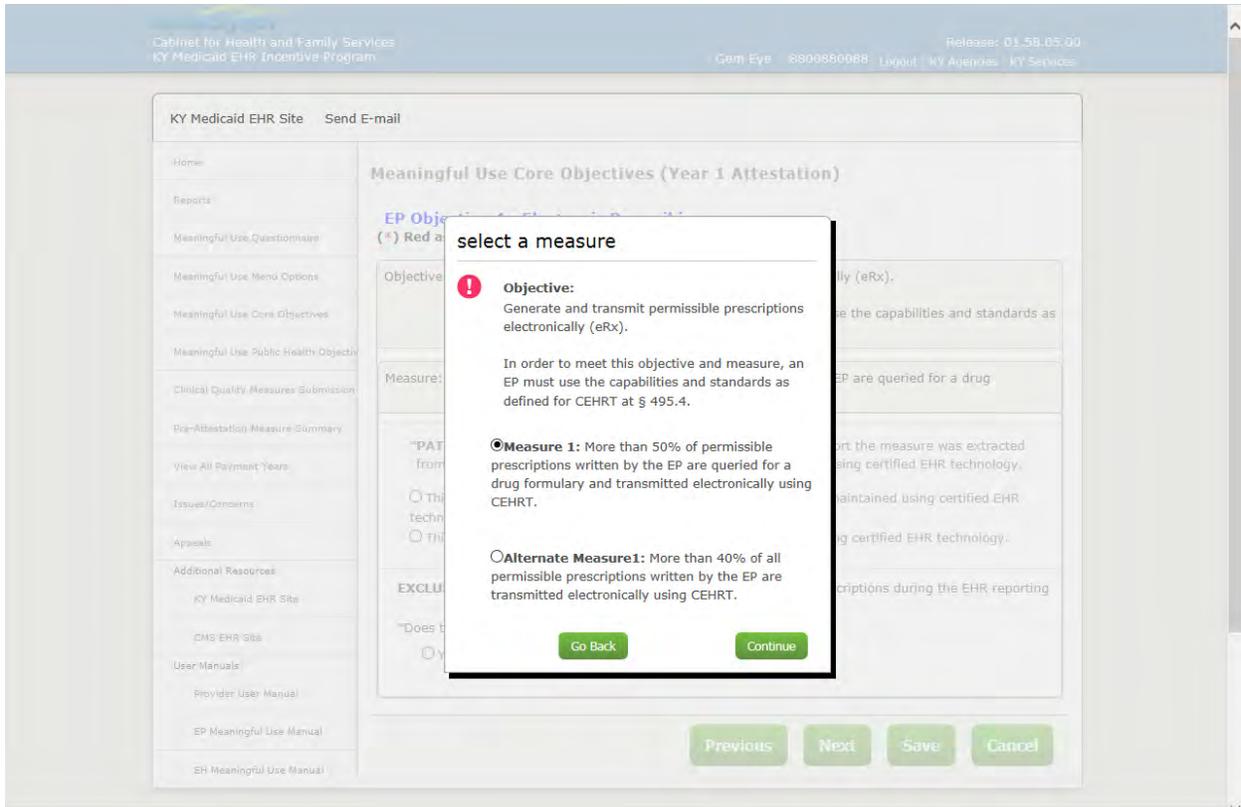
When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 7.2.8 MU Core Objective 4 Selection – Electronic Prescribing

**OBJECTIVE:** Generate and transmit permissible prescriptions electronically (eRx).

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.



**MEASURE 1:** More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

**ALTERNATE MEASURE 1:** More than 40% of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.

Select the Measure Resource being reported to.

- Click **Continue** to move on to the Measure details.
- Click **Go Back** to return to the previous screen.

### 7.2.9 MU Core Objective 4 – Electronic Prescribing

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EH Meaningful Use Manual

#### Meaningful Use Core Objectives (Year 1 Attestation)

##### EP Objective 4 - Electronic Prescribing

(\*) Red asterisk indicates a required field.

**Objective:** Generate and transmit permissible prescriptions electronically (eRx).  
In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure:** More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

**\*PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.  
 This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION 1 -** Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period  
**\*Does this exclusion apply to you?**  
 Yes  No

**EXCLUSION 2 -** Any EP who does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.  
**\*Does this exclusion apply to you?**  
 Yes  No

Complete the following information:

**Numerator =** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

**Denominator =** Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.

**\*Numerator :**  **\*Denominator :**

Previous Next Save Cancel

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to Exclusion 1.
  - If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.10 MU Core Objective 4 – Electronic Prescribing Alternate

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#### Meaningful Use Core Objectives (Year 1 Attestation)

##### EP Objective 4 - Electronic Prescribing

(\* Red asterisk indicates a required field.)

**Objective:** Generate and transmit permissible prescriptions electronically (eRx).  
In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure:** More than 40% of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.

**\*PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.  
 This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION 1 -** Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period  
**\*Does this exclusion apply to you?**  
 Yes  No

**EXCLUSION 2 -** Any EP who does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.  
**\*Does this exclusion apply to you?**  
 Yes  No

Complete the following information:

**Numerator =** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.  
**Denominator =** Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.

**\*Numerator :**  **\*Denominator :**

**Previous** **Next** **Save** **Cancel**

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to Exclusion 1.
  - If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 40% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.11 MU Core Objective 5 – Health Information Exchange

**OBJECTIVE:** The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows a web application interface for the KY Medicaid EHR Site. The header includes the Kentucky.gov logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', and a release date of 01.58.05.00. Navigation links for 'Gem Eye', '8800880088', 'Logout', 'KY Agencies', and 'KY Services' are present. A sidebar on the left contains a menu with items like 'Home', 'Reports', 'Meaningful Use Questionnaire', and 'Meaningful Use Core Objectives'. The main content area is titled 'Meaningful Use Core Objectives (Year 1 Attestation)' and features 'EP Objective 5 - Health Information Exchange'. A red asterisk indicates a required field. The objective text states: 'The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.' Below this, it notes that to meet this objective, an EP must use CEHRT capabilities and standards as defined in 495.4. The 'Measure' section specifies that the EP must (1) use CEHRT to create a summary of care record and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals. An 'ALTERNATE EXCLUSION' section allows providers to claim an exclusion for the Stage 2 measure if they were scheduled to demonstrate Stage 1, which does not have an equivalent measure. A question asks 'Does this exclusion apply to you?' with radio buttons for 'Yes' and 'No'. The 'PATIENT RECORDS' section asks the user to select whether data was extracted from ALL patient records or only from certified EHR technology, with the latter option selected.

**EXCLUSION:** Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

\*Does this exclusion apply to you?

Yes  No

Complete the following information:

**Numerator =** The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and is exchanged electronically.

**Denominator =** Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

\*Numerator :  \*Denominator :

Previous Next Save Cancel

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No is selected, make two selections
  - First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
  - Second, respond to the Exclusion.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.12 MU Core Objective 6 – Patient Specific Education

**OBJECTIVE:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

KY Medicaid EHR Site    Send E-mail

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Objectives  
Meaningful Use Public Health Objectives  
Clinical Quality Measures Submission  
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User Manuals  
    Provider User Manual  
    EP Meaningful Use Manual  
    EH Meaningful Use Manual

### Meaningful Use Core Objectives (Year 1 Attestation)

#### EP Objective 6 - Patient Specific Education

(\*) Red asterisk indicates a required field.

**Objective:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

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

**ALTERNATE EXCLUSION**    Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.

\* Does this exclusion apply to you?  
 Yes     No

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

\* Does this exclusion apply to you?  
 Yes     No

Complete the following information:

**Numerator =**    Number of patients in the denominator who were provided patient specific education resources identified by the CEHRT.

**Denominator =**    Number of unique patients with office visits seen by the EP during the EHR reporting period.

\*Numerator :        \*Denominator :   

Previous    Next    Save    Cancel

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No is selected, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.13 MU Core Objective 7 – Medication Reconciliation

**OBJECTIVE:** The EP that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows the 'Meaningful Use Core Objectives (Year 1 Attestation)' page for 'EP Objective 7 - Medication Reconciliation'. The page includes a sidebar with navigation links, a main content area with objective and measure descriptions, exclusion options, and a form to enter numerator and denominator values.

**Objective:** The EP that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

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

**ALTERNATE EXCLUSION:** Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.

\*Does this exclusion apply to you?  
 Yes  No

\*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.  
 This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION:** Any EP who was not the recipient of any transitions of care during the EHR reporting period.

\*Does this exclusion apply to you?  
 Yes  No

Complete the following information:

**Numerator =** The number of transitions of care in the denominator where medication reconciliation was performed.

**Denominator =** Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

\*Numerator :  \*Denominator :

Buttons: Previous, Next, Save, Cancel

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No is selected, make two selections

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

#### 7.2.14 MU Core Objective 8 – Patient Electronic Access

**OBJECTIVE:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:

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

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.


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 KY Medicaid EHR Incentive Program
 

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 Test User | 2111111111 | Logout | KY Agencies | KY Services

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KY Medicaid EHR Site    Send E-mail

- Home
- Reports
- Meaningful Use Questionnaire
- Meaningful Use Menu Options
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- Meaningful Use Public Health Objectiv
- Clinical Quality Measures Submission
- Pre-Attestation Objective Summary
- View All Payment Years
- Issues/Concerns
- Appeals
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  - KY Medicaid EHR Site
  - CMS EHR Site
- User Manuals
  - Provider User Manual
  - EP Meaningful Use Manual
  - EH Meaningful Use Manual

### Meaningful Use Core Objectives (Year 2 Attestation)

#### EP Objective 8 - Patient Electronic Access

**Both measures must be met in order for the attestation to be accepted.**

**Objective:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:

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

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

---

**Measure 1:** More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

---

**EXCLUSION:** Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for 'Patient Name' and 'Provider's name and office contact information'.

\*Does this exclusion apply to you?

Yes     No

---

Complete the following information:

**Numerator =**      The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.

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

\*Numerator :          \*Denominator :   

---

**Measure 2:** At least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.

[The National Broadband Map \(NBM\)](#) is a searchable and interactive tool that allows users to view broadband availability across every neighborhood in the United States.

The NBM is particularly helpful for providers in the EHR Incentive Programs that need to determine their broadband download speed for exclusion criteria. Providers can use the NBM to search, analyze, and map broadband availability in their area to determine if these exclusions apply.

**ALTERNATE EXCLUSION:** Provider may claim an exclusion for this measure if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

\*Does this exclusion apply to you?

Yes  No

---

**EXCLUSION 1:** Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures.

\*Does this exclusion apply to you?

Yes  No

---

**EXCLUSION 2:** Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

\*Does this exclusion apply to you?

Yes  No

---

Complete the following information:

**Numerator =** The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.

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

\*Numerator :  \*Denominator :

Previous Next Save Cancel

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy both measures for this objective.

To satisfy Measure 1, respond to the Exclusion.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

To satisfy Measure 2, respond to the Alternate Exclusion.

- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator must be greater than or equal to 1, in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.15 MU Core Objective 9 – Secure Electronic Messaging

**OBJECTIVE:** Use secure electronic messaging to communicate with patients on relevant health information.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

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KY Medicaid EHR Incentive Program

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    EH Meaningful Use Manual

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**Meaningful Use Core Objectives (Year 1 Attestation)**

**EP Objective 9 - Secure Electronic Messaging**  
(\* Red asterisk indicates a required field.)

**Objective:** Use secure electronic messaging to communicate with patients on relevant health information.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure:** During the EHR reporting period, the capability for patients to send and receive a secure electronic message with the provider was fully enabled.

**ALTERNATE EXCLUSION**    Any EP who has no office visits during the EHR reporting period

\*Does this exclusion apply to you?  
 Yes     No

**EXCLUSION 1**    An EP may claim an exclusion for the measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

\*Does this exclusion apply to you?  
 Yes     No

**EXCLUSION 2**    Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

\*Does this exclusion apply to you?  
 Yes     No

Complete the following information:  
 \*Has an EP fully enabled the capability for patients to send and receive a secure electronic message during the EHR reporting period?  
 Yes     No

Previous    Next    Save    Cancel

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or they must be able to satisfy the question.

To satisfy the Measure, respond to the Alternate Exclusion.

- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
  - If No is selected, respond the question.

- If No is selected, upon navigation, a message will pop up stating the entry for the Measure does not meet the threshold to qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

#### 7.2.16 MU Core Objective 10 – Public Health

**OBJECTIVE:** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

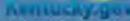
We further specify that providers must use the functions and standards as defined for CEHRT at 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EPs need to meet one of the three measures. Exclusions do not count toward meeting the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available is less than one, the EP can meet the objective by meeting the one remaining measure available and claiming the applicable exclusions. If no measures remain available, you can meet the objective by claiming applicable exclusions for all measures. An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

Providers scheduled to attest to Stage 1 requirements must meet one of the three public health measures.

#### 7.2.17 MU Core Objective 10 – Immunization Registry Reporting

**MEASURE:** The EP is in active engagement with a public health agency to submit immunization data.


**Cabinet for Health and Family Services**  
 KY Medicaid EHR Incentive Program
 

 Release: 01.58.07.03  
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KY Medicaid EHR Site    Send E-mail

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  - Provider User Manual
  - EP Meaningful Use Manual
  - EH Meaningful Use Manual

### Public Health Objective Measures (Year 1 Attestation)

#### Immunization Registry Reporting

**Objective**

The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EPs need to meet one of the three measures. Exclusions do not count toward meeting the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available is less than one, the EP can meet the objective by meeting the one remaining measure available and claiming the applicable exclusions. If no measures remain available, you can meet the objective by claiming applicable exclusions for all measures. An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

**Measure**

The EP is in active engagement with a public health agency to submit immunization data.

**\*Would you like to attest to this measure?**

Yes    No

**ALTERNATE EXCLUSION:**    Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.

**\*Does this exclusion apply to you?**

Yes    No

**EXCLUSION 1:**    Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.

**\*Does this exclusion apply to you?**

Yes    No

**EXCLUSION 2:**    Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

**\*Does this exclusion apply to you?**

Yes    No

**EXCLUSION 3:**    Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP, at the start of the EHR reporting period.

**\*Does this exclusion apply to you?**

Yes    No

**Active Engagement Options:**

**Active Engagement Option 1: Completed Registration to Submit Data:** The EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

**Active Engagement Option 2: Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

**Active Engagement Option 3: Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.



To satisfy the Measure, respond to the question.

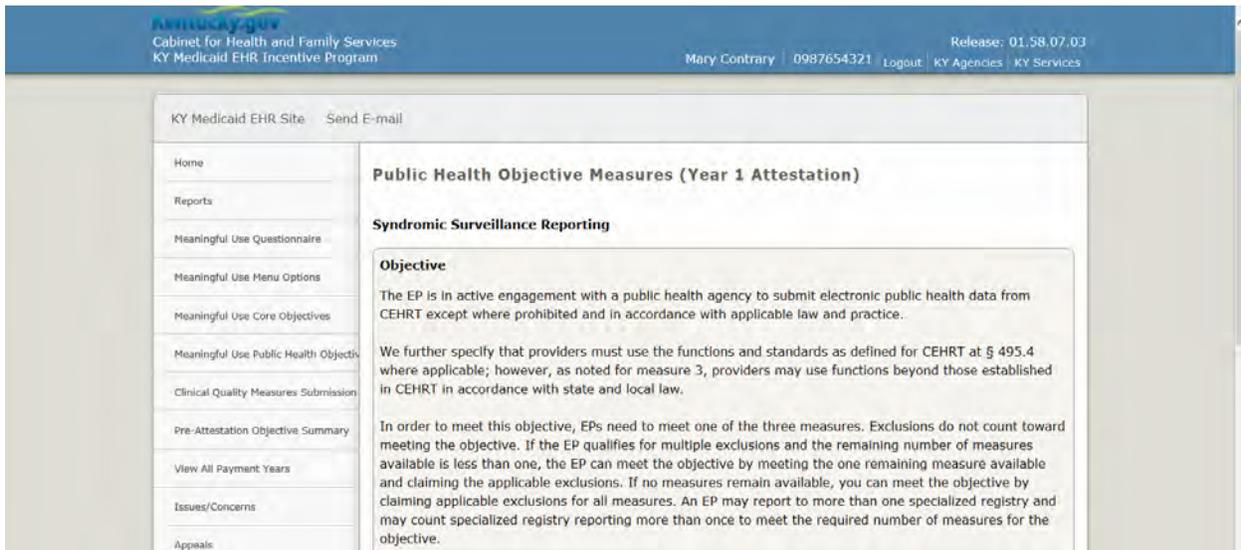
- If Yes is selected, respond to the Alternate Exclusion.
- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
  - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.18 MU Core Objective 10 – Syndromic Surveillance Reporting

**MEASURE:** The EP is in active engagement with a public health agency to submit syndromic surveillance data.



**Additional Resources**

- KY Medicaid EHR Site
- CMS EHR Site

**User Manuals**

- Provider User Manual
- EP Meaningful Use Manual
- EH Meaningful Use Manual

**Measure**

The EP is in active engagement with a public health agency to submit syndromic surveillance data.

