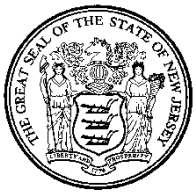


New Jersey EHR Incentive Program
Attestation Application User Manual
For Eligible Professional
Meaningful Use Attestations

Date of Publication: 7/2012

Document Version: 1.0

Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Molina Healthcare. It is healthcare data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Table of Contents

Table of Figures and Tables

1. Introduction

Providers that have received a Year 1 Medicaid EHR Incentive Program payment will need to demonstrate full meaningful use of an EHR system certified by the federal Office of the National Coordinator for Health Information Technology (ONC) in order to receive additional incentive payments. In order to receive an initial EHR Incentive Program payment, providers had to demonstrate the adoption, implementation or upgrade of a certified EHR system in order to lay the foundation for achieving meaningful use. In order to receive the final five years of payments, providers must expand upon this foundation and become meaningful users of EHR technology.

What is meaningful use? The American Recovery and Reinvestment Act of 2009 (ARRA) defines three main components of meaningful use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

Simply put, "meaningful use" means providers need to show they are using certified EHR technology to measure both the quality and quantity of the health care services they are supplying to their patients.

CMS has defined meaningful use in the following three stages that will occur over the next five years:

- Stage 1 meaningful use requirements were formalized in federal regulations in July 2010 and sets the baseline for electronic data capture and information sharing. The initial Medicaid EHR Incentive Program payment for adoption, implementation, or upgrade of certified EHR technology prepared providers to meet these criteria. Providers are required to meet these criteria for 90 days to receive a Year 2 Medicaid EHR Incentive Program payment and for a full year to receive a Year 3 Medicaid EHR Incentive Program payment.
- Stage 2 requirements are expected to be formalized in federal regulations before the end of 2012.
- Stage 3 requirements are currently expected to be formalized in 2015. CMS is expected to continue developing the current meaningful use foundation in establishing future requirements.

The Stage 1 meaningful use requirements are summarized as follows:

- There are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. This also includes Clinical Quality Measures (CQM).
  - There are 15 required core objectives.
  - The remaining 5 objectives may be chosen from the list of 10 menu set objectives, which one of the 5 must be a public health question.
  - EPs must also report on 6 total clinical quality measures:
    - 3 required core measures. EP may substitute alternate core measures. If questions have a denominator of zero, three additional questions will require response
    - 3 additional measures selected from the set of 38 clinical quality measures

1.1 Eligible Professionals (EP)

In addition to meeting Stage 1 meaningful use, providers must continue to meet other eligibility criteria to continue receiving New Jersey Medicaid EHR Incentive Program payments. The Center for Medicare & Medicaid Services (CMS) has defined eligible professionals for the Electronic Health Record Incentive program for Medicaid as follows:

- **An actively enrolled Medicaid provider with the sMedicaid program with one of the below provider types:**

  - ❑ Physicians (primarily doctors of medicine and doctors of osteopathy)
  - ❑ Nurse practitioner
  - ❑ Certified nurse-midwife
  - ❑ Dentist

- **To be eligible for the incentive payment, professional providers meeting the provider type requirement above, must also meet one of the following Medicaid patient volume criteria:**

  - ❑ Have a minimum 30% Medicaid (Title XIX only) patient volume
  - ❑ Have a minimum 20% Medicaid (Title XIX only) patient volume, and also be enrolled as a practicing physician with a specialty of pediatrician with NJ Medicaid
  - ❑ Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to “needy individuals”.

- **The provider must also not practice predominantly in a hospital setting. Providers who see more than 90% of their Medicaid patients in a hospital inpatient or emergency room setting are considered to be practicing predominately in a hospital setting.**
- **Providers must indicate if they are adopting, upgrading, or implementing a certified EHR system during the attestation process to receive a Year 1 Medicaid EHR Incentive Program payment. *For Year 1, providers do not have to demonstrate meaningful use*. If completed, meaningful use question responses will be recorded, but will not be used to determine eligibility for a Year 1 EHR Incentive Program payment.**

The EHR Incentive Program Attestation Application will verify providers meet the above requirements by validating the provider's fee-for-service claim and managed care encounter data within the MMIS upon provider completion of the state level registration and attestation process. In addition to validating the above criteria electronically, the system will perform the following validations:

- ❑ Providers must pass a systematic checking of the claims volume and place of service relative to the amount of Medicaid patient volume they claim to have seen during the attestation process they complete online.
- ❑ Providers currently under review with the State of New Jersey or not actively enrolled with Medicaid are not eligible to receive incentive payments.
- ❑ The "Pay-To" provider indicated within the provider's National Level Repository (NLR) registration must also be an active Medicaid provider in order to receive payment on behalf of the attesting provider.

1.2 Registering with CMS

Providers do not need to register with CMS in order to receive Year 2 and later Medicaid EHR Incentive Program payments. However, if any of the information included in a provider's original CMS registration needs to be updated, the provider should log into the CMS registration website to make these changes.

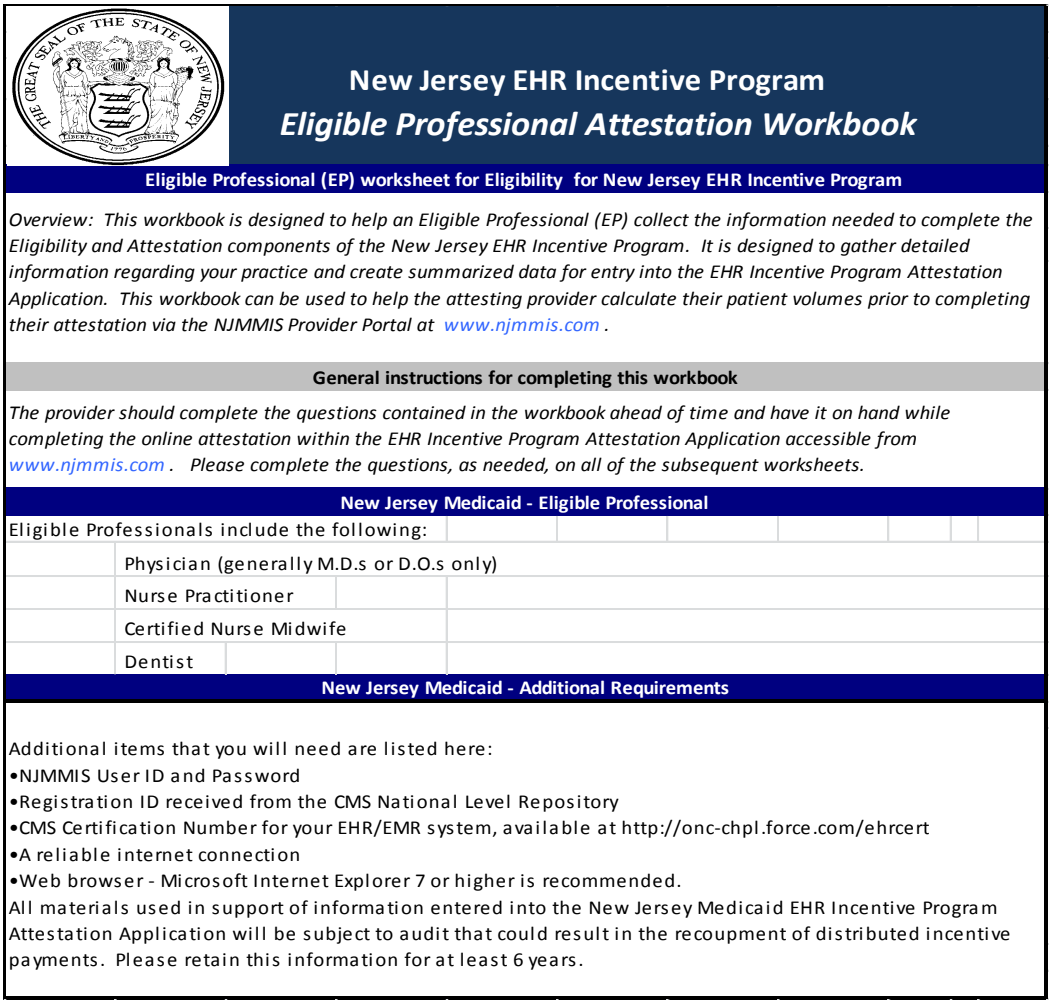
If you review your CMS registration and no changes are made, you will still need to resubmit the registration. If you do not, this will stop the processing of your attestation.

2. Information Needed

Before a provider can begin to complete the New Jersey EHR Incentive Program attestation process, the provider or clinic/practice will need to gather all of the information necessary to complete the attestation correctly. The New Jersey EHR Provider Incentive Program has created a workbook to guide the provider or representative user through the data needed to complete an attestation successfully. The workbook is available in Excel format at www.nj.gov/njhit/ehr/ or within the Provider Portal at www.njmmis.com. The Eligible Professional Workbook provides the questions CMS requires for their registration process and that the EHR Incentive Program Attestation Application requires for New Jersey's attestation process. The Workbook can be used to gather answers before logging in to the EHR Incentive Program Attestation Application. The items below provide the minimum that is needed in order to use the EHR Incentive Program Attestation Application in addition to the workbook.

2.1 Eligible Provider Attestation Workbook - Overview

The workbook describes the eligibility requirements, the Meaningful Use Core and Menu Measures, and the Clinical Quality Measures for the professional provider and web requirements for utilizing the NJ EHR Incentive payment attestation solution. It can also hold your responses before accessing the application. A sample page from the workbook is below; the full version is available at the Medicaid EHR Incentive Program website (www.nj.gov/njhit/ehr).



New Jersey EHR Incentive Program

Eligible Professional Attestation Workbook

Eligible Professional (EP) worksheet for Eligibility for New Jersey EHR Incentive Program

Overview: This workbook is designed to help an Eligible Professional (EP) collect the information needed to complete the Eligibility and Attestation components of the New Jersey EHR Incentive Program. It is designed to gather detailed information regarding your practice and create summarized data for entry into the EHR Incentive Program Attestation Application. This workbook can be used to help the attesting provider calculate their patient volumes prior to completing their attestation via the NJMMIS Provider Portal at www.njmmis.com .