**\*Would you like to attest to this measure?**

Yes  No

**ALTERNATE EXCLUSION:** Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.

**\*Does this exclusion apply to you?**

Yes  No

**EXCLUSION 1:** Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system.

**\*Does this exclusion apply to you?**

Yes  No

**EXCLUSION 2:** Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

**\*Does this exclusion apply to you?**

Yes  No

**EXCLUSION 3:** Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

**\*Does this exclusion apply to you?**

Yes  No

**Active Engagement Options:**

Active Engagement Option 1: Completed Registration to Submit Data: The EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2: Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3: Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

**Please select the applicable active engagement option (may only select one).**

Option1  
 Option2  
 Option3

**Previous** **Next** **Save** **Cancel**

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to the Alternate Exclusion.
- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
  - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.2.19 MU Core Objective 10 – Specialized Registry Reporting

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

The screenshot displays the 'Public Health Objective Measures (Year 1 Attestation)' page. The left sidebar contains navigation links such as 'Home', 'Reports', 'Meaningful Use Questionnaire', and 'Additional Resources'. The main content area is titled 'Specialized Registry Reporting' and includes the following sections:

- Objective:** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. It further specifies that providers must use CEHRT functions and standards as defined in § 495.4, with exceptions for measure 3.
- Measure:** The EP is in active engagement to submit data to a specialized registry.
- Would you like to attest to this measure?:** A radio button selection with 'Yes' selected and 'No' unselected.
- ALTERNATE EXCLUSION:** Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective. A question asks if this exclusion applies, with 'No' selected.
- EXCLUSION 1:** Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period. A question asks if this exclusion applies, with 'No' selected.

**EXCLUSION 2:** Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

\*Does this exclusion apply to you?  
 Yes  No

---

**EXCLUSION 3:** Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

\*Does this exclusion apply to you?  
 Yes  No

---

**Active Engagement Options:**

Active Engagement Option 1: Completed Registration to Submit Data: The EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2: Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3: Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

\* Please select the applicable active engagement option (may only select one).

Option1  
 Option2  
 Option3

---

**Instructions:**

Provider may report to more than one specialized registry and may count specialized registry reporting a maximum of two times to meet the required number of measures for the objective. You may enter as many registries as you wish but only two will be counted towards the objective.

To report the first specialized registry, enter the information in the text box, then click 'Add'. To report the additional specialized registries, select the active engagement option applicable for the next registry you are reporting, enter the information in the text box and click 'Add'. Specialized Registry information you are attesting to will be displayed in the Registry table below.

\* Please add the specialized registry below:

KY Cancer Registry  
 Other

LIST OF SPECIALIZED REGISTRIES YOU ADDED:

Type of Registry	Active Engagement Option	Description	Edit	Delete
KY Cancer Registry	3	KY Cancer Registry	<a href="#">Edit</a>	<a href="#">Delete</a>

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to the Alternate Exclusion.
- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
  - If No is selected, make two selections
    - Select the applicable Active Engagement Option for each registry.
    - Add each specialized registry to the table.

- If KY Cancer Registry is selected, click **Add** to add it to the table.
- If Other is selected, type the name of the registry into the text box. Click **Add** to add it to the table.
  - To Edit the entries in the table, click the Edit link next to the registry to make changes. Click **Update** to accept changes or click **Cancel Edit Mode** to remove changes.
  - To Delete the entries in the table, click the Delete link next to the registry.

When final selections have been made, choose a navigation button at the bottom of the screen.

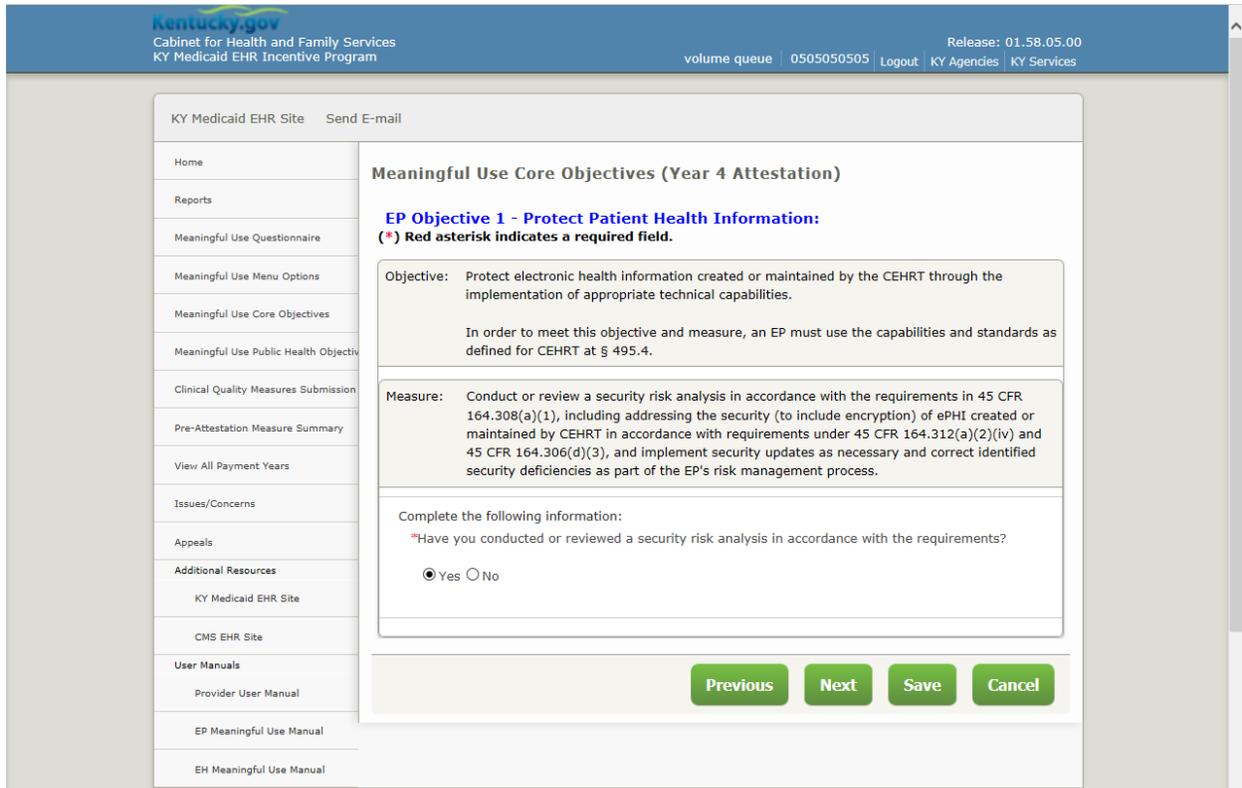
- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 7.3 Meaningful Use Core Objectives - Modified Stage 2

### 7.3.1 MU Core Objective 1 – Protect Patient Health Information

**OBJECTIVE:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.



In order for EPs to meet the objectives, they must be able to satisfy the measure.

To satisfy the Measure, select a response to the question.

- If No is selected, upon navigation, a message will pop up stating that the entry for the measure does not meet the threshold to qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.2 MU Core Objective 2 – Clinical Decision Support

**OBJECTIVE:** Use clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program
Release: 01.58.05.00  
volume queue | 0505050505 | Logout | KY Agencies | KY Services

KY Medicaid EHR Site
Send E-mail

- Home
- Reports
- Meaningful Use Questionnaire
- Meaningful Use Menu Options
- Meaningful Use Core Objectives
- Meaningful Use Public Health Objectives
- Clinical Quality Measures Submission
- Pre-Attestation Measure Summary
- View All Payment Years
- Issues/Concerns
- Appeals
- Additional Resources
  - KY Medicaid EHR Site
  - CMS EHR Site
- User Manuals
  - Provider User Manual
  - EP Meaningful Use Manual
  - EH Meaningful Use Manual

### Meaningful Use Core Objectives (Year 4 Attestation)

#### EP Objective 2 - Clinical Decision Support:

**Objective:** Use clinical decision support to improve performance on high-priority health conditions.

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**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. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

\*Have you implemented 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 and absent four clinical quality measures related to your scope of practice or patient population, were the clinical decision support interventions related to high-priority health conditions?

Yes  No

If you have implemented four or more clinical quality measures related to five clinical decision support interventions, please select from the list.

<input type="checkbox"/> Closing the referral loop: receipt of specialist report	Use of Appropriate Medications for Asthma
<input checked="" type="checkbox"/> Use of Appropriate Medications for Asthma	Diabetes: Eye Exam
<input checked="" type="checkbox"/> Diabetes: Eye Exam	Diabetes: Urine Protein Screening
<input checked="" type="checkbox"/> Diabetes: Urine Protein Screening	

**Measure 2:** The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.

**EXCLUSION:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

\*Does this exclusion apply to you?

Yes  No

Complete the following information:

\*Has the EP enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period?

Yes  No

Previous
Next
Save
Cancel

In order for EPs to meet the objective, they must satisfy both of the following measures through a combination of selecting yes to the measures or claiming the exclusion.

To satisfy Measure 1, respond to the question.

- If Yes is selected, select the five clinical decision support interventions implemented related to four or more clinical quality measures.
- If No is selected, upon navigation, a message will pop up stating the entry for the Measure does not qualify for an incentive payment.

To satisfy Measure 2, respond to the Exclusion.

- If No is selected, respond to the question for measure 2.
  - If No is selected in response to the question for measure 2, upon navigation, a message will pop up stating the entry for Measure 2 does not qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.3 MU Core Objective 3 – Computerized Provider Order Entry

**OBJECTIVE:** Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows the 'KY Medicaid EHR Site' interface. The header includes the Kentucky.gov logo and 'Cabinet for Health and Family Services, KY Medicaid EHR Incentive Program'. A navigation menu on the left lists various options like 'Home', 'Reports', and 'Meaningful Use Core Objectives'. The main content area is titled 'Meaningful Use Core Objectives (Year 4 Attestation)'. Under the sub-heading 'EP Objective 3 - Computerized Provider Order Entry:', the objective is defined as using computerized provider order entry for medication, laboratory, and radiology orders. Below this, 'Measure 1' is defined as recording more than 60% of medication orders using computerized provider order entry. A section for '\*PATIENT RECORDS:' asks if data was extracted from ALL patient records or only from certified EHR technology, with radio buttons for 'This data was extracted from ALL patient records...' and 'This data was extracted only from patient records maintained using certified EHR technology.' An 'EXCLUSION:' section asks if any EP who writes fewer than 100 medication orders during the reporting period, with radio buttons for 'Yes' and 'No'.

EH Meaningful Use Manual

Complete the following information:

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

**Denominator** = Number of medication orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

---

**Measure 2:** More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

\***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

---

**EXCLUSION:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

\* Does this exclusion apply to you?

Yes  No

---

Complete the following information:

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

**Denominator** = Number of laboratory orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

---

**Measure 3:** More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

\***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

---

**EXCLUSION:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

\* Does this exclusion apply to you?

Yes  No

---

Complete the following information:

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

**Denominator** = Number of radiology orders created by the EP during the EHR reporting period.

\*Numerator :  \*Denominator :

Previous
Next
Save
Cancel

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

To satisfy Measure 1, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

To satisfy Measure 2, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

To satisfy Measure 3, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 30% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

#### 7.3.4 MU Core Objective 4 – Electronic Prescribing

**OBJECTIVE:** Generate and transmit permissible prescriptions electronically (eRx).

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

KY Medicaid EHR Site    Send E-mail

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Objectives  
Meaningful Use Public Health Objectiv  
Clinical Quality Measures Submission  
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    Provider User Manual  
    EP Meaningful Use Manual  
    EH Meaningful Use Manual

### Meaningful Use Core Objectives (Year 4 Attestation)

**EP Objective 4 - Electronic Prescribing:**  
(\* Red asterisk indicates a required field.)

**Objective:** Generate and transmit permissible prescriptions electronically (eRx).  
In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure:** More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

**\*PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.  
 This data was extracted only from patient records maintained using certified EHR technology.

**EXCLUSION 1 -** Writes fewer than 100 permissible prescriptions during the EHR reporting period.  
**\*Does this exclusion apply to you?**  
 Yes  No

**EXCLUSION 2 -** Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.  
**\*Does this exclusion apply to you?**  
 Yes  No

Complete the following information:

**Numerator =** The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.  
**Denominator =** Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.

**\*Numerator :**       **\*Denominator :**

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to Exclusion 1.
  - If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.5 MU Core Objective 5 – Health Information Exchange

**OBJECTIVE:** The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows a web application interface for the Kentucky Medicaid EHR Incentive Program. The page title is "Meaningful Use Core Objectives (Year 4 Attestation)". The main heading is "EP Objective 5 - Health Information Exchange". A red asterisk indicates a required field. The objective text states: "The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral." Below this, it notes that to meet this objective, an EP must use CEHRT capabilities and standards as defined in § 495.4. The measure text states: "The EP that transitions or refers their patient to another setting of care or provider of care must-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals." There is a section for "PATIENT RECORDS" with two radio button options: "This data was extracted from ALL patient records not just those maintained using certified EHR technology." (selected) and "This data was extracted only from patient records maintained using certified EHR technology." There is an "EXCLUSION" section stating: "Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period." and a question: "Does this exclusion apply to you?" with radio button options "Yes" and "No" (selected). The form requires completion of the following information: Numerator = "The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically." and Denominator = "Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider." At the bottom, there are input fields for Numerator (40) and Denominator (100). Navigation buttons for "Previous", "Next", "Save", and "Cancel" are located at the bottom right.

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, make two selections

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.6 MU Core Objective 6 – Patient Specific Education

**OBJECTIVE:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Exclusion.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 10% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.7 MU Core Objective 7 – Medication Reconciliation

**OBJECTIVE:** The EP that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, respond to the Exclusion.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.8 MU Core Objective 8 – Patient Electronic Access

**OBJECTIVE:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:

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

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

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stage 2 flows | 1010101010 | Logout | KY Agencies | KY Services

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### Meaningful Use Core Objectives (Year 4 Attestation)

#### EP Objective 8 - Patient Electronic Access

**Both measures must be met in order for the attestation to be accepted.**

**Objective:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:

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

In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.

**Measure 1:** More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

**EXCLUSION:** Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for 'Patient Name' and 'Provider's name and office contact information'.

**\*Does this exclusion apply to you?**  
 Yes  No

Complete the following information:

**Numerator =** The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.

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

**\*Numerator :**  **\*Denominator :**

---

**Measure 2:** At least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.

[The National Broadband Map \(NBM\)](#) is a searchable and interactive tool that allows users to view broadband availability across every neighborhood in the United States.

The NBM is particularly helpful for providers in the EHR Incentive Programs that need to determine their broadband download speed for exclusion criteria. Providers can use the NBM to search, analyze, and map broadband availability in their area to determine if these exclusions apply.

---

**EXCLUSION 1:** Neither orders nor creates any of the information listed for inclusion as part of the measures.

**\*Does this exclusion apply to you?**  
 Yes  No

---

**EXCLUSION 2:** Conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

**\*Does this exclusion apply to you?**  
 Yes  No

Complete the following information:

**Numerator =** The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.

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

**\*Numerator :**  **\*Denominator :**

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy both measures for this objective.

To satisfy Measure 1, respond to the Exclusion.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

To satisfy Measure 2, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
  - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator must be greater than or equal to 1, in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.9 MU Core Objective 9 – Secure Electronic Messaging

**OBJECTIVE:** Use secure electronic messaging to communicate with patients on relevant health information.

In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at 495.4.

The screenshot shows a web application interface for the KY Medicaid EHR Site. The header includes the Kentucky.gov logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', and user information like 'volume queue | 0505050505 | Logout | KY Agencies | KY Services'. The main content area is titled 'Meaningful Use Core Objectives (Year 4 Attestation)' and focuses on 'EP Objective 9 - Secure Electronic Messaging'. A red asterisk indicates a required field. The form contains the following sections:

- Objective:** Use secure electronic messaging to communicate with patients on relevant health information. In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.
- Measure:** The capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period.
- EXCLUSION 1 -** Any EP who has no office visits during the EHR reporting period. \*Does this exclusion apply to you?  Yes  No
- EXCLUSION 2 -** Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. \*Does this exclusion apply to you?  Yes  No
- Complete the following information:** \*Has an EP fully enabled the capability for patients to send and receive a secure electronic message during the EHR reporting period?  Yes  No

At the bottom of the form are four green buttons: 'Previous', 'Next', 'Save', and 'Cancel'.

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or they must be able to satisfy the question.

To satisfy the Measure, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.

- If No is selected, respond the question.
  - If No is selected in response to the question, upon navigation, a message will pop up stating the entry for the Measure does not meet the threshold to qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.10 MU Core Objective 10 – Public Health

**OBJECTIVE:** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EPs need to meet two of the three measures. Exclusions do not count toward meeting the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available is less than two, the EP can meet the objective by meeting the one remaining measure available and claiming the applicable exclusions. If no measures remain available, you can meet the objective by claiming applicable exclusions for all measures. An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

Providers attesting to Modified Stage 2 requirements must meet two of the three measures.

### 7.3.11 MU Core Objective 10 – Measure 1 Immunization Reporting

**MEASURE:** The EP is in active engagement with a public health agency to submit immunization data.


**Cabinet for Health and Family Services**  
 KY Medicaid EHR Incentive Program
 

 Release: 01.58.07.03  
 Two flow 2020202020 Logout KY Agencies KY Services

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KY Medicaid EHR Site    Send E-mail

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### Public Health Objective Measures (Year 4 Attestation)

**Immunization Registry Reporting:**

**Objective**

The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.

In order to meet this objective, EPs need to meet two of the three measures. Exclusions do not count toward meeting the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available is less than two, the EP can meet the objective by meeting the one remaining measure available and claiming the applicable exclusions. If no measures remain available, you can meet the objective by claiming applicable exclusions for all measures. An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

**Measure**

The EP is in active engagement with a public health agency to submit immunization data.

**\*Would you like to attest to this measure?**

Yes  No

**EXCLUSION 1:** Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.

\*Does this exclusion apply to you?

Yes  No

**EXCLUSION 2:** Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

\*Does this exclusion apply to you?

Yes  No

**EXCLUSION 3:** Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP, at the start of the EHR reporting period.

\*Does this exclusion apply to you?

Yes  No

**Active Engagement Options:**

Active Engagement Option 1: Completed Registration to Submit Data: The EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2: Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3: Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

**Please select the applicable active engagement option (may only select one).**

Option1  
 Option2  
 Option3

Previous
Next
Save
Cancel

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
  - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.12 MU Core Objective 10 – Measure 2 Syndromic Surveillance Reporting

**MEASURE:** The EP is in active engagement with a public health agency to submit syndromic surveillance data.

The screenshot shows the KY Medicaid EHR Site interface. The header includes the Kentucky logo, 'Cabinet for Health and Family Services', 'KY Medicaid EHR Incentive Program', and 'Release: 01.58.07.03'. The main content area is titled 'Public Health Objective Measures (Year 4 Attestation)'. Under the heading 'Syndromic Surveillance Reporting:', there is an 'Objective' section. The objective text states: 'The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.' Below this, it specifies: 'We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.' The final paragraph explains: 'In order to meet this objective, EPs need to meet two of the three measures. Exclusions do not count toward meeting the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available is less than two, the EP can meet the objective by meeting the one remaining measure available and claiming the applicable exclusions. If no measures remain available, you can meet the objective by claiming applicable exclusions for all measures. An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.'

**Additional Resources**

- KY Medicaid EHR Site
- CHS EHR Site

**User Manuals**

- Provider User Manual
- EP Meaningful Use Manual
- EHR Meaningful Use Manual

**Measure:**  
The EP is in active engagement with a public health agency to submit syndromic surveillance data.

**\*Would you like to attest to this measure?**  
 Yes  No

**ALTERNATE EXCLUSION:** Providers may claim an alternate exclusion for a measure if they did not intend to attest to the equivalent prior menu objective.  
**\*Does this exclusion apply to you?**  
 Yes  No

**EXCLUSION 1:** Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system.  
**\*Does this exclusion apply to you?**  
 Yes  No

**EXCLUSION 2:** Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.  
**\*Does this exclusion apply to you?**  
 Yes  No

**EXCLUSION 3:** Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.  
**\*Does this exclusion apply to you?**  
 Yes  No

**Active Engagement Options:**

Active Engagement Option 1: Completed Registration to Submit Data: The EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2: Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3: Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

**Please select the applicable active engagement option (may only select one).**

Option1  
 Option2  
 Option3

**Previous** **Next** **Save** **Cancel**

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to the Alternate Exclusion.
- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
  - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 7.3.13 MU Core Objective 10 – Measure 3 Specialized Registry Reporting

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

The screenshot displays the 'Public Health Objective Measures (Year 4 Attestation)' page. On the left is a navigation menu with items like 'Home', 'Reports', 'Meaningful Use Questionnaire', and 'Additional Resources'. The main content area is titled 'Public Health Objective Measures (Year 4 Attestation)' and contains the following sections:

- Specialized Registry Reporting:**
  - Objective:** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. It further specifies that providers must use CEHRT functions and standards as defined in § 495.4, and that EPs need to meet two of three measures, with exclusions allowed.
  - Measure:** The EP is in active engagement to submit data to a specialized registry.
  - Attestation:** A question asks 'Would you like to attest to this measure?' with radio buttons for 'Yes' (selected) and 'No'.
  - ALTERNATE EXCLUSION:** Providers may claim an alternate exclusion if they did not intend to attest to the equivalent prior menu objective. A question asks 'Does this exclusion apply to you?' with radio buttons for 'Yes' and 'No' (selected).
  - EXCLUSION 1:** Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period. A question asks 'Does this exclusion apply to you?' with radio buttons for 'Yes' and 'No' (selected).
  - EXCLUSION 2:** Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. A question asks 'Does this exclusion apply to you?' with radio buttons for 'Yes' and 'No' (selected).
  - EXCLUSION 3:** Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period. A question asks 'Does this exclusion apply to you?' with radio buttons for 'Yes' and 'No' (selected).

**Active Engagement Options:**

Active Engagement Option 1: Completed Registration to Submit Data: The EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days of the beginning of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. This option allows providers to meet the measure when the PHA has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2: Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3: Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

\* Please select the applicable active engagement option (may only select one).

Option1  
 Option2  
 Option3

**Instructions:**

Provider may report to more than one specialized registry and may count specialized registry reporting a maximum of two times to meet the required number of measures for the objective. You may enter as many registries as you wish but only two will be counted towards the objective.

To report the first specialized registry, enter the information in the text box, then click 'Add'. To report the additional specialized registries, select the active engagement option applicable for the next registry you are reporting, enter the information in the text box and click 'Add'. Specialized Registry information you are attesting to will be displayed in the Registry table below.

\* Please add the specialized registry below:

KY Cancer Registry  
 Other

LIST OF SPECIALIZED REGISTRIES YOU ADDED:

Type of Registry	Active Engagement Option	Description	Edit	Delete
KY Cancer Registry	1	KY Cancer Registry	<a href="#">Edit</a>	<a href="#">Delete</a>

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to the Alternate Exclusion.
- If No is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
  - If No is selected, make two selections
    - Select the applicable Active Engagement Option for each registry.
    - Add each specialized registry to the table.
      - If KY Cancer Registry is selected, click **Add** to add it to the table.
      - If Other is selected, type the name of the registry into the text box. Click **Add** to add it to the table.
        - To Edit the entries in the table, click the Edit link next to the registry to make changes. Click **Update** to accept the changes or **Cancel Edit Mode** to remove changes.
        - To Delete the entries in the table, click the Delete link next to the registry.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8 Clinical Quality Measures

### 8.1 Clinical Quality Measure Submission Selection Screen

KY Medicaid EHR Site | Send E-mail

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Objectives  
Meaningful Use Public Health Objectives  
Clinical Quality Measures Submission  
Pre-Attestation Objective Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
KY Medicaid EHR Site  
CMS EHR Site  
User Manuals  
Provider User Manual  
EP Meaningful Use Manual  
EH Meaningful Use Manual

Release: 01.58.07.03  
Mary Contrary | 0987654321 | Logout | KY Agencies | KY Services

#### Clinical Quality Measure (CQM) Submission Selection Screen (Year 1 Attestation)

##### Reporting Clinical Quality Measures

In order to report CQMs, you will need to select the method of submission below.

Note: If you are using 2014 CEHRT that is capable of producing QRDA III files in a .XML format, electronic submission is encouraged.  
EPs must report on 9 of the 64 approved CQMs. Selected CQMs must cover at least 3 of the National Quality Strategy domains. For additional information on CQM reporting, please [click here](#).

\*\*\*PROVIDERS MUST MEET THE REQUIRED DOMAINS IN ORDER TO SUBMIT THE ATTESTATION\*\*\*

How would you like to submit CQMs?  
 Manually  Electronically

For Program Year 2015, any continuous 90 days within the calendar year is permitted. Please provide the CQM reporting period associated with this attestation:

\*CQM Reporting Period Start Date:  (mm/dd/yy)

\*CQM Reporting Period End Date:  (mm/dd/yy)

Previous Next Save Cancel

Select how to submit CQMs, manually or electronically.

- If **Manually** is selected, enter the CQM reporting period start date and end date.
  - Start and end date must be any continuous 90-day period within the calendar year.
- If **Electronically** is selected, upon clicking **Next**, the EP is advanced to the eCQM Detail Report screen.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.

- Click **Cancel** to remove selections and stay on the current screen.

## 8.2 Clinical Quality Measures Electronically Reported

### 8.2.1 eCQM Detail Report

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

Test User | 2111111111 | Logout | KY Agencies | KY Services

Release: 01.58.07.03

KY Medicaid EHR Site | Send E-mail

Home  
Reports  
Meaningful Use Questionnaire  
Meaningful Use Menu Options  
Meaningful Use Core Objectives  
Meaningful Use Public Health Objectives  
Clinical Quality Measures Submission  
Pre-Attestation Objective Summary  
View All Payment Years  
Issues/Concerns  
Appeals  
Additional Resources  
KY Medicaid EHR Site  
CMS EHR Site  
User Manuals  
Provider User Manual  
EP Meaningful Use Manual  
EH Meaningful Use Manual

#### eCQM (Year 2 Attestation)

eCQM Detail Report

QRDA File Upload

Please use the browse function below to upload your eCQM file following HL7 Standards (<http://www.hl7.org/>). QRDA III xml files are required and you must meet CMS defined thresholds in order to successfully attest. The most recent submission with an accepted status will be used for validation. QRDA I xml files will be accepted however will not fulfill the requirement of electronic submission of eCQMs.

Uploaded Invalid Files

No errors to report.

To view the emeasures from your QRDA III file, click the select link in the corresponding row. Before proceeding, please review the emeasures and details.  
**The most recent submission with an accepted status will be used for validation.**  
Rows that do not include a select link are QRDA I documents that have been uploaded.

Uploaded Valid Files

	FileTransmissionID	Status	DateReceived	FileName
<a href="#">Select</a>	538	Accepted	2/23/2016 9:42:03 AM	2015 KLIPPENSTEIN KELLI - NPI 2111111111.xml

Selected File ECQMs

Measure Details					Domain
eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID	
Use of High-Risk Medications in the Elderly	a3837ff8-1abc-4ba9-800e-fd4e7953adbd	2		40280381-3D61-56A7-013E-65C9C3043E54	Patient Safety
Member of Measure Set: NONE - eMeasure ID:5b3d9245-fb54-499c-b5c5-21c20564f0bd Initial Patient Population: 73 SexFemale: 48Male: 23Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 70 RaceAsian: 5Black or African American: 3White: 4Other Race: 2 Denominator: 73 SexFemale: 48Male: 23Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 70 RaceAsian: 5Black or African American: 3White: 4Other Race: 2 Numerator 1: 22 SexFemale: 14Male: 8 PayerUnavailable / Unknown: 22 Numerator 2: 10 SexFemale: 5Male: 5 PayerUnavailable / Unknown: 10					
eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID	
CERVICAL CANCER SCREENING	42e7e489-790f-427a-a1a6-d6e807f65a6d	2		40280381-3D61-56A7-013E-669CBC034836	Clinical Process / Effectiveness
Member of Measure Set: NONE - eMeasure ID:e1d695b0-acee-472f-bfaf-dbb6e1515933 Initial Patient Population: 107 SexFemale: 107 EthnicityNot Hispanic or Latino: 3 PayerMEDICARE: 20BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 86 RaceAmerican Indian or Alaska Native: 1Black or African American: 2 Denominator: 107 SexFemale: 107 EthnicityNot Hispanic or Latino: 3 PayerMEDICARE: 20BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 86 RaceAmerican Indian or Alaska Native: 1Black or African American: 2Numerator: 0Denominator Exclusions: 0					
eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID	
Chlamydia Screening in Women	c9930664-be3d-4ffe-ae4a-5cf4933ecb89	2		40280381-3D61-56A7-013E-5D4001866C09	Population and Public Health
Member of Measure Set: NONE - eMeasure ID:60caa8bf-3285-4d63-b686-0d737eec5e53 Initial Patient Population: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Denominator: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Numerator: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Denominator Exclusions: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0					
eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID	
Preventive Care and Screening: Influenza Immunization	a244aa29-7d11-4616-888a-86e376bfcc6f	2		40280381-3D61-56A7-013E-57F49972361A	Population and Public Health
Member of Measure Set: NONE - eMeasure ID:40d83c98-aaa9-4436-9c12-54b0896b0b2c Initial Patient Population: 158 SexFemale: 51Male: 104Undifferentiated: 3 EthnicityHispanic or Latino: 6Not Hispanic or Latino: 4 PayerMEDICARE: 6Unavailable / Unknown: 152 RaceAmerican Indian or Alaska Native: 3Asian: 4White: 1Other Race: 2 Denominator: 83 SexFemale: 17Male: 66 EthnicityHispanic or Latino: 1Not Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 82 RaceAmerican Indian or Alaska Native: 1Asian: 1 Numerator: 15 SexFemale: 3Male: 12 PayerUnavailable / Unknown: 15 Denominator Exceptions: 24 SexFemale: 6Male: 18 PayerUnavailable / Unknown: 24					
eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID	
Pneumonia Vaccination Status for Older Adults	59657b9b-01bf-4979-a090-8534da1d0516	2		40280381-3D61-56A7-013E-66A79D4A4A23	Clinical Process / Effectiveness

Member of Measure Set: NONE - eMeasure ID:097e91e6-bb8d-4f16-9acf-f7d9dce26799  
 Initial Patient Population: 75 SexFemale: 49Male: 24Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 6 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 72 RaceAsian: 5Black or African American: 3White: 5Other Race: 2 Denominator: 75 SexFemale: 49Male: 24Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 6 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 72 RaceAsian: 5Black or African American: 3White: 5Other Race: 2 Numerator: 1 SexFemale: 1 PayerUnavailable / Unknown: 1

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Diabetes: Foot Exam	c0d72444-7c26-4863-9b51-8080f8928a85	2		40280381-3D61-56A7-013E-5D11ABE068EB