General instructions for completing this workbook

The provider should complete the questions contained in the workbook ahead of time and have it on hand while completing the online attestation within the EHR Incentive Program Attestation Application accessible from www.njmmis.com . Please complete the questions, as needed, on all of the subsequent worksheets.

New Jersey Medicaid - Eligible Professional

Eligible Professionals include the following:

- Physician (generally M.D.s or D.O.s only)
- Nurse Practitioner
- Certified Nurse Midwife
- Dentist

New Jersey Medicaid - Additional Requirements

Additional items that you will need are listed here:

- NJMMIS User ID and Password
- Registration ID received from the CMS National Level Repository
- CMS Certification Number for your EHR/EMR system, available at http://onc-chpl.force.com/ehrcert
- A reliable internet connection
- Web browser - Microsoft Internet Explorer 7 or higher is recommended.

All materials used in support of information entered into the New Jersey Medicaid EHR Incentive Program Attestation Application will be subject to audit that could result in the recoupment of distributed incentive payments. Please retain this information for at least 6 years.

Figure 1 – Example of Workbook Page

3. Required Supporting Documentation

CMS and the New Jersey Division of Medical Assistance and Health Services (DMAHS) recommend documentation supporting provider attestations be retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits.
The provider must make all records and documentation available upon request to DMAHS, DHHS, or contracted entities acting on their behalf. Such records and documentation should include, but not be limited to, the following:

- ❑ Practicing Provider Information (credentials)
- ❑ Identification of Service Sites
- ❑ Supporting material used to measure Medicaid patient volume (including Excel spreadsheets or any other report identifying the unique patient, place of service, and date of service combinations used to count patient encounters
- ❑ Invoices, lease agreement, contract or other documentation supporting adoption, implementation, or upgrading of ONC-certified EHR technology
- ❑ EHR reports supporting Meaningful Use attestation

Please review DMAHS requirements and applicable provider manuals for the specific service requirements, retention periods, and lists.

OUT OF STATE DOCUMENTATION

If the provider plans to include encounter counts from another state (this is optional), the following documentation is required in an electronic format (pdf, Microsoft Word or Excel, or jpeg) and will need to be included with the electronic attestation:

- ❑ Certification on official letterhead from the other state Medicaid agency or agencies declaring the numbers obtained were derived from the State's MMIS and are accurate.
- ❑ Report generated by the other State Medicaid agency or agencies with the total Fee-for-Service and Managed Care Organization encounter count and reporting period.

4. Obtaining a New Jersey (NJ) Medicaid Management Information System (NJMMIS) Login

Medicaid providers must have an account in the New Jersey MMIS Provider Web Portal (www.njmmis.com) in order to gain access to the EHR Incentive Program Attestation Application.

To sign up for a user name and password to the New Jersey MMIS Provider Portal, a Medicaid enrolled provider must visit https://www.NJmmis.com/xjRegManage/tradingPartnerRegRight.screen or contact NJ Medicaid Provider Services staff at (800) 776-6334 or via e-mail at njmmis@molinahealthcare.com..

5. Using Group/Clinic Medicaid Patient Volume

Eligible Professionals (EPs) may elect to use group practice or clinic locations encounter to achieve the Medicaid patient volume required to begin receiving New Jersey EHR Incentive Program incentive payments. If the EP elects to use a group or clinic's patient encounter volume as a proxy for their individual count, all providers attesting from the practice or location **must** follow suit and use the group proxy patient volume as well.

EPs may use a clinic or group practice's patient volume as a proxy under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);

2. There is an auditable data source to support the group practice's or clinic's patient volume determination;

3. The practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or group practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

6. Finding EHR Certification Number

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) tests and certifies electronic medical record (EHR) systems. If the EHR system is approved, it is assigned a certification number. The website below is the Certified Health IT Product List website to look up EHR certification number or even to register an EHR http://onc-chpl.force.com/ehrcert.

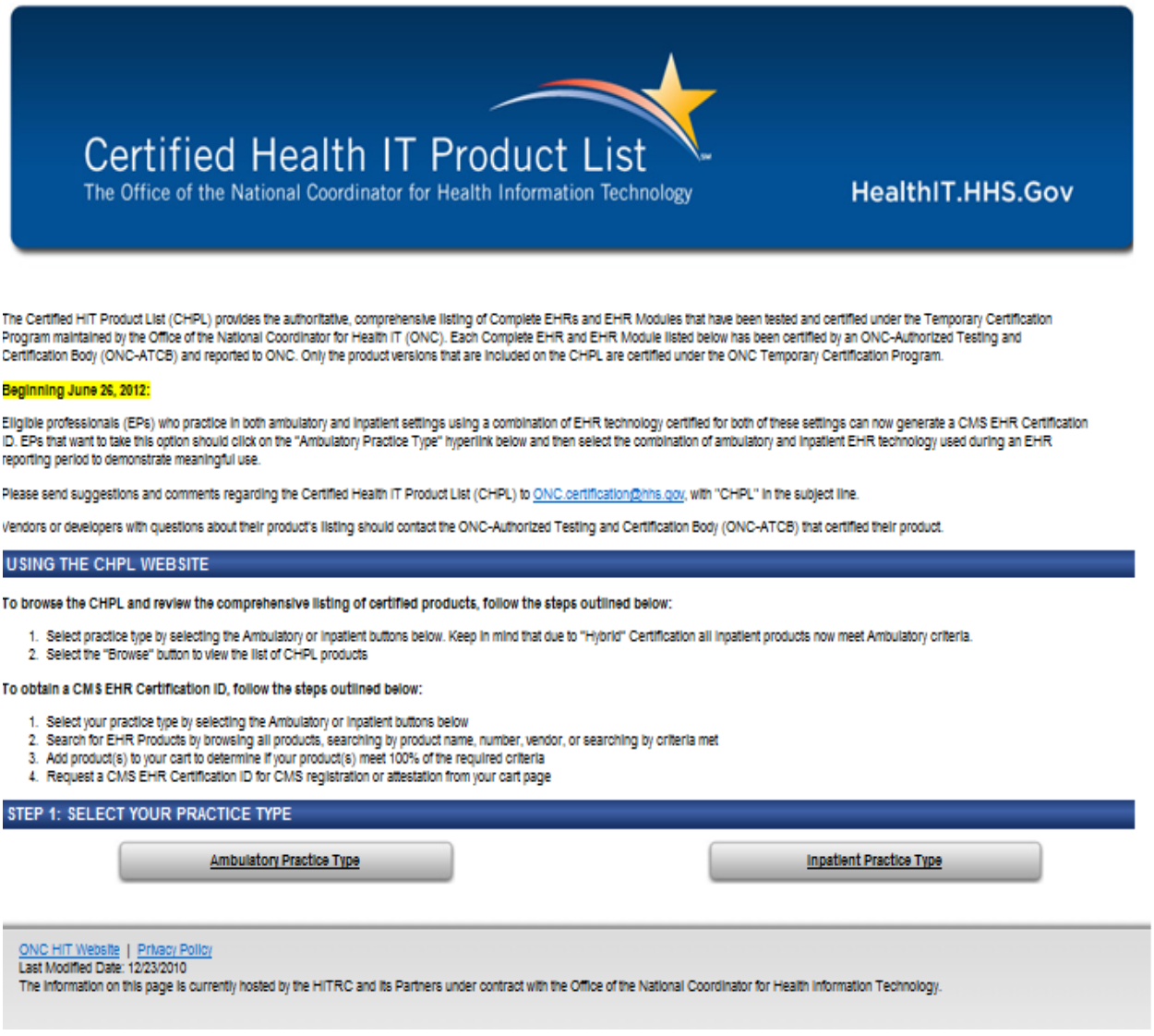


Figure 2 – Certified Health IT Product List Window

7. System Requirements

To successfully use all features of the Provider Incentive Program (NJ EHR Incentive Program), ensure that the computer system meets the following minimum requirements:

- PC with a reliable internet connection
- Web browser – The latest version of Microsoft® Internet Explorer is recommended (IE7.0 and higher). As versions of Internet Explorer become available it is recommended that these versions are used
- Adobe® Acrobat Reader

8. Navigation

This section describes all of the different navigation options within the navigation section that are not discussed throughout the user guide.

8.1 Breadcrumbs

When a hyperlink is clicked, the appropriate web page is displayed to the right of the navigation bar. The breadcrumbs indicate the current position within the site. Breadcrumbs are a visual representation of pages and sub-pages followed to reach this page. Select the underlined name to return to the specific page. For the example screen, the breadcrumb translates to the following:

- The gray text that is not underlined in the breadcrumb indicates the current section. In this case it is the Meaningful Use Core Measures.
- The underlined text will display the page that it is assigned. For example:
    - Attest displays the Reason for Attestation page.
    - Attestations displays the Attestation Instructions page.

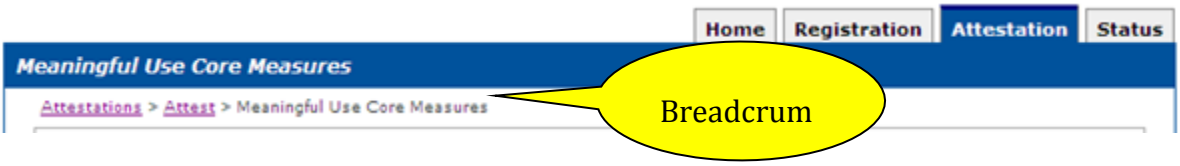


Figure 3 - Breadcrumbs

8.2 Use of the Navigation Features

Every window of the NJ EHR Incentive Program has a set of standard navigation features. The features are located on the upper right-hand corner of the application. Refer to Figure 4.