Clinical Process / Effectiveness

Member of Measure Set: NONE - eMeasure ID:e5a14575-bfe4-473a-beae-32d13922bb52  
 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator: 96 SexFemale: 60Male: 34Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 93 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Numerator: 14 SexFemale: 2Male: 12 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 13 RaceAmerican Indian or Alaska Native: 1 Denominator Exclusions: 15 SexFemale: 5Male: 10 PayerUnavailable / Unknown: 15

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Diabetes: HbA1c Poor Control	f2986519-5a4e-4149-a8f2-af0a1dc7f6bc	2		40280381-3D61-56A7-013E-62240559256D

Clinical Process / Effectiveness

Member of Measure Set: NONE - eMeasure ID:bc0c7003-0d58-4dbd-a135-fe4456de3432  
 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator: 108 SexFemale: 62Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 105 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Numerator: 108 SexFemale: 62Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 105 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator Exclusions: 3 SexFemale: 3 PayerUnavailable / Unknown: 3

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Diabetes: Urine Protein Screening	7b2a9277-43da-4d99-9bee-6ac271a07747	2		40280381-3D61-56A7-013E-62ABF5662FFF

Clinical Process / Effectiveness

Member of Measure Set: NONE - eMeasure ID:6122e70a-c683-4c01-a521-c72afbd564f9  
 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator: 106 SexFemale: 62Male: 42Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 103 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Numerator: 30 SexFemale: 30 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 29 RaceAmerican Indian or Alaska Native: 1 Denominator Exclusions: 5 SexFemale: 3Male: 2 PayerUnavailable / Unknown: 5

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Diabetes: LDL Management And Control	0dac1dec-e011-493b-a281-7c28964872dd	2		40280381-3D61-56A7-013E-5D5B19BF6DFB

Clinical Process / Effectiveness

Member of Measure Set: NONE - eMeasure ID:be0483ef-48ae-4feb-b98e-078f56b157c0  
 Initial Patient Population: 111 SexFemale: 65Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 108 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Denominator: 108 SexFemale: 62Male: 44Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 105 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Other Race: 2 Numerator: 0 Denominator Exclusions: 3 SexFemale: 3 PayerUnavailable / Unknown: 3

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0713ea8f-0e5b-4099-8c7c-dd677280398f	2		40280381-3D61-56A7-013E-7BC5AEC17282

Clinical Process / Effectiveness

Member of Measure Set: NONE - eMeasure ID:4ffca4e9-fbe0-4a55-80e2-39280a9bc822Initial Patient Population: 0Denominator: 0Numerator: 0

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0b63f730-25d6-4248-b11f-8c09c66a04eb	2		40280381-3D61-56A7-013E-5D530FD26D47

Population and Public Health

Member of Measure Set: NONE - eMeasure ID:2b59c988-1e6a-44d7-a39d-aab90ad3a33a  
 Initial Patient Population: 6 StrataReporting Stratum 1: 3Reporting Stratum 2: 3 SexFemale: 2Male: 4 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 2Unavailable / Unknown: 4 RaceAmerican Indian or Alaska Native: 1 Denominator: 6 StrataReporting Stratum 1: 3Reporting Stratum 2: 3 SexFemale: 2Male: 4 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 2Unavailable / Unknown: 4 RaceAmerican Indian or Alaska Native: 1 Numerator 1: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Numerator 2: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Numerator 3: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0 Denominator Exclusions: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID
Childhood Immunization Status	b2802b7a-3580-4be8-9458-921aea62b78c	2		40280381-3D61-56A7-013E-6224E2AC25F3

Population and Public Health

Member of Measure Set: PREVENTIVE CARE AND SCREENING - eMeasure ID:05ddea75-fe78-49b0-a37a-76d06b219c07 Initial Patient Population 1: 289 SexFemale: 134Male: 153Undifferentiated: 2 EthnicityHispanic or Latino: 3Not Hispanic or Latino: 12 PayerMEDICARE: 31BLUE CROSS/BLUE SHIELD: 2Unavailable / Unknown: 256 RaceAmerican Indian or Alaska Native: 4Asian: 1Black or African American: 4White: 4Other Race: 2 Initial Patient Population 2: 289 SexFemale: 134Male: 153Undifferentiated: 2 EthnicityHispanic or Latino: 3Not Hispanic or Latino: 12 PayerMEDICARE: 31BLUE CROSS/BLUE SHIELD: 2Unavailable / Unknown: 256 RaceAmerican Indian or Alaska Native: 4Asian: 1Black or African American: 4White: 4Other Race: 2 Initial Patient Population 3: 289 SexFemale: 134Male: 153Undifferentiated: 2 EthnicityHispanic or Latino: 3Not Hispanic or Latino: 12 PayerMEDICARE: 31BLUE CROSS/BLUE SHIELD: 2Unavailable / Unknown: 256 RaceAmerican Indian or Alaska Native: 4Asian: 1Black or African American: 4White: 4Other Race: 2 Denominator 1: 107 SexFemale: 62Male: 45 EthnicityNot Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 104 RaceAmerican Indian or Alaska Native: 1Black or African American: 2White: 2Denominator 2: 0 Denominator 3: 173 SexFemale: 63Male: 108Undifferentiated: 2 EthnicityHispanic or Latino: 3Not Hispanic or Latino: 7 PayerMEDICARE: 27BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 145 RaceAmerican Indian or Alaska Native: 3Asian: 1Black or African American: 2White: 2Other Race: 2 Numerator 1: 8 SexFemale: 8 PayerUnavailable / Unknown: 8Numerator 2: 0 Numerator 3: 1 SexMale: 1 EthnicityNot Hispanic or Latino: 1 PayerMEDICARE: 1 RaceAmerican Indian or Alaska Native: 1 Denominator Exclusions 1: 3 SexFemale: 3 PayerUnavailable / Unknown: 3Denominator Exclusions 2: 0 Denominator Exclusions 3: 4 SexFemale: 4 PayerUnavailable / Unknown: 4Denominator Exceptions 1: 0Denominator Exceptions 2: 0Denominator Exceptions 3: 0

eMeasure Title	Version Neutral ID	eMeasure Version Number	NQF Measure Number	Version Specific ID	Clinical Process / Effectiveness
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	0b81b6ba-3b30-41bf-a2f3-95bdc9f558f2	3		40280381-3D61-56A7-013E-8ACBF873BCB	
Member of Measure Set: NONE - eMeasure ID:75d957a0-bdaf-49ad-b592-0e8fbb69d619 Initial Patient Population: 229 StrataReporting Stratum 1: 220Reporting Stratum 2: 2Reporting Stratum 3: 7 SexFemale: 3Male: 224Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 4 PayerMEDICARE: 4Unavailable / Unknown: 225 RaceAmerican Indian or Alaska Native: 2White: 2Other Race: 2 Denominator: 229 StrataReporting Stratum 1: 220Reporting Stratum 2: 2Reporting Stratum 3: 7 SexFemale: 3Male: 224Undifferentiated: 2 EthnicityHispanic or Latino: 2Not Hispanic or Latino: 4 PayerMEDICARE: 4Unavailable / Unknown: 225 RaceAmerican Indian or Alaska Native: 2White: 2Other Race: 2 Numerator: 0 StrataReporting Stratum 1: 0Reporting Stratum 2: 0Reporting Stratum 3: 0					
<span>Previous</span> <span>Continue</span>					

There are four sections to consider on the eCQM Detail Report including QRDA File Upload, Uploaded Invalid Files, Uploaded Valid Files, and Selected File eCQMs.

### QRDA File Upload

- To upload the eCQM file, click **Browse** to locate the extracted QRDA III file. Click the **Upload QRDA File** button to upload.
  - Note that to upload the eCQM file follow the HL7 Standards (<http://www.hl7.org/>). QRDA III xml files are required and you must meet CMS defined thresholds in order to successfully attest. QRDA I xml files will be accepted however will not fulfill the requirement of electronic submission of eCQMs.

### Uploaded Invalid Files

- The file is listed in this section if there are errors found in the report.

### Uploaded Valid Files

- If file upload is successful, the file will appear here. Click the **Select** link to display the details of the eCQMs.
  - The most recent submission with an accepted status will be used for validation. Rows that do not include a Select link are QRDA I documents that have been uploaded.

### Selected Files

- This section will display all of the measure details from the file selected.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Continue** to move on to the eCQM Summary Report.



## 8.3 Clinical Quality Measures Manually Reported

### 8.3.1 Clinical Quality Measure CMS146

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 1 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS146/NQF 0002  
**Versions:** CMS146v3  
**Title:** Appropriate Testing for Children with Pharyngitis.  
**Description:** Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

**Denominator:** Children 2-18 years of age who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit.  
**Numerator:** Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis.  
**Denominator Exclusions:** Exclusion 1: Children who are taking antibiotics in the 30 days prior to the diagnosis of pharyngitis.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
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### 8.2.2 Clinical Quality Measure CMS137

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Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 2 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS137/NQF 0004  
**Versions:** CMS137v3  
**Title:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.  
**Description:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported.  
a. Percentage of patients who initiated treatment within 14 days of the diagnosis.  
b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

**Denominator :** Denominator 1: Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period.  
**Numerator :** Numerator 1: Patients who initiated treatment within 14 days of the diagnosis. Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.  
**Denominator Exclusions:** Exclusion 1: Patients with a previous active diagnosis of alcohol or drug dependence in the 60 days prior to the first episode of alcohol or drug dependence.

Complete the following information:

Stratum 1: Patients age 13 - 17

Denominator 1: 100	Numerator 1: 50	Performance Rate 1 (%): 2.00	Exclusion 1: 10
Denominator 2: 10	Numerator 2: 10	Performance Rate 2 (%): 10.00	Exclusion 2: 10

Stratum 2: Patients age > = 18

Denominator 1: 10	Numerator 1: 10	Performance Rate 1 (%): 10.00	Exclusion 1: 10
Denominator 2: 10	Numerator 2: 10	Performance Rate 2 (%): 10.00	Exclusion 2: 10

Stratum 3: Total Score

Denominator 1: 10	Numerator 1: 10	Performance Rate 1 (%): 10.00	Exclusion 1: 10
Denominator 2: 10	Numerator 2: 10	Performance Rate 2 (%): 10.00	Exclusion 2: 10

Previous    Next    Save    Cancel

To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes, for all three Stratums.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
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### 8.2.3 Clinical Quality Measure CMS165

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KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 3 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS165/NQF 0018  
**Versions:** CMS165V3

**Title:** Controlling High Blood Pressure.  
**Description:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

**Denominator:** Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.  
**Numerator:** Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.  
**Denominator Exclusions:** Exclusion 1: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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### 8.2.4 Clinical Quality Measure CMS156

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KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 4 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS156/NQF 0022  
**Versions:** CMS156V3  
**Title:** Use of High-Risk Medications in the Elderly.  
**Description:** 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.

**Denominator :** Denominator 1: Patients 66 years and older who had a visit during the measurement period.  
**Numerator :** Numerator 1: Patients with an order for at least one high-risk medication during the measurement period.  
Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):
10	10	10.00
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):
10	10	10.00

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.5 Clinical Quality Measure CMS155

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 5 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS155/NQF 0024  
**Versions:** CMS155v3  
**Title:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents.  
**Description:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.  
- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation  
- Percentage of patients with counseling for nutrition  
- Percentage of patients with counseling for physical activity

**Denominator :** Denominator 1: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period.  
**Numerator :** Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period.  
Numerator 2: Patients who had counseling for nutrition during the measurement period.  
Numerator 3: Patients who had counseling for physical activity during the measurement period.  
**Denominator Exclusions:** Exclusion 1: Patients who have a diagnosis of pregnancy during the measurement period.

Complete the following information:

Stratum 1: Patients age 3 - 11

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
10	10	10.00	10
* Denominator 3:	* Numerator 3:	* Performance Rate 3 (%):	* Exclusion 3:
10	10	10.00	10

Stratum 2: Patients age 12 - 17

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
10	10	10.00	10
* Denominator 3:	* Numerator 3:	* Performance Rate 3 (%):	* Exclusion 3:
10	10	10.00	10

Stratum 3: Total Score

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	Exclusion 1:
10	10	10.00	10
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	Exclusion 2:
10	10	10.00	10
* Denominator 3:	* Numerator 3:	* Performance Rate 3 (%):	Exclusion 3:
10	10	10.00	10

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes, for all three Stratums.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.6 Clinical Quality Measure CMS138

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 6 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS138/NQF 0028  
**Versions:** CMS138V3

**Title:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

**Description:** 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.

**Denominator:** All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

**Numerator:** Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.

**Denominator Exceptions:** Exception 1: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason).

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.7 Clinical Quality Measure CMS125

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 7 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS125/NQF XXXX  
**Versions:** CMS125V3  
**Title:** Breast Cancer Screening.  
**Description:** Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

**Denominator:** Women 41-69 years of age with a visit during the measurement period.  
**Numerator:** Women with one or more mammograms during the measurement period or the year prior to the measurement period.  
**Denominator Exclusions:** Exclusion 1: Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.8 Clinical Quality Measure CMS124

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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 8 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS124/NQF 0032  
**Versions:** CMS124v3  
**Title:** Cervical Cancer Screening.  
**Description:** Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.

**Denominator:** Women 23-64 years of age with a visit during the measurement period.  
**Numerator:** Women with one or more Pap tests during the measurement period or the two years prior to the measurement period.

**Denominator Exclusions:** Exclusion 1: Women who had a hysterectomy with no residual cervix.

Complete the following information:

Denominator 1:	Numerator 1:	Performance Rate 1 (%):	Exclusion 1:
10	10	10.00	10

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.9 Clinical Quality Measure CMS153

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 1 Attestation)

**Questionnaire 9 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS153/NQF 0033  
**Versions:** CMS153v3  
**Title:** Chlamydia Screening for Women  
**Description:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

**Denominator :** Denominator 1: Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.  
**Numerator :** Numerator 1: Women with at least one chlamydia test during the measurement period.  
**Denominator Exclusions:** Exclusion 1: Women who received a pregnancy test solely as a safety precaution before ordering an x-ray or specified medications.

Complete the following information:

Stratum 1: Patients age 16-20  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Stratum 2: Patients age 21-24  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Stratum 3: Total Score  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes, for all three Stratums.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.10 Clinical Quality Measure CMS130

Kentucky.gov  
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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 10 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS130/NQF 0034  
**Versions:** CMS130v3

**Title:** Colorectal Cancer Screening.  
**Description:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

**Denominator:** Patients 50-75 years of age with a visit during the measurement period.  
**Numerator:** Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below:  
- Fecal occult blood test (FOBT) during the measurement period  
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period  
- Colonoscopy during the measurement period or the nine years prior to the measurement period.

**Denominator Exclusions:** Exclusion 1: Patients with a diagnosis or past history of total colectomy or colorectal cancer.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.11 Clinical Quality Measure CMS126

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 11 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS126/NQF 0036  
**Versions:** CMS126v3  
**Title:** Use of Appropriate Medications for Asthma.  
**Description:** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

**Denominator :** Denominator 1: Patients 5-64 years of age with persistent asthma and a visit during the measurement period.  
**Numerator :** Numerator 1: Patients who were dispensed at least one prescription for a preferred therapy during the measurement period.  
**Denominator Exclusions:** Exclusion 1: Patients with emphysema, COPD, cystic fibrosis or acute respiratory failure during or prior to the measurement period.

Complete the following information:

Stratum 1: Patients age 5 - 11  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Stratum 2: Patients age 12 - 18  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Stratum 3: Patients age 19 - 50  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Stratum 4: Patients age 51 - 64  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Stratum 5: TotalScore  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes, for all 5 Stratum.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.12 Clinical Quality Measure CMS117

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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 12 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS117/NQF 0038  
**Versions:** CMS117V3  
**Title:** Childhood Immunization Status.  
**Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

**Denominator:** Children who turn 2 years of age during the measurement period and who have a visit during the measurement period.  
**Numerator:** Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.13 Clinical Quality Measure CMS147

Kentucky.gov  
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KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 13 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS147/NQF 0041  
**Versions:** CMS147v4  
**Title:** Preventive Care and Screening: Influenza Immunization.  
**Description:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.