Figure 4 – Feature Description

8.2.1 Help Hyperlink

- Each meaningful use question screen includes a Help link. When selected, the CMS specifications for the meaningful use question displays in a separate Internet Explorer window. An example of the link:

For additional information: Clinical Quality Measure Specification Page

8.2.2 NJ EHR Incentive Program Account Hyperlink

Displays a screen with e-mail address. The NJ EHR Incentive Program will send attestation status updates and other system notifications to the e-mail address listed. The user may enter a new address or update an existing one. Save changes by selecting the "Update" button. Press the "Cancel" button and changes will not be saved.

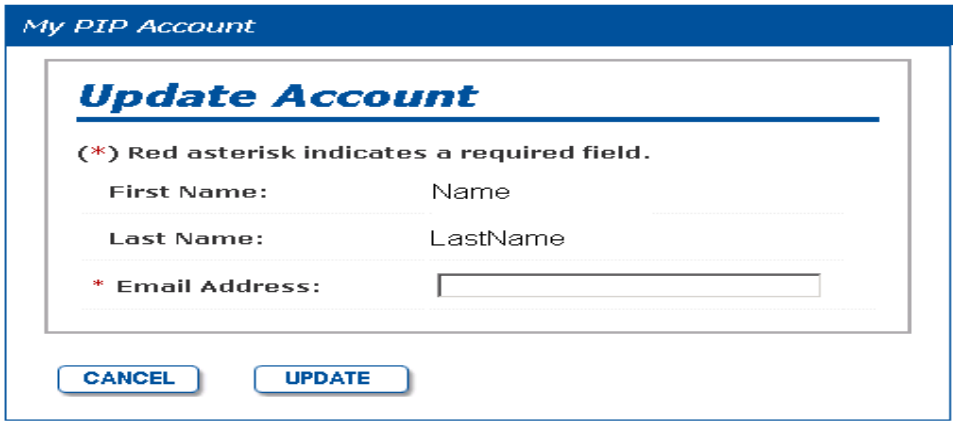


Figure 5 – Update Account Screen

8.2.3 Back to NJ MMIS Portal

- Displays the NJ MMIS Portal Welcome screen. Refer to Figure 12 NJ Welcome Screen.

8.2.4 Home Tab

- The Home tab displays the Home page. Refer to Figure 6.

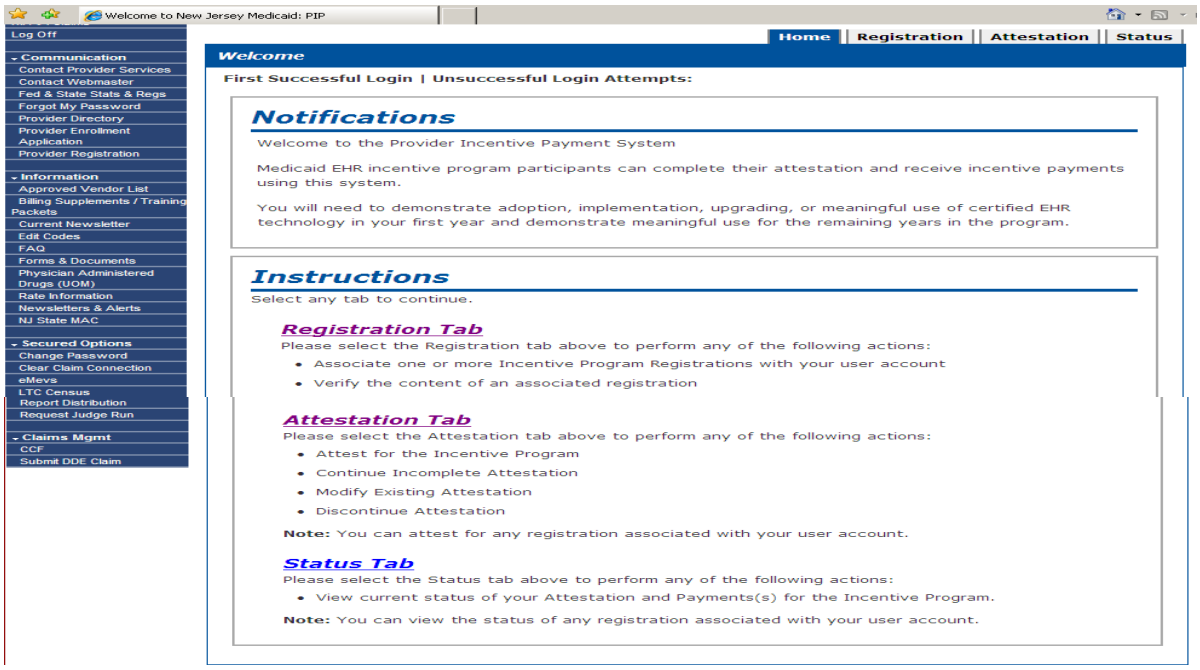


Figure 6 – Home Page

8.2.5 Registration Tab

The Registration tab displays the registration instruction window. Refer to Figure 7.

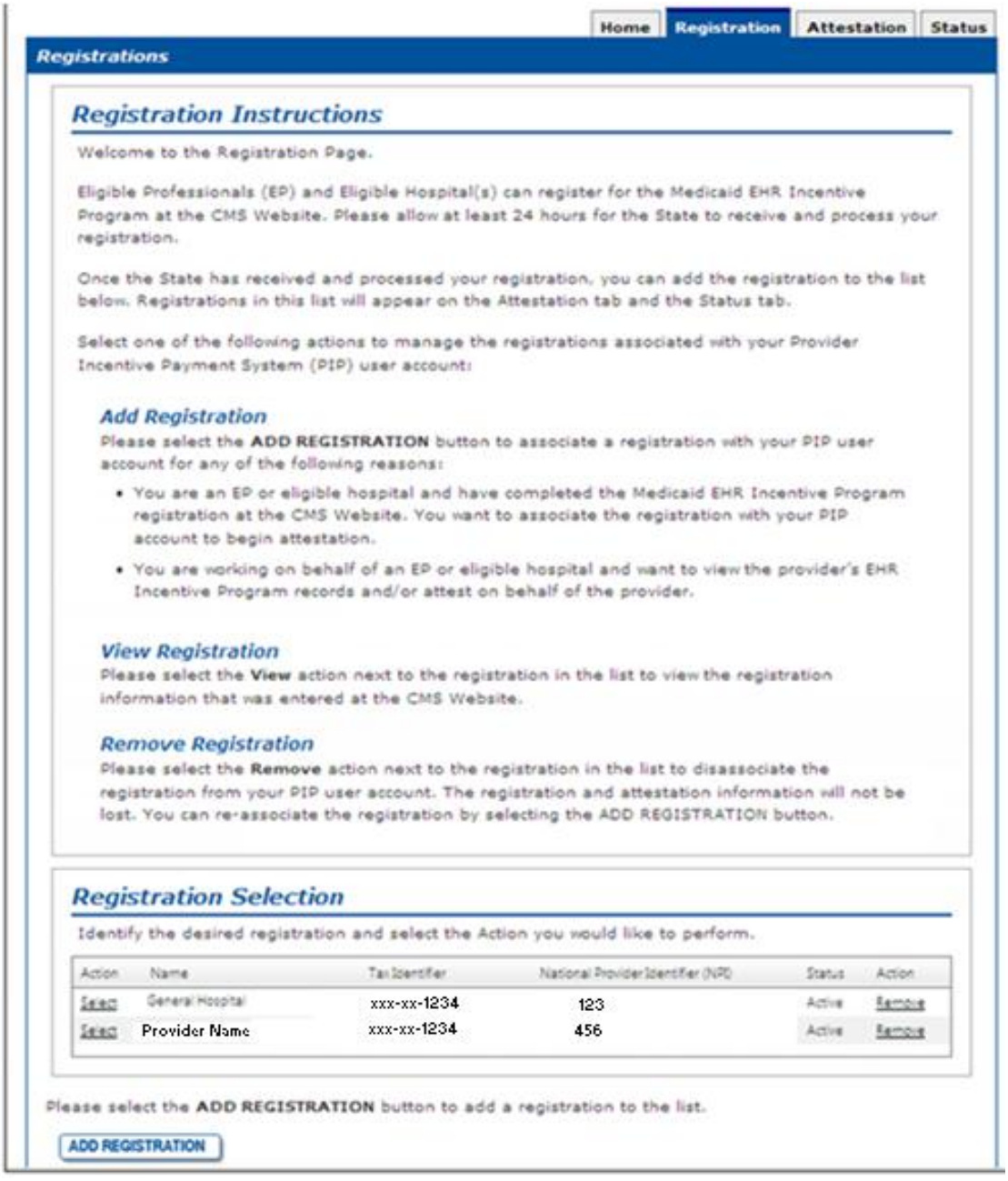


Figure 7 – Registration Window

8.2.6 Attestation Tab

The Attestation tab displays the Attestation home page. Refer to Figure 8.

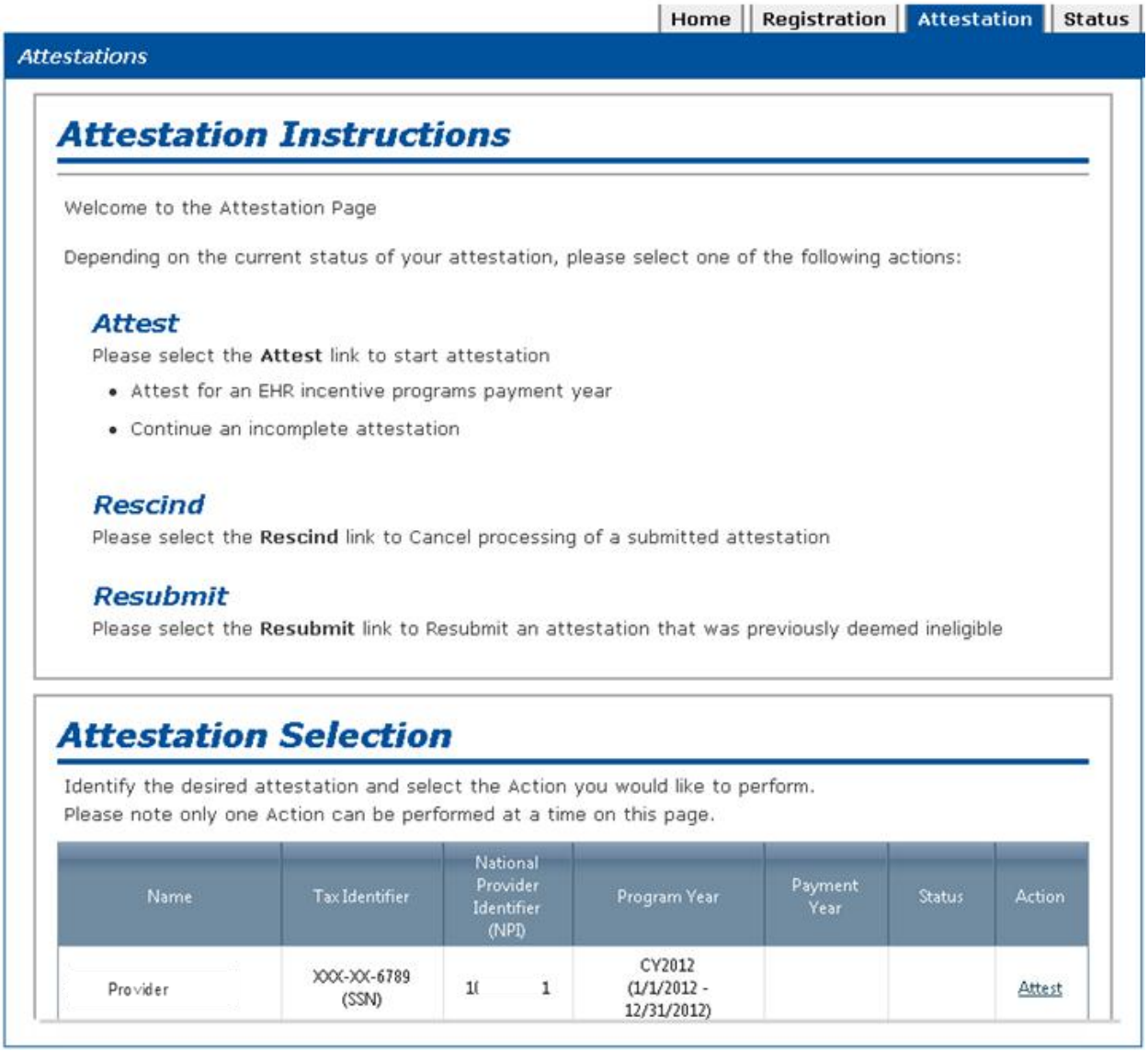


Figure 8 – Attestation Tab

8.2.7 The Standard Buttons

There are buttons found below the fields of each functional window that enable certain actions. The available actions depend on the purpose of the window. The most common buttons are the "Previous Page" and "Save and Continue" buttons. The "Previous Page" button displays the

previous page in the current page sequence. The “Save and Continue” button must be selected to retain information entered in any screen. If it is not selected, any entries in the screen are lost and must be re-entered. At the last attestation screen, the “Submit” button is also an option and is used when the user is ready to submit an attestation for processing and possible payment.

Figure 9 – Standard Buttons

9. Using the New Jersey EHR Incentive Program Attestation Application

The New Jersey EHR Incentive Program Attestation Application guides the user through the CMS required questions to determine if a provider is eligible to receive provider incentive payments. A workbook that contains the questions and the rules outlined by CMS is available and provides areas where answers may be recorded. A provider may enter the information or assign someone to enter the information on their behalf.

The list below contains the different sections. Each section is discussed in detail.

- Pre-eligibility checks, which is executed on the receipt of a registration ID from CMS
- Log into the NJ EHR Incentives instructions
- How to Register a provider
- Entry of Eligibility responses
    - Respond to practice setting
    - Respond with Medicaid volume and determine if the amount is accurate. If not, then determine if certain criteria are met.
- Payment Schedule
- Entry of CMS EHR information
- Submit Attestation

The figure below is a pictorial view of the New Jersey EHR Incentive Program Attestation Application steps.

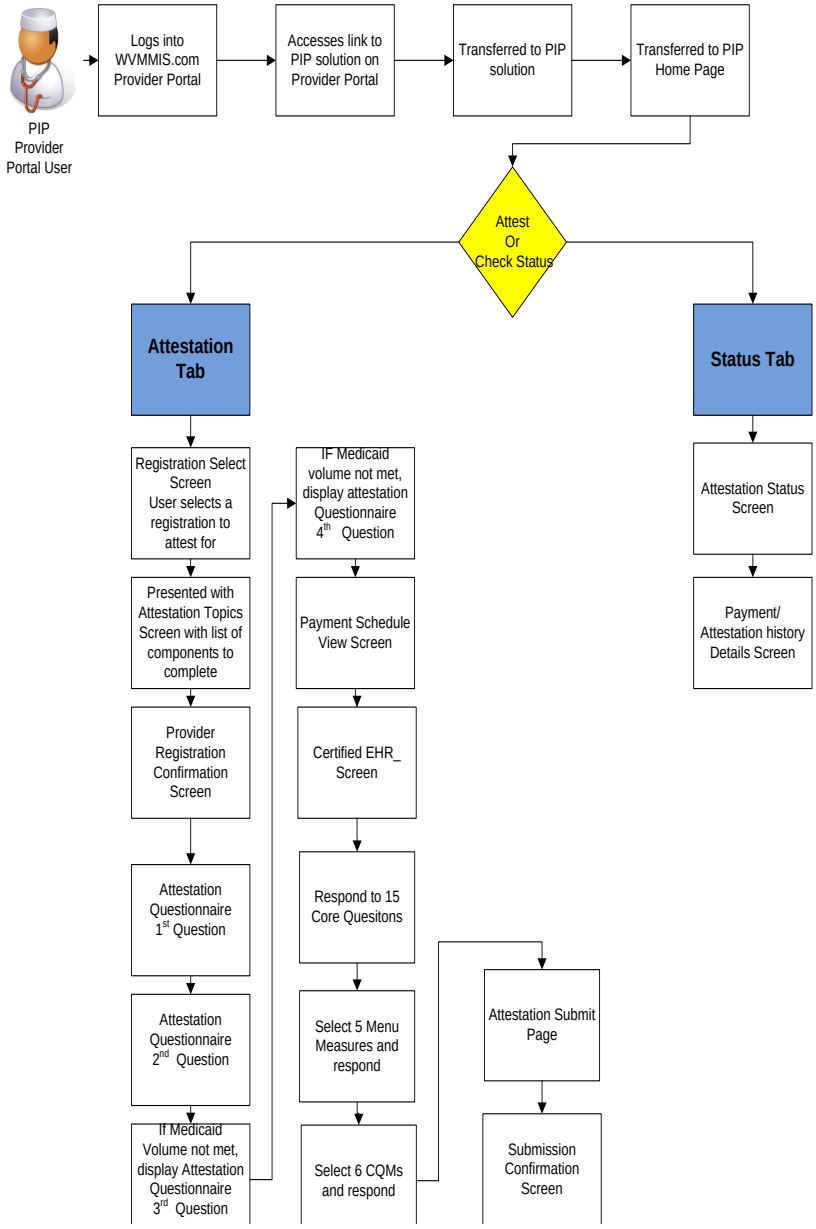


Figure 10 – Attestation Flowchart

9.1 Login to the New Jersey EHR Incentive Program Attestation Application

This section provides instructions on how to start the NJ EHR Incentive Program Attestation Application and log into the system to use the application. Please obtain authorization from the registering provider to enter the data on their behalf.

9.1.1 Starting the New Jersey EHR Incentive Program Attestation Application

The application runs on the Internet. Execute the following steps to start the application.

Access the NJMMIS.com main page. As shown in the figure below:

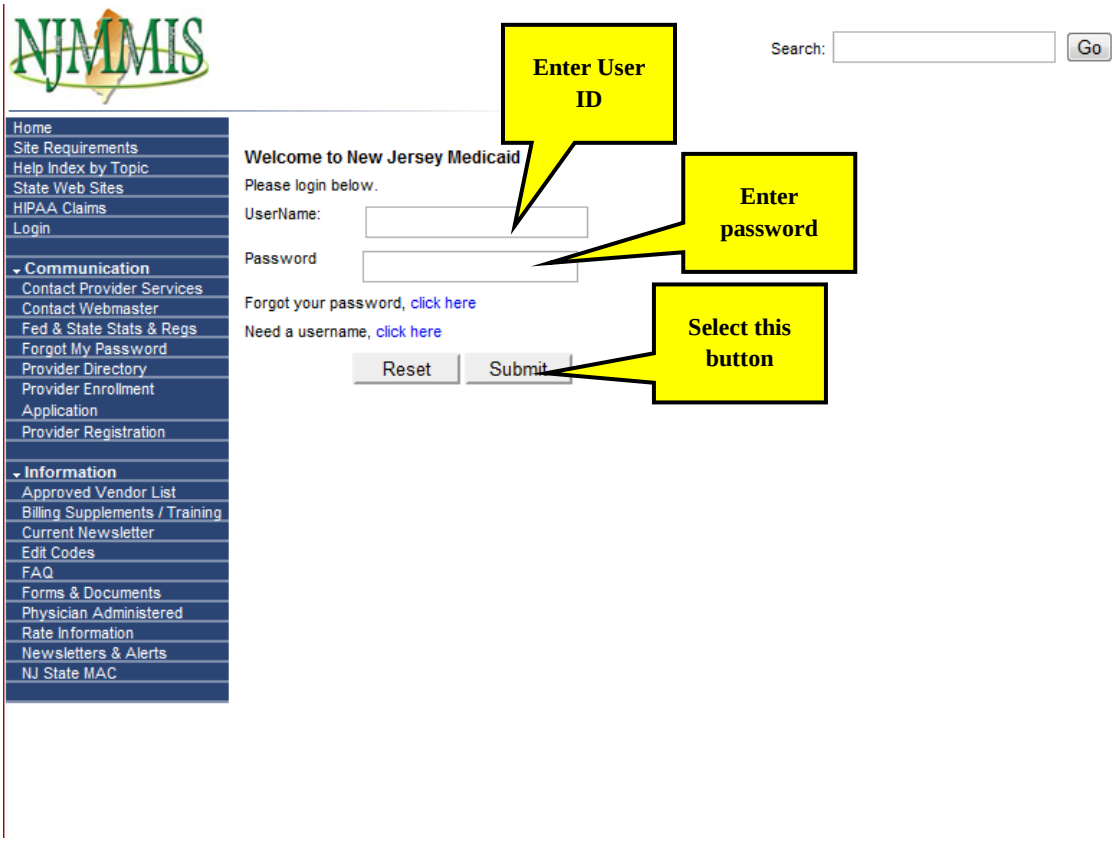


Figure 11 – NJ Login Screen

Prepare to Logon by entering in Logon Name and Password in the appropriate entry boxes and select Submit