**Denominator:** All patients aged 6 months and older seen for at least two visits or at least one preventive visit during the measurement period and seen for a visit between October 1 and March 31.  
**Numerator:** Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons).  
Exception 2: Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons).  
Exception 3: Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons).

Complete the following information:

* Denominator 1: 10	* Numerator 1: 10	* Performance Rate 1 (%): 10.00	* Exception 1: 10
* Exception 2: 10	* Exception 3: 10		

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and each of the three Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.14 Clinical Quality Measure CMS127

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 14 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS127/NQF 0043  
**Versions:** CMS127V3

**Title:** Pneumonia Vaccination Status for Older Adults.  
**Description:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

**Denominator:** Patients 65 years of age and older with a visit during the measurement period.  
**Numerator:** Patients who have ever received a pneumococcal vaccination.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.15 Clinical Quality Measure CMS166

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 15 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS166/NQF 0052  
**Versions:** CMS166V4  
**Title:** Use of Imaging Studies for Low Back Pain.  
**Description:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

**Denominator:** Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency department visit.  
**Numerator:** Patients without an imaging study conducted on the date of the outpatient or emergency department visit or in the 28 days following the outpatient or emergency department visit.

**Denominator Exclusions:**  
Exclusion 1: Exclude patients with a diagnosis of cancer any time in their history or patients with a diagnosis of recent trauma, IV drug abuse, or neurologic impairment during the 12-month period prior to the outpatient or emergency department visit.  
Exclusion 2: Exclude patients with a diagnosis of low back pain within the 180 days prior to the outpatient or emergency department visit.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:   
\* Exclusion 2:

**Previous** **Next** **Save** **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and both Exclusion boxes.

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## 8.2.16 Clinical Quality Measure CMS131

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 16 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS131/NQF 0055  
**Versions:** CMS131V3  
**Title:** Diabetes: Eye Exam.  
**Description:** Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.  
**Numerator:** Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following:  
A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.17 Clinical Quality Measure CMS123

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 17 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS123/NQF 0056  
**Versions:** CMS123V3  
**Title:** Diabetes: Foot Exam.  
**Description:** Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.  
**Numerator:** Patients who received visual, pulse and sensory foot examinations during the measurement period.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.18 Clinical Quality Measure CMS122

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 18 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS122/NQF 0059  
**Versions:** CMS122V3  
**Title:** Diabetes: Hemoglobin A1c Poor Control.  
**Description:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.  
**Numerator:** Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.19 Clinical Quality Measure CMS148

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Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 19 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS148/NQF 0060  
**Versions:** CMS148v3  
**Title:** Hemoglobin A1c Test for Pediatric Patients.  
**Description:** Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.

**Denominator:** Patients 5 to 17 years of age with a diagnosis of diabetes and a face-to-face visit between the physician and the patient that predates the most recent visit by at least 12 months.  
**Numerator:** Patients with documentation of date and result for a HbA1c test during the measurement period.

Complete the following information:

\* Denominator 1:     \* Numerator 1:     \* Performance Rate 1 (%):

[Previous](#)    [Next](#)    [Save](#)    [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.20 Clinical Quality Measure CMS134

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 20 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS134/NQF 0062  
**Versions:** CMS134V3  
**Title:** Diabetes: Urine Protein Screening.  
**Description:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.  
**Numerator:** Patients with a screening for nephropathy or evidence of nephropathy during the measurement period.

Complete the following information:

\* Denominator 1:     \* Numerator 1:     \* Performance Rate 1 (%):

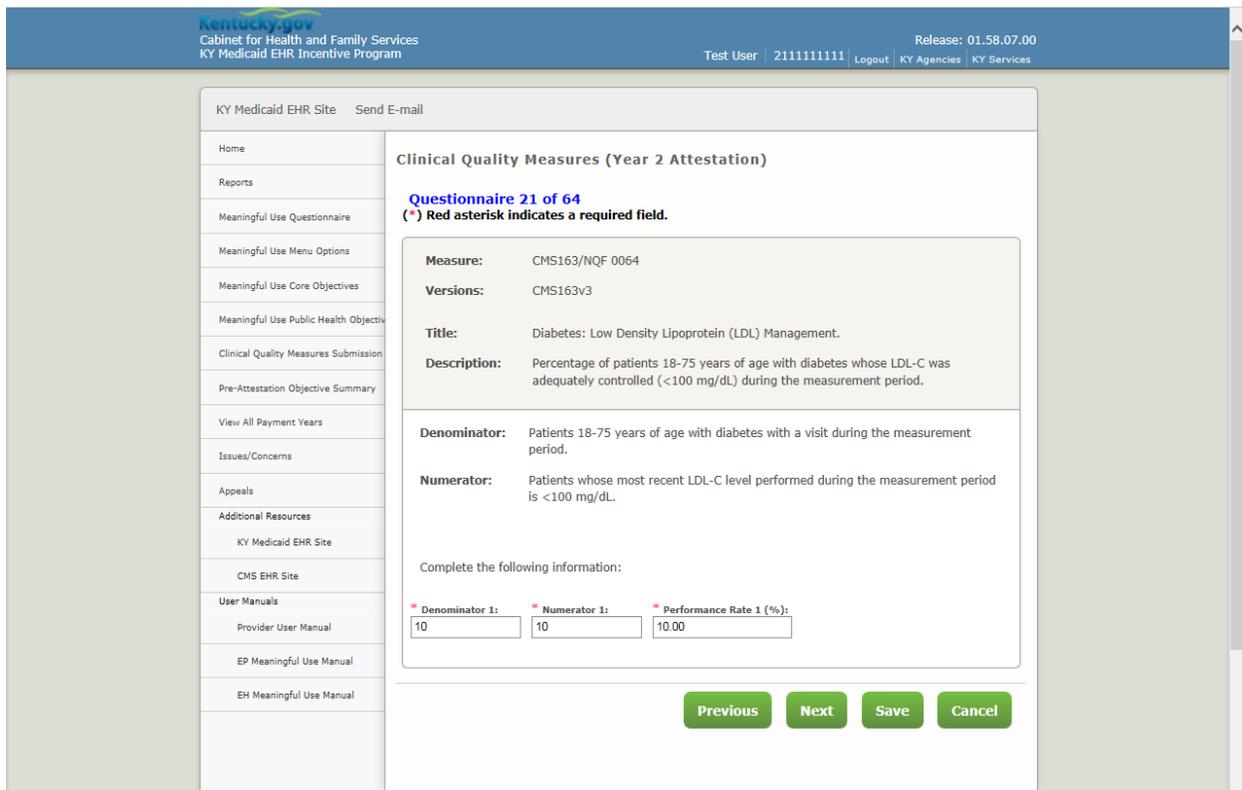
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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.21 Clinical Quality Measure CMS163



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**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 21 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS163/NQF 0064  
**Versions:** CMS163V3

**Title:** Diabetes: Low Density Lipoprotein (LDL) Management.  
**Description:** Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.

**Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period.  
**Numerator:** Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

[Previous](#) [Next](#) [Save](#) [Cancel](#)

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.22 Clinical Quality Measure CMS164

Kentucky.gov  
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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 22 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS164/NQF 0068  
**Versions:** CMS164V3

**Title:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic.  
**Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.

**Denominator:** Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period.  
**Numerator:** Patients who have documentation of use of aspirin or another antithrombotic during the measurement period.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.23 Clinical Quality Measure CMS154

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**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 23 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS154/NQF 0069  
**Versions:** CMS154v3

**Title:** Appropriate Treatment for Children with Upper Respiratory Infection (URI).  
**Description:** Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

**Denominator:** Children age 3 months to 18 years who had an outpatient or emergency department (ED) visit with a diagnosis of upper respiratory infection (URI) during the measurement period.  
**Numerator:** Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection.

**Denominator Exclusions:** Exclusion 1: Exclude children who are taking antibiotics in the 30 days prior to the date of the encounter during which the diagnosis was established. Exclude children who had an encounter with a competing diagnosis within three days after the initial diagnosis of URI.

Complete the following information:

\* Denominator 1:     \* Numerator 1:     \* Performance Rate 1 (%):     \* Exclusion 1:

**Previous**    **Next**    **Save**    **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.24 Clinical Quality Measure CMS145

**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 24 of 64**  
 (\*) Red asterisk indicates a required field.

**Measure:** CMS145/NQF 0070  
**Versions:** CMS145v3

**Title:** Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%).

**Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.

**Denominator:** All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40%.

**Numerator:** Patients who were prescribed beta-blocker therapy.

**Denominator Exceptions:**  
 Exception 1: Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons).  
 Exception 2: Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons).  
 Exception 3: Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system).

Complete the following information:

**Population Criteria 1: Patients with left ventricular systolic dysfunction (LVEF<40%)**

Denominator 1:	Numerator 1:	Performance Rate 1 (%):	Exception 1:
10	10	10.00	10
Exception 2:	Exception 3:		
10	10		

**Population Criteria 2: Patients with a prior (resolved) myocardial infarction**

Denominator 1:	Numerator 1:	Performance Rate 1 (%):	Exception 1:
10	10	10.00	10
Exception 2:	Exception 3:		
10	10		

**Navigation:** Previous, Next, Save, Cancel

To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exception boxes, for both Population Criteria.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.25 Clinical Quality Measure CMS182

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**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 25 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS182/NQF 0075  
**Versions:** CMS182v4

**Title:** Ischemic Vascular Disease(IVD): Complete Lipid Panel and LDL Control.  
**Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).

**Denominator :** Denominator 1: Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period.

**Numerator :** Numerator 1: Patients with a complete lipid profile performed during the measurement period.  
Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):
10	10	10.00
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):
10	10	10.00

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To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, and Performance Rate boxes.

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## 8.2.26 Clinical Quality Measure CMS135

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 26 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS135/NQF 0081  
**Versions:** CMS135V3

**Title:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).

**Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

**Denominator:** All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%.

**Numerator:** Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons)  
Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, patient declined, other patient reasons)  
Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, other system reasons).

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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## 8.2.27 Clinical Quality Measure CMS144

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 27 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS144/NQF 0083  
**Versions:** CMS144V3

**Title:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).

**Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

**Denominator:** All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%.

**Numerator:** Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons).  
Exception 2: Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons).  
Exception 3: Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the healthcare system).

Complete the following information:

* Denominator 1: 10	* Numerator 1: 10	* Performance Rate 1 (%): 10.00	* Exception 1: 10
* Exception 2: 10	* Exception 3: 10		

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and all three Exception boxes.

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### 8.2.28 Clinical Quality Measure CMS143

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 28 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS143/NQF 0086  
**Versions:** CMS143v3

**Title:** Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.  
**Description:** 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 one or more office visits within 12 months.

**Denominator:** All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma.  
**Numerator:** Patients who have an optic nerve head evaluation during one or more office visits within 12 months.

**Denominator Exceptions:** Exception 1: Documentation of medical reason(s) for not performing an optic nerve head evaluation.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
10	10	10.00	10

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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### 8.2.29 Clinical Quality Measure CMS167

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 29 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS167/NQF 0088  
**Versions:** CMS167V3

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

**Description:** 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.

**Denominator:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy.

**Numerator:** Patients 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.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not performing a dilated macular or fundus examination.  
Exception 2: Documentation of patient reason(s) for not performing a dilated macular or fundus examination.

Complete the following information:

\* Denominator 1:     \* Numerator 1:     \* Performance Rate 1 (%):     \* Exception 1:   
\* Exception 2:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and both Exception boxes.

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## 8.2.30 Clinical Quality Measure CMS142

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 30 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS142/NQF 0089  
**Versions:** CMS142v3

**Title:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.

**Description:** 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.

**Denominator:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.

**Numerator:** Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.  
Exception 2: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:   
\* Exception 2:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and both Exception boxes.

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## 8.2.31 Clinical Quality Measure CMS139

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 31 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS139/NQF 0101  
**Versions:** CMS139V3

**Title:** Falls: Screening for Future Fall Risk.  
**Description:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.

**Denominator:** Patients aged 65 years and older with a visit during the measurement period.  
**Numerator:** Patients who were screened for future fall risk at least once within the measurement period.

**Denominator Exceptions:** Exception 1: Documentation of medical reason(s) for not screening for fall risk (e.g., patient is not ambulatory).

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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## 8.2.32 Clinical Quality Measure CMS161

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 32 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS161/NQF 0104  
**Versions:** CMS161V3

**Title:** Adult Major Depressive Disorder (MDD): Suicide Risk Assessment.  
**Description:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

**Denominator:** All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD).  
**Numerator:** Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

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### 8.2.33 Clinical Quality Measure CMS128

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 33 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS128/NQF 0105  
**Versions:** CMS128v3

**Title:** Anti-depressant Medication Management.

**Description:** Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported.  
a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).  
b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

**Denominator :** Denominator 1: Patients 18 years of age and older with a diagnosis of major depression in the 270 days (9 months) prior to the measurement period or the first 90 days (3 months) of the measurement period, who were treated with antidepressant medication, and with a visit during the measurement period.

**Numerator :** Numerator 1: Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date.  
Numerator 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date.

**Denominator Exclusions:** Exclusion 1: Patients who were actively on an antidepressant medication in the 90 days prior to the Index Prescription Start Date

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
10	10	10.00	10

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To satisfy this CQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.34 Clinical Quality Measure CMS136

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 34 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS136/NQF 0108  
**Versions:** CMS136v4  
**Title:** ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication.  
**Description:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.  
a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.  
b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

**Denominator :** Denominator 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period.  
Denominator 2: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSP, and who had a visit during the measurement period.

**Numerator :** Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSP.  
Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.

**Denominator Exclusions:** Exclusion 1: Exclude patients diagnosed with narcolepsy at any point in their history or during the measurement period.  
Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 30 days after the IPSP.  
Exclude patients who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date.  
Exclusion 2: Exclude patients diagnosed with narcolepsy at any point in their history or during the measurement period.  
Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 300 days after the IPSP.  
Exclude patients who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date.

Complete the following information:

Population Criteria 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period.

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

Population Criteria 2: Children 6-12 years of age dispensed an ADHD medication and who remained on medication.

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes, for both Population Criteria.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.35 Clinical Quality Measure CMS169

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**Measure:** CMS169/NQF 0110

**Versions:** CMS169V3

**Title:** Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use.

**Description:** Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

**Denominator:** Patients 18 years of age or older at the start of the measurement period with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and evidence of treatment for unipolar depression or bipolar disorder within 42 days of diagnosis. The existence of a "new diagnosis" is established by the absence of diagnoses and treatments of unipolar depression or bipolar disorder during the 180 days prior to the diagnosis.

**Numerator:** Patients in the denominator with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis, and prior to or concurrent with the initiation of treatment for that diagnosis.  
(Note: the endorsed measure calls for the assessment to be performed prior to discussion of the treatment plan with the patient, but the current approach was considered more feasible in an EHR setting. The "Assessment for Alcohol or Other Drug Use" required in the numerator is meant to capture a provider's assessment of the patient's symptoms of substance use. The essence of the measure is to avoid treating the patient for unipolar depression or bipolar disorder without an assessment of their use of alcohol or other drugs.)

Complete the following information:

\* Denominator 1:     \* Numerator 1:     \* Performance Rate 1 (%):

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

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## 8.2.36 Clinical Quality Measure CMS157

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**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 36 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS157/NQF 0384  
**Versions:** CMS157V3  
**Title:** Oncology: Medical and Radiation - Pain Intensity Quantified.  
**Description:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.

**Denominator:** All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy.  
**Numerator:** Patient visits in which pain intensity is quantified.

Complete the following information:

\* Denominator 1:     \* Numerator 1:     \* Performance Rate 1 (%):

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

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### 8.2.37 Clinical Quality Measure CMS141

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 37 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS141/NQF 0385  
**Versions:** CMS141v4  
**Title:** Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients.  
**Description:** Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.

**Denominator:** All patients aged 18 through 80 years with colon cancer with AJCC Stage III colon cancer.  
**Numerator:** Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12 month reporting period.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, medical co-morbidities, diagnosis date more than 5 years prior to the current visit date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status, other medical reasons)  
Exception 2: Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient refusal, other patient reasons).  
Exception 3: Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy, other system reasons).