- Enter Provider Web portal user ID
- Enter Provider Web portal password
- Select Submit button

On the **Welcome** window, select the **EHR Incentive Program** option to display the **Provider Incentive Program About This Site** window. Refer to Figure 13.

Figure 12 – NJ Welcome Screen

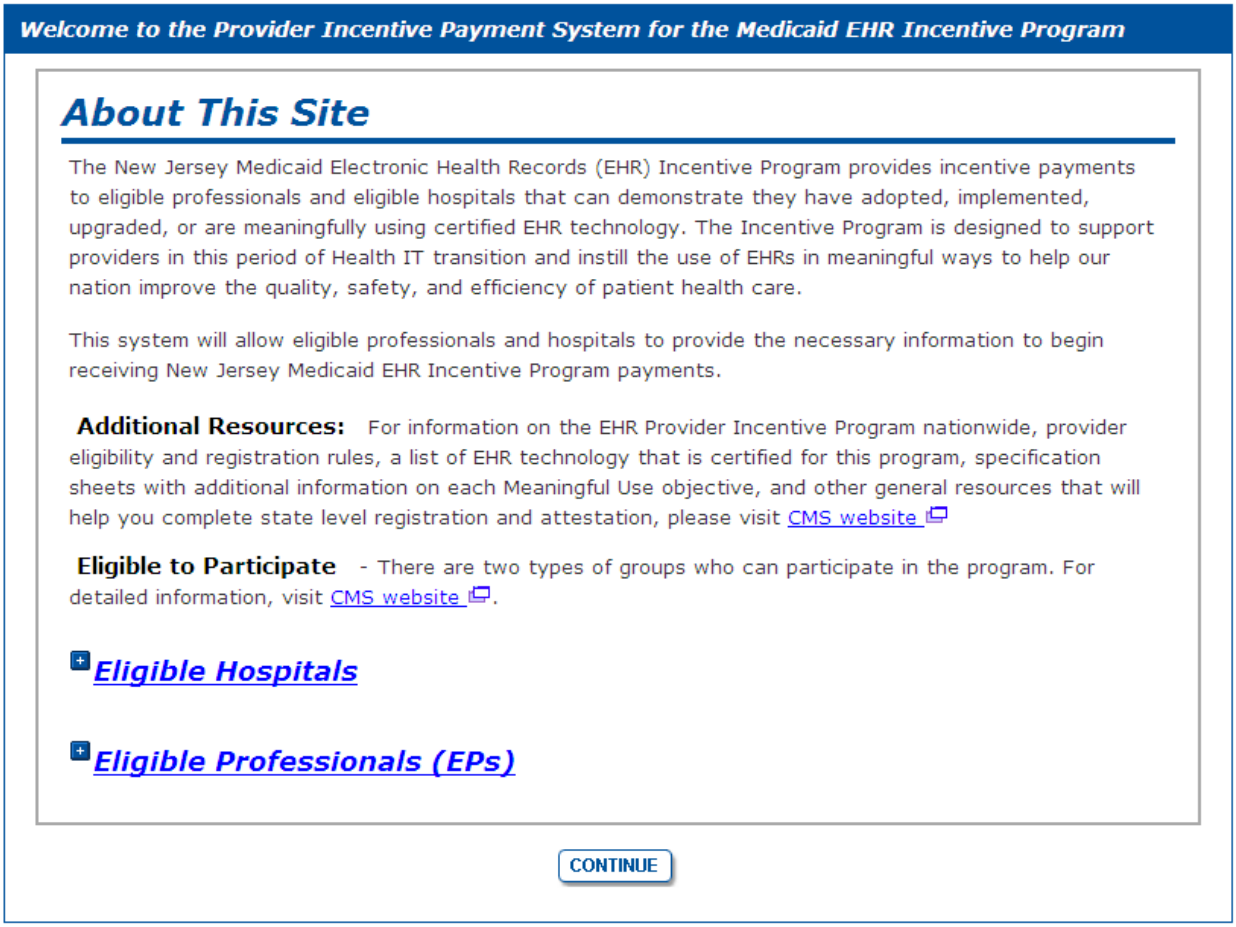


Figure 13 – Provider Incentive About this Site Page

On the **About This Site** window (shown above), select the **Continue** button to display the New Jersey EHR Incentive Program Home Page. Refer to Figure 14.

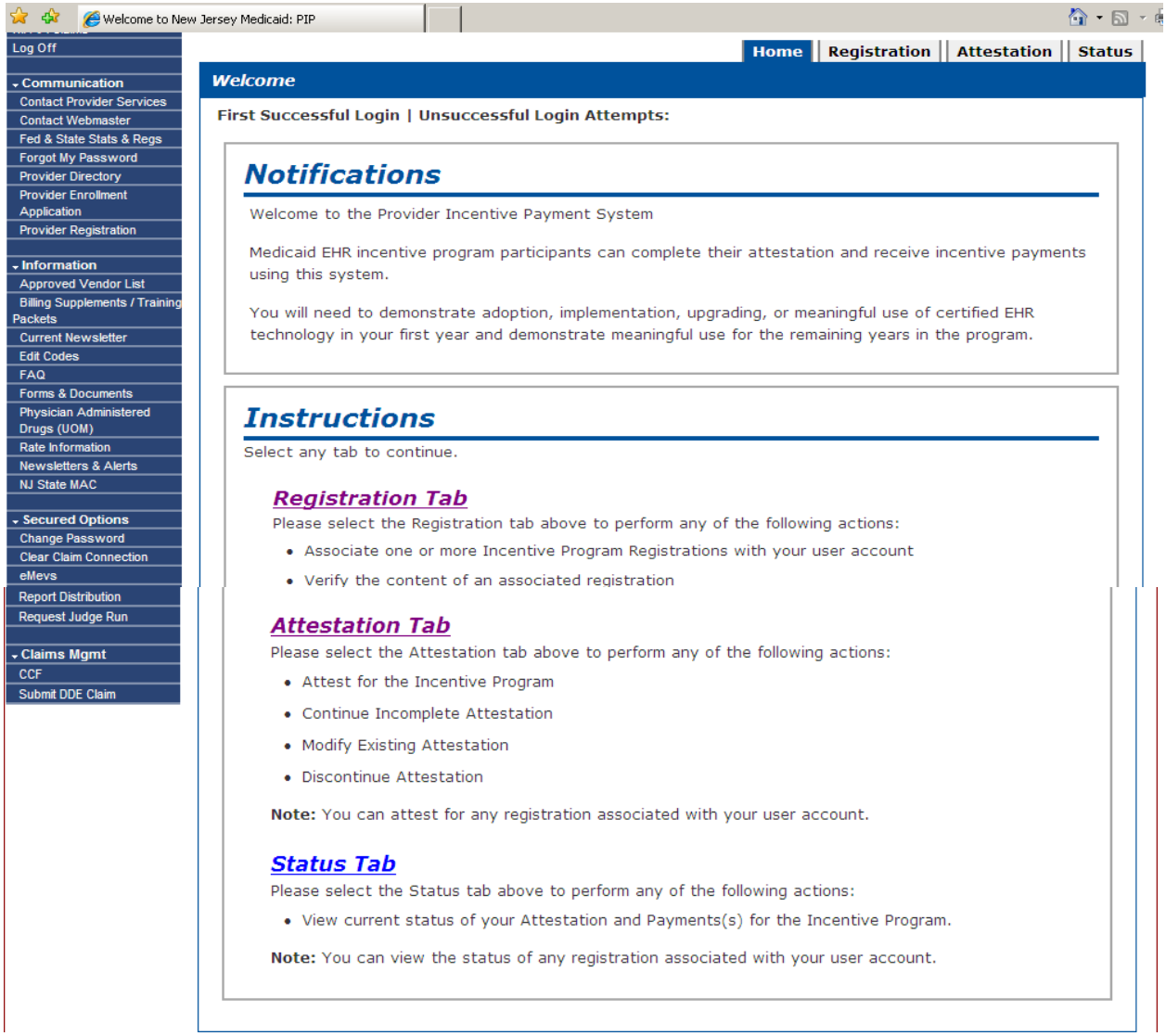


Figure 14 – Home Page

9.2 Registering a Provider within the New Jersey EHR Incentive Program Attestation Application

Within the application, the user registered for Year 1 payment and registered with CMS. The user does not need to register within this application unless the user was not the user who attested for the provider for the first Year. If a "new" user is going to attest for Year 2, then execute the registration process. Please obtain authorization with the provider to enter the data on their behalf. If provider's information has changed, you may need to update CMS information.