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:   
\* Exception 2:  \* Exception 3:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and all three Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.38 Clinical Quality Measure CMS140

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**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 38 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS140/NQF 0387  
**Versions:** CMS140v3

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

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

**Denominator:** All female patients aged 18 years and older with a diagnosis of breast cancer with stage IC through IIIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer.

**Numerator:** Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient's diagnosis date is within 120 days of the end of the 12 month reporting period, other medical reason).  
Exception 2: Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient refusal, other patient reasons).  
Exception 3: Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial, other system reasons).

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
10	10	10.00	10
* Exception 2:	* Exception 3:		
10	10		

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and all three Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.39 Clinical Quality Measure CMS129

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 39 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS129/NQF 0389  
**Versions:** CMS129V4

**Title:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.

**Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

**Denominator:** All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy.

**Numerator:** Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer.

**Denominator Exceptions:** Exception 1: Documentation of reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons, bone scan ordered by someone other than reporting physician).

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.40 Clinical Quality Measure CMS62

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 40 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS62/NQF XXXX  
**Versions:** CMS62v3  
**Title:** HIV/AIDS: Medical Visit.  
**Description:** Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.

**Denominator:** All patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12 month period.  
**Numerator:** Patients with at least two medical visits during the measurement year with a minimum of 90 days between each visit.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.41 Clinical Quality Measure CMS52

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 41 of 64**

(\*) Red asterisk indicates a required field.

**Measure:** CMS52/NQF 0405

**Versions:** CMS52v3

**Title:** HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis.

**Description:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.

**Denominator :** Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit.  
Denominator 2: All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit.  
Denominator 3: All patients aged 6 weeks to 12 months with a diagnosis of HIV who had at least two visits during the measurement year, with at least 90 days in between each visit.

**Numerator :** Numerator 1: Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3.  
Numerator 2: Patients who were prescribed pneumocystic jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/ mm3 or a CD4 percentage below 15%.  
Numerator 3: Patients who were prescribed Pneumocystic jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV.

**Denominator Exceptions:** Exception 1: Numerator 1: Patient did not receive PCP prophylaxis because there was a CD4 count above 200 cells/mm3 during the three months after a CD4 count below 200 cells/mm3.  
Exception 2: Numerator 2: Patient did not receive PCP prophylaxis because there was a CD4 count above 500 cells/mm3 or CD4 percentage above 15% during the three months after a CD4 count below 500 cells/mm3 or CD4 percentage below 15% .

Complete the following information:

Population Criteria 1: All patients 6 years and older.

<b>* Denominator 1:</b>	<b>* Numerator 1:</b>	<b>* Performance Rate 1 (%):</b>	<b>* Exception 1:</b>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>

Population Criteria 2: All patients aged 1-5 years of age.

<b>* Denominator 2:</b>	<b>* Numerator 2:</b>	<b>* Performance Rate 2 (%):</b>	<b>* Exception 2:</b>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>

Population Criteria 3: All patients ages 6 weeks to 12 months.

<b>* Denominator 3:</b>	<b>* Numerator 3:</b>	<b>* Performance Rate 3 (%):</b>	
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes, for the first two Population Criteria. The third Population Criteria only requires whole number entry into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.42 Clinical Quality Measure CMS77

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 42 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS77/NQF XXXX  
**Versions:** CMS77v3  
**Title:** HIV/AIDS: RNA control for Patients with HIV.  
**Description:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.

**Denominator:** All patients aged 13 years and older with a diagnosis of HIV/AIDS with at least two visits during the measurement year, with at least 90 days between each visit.  
**Numerator:** Patients whose most recent HIV RNA level is <200 copies/mL.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

**Previous** **Next** **Save** **Cancel**

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.43 Clinical Quality Measure CMS2

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 43 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS2/NQF 0418  
**Versions:** CMS2v4

**Title:** Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan.  
**Description:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

**Denominator:** All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.  
**Numerator:** Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

**Denominator Exclusions:** Exclusion 1: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder  
**Denominator Exceptions:** Exception 1: Patient Reason(s)  
Patient refuses to participate  
OR  
Medical Reason(s)  
Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patients health status  
OR  
Situations where the patients functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:   
\* Exception 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.44 Clinical Quality Measure CMS68

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 44 of 64**  
(\*) Red asterisk indicates a required field.

**Measure:** CMS68/NQF 0419  
**Versions:** CMS68v4

**Title:** Documentation of Current Medications in the Medical Record.

**Description:** 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.

**Denominator:** All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period.

**Numerator:** Eligible professional attests to documenting, updating or reviewing the patient's 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, dosages, frequency and route of administration.

**Denominator Exceptions:** Exception 1: Medical Reason: 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.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.45 Clinical Quality Measure CMS69

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 45 of 64**

(\*) Red asterisk indicates a required field.

**Measure:** CMS69/NQF 0421

**Versions:** CMS69v3

**Title:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan.

**Description:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.  
Normal Parameters:

- Age 65 years and older BMI => 23 and < 30 kg/m2
- Age 18 - 64 years BMI => 18.5 and < 25 kg/m2

**Denominator :** Denominator 1: Initial Patient Population 1: All patients 18 through 64 years on the date of the encounter with at least one eligible encounter during the measurement period NOT INCLUDING 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.  
Denominator 2: Initial Patient Population 2: All patients 65 years of age and older on the date of the encounter with at least one eligible encounter during the measurement period NOT INCLUDING 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 :** Numerator 1: 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 current encounter.

**Denominator Exclusions:** Exclusion 1: Patients who are pregnant.

Complete the following information:

Population Criteria 1: Patients 18 through 64 years.

<b>* Denominator 1:</b>	<b>* Numerator 1:</b>	<b>* Performance Rate 1 (%):</b>	<b>* Exclusion 1:</b>
<input type="text" value="100"/>	<input type="text" value="50"/>	<input type="text" value="2.00"/>	<input type="text" value="0"/>

Population Criteria 2: Patients 65 years and older.

<b>* Denominator 1:</b>	<b>* Numerator 1:</b>	<b>* Performance Rate 1 (%):</b>	<b>* Exclusion 1:</b>
<input type="text" value="100"/>	<input type="text" value="50"/>	<input type="text" value="2.00"/>	<input type="text" value="0"/>

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes, for both Population Criteria.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Save** to save selections and stay on the current screen.
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### 8.2.46 Clinical Quality Measure CMS132

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 46 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS132/NQF 0564  
**Versions:** CMS132v3

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

**Description:** 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.

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

**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.

**Denominator Exclusions:** Exclusion 1: Patients with any one of a specified list of significant ocular conditions that impact the surgical complication rate.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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## 8.2.47 Clinical Quality Measure CMS133

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 47 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS133/NQF 0565  
**Versions:** CMS133V3

**Title:** Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery.

**Description:** 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.

**Denominator:** All patients aged 18 years and older who had cataract surgery.

**Numerator:** Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery.

**Denominator Exclusions:** Exclusion 1: Patients with significant ocular conditions impacting the visual outcome of surgery.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.48 Clinical Quality Measure CMS158

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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 48 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS158/NQF XXXX  
**Versions:** CMS158V3

**Title:** Pregnant women that had HBsAg testing.  
**Description:** This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.

**Denominator:** All female patients aged 12 and older who had a live birth or delivery during the measurement period.  
**Numerator:** Patients who were tested for Hepatitis B surface antigen (HBsAg) during pregnancy within 280 days prior to delivery.

**Denominator Exceptions:** Exception 1: Patients with current or past Hepatitis B infection.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.49 Clinical Quality Measure CMS159

**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 49 of 64**  
 (\*) Red asterisk indicates a required field.

**Measure:** CMS159/NQF 0710  
**Versions:** CMS159v3  
**Title:** Depression Remission at Twelve Months.  
**Description:** Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

**Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.  
**Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.

**Denominator Exclusions:**  
 Exclusion 1: Patients who died  
 Exclusion 2: Patients who received hospice services  
 Exclusion 3: Patients who were permanent nursing home residents  
 Exclusion 4: Patients with a diagnosis of bipolar disorder  
 Exclusion 5: Patients with a diagnosis of personality disorder

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Exclusion 2:	* Exclusion 3:	* Exclusion 4:	* Exclusion 5:
10	10	10	10

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and all five Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.50 Clinical Quality Measure CMS160

**Clinical Quality Measures (Year 2 Attestation)**

**Questionnaire 50 of 64**  
 (\*) Red asterisk indicates a required field.

**Measure:** CMS160/NQF 0712  
**Versions:** CMS160v3  
**Title:** Depression Utilization of the PHQ-9 Tool.  
**Description:** Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.

**Denominator:** Adult patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during each four month period.  
**Numerator:** Adult patients who have a PHQ-9 tool administered at least once during the four-month period.

**Denominator Exclusions:**  
 Exclusion 1: Patients who died.  
 Exclusion 2: Patients who received hospice services.  
 Exclusion 3: Patients who were permanent nursing home residents.  
 Exclusion 4: Patients with a diagnosis of bipolar disorder.  
 Exclusion 5: Patients with a diagnosis of personality disorder.

Complete the following information:

Population Criteria 1: Patients with major depression or dysthymia with an office visit during months January through April.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Exclusion 2:	* Exclusion 3:	* Exclusion 4:	* Exclusion 5:
10	10	10	10

Population Criteria 2: Patients with major depression or dysthymia with an office visit during months May through August.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Exclusion 2:	* Exclusion 3:	* Exclusion 4:	* Exclusion 5:
10	10	10	10

Population Criteria 3: Patients with major depression or dysthymia with an office visit during months September through December.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10
* Exclusion 2:	* Exclusion 3:	* Exclusion 4:	* Exclusion 5:
10	10	10	10

Navigation buttons: Previous, Next, Save, Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and five Exclusion boxes, for all three Population Criteria.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.51 Clinical Quality Measure CMS75

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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 51 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS75/NQF XXXX  
**Versions:** CMS75v3  
**Title:** Children who have dental decay or cavities.  
**Description:** Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.

**Denominator:** Children, age 0-20 years, with a visit during the measurement period.  
**Numerator:** Children who had cavities or decayed teeth.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.52 Clinical Quality Measure CMS177

Kentucky.gov  
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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 52 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS177/NQF 1365  
**Versions:** CMS177v3  
**Title:** Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment.  
**Description:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.

**Denominator:** All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder.  
**Numerator:** Patient visits with an assessment for suicide risk.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.53 Clinical Quality Measure CMS82

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 53 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS82/NQF 1401  
**Versions:** CMS82v2

**Title:** Maternal depression screening.  
**Description:** The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.

**Denominator:** Children with a visit who turned 6 months of age in the measurement period.  
**Numerator:** Children with documentation of maternal screening or treatment for postpartum depression for the mother.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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### 8.2.54 Clinical Quality Measure CMS74

Kentucky.gov  
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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 54 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS74/NQF XXXX  
**Versions:** CMS74v4  
**Title:** Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists.  
**Description:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.

**Denominator :** Denominator 1: Children, age 0-20 years, with a visit during the measurement period.  
**Numerator :** Numerator 1: Children who receive a fluoride varnish application.

Complete the following information:

Stratum 1: Population 1: age 0 - 5  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

Stratum 2: Population 2: age 6 - 12  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

Stratum 3: Population 3: age 13 - 20  
 \* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes, for all three Stratum.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.55 Clinical Quality Measure CMS61

Kentucky.gov  
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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 55 of 64**

**(\*) Red asterisk indicates a required field.**

**Measure:** CMS61/NQF XXXX

**Versions:** CMS61v4

**Title:** Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed.

**Description:** Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.

**Denominator :** Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent OR 10-Year Framingham Risk > 20%.  
 Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who have 2 or more Major CHD Risk Factors OR 10-Year Framingham Risk 10-20%.  
 Denominator 3: (Low Risk) All patients aged 20 through 79 years who have 0 or 1 Major CHD Risk Factors OR 10-Year Framingham Risk <10%.  
 \*\* For Denominator 2 and Denominator 3, Fasting HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)

**Numerator :** Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period.  
 Numerator 2: (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period.  
 Numerator 3: (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period.

**Denominator Exclusions:** Exclusion 1: Patients who have an active diagnosis of pregnancy OR Patients who are receiving palliative care.

When a fasting LDL-C test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed.

**Denominator Exceptions:** Exception 1: Patient Reason(s): Patient Refusal.  
 When a fasting LDL-C test is not performed during the measurement period for a valid patient reason, the appropriate test that should have been performed should be submitted along with a negation code to indicate the reason the appropriate test was not performed.

Complete the following information:

Stratum: There are three criteria for this measure based on the patient's risk category. When a patient could be included in multiple risk categories; the "higher" level of risk will be utilized.

Stratum 1: Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent OR 10-Year Framingham Risk >20%.

<b>Denominator 1:</b>	<b>Numerator 1:</b>	<b>Performance Rate 1 (%):</b>	<b>Exclusion 1:</b>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>
<b>Exception 1:</b>			
<input type="text" value="10"/>			

Stratum 2: Moderate Level of Risk: Multiple (2+) Risk Factors OR 10-Year Framingham Risk 10-20%

<b>Denominator 1:</b>	<b>Numerator 1:</b>	<b>Performance Rate 1 (%):</b>	<b>Exclusion 1:</b>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>
<b>Exception 1:</b>			
<input type="text" value="10"/>			

Stratum 3: Lowest Level of Risk: 0 or 1 Risk Factor OR 10-Year Framingham Risk <10%

<b>Denominator 1:</b>	<b>Numerator 1:</b>	<b>Performance Rate 1 (%):</b>	<b>Exclusion 1:</b>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>
<b>Exception 1:</b>			
<input type="text" value="10"/>			

Previous
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Cancel

To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes, for all three Stratums.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.56 Clinical Quality Measure CMS64

The screenshot shows the Kentucky.gov website interface. At the top, there is a blue header with the Kentucky.gov logo, the text "Cabinet for Health and Family Services" and "KY Medicaid EHR Incentive Program", and user information including "Test User | 2111111111 | Logout | KY Agencies | KY Services" and a release date of "01.58.07.00". Below the header is a navigation menu with options like "Home", "Reports", "Meaningful Use Questionnaire", and "Clinical Quality Measures Submission". The main content area is titled "Clinical Quality Measures (Year 2 Attestation)" and displays "Questionnaire 56 of 64" with a note that a red asterisk indicates a required field. The questionnaire details include:

- Measure:** CMS64/NQF XXXX
- Versions:** CMS64v4
- Title:** Preventive Care and Screening: Risk-Stratified Cholesterol - Fasting Low Density Lipoprotein (LDL-C).
- Description:** Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.
- Denominator:**
  - Denominator 1: All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have CHD or CHD Risk Equivalent OR 10 year Framingham risk > 20%.
  - Denominator 2: All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have 2 or more Major CHD Risk Factors OR 10 year Framingham Risk 10-20%.
  - Denominator 3: All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 Major CHD Risk Factors OR 10 year Framingham risk <10%.

Additional notes for the denominator include: "\*\* For Denominator 2 and Denominator 3, HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)"

EP Meaningful Use Manual

EH Meaningful Use Manual

**Numerator :** Numerator 1: Patients whose most recent fasting LDL-C test result is in good control, defined as <100 mg/dL.  
 Numerator 2: Patients whose most recent fasting LDL-C test result is in good control, defined as <130 mg/dL.  
 Numerator 3: Patients whose most recent fasting LDL-C test result is in good control, defined as <160 mg/dL.

**Denominator** Exclusion 1: Patients who have an active diagnosis of pregnancy

**Exclusions:** OR  
 Patients who are receiving palliative care.

Complete the following information:

Stratum: There are three criteria for this measure based on the patient's risk category. When a patient could be included in multiple risk categories; the "higher" level of risk will be utilized.

Stratum 1: Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent OR 10-Year Framingham Risk >20%.