The Register tab associates one or more provider registrations to a user ID, view registration IDs that are attached to a user ID, and removes any provider registrations. Please obtain authorization with the provider to enter the data on their behalf.

1. To view, add, and remove registrations, click the **Registration** tab on the navigation bar.

Figure 15 – Registration tab

2. The Registration home page displays. Refer to Figure 16.

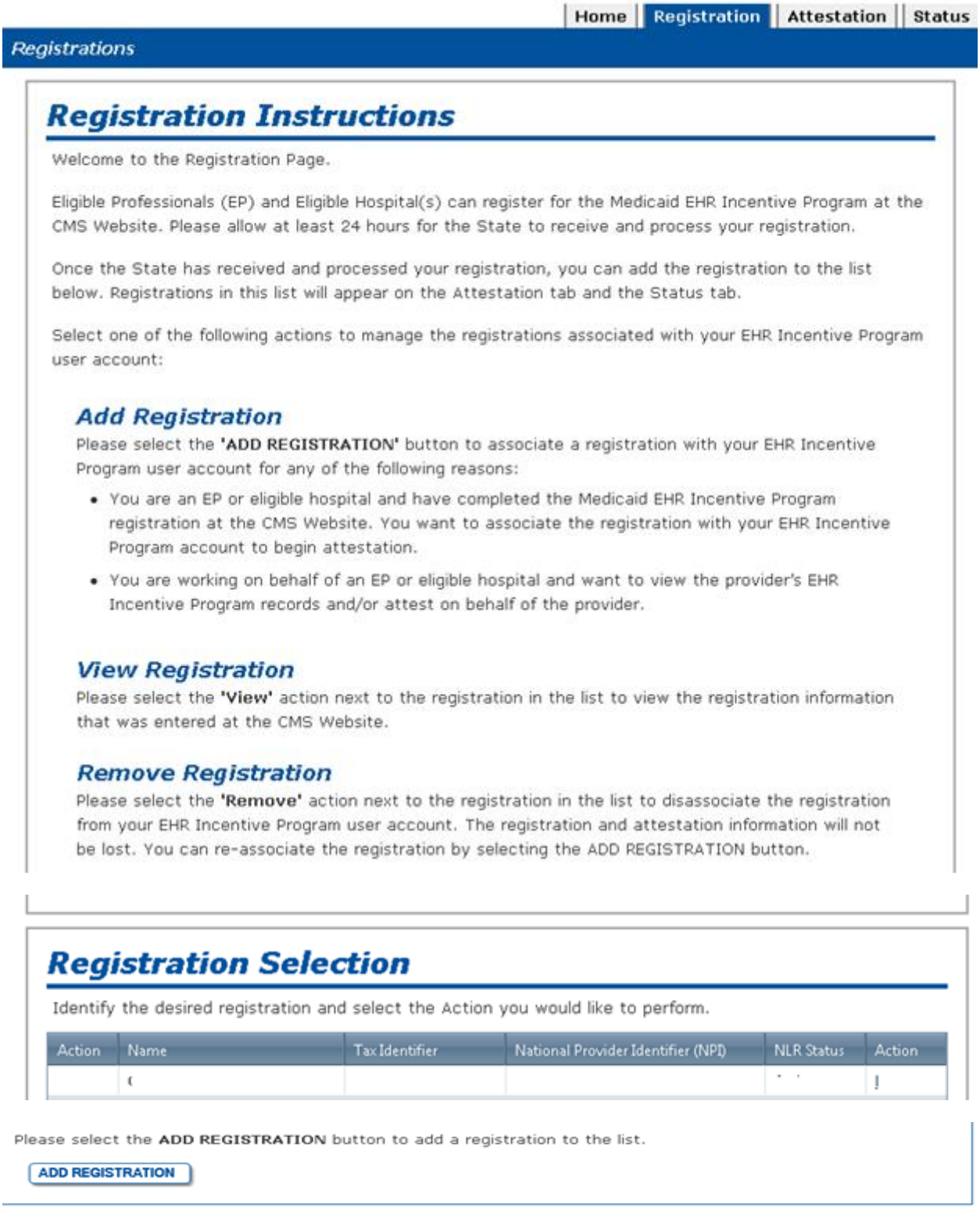


Figure 16 –Registration Tab - Registration Home Page

3. The Registration home page lists all registrations that you have added. If you have not added any, the Registration Selection section will display "No records to display" as shown in the figure below.

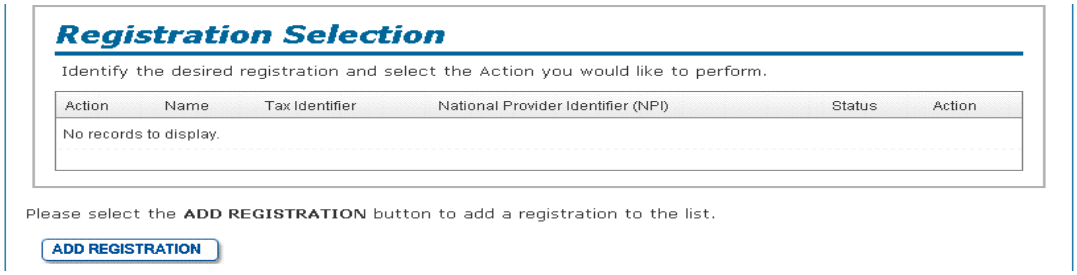


Figure 17 –Registration Tab– No Records to Display

4. The Registration sections below explains the options that are available on the Registration home page, which are Add Registration, Select, and Remove.

9.2.1 Registration – Add Option

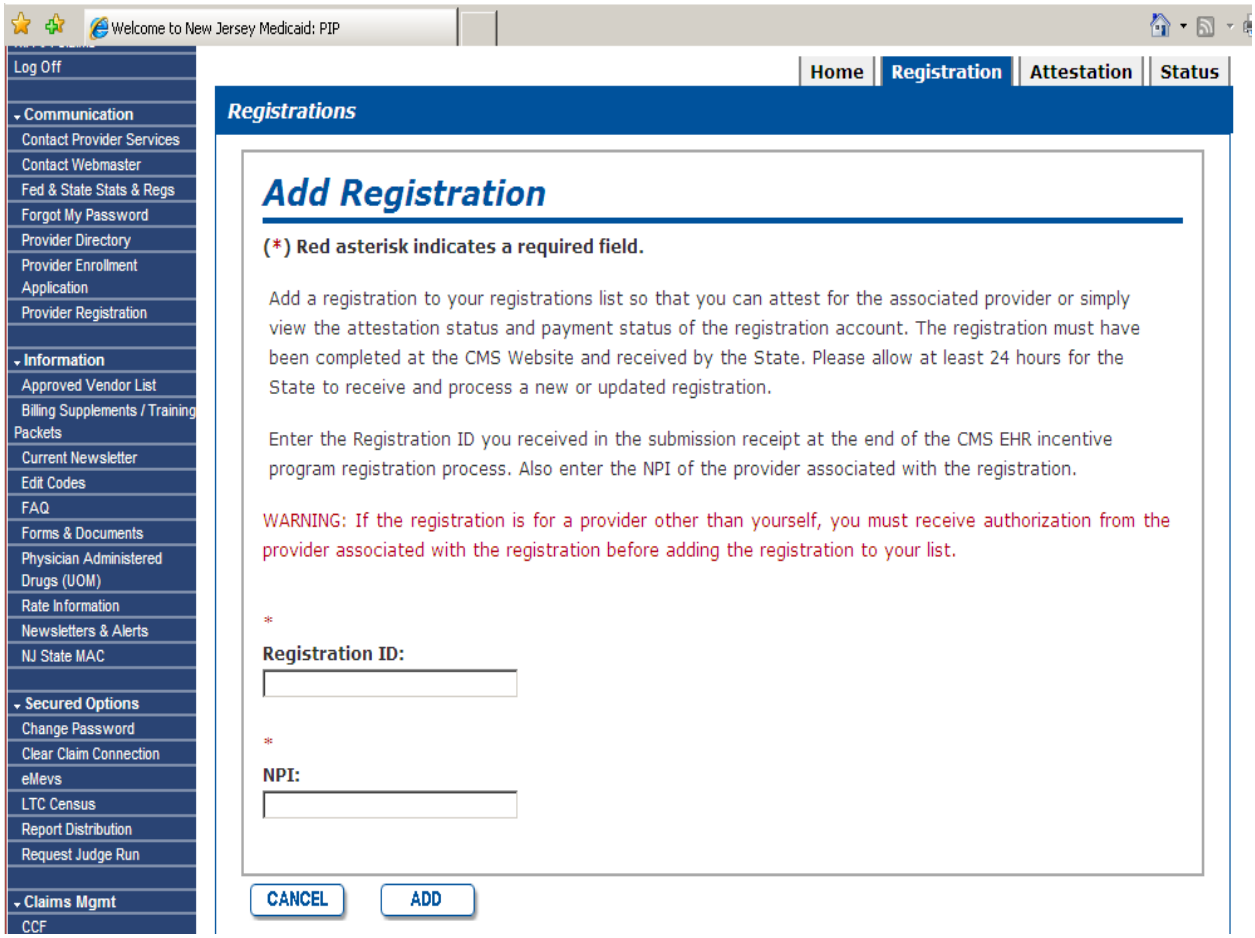


Figure 18 – Registration Tab – Add Registration

5. Click the **Add Registration** button on the **Registration** home page.
6. Enter Registration ID obtained from the CMS website.
7. Enter the provider's NPI.
8. Click the **Add** button.
9. The system validates that the Registration ID is a valid ID assigned by CMS and that the correct NPI was entered.
10. If valid, the Registration ID and NPI is associated with the user ID. The Registration Information window displays with the registration information that was entered. Refer to Figure 19.
11. The **Previous Page** button returns to the **Registration** home page.