<small>* Denominator 1:</small>	<small>* Numerator 1:</small>	<small>* Performance Rate 1 (%):</small>	<small>* Exclusion 1:</small>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>

Stratum 2: Moderate Level of Risk: Multiple (2+) Risk Factors OR 10-Year Framingham Risk 10-20%

<small>* Denominator 1:</small>	<small>* Numerator 1:</small>	<small>* Performance Rate 1 (%):</small>	<small>* Exclusion 1:</small>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>

Stratum 3: Lowest Level of Risk: 0 or 1 Risk Factor OR 10-Year Framingham Risk <10%

<small>* Denominator 1:</small>	<small>* Numerator 1:</small>	<small>* Performance Rate 1 (%):</small>	<small>* Exclusion 1:</small>
<input type="text" value="10"/>	<input type="text" value="10"/>	<input type="text" value="10.00"/>	<input type="text" value="10"/>

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes, for all three Stratum.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.57 Clinical Quality Measure CMS149

Kentucky.gov  
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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 57 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS149/NQF XXXX  
**Versions:** CMS149v3  
**Title:** Dementia: Cognitive Assessment.  
**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.

**Denominator:** All patients, regardless of age, with a diagnosis of dementia.  
**Numerator:** Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.

**Denominator Exceptions:**  
Exception 1: Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason).  
Exception 2: Documentation of patient reason(s) for not assessing cognition.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exception 1:   
\* Exception 2:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and both Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.58 Clinical Quality Measure CMS65

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KY Medicaid EHR Incentive Program

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 58 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS65/NQF XXXX  
**Versions:** CMS65v4  
**Title:** Hypertension: Improvement in blood pressure.  
**Description:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.

**Denominator:** All patients aged 18-85 years of age, who had at least one outpatient visit in the first six months of the measurement year, who have a diagnosis of essential hypertension documented during that outpatient visit, and who have uncontrolled baseline blood pressure at the time of that visit.

**Numerator:** Patients whose follow-up blood pressure is at least 10 mmHg less than their baseline blood pressure or is adequately controlled. If a follow-up blood pressure reading is not recorded during the measurement year, the patient's blood pressure is assumed "not improved".

**Denominator Exclusions:**  
Exclusion 1: Exclude from the denominator all patients with evidence of end-stage renal disease (ESRD) on or prior to December 31 of the measurement year. Documentation of dialysis or kidney transplant also meets the criteria for evidence of ESRD.  
Exclusion 2: Exclude from the denominator all patients with a diagnosis of pregnancy during the measurement year.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:   
\* Exclusion 2:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and both Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.59 Clinical Quality Measure CMS50

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 59 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS50/NQF XXXX  
**Versions:** CMS50v3  
**Title:** Closing the referral loop: receipt of specialist report.  
**Description:** 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.

**Denominator:** Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.  
**Numerator:** Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.60 Clinical Quality Measure CMS66

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 60 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS66/NQF XXXX  
**Versions:** CMS66v3

**Title:** Functional status assessment for knee replacement.  
**Description:** Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.

**Denominator:** Adults aged 18 and older who had a primary total knee arthroplasty (TKA) within the 12 month period that begins 180 days before the start of the measurement period and ends 185 days after the start of the measurement period and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after TKA procedure.

**Numerator:** Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10 Global Health, PROMIS-29, KOOS) not more than 180 days prior to the primary TKA procedure, and at least 60 days and not more than 180 days after TKA procedure.

**Denominator Exclusions:** Exclusion 1: Patients with multiple traumas at the time of the total knee arthroplasty or patients with severe cognitive impairment.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.61 Clinical Quality Measure CMS56

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KY Medicaid EHR Incentive Program

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 61 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS56/NQF XXXX  
**Versions:** CMS56v3

**Title:** Functional status assessment for hip replacement.

**Description:** Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.

**Denominator:** Adults aged 18 and older who had a primary total hip arthroplasty (THA) within the 12 month period that begins 180 days before the start of the measurement period and ends 185 days after the start of the measurement period and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after THA procedure.

**Numerator:** Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10-Global Health, PROMIS-29, HOOS) not more than 180 days prior to the primary THA procedure, and at least 60 days and not more than 180 days after THA procedure.

**Denominator Exclusions:** Exclusion 1: Patients with multiple trauma at the time of the total hip arthroplasty or patients with severe cognitive impairment.

Complete the following information:

\* Denominator 1:  \* Numerator 1:  \* Performance Rate 1 (%):  \* Exclusion 1:

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.62 Clinical Quality Measure CMS90

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 62 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS90/NQF XXXX  
**Versions:** CMS90v4

**Title:** Functional status assessment for complex chronic conditions.  
**Description:** Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.

**Denominator:** Adults aged 65 years and older who had two outpatient encounters during the measurement year and an active diagnosis of heart failure.  
**Numerator:** Patients with patient reported functional status assessment results (e.g., VR-12; VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR within two weeks before or during the initial encounter and the follow-up encounter during the measurement year.  
**Denominator Exclusions:** Exclusion 1: Patients with severe cognitive impairment or patients with an active diagnosis of cancer.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
10	10	10.00	10

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To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Next** to move on to the next screen. Selections will be saved.
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- Click **Cancel** to remove selections and stay on the current screen.

## 8.2.63 Clinical Quality Measure CMS179

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### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 63 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS179/NQF XXXX  
**Versions:** CMS179v3

**Title:** ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range.  
**Description:** Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.

**Denominator :** Denominator 1: NA  
**Numerator :** Numerator 1: NA

Complete the following information:

\* Average % of Time:

Previous Next Save Cancel

To satisfy this CQM, enter a whole number into the Average % of Time box.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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- Click **Cancel** to remove selections and stay on the current screen.

### 8.2.64 Clinical Quality Measure CMS22

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#### Clinical Quality Measures (Year 2 Attestation)

**Questionnaire 64 of 64**  
(\* Red asterisk indicates a required field.)

**Measure:** CMS22/NQF XXXX  
**Versions:** CMS22v3  
**Title:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.  
**Description:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.

**Denominator:** All patients aged 18 years and older before the start of the measurement period.  
**Numerator:** Patients who were screened for high blood pressure AND have a recommended follow-up plan documented as indicated if the blood pressure is pre-hypertensive or hypertensive.  
**Denominator Exclusions:** Exclusion 1: Patient has an active diagnosis of hypertension  
**Denominator Exceptions:** Exception 1: Patient Reason(s): Patient refuses to participate OR Medical Reason(s): 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. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated.

Complete the following information:

Denominator 1: 10 | Numerator 1: 10 | Performance Rate 1 (%): 10.00 | Exclusion 1: 10  
Exception 1: 10

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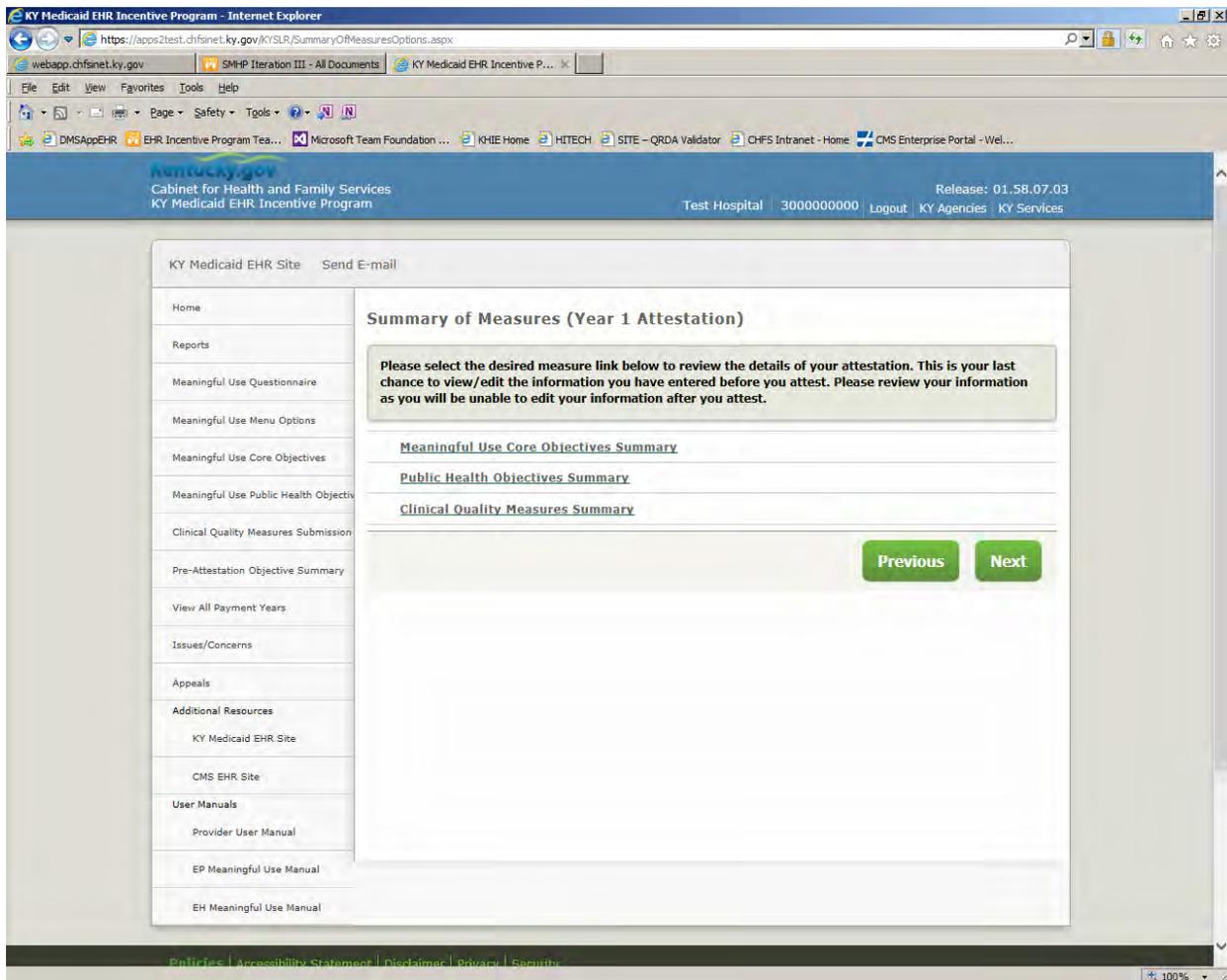
To satisfy this CQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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## 9 Submitting Attestation

### 9.1 Pre-Attestation Summary Screen



The Pre-Attestation Summary allows the EP to review/edit entries made for Meaningful Use Objectives, Public Health Objectives, and Clinical Quality Measures.

- Click on a link to review the summary.

When final reviews have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

## 9.1.2 Objectives Summary

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### Summary of Meaningful Use Core Measures (Year 1 Attestation)

Meaningful Use Core Measure List Table

**Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.**

ObjectiveText	Description	Data Entered	Selection
<p>Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT 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 eligible hospital or CAH's risk management process.</p>	Yes	<a href="#">Edit</a>
<p>Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>Implement one clinical decision support rule.</p>	Yes	<a href="#">Edit</a>
<p>Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.</p>	Yes	<a href="#">Edit</a>
<p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry.</p>	Numerator = 30 Denominator = 100	<a href="#">Edit</a>

<p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 30% of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p>	<p>Numerator = 30 Denominator = 100</p>	<p><a href="#">Edit</a></p>
<p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measures, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p>	<p>Numerator = 30 Denominator = 100</p>	<p><a href="#">Edit</a></p>
<p>Generate and transmit permissible discharge prescriptions electronically (eRx).</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 10% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.</p>	<p>Numerator = 10 Denominator = 100</p>	<p><a href="#">Edit</a></p>
<p>The eligible hospital or CAH who transitions a patient to another setting of care or provider of care or refers a patient to another provider of care provides a summary care record for each transition of care or referral.</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>The eligible hospital or CAH that transitions or refers its patient to another setting of care or provider of care must do the following-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.</p>	<p>Numerator = 10 Denominator = 100</p>	<p><a href="#">Edit</a></p>
<p>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources identified by CEHRT.</p>	<p>Numerator = 10 Denominator = 100</p>	<p><a href="#">Edit</a></p>

<p>The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</p> <p>In order to meet this objective and measure, an EH or CAH must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</p>	<p>Numerator = 50 Denominator = 100</p>	<p><a href="#">Edit</a></p>
<p>Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.</p>	<p>More than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information.</p>	<p>Numerator = 50 Denominator = 100</p>	<p><a href="#">Edit</a></p>
<p>Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.</p>	<p>At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.</p>	<p>Numerator = 1 Denominator = 50</p>	<p><a href="#">Edit</a></p>

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The Objectives Summary lists each Meaningful Use Objective with responses.

- If changes need to be made, click the **Edit** link for the MU Objective to update. This will redirect to the MU Objective details screen for changes to be made.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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### 9.1.3 Public Health Objectives Summary

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#### Summary of Public Health Objective Measures (Year 1 Attestation)

Public Health Objective List Table

Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

ObjectiveText	Measure	Entered	Selection
The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.	The eligible hospital or CAH is in active engagement to submit data to a specialized registry.	Option 2 - Peanut Butter Option 2 - Jelly	<a href="#">Edit</a>
We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3 (Specialized Registry Reporting), providers may use functions beyond those established in CEHRT in accordance with state and local law.			

Previous Next

The Public Health Objectives Summary lists each Public Health Measure attested to, with responses.

- If changes need to be made, click the **Edit** link for the PH Measure to update. This will redirect to the PH Measure details screen for changes to be made.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

### 9.1.4 Clinical Quality Measures Summary

Kentucky.gov  
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#### Summary of Clinical Quality Measures (Year 1 Attestation)

Clinical Quality Measures List Table

**Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.**

PATIENT AND FAMILY ENGAGEMENT				
Measure #	Title	Measure	Data Entered	Selection
CMS111v3/NQF 0497	Median Admit Decision Time to ED Departure Time for Admitted Patients	Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.	Average Time = 50.00 Average Time = 20.00 Average Time = 2.00	<a href="#">Edit</a>
CMS55v3/NQF 0495	Median Time from ED Arrival to ED Departure for Admitted ED Patients	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.	Average Time = 50.00 Average Time = 25.00 Average Time = 10.00	<a href="#">Edit</a>
CMS107v3/NQF XXXX	Stroke Education	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2	<a href="#">Edit</a>
CMS110v3/NQF XXXX	Venous Thromboembolism Discharge Instructions	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.	Denominator = 100 Numerator = 50 Performance Rate = 2.00	<a href="#">Edit</a>

PATIENT SAFETY				
Measure #	Title	Measure	Data Entered	Selection
CMS114v3/NQF XXXX	Incidence of Potentially-Preventable Venous Thromboembolism	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0	<a href="#">Edit</a>

CMS190v3/NQF 0372	Intensive Care Unit Venous Thromboembolism Prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 Exception = 2	<a href="#">Edit</a>
CMS108v3/NQF 0371	Venous Thromboembolism Prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0	<a href="#">Edit</a>

CARE COORDINATION

Measure #	Title	Measure	Data Entered	Selection
CMS102v3/NQF 0441	Assessed for Rehabilitation	Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2	<a href="#">Edit</a>

CLINICAL PROCESS/EFFECTIVENESS

Measure #	Title	Measure	Data Entered	Selection
CMS71v4/NQF 0436	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.	Denominator = 100 Numerator = 50 Performance Rate = 20.00 Exclusion = 2 Exception = 2	<a href="#">Edit</a>
CMS72v3/NQF 0438	Antithrombotic Therapy by End of Hospital Day 2	Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.	Denominator = 100 Numerator = 50 Performance Rate = 50.00 Exclusion = 5 Exception = 5	<a href="#">Edit</a>
CMS104v3/NQF 0435	Discharged on Antithrombotic Therapy	Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 Exception = 2	<a href="#">Edit</a>
CMS105v3/NQF 0439	Discharged on Statin Medication	Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2 Exception = 2	<a href="#">Edit</a>

CMS113v3/NQF 0469	Elective Delivery	Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exclusion = 2	<a href="#">Edit</a>
CMS91v4/NQF 0437	Thrombolytic Therapy	Acute Ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.	Denominator = 100 Numerator = 50 Performance Rate = 2.00 Exception = 2	<a href="#">Edit</a>
CMS109v3/NQF XXXX	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0	<a href="#">Edit</a>
CMS73v3/NQF 0373	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they should be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy should be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.	Denominator = 100 Numerator = 50 Performance Rate = 0.00 Exclusion = 0	<a href="#">Edit</a>

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The Clinical Quality Measures Summary lists each Clinical Quality Measure attested to, with responses.

- If changes need to be made, click the **Edit** link for the CQM to update. This will redirect to the CQM details screen for changes to be made.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

## 9.2 Incentive Payment Calculation Screen

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

Release: 01.58.07.00  
Test User | 2111111111 | Logout | KY Agencies | KY Services

KY Medicaid EHR Site | Send E-mail

### Incentive Payment Calculations (Year 2 Attestation)

Estimated Amount of Medicaid EHR Incentive Payment:	\$8,500.00
---	------------

(This amount may also include adjustments)

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  - EP Meaningful Use Manual
  - EH Meaningful Use Manual

The Incentive Payment Calculation screen is view only and provides the estimated amount of Medicaid EHR incentive payment.

When final reviews have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

## 9.3 Document Upload Screen

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

Test User | 2111111111 | Logout | KY Agencies | KY Services

Release: 01.58.07.00

KY Medicaid EHR Site | Send E-mail

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EH Meaningful Use Manual

### Document Upload (Year 2 Attestation)

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance.

Required Documents for AIU & MU attesters:  
1) Proof of certified technology being attested for your practice or facility. This can be: • a signed contract • a signed lease • a current invoice • a license agreement • a purchase order (PO) • or other legal documents showing that you have contracted with a certified EHR vendor for adopt, implement or upgrade.

Additional Required Documents for MU attesters:  
2) KHIE on-boarding documentation.  
3) Documentation on your testing with other entities as well as documentation supporting your Public Health Measure response.  
4) Payment reassignment documentation if payment is assigned to any other NPI than the individual NPI.  
5) Patient volume report.  
If you are using Medicaid patients from multiple states you could be requested to provide additional documentation.

**Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

Browse...

--Select the type of a document--

Upload

Previous Next

The document upload screen allows providers to submit PDF documents as part of the attestation. This is used for supporting documentation of the attestation which includes but is not limited to patient volume report, CEHRT ID documentation, Meaningful Use report(s) from their CEHRT, and KHIE onboarding documentation.

- Select **Browse** to locate a document to upload.
- Select the documentation type from the dropdown.
- Click **Upload**.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

## 9.4 Attestation Statement Screen

KY Medicaid EHR Site    Send E-mail

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    EH Meaningful Use Manual

Test User | 2111111111 | Logout | KY Agencies | KY Services    Release: 01.58.07.00

### Attestation Statement (Year 2 Attestation)

**You are about to submit your attestation for EHR**  
Please check the box next to each statement below to attest, then select the **SUBMIT** button to complete your attestation:

- The information submitted for CQMs was generated as output from an identified certified EHR technology.
- The information submitted is accurate to the knowledge and belief of the EP.
- The information submitted is accurate and complete for numerators, denominators, and exclusions for functional measures that are applicable to the EP.
- The information submitted includes information on all patients to whom the measure applies.
- A zero was reported in the denominator of a measure when an EP did not care for any patients in the denominator population during the EHR reporting period.
- As a meaningful EHR user, at least 50% of my patient encounters during the EHR reporting period occurred at the practice/location given in my Attestation information and is equipped with certified EHR technology.

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

(\*)Red asterik indicates a required field.

Initials: \*

NPI: \*

Note: Once you press the submit button below, you will not be able to change your information.

[Previous](#)    [Submit](#)

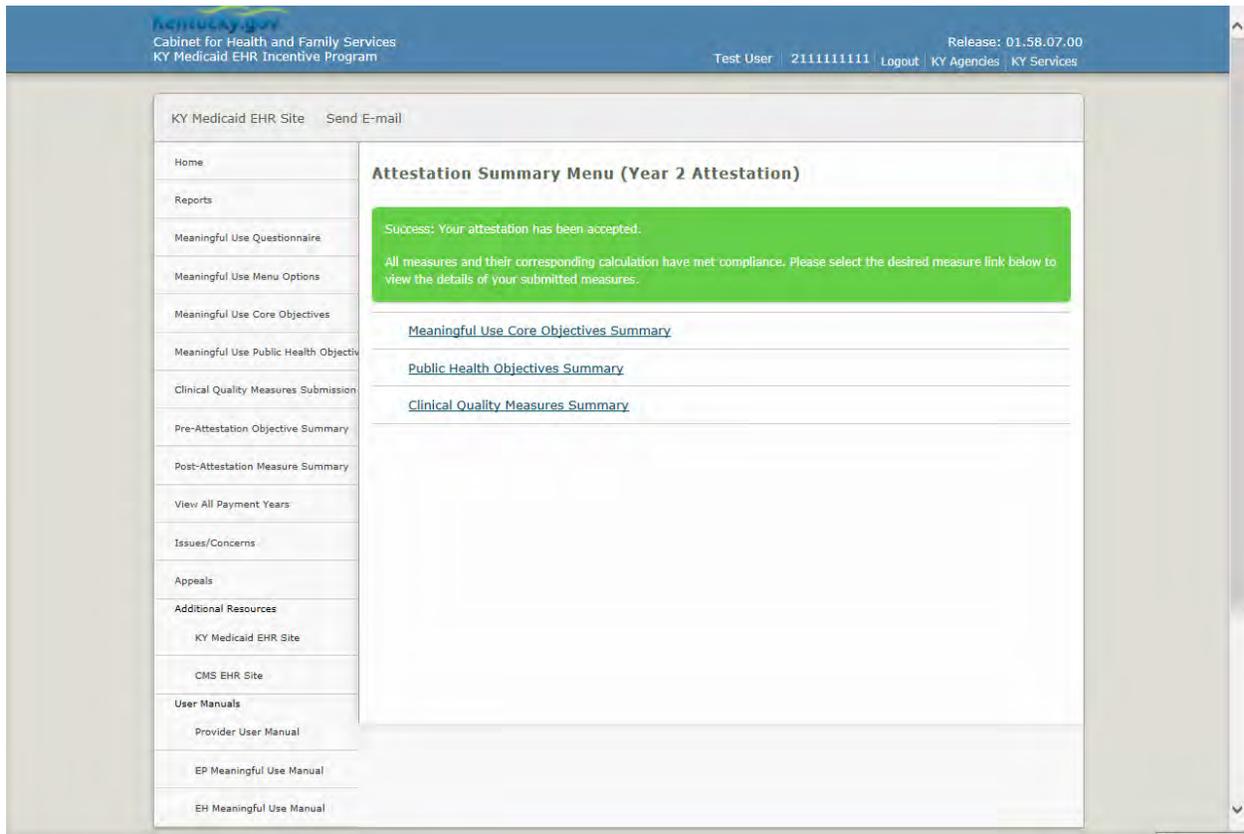
All boxes must be checked in order to submit the attestation.

Enter initials and NPI to submit the attestation.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

## 9.5 Accepted Attestation Screen



Once the attestation is accepted, no updates can be made to any data from the attestation. Click on the summary links to view the measure data that was submitted and accepted for attestation.

## 9.6 Attestation Not Accepted Screen

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program

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**Attestation Summary Menu (Year 2 Attestation)**

**Alert: Your attestation cannot be accepted at this time.**  
 One or more of the MU Core measure calculations did not meet MU minimum standards.  
 One or more of the Public health measures did not meet MU minimum standards.  
 Please select the summary of measures link below to view all measures and their corresponding calculation/compliance.

[Meaningful Use Core Objectives Summary](#)

[Public Health Objectives Summary](#)

[Clinical Quality Measures Summary](#)

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Clinical Quality Measures Submission

Pre-Attestation Objective Summary

View All Payment Years

Issues/Concerns

Appeals

**Additional Resources**

KY Medicaid EHR Site

CMS EHR Site

**User Manuals**

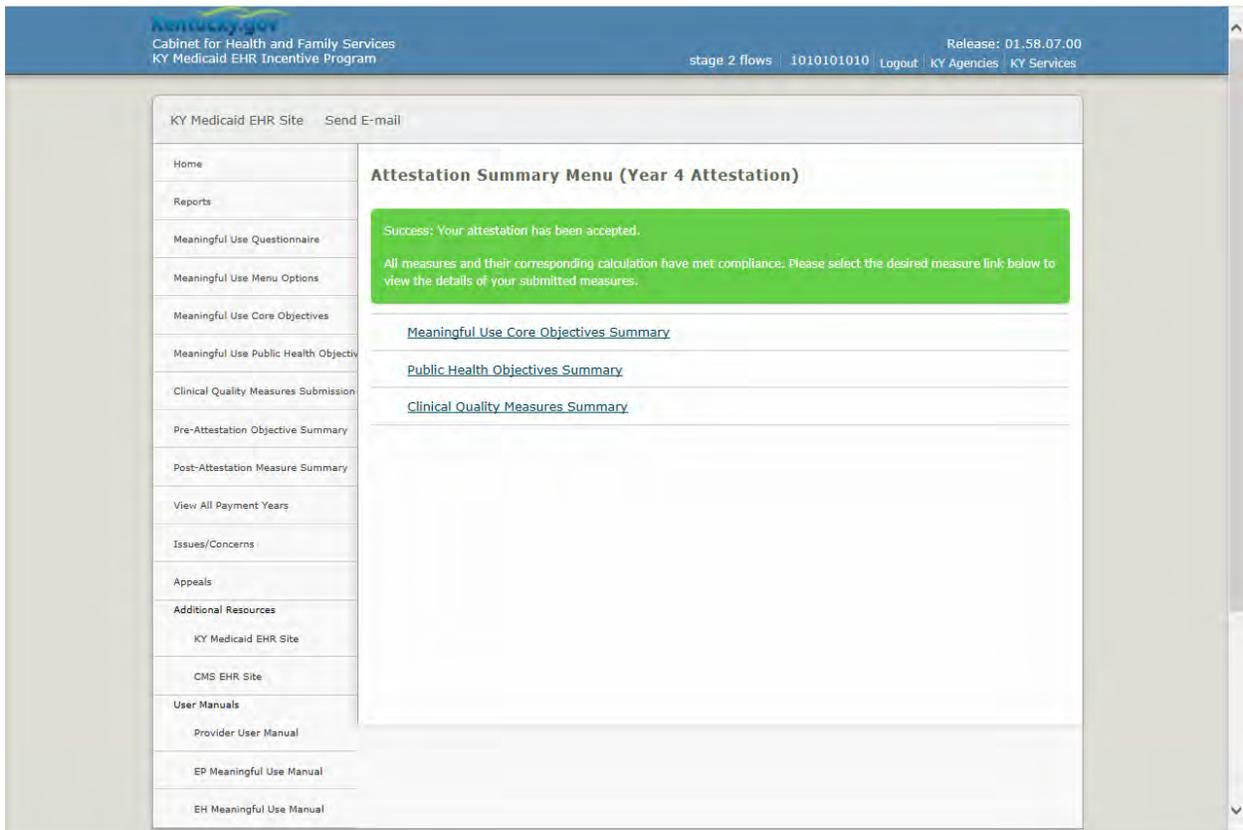
Provider User Manual

EP Meaningful Use Manual

EH Meaningful Use Manual

Click on the summary links to view the measure data responses. The summary page will indicate which measures were accepted and which were rejected.

## 9.7 Post Attestation Summary Screen



After attestation is completed, a statement will appear that the attestation has been accepted.

### 9.7.1 Objective Summary

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program
Release: 01.58.07.00  
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<ul style="list-style-type: none"> <li>Home</li> <li>Reports</li> <li>Meaningful Use Questionnaire</li> <li>Meaningful Use Menu Options</li> <li>Meaningful Use Core Objectives</li> <li>Meaningful Use Public Health Objectives</li> <li>Clinical Quality Measures Submission</li> <li>Pre-Attestation Objective Summary</li> <li>Post-Attestation Measure Summary</li> <li>View All Payment Years</li> <li>Issues/Concerns</li> <li>Appeals</li> <li>Additional Resources                             <ul style="list-style-type: none"> <li>KY Medicaid EHR Site</li> <li>CMS EHR Site</li> </ul> </li> <li>User Manuals                             <ul style="list-style-type: none"> <li>Provider User Manual</li> <li>EP Meaningful Use Manual</li> <li>EH Meaningful Use Manual</li> </ul> </li> </ul>	<h4 style="text-align: center;">Meaningful Use Core Measure Summary (Year 4 Attestation)</h4> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d3d3d3;"> <th style="width: 30%;">Objective</th> <th style="width: 30%;">Measure</th> <th style="width: 15%;">Entered</th> <th style="width: 25%;">Status</th> </tr> </thead> <tbody> <tr> <td>Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.</td> <td>Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT 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 EP's risk management process.</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">Accepted</td> </tr> <tr> <td>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Use clinical decision support to improve performance on high-priority health conditions.</td> <td>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. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">Accepted</td> </tr> <tr> <td>In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Use clinical decision support to improve performance on high-priority health conditions.</td> <td>The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">Accepted</td> </tr> <tr> <td>In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</td> <td>More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</td> <td style="text-align: center;">100%</td> <td style="text-align: center;">Accepted</td> </tr> <tr> <td>In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</td> <td>More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</td> <td style="text-align: center;">100%</td> <td style="text-align: center;">Accepted</td> </tr> <tr> <td>In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Objective	Measure	Entered	Status	Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT 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 EP's risk management process.	Yes	Accepted	In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.				Use clinical decision support to improve performance on high-priority health conditions.	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. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.	Yes	Accepted	In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.				Use clinical decision support to improve performance on high-priority health conditions.	The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.	Yes	Accepted	In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.				Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.	More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	100%	Accepted	In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.				Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.	More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	100%	Accepted	In order to meet this objective and measures, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.			
Objective	Measure	Entered	Status																																										
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Use clinical decision support to improve performance on high-priority health conditions.	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. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.	Yes	Accepted																																										
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Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.	More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	100%	Accepted																																										
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<p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p>	100%	Accepted
<p>Generate and transmit permissible prescriptions electronically (eRx).</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</p>	50%	Accepted
<p>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>The EP that transitions or refers their patient to another setting of care or provider of care must-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</p>	10%	Accepted
<p>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.</p>	10%	Accepted
<p>The EP that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</p> <p>In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.</p>	<p>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.</p>	50%	Accepted
<p>Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p>	<p>More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.</p>	50%	Accepted
<p>Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p>	<p>At least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.</p>	1	Accepted

Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.	50%	Accepted
Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	At least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.	1	Accepted
Use secure electronic messaging to communicate with patients on relevant health information.  In order to meet this objective and measure, an EP must use the capabilities and standards as defined for CEHRT at § 495.4.	The capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period.	Yes	Accepted

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Click on the summary links to view the measure data that was submitted. The summary page will indicate which measures were accepted.

### 9.7.2 Public Health Objectives Summary

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program
Release: 01.58.07.00  
stage 2 flows | 1010101010 | Logout | KY Agencies | KY Services

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#### Public Health Measures Summary (Year 4 Attestation)

ObjectiveText	Measure	Entered	Status
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.  We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.	The EP is in active engagement with a public health agency to submit immunization data.	Option 3	Accepted
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.  We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.	The EP is in active engagement to submit data to a specialized registry.	Option 2 - KY Cancer Registry	Accepted

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Click on the summary links to view the measure data that was submitted. The summary page will indicate which measures were accepted.

### 9.7.3 Clinical Quality Measures Summary

Kentucky.gov  
Cabinet for Health and Family Services  
KY Medicaid EHR Incentive Program
Release: 01.58.07.00  
stage 2 flows | 1010101010 | Logout | KY Agencies | KY Services

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#### Meaningful Use Clinical Quality Measures Summary (Year 4 Attestation)

Summary of Clinical Quality Measures

PATIENT AND FAMILY ENGAGEMENT		
Title	Description	Status
Oncology: Medical and Radiation - Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Accepted
Functional Status Assessment for Knee Replacement	Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Accepted

PATIENT SAFETY		
Title	Description	Status
Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Accepted
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.	Accepted

CARE COORDINATION		
Title	Description	Status
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.	Accepted

POPULATION AND PUBLIC HEALTH		
Title	Description	Status
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.  Percentage of patients with height, weight, and body mass index (BMI) percentile documentation.  Percentage of patients with counseling for nutrition. Percentage of patients with counseling for physical activity.	Accepted
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.	Accepted
Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Accepted
Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Accepted

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