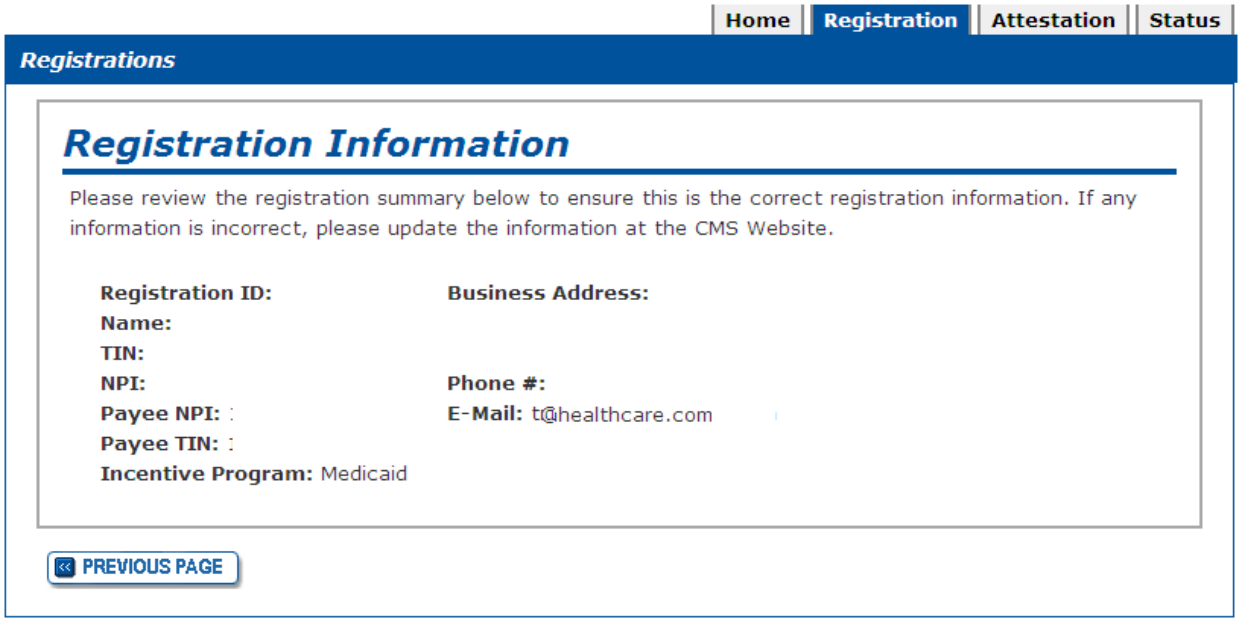


Figure 19 – Registration Tab - Registration Information Window

If invalid, an error message displays. The Add Registration page continues to display until the information is entered correctly or a navigation option is selected.

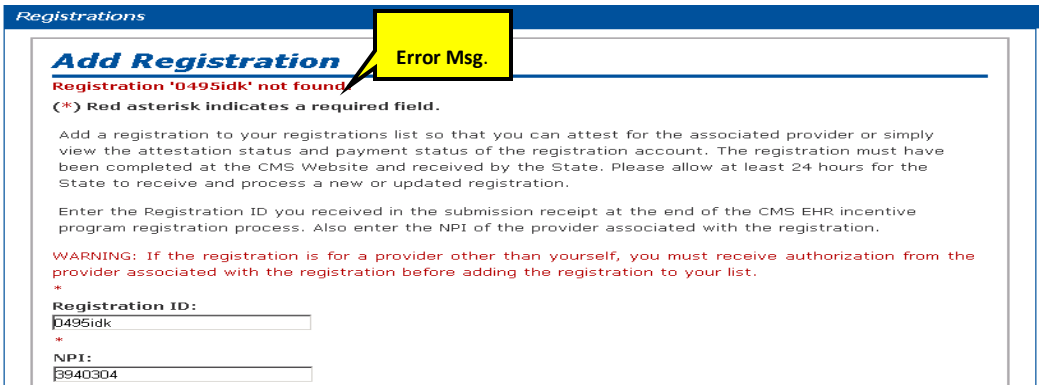


Figure 20 – Add Registration Error Message

The most common reasons why an error occurs:

- Information entered incorrectly - if necessary, access the CMS NLR website at ehrincentives.cms.gov to check the information or add a new registration.
- The registration ID will not be found if 48 hours have not expired since completing the registration on the CMS NLR website.

The Cancel button is an additional option that is available. Clicking the Cancel button does not add the registration ID and the Registration home page displays. No additional registration ID displays.

9.2.2 Registration – Select Option

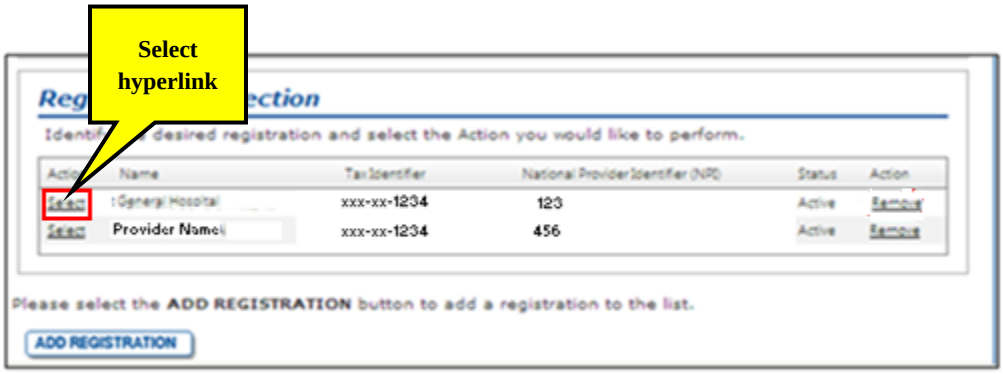


Figure 21 – Registration Tab - Registration Information Window

Click the **Select** hyperlink and the registration details displays for the registration ID selected. Refer to Figure 21.

9.2.3 Registration – Remove Option

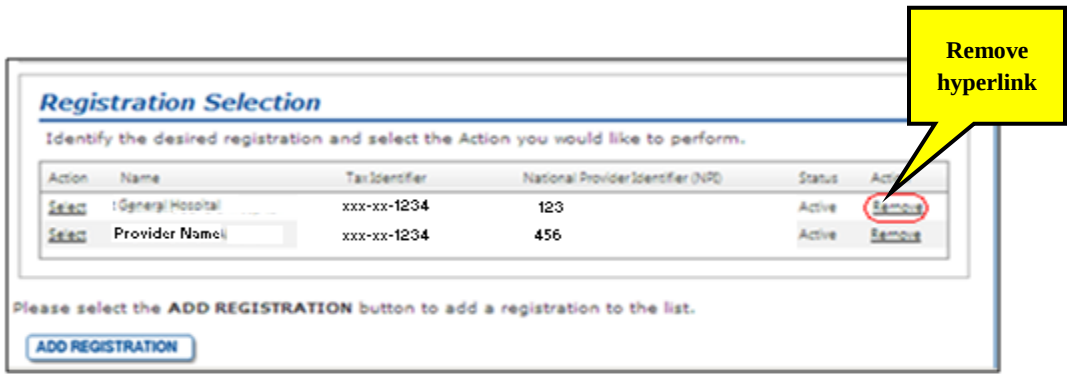


Figure 22 – Registration Tab – Remove Option

The Remove hyperlink next to a Registration ID removes the Registration ID from the user ID. The Registration ID no longer displays in the registration and in the Attestation window. Refer to Figure 22.

The Registration ID is still available for the user to reassign by executing the add registration steps. The data that was entered is saved. NOTE: If someone also registered the provider, the data that was entered by this user will display.

9.3 Attestation

The provider will select the registration and continue with populating the provider's attestation for that year. The solution will walk the eligible provider through a series of Attestation screens that directly relate to the provider workbook the State has provided to assist the provider with completing attestation. The provider must complete these questions in order to proceed with submitting the attestation and potentially receiving payment.

The workbook provides the answers that will be entered in the appropriate screen so that the provider is prepared for answering all related questions prior to beginning the attestation process.

The Attestation workflow consists of the following topics. The application will guide the user through the topics. A topic does not become active until the prerequisite topic is completed. Each topic will be addressed.

- ❑ Verify Registration Information
  - ♦ Verify that the provider information is accurate and not from another provider
  - ♦ Ability to indicate proxy usage

- ❑ Eligibility Screens

- These screens walk the provider through the attestation specific eligibility questions that they must complete in order to be validated as an eligible provider for the Incentive Program
    - These screens include:
        - Questions on provider practice location
        - Questions on provider Medicaid volume

- Payment Screens
    - These screens walk the provider through the expected payment schedule

- Certified EHR Technology
    - This screen validates that the provider is indeed using a valid EHR solution for the purposes of supporting Meaningful Use in Years 2-6.

- Meaningful Use Core
    - There are 15 required core objectives that the user is required to answer.
- Meaningful Use Menu Measures
    - Selection of five objectives may be chosen from the list of ten menu set objectives; one of the five selected must be a public health question.
- Clinical Quality Measures
    - Selection of six total clinical quality measures.
        - 3 required Core measures. EP may substitute alternate core measures
        - 3 additional measures selected from the set of 38 clinical quality measures

To access the Attestation process, select the Attestation Tab.

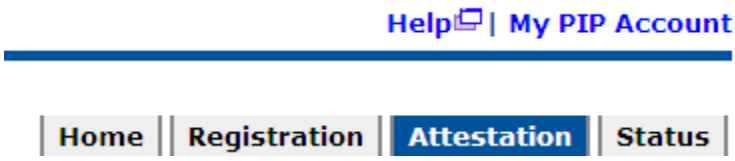


Figure 23– Attestation Tab

When selected, the Attestation Instructions page displays. This page indicates the Registration IDs that are assigned to the user.

The user does not need to complete the Attestation process in one sitting. Each screen in the Attestation flow has a Save and Continue button. This will save changes and allow the user to stop at any time without the loss of data that has been entered on that page. The attestation

process does not allow the user to skip forward to screens or jump past a screen without entering data. The user may edit answers until the attestation is submitted.

To start the attestation process:

1. Select the Attestation option on the row for the Registration information.

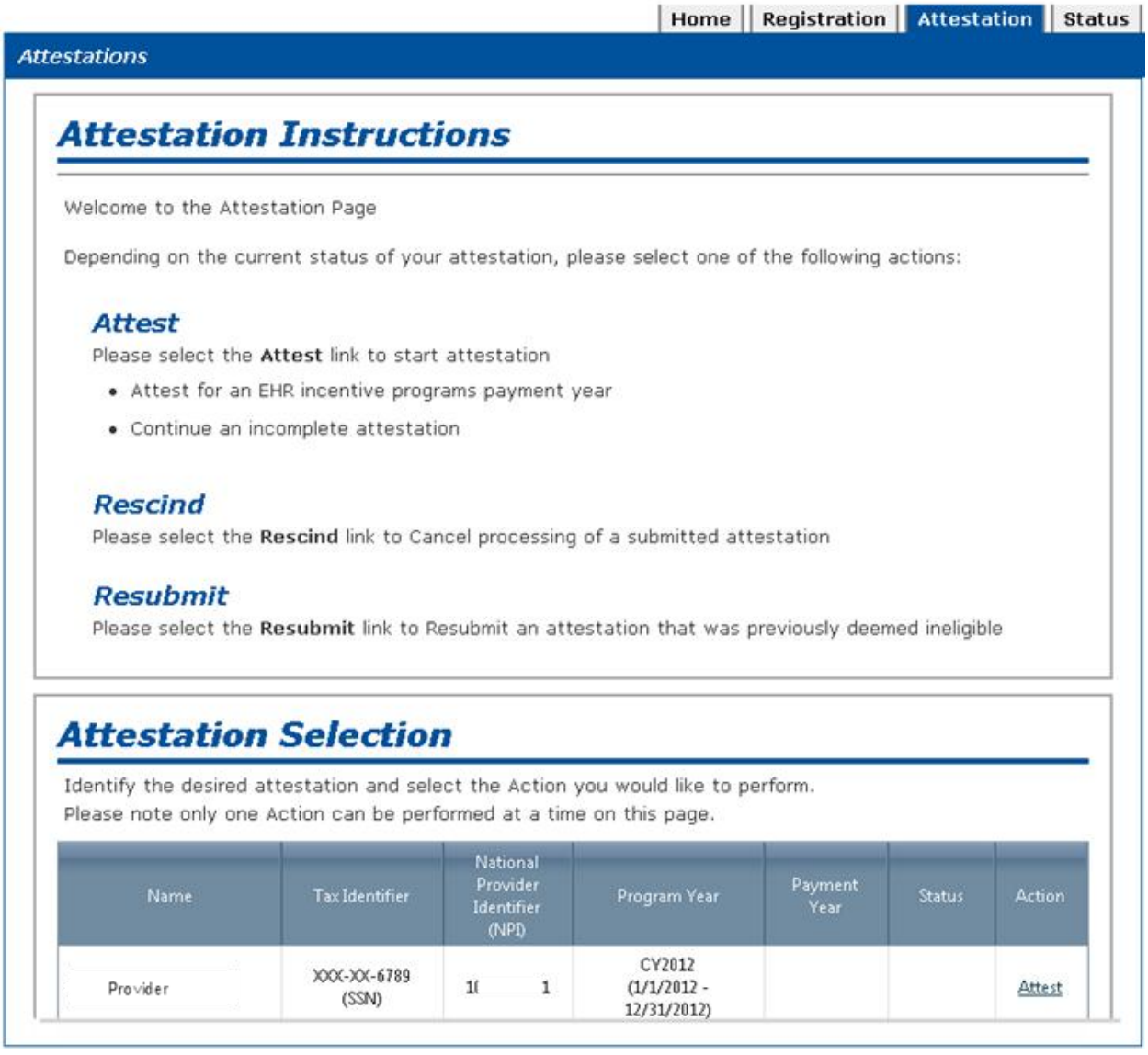


Figure 24 – Attestations Tab – Attestation Selection

Review the Attestation status displayed on the Attestation Topics Page. If the provider is not listed, please select the Status tab. The Status tab will display the current attestation. Locate the

provider in the list to see the error that prevented the provider from executing the attestation process.

The topics available on this page are as follows.

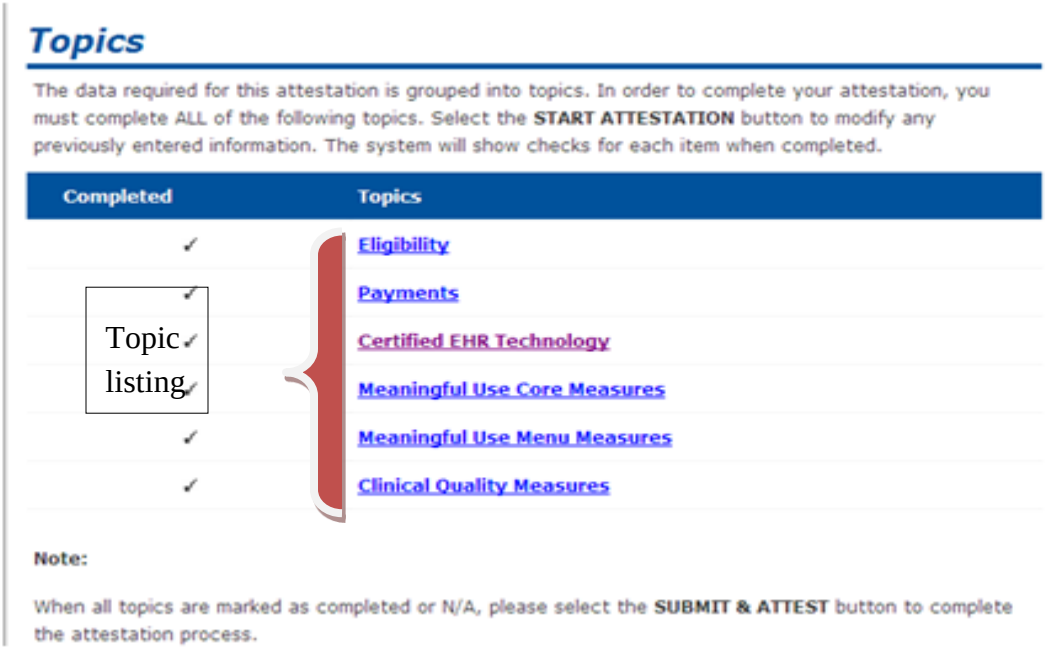


Figure 25 – Attestation Tab; Attestation Topic Listing

- The topic listing identifies the completed topic by placing an indicator next to the topic. A topic is completed when the required answers are entered and saved.
- Topics become available as prerequisite topics are completed.

Select the Start Attestation button to start the attestation process or to continue to add and modify data already entered.

Select the Submit & Attest button when satisfied with the data that is entered. This submits the data to the State for review.

- The Submit & Attest button is disabled on the initial selection of a registration ID.
- The Submit & Attest button is disabled if the Eligibility check was set to Ineligible.

Select the Previous page button to display the Attestation Instructions page.

On selection of the Start Attestation button, the Registration Information will display.

Figure 26 – Attestation Tab – Verify Registration

- Select Medicaid ID
    - Purpose: If a provider matches on more than one Medicaid ID, the provider may select which Medicaid ID attesting to or wishing to pay
    - Displays the NLR submitted NPI number's matching Medicaid IDs for the payee that was registered for along with their active Medicaid ID enrollment dates**.**
    - Please note that the provider does not have to be actively enrolled in Medicaid to be paid. The provider needs to have a "pay to" affiliation active in NJMMIS for the 90 day periods selected for Medicaid patient volume and meaningful use.
    - Dropdown box displays the Medicaid IDs. Select drop down box option to display the Medicaid IDs that were found. Highlight the desired ID and click mouse to select.
- Select Payee Medicaid ID
    - Select the Medicaid ID that will be used for payment. A provider may have one-to-many Medicaid IDs on file matching to the provider's single NPI on record. The designated NPI for payee should be matched to the corresponding Medicaid ID that the provider wishes to have the payment sent to ensure the appropriate match to the local Medicaid payee affiliation records.
    - Dropdown box displays the Medicaid IDs. Select drop down box to display the Medicaid IDs that were found.
- Select election to use Provider Proxy

Please enter the election to use the provider proxy usage for Medicaid Volume. Please remember that the following criteria must be met:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- There is an auditable data source to support the clinic's patient volume determination;
- So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works both in the clinic and outside the clinic (or with and outside a group practice), the clinic/practice level determination includes only those encounters associated with the clinic/practice.

1. Select Yes or No
2. If selected Yes, enter organization's NPI number.
3. Select Save and Continue button.

9.3.1 Attestation Eligibility

The purpose of the Attestation Eligibility section is to determine if the practice setting and Medicaid thresholds are met. In order to be eligible for the Medicaid EHR Incentive Program, eligible professionals (EPs) must meet eligible patient volume thresholds. For most professionals, this means a 30% eligible patient volume based on total patient encounters. For most EPs, eligible patient volume only includes Medicaid encounters; however, EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria; as described in the details below.

Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20% instead of 30%). If pediatricians have greater than 20%, but less than a 30%, eligible patient volume, their annual incentive cap is reduced to 2/3. Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount.

The New Jersey EHR Incentive Program defines an encounter as "one or more claims for the same patient for the same rendering physician for the same date of service (DOS). This should be a count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services. The New Jersey EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count within the numerator."

9.3.1.1 Encounter Calculation

For purposes of calculating EP eligible patient volume, a Medicaid encounter as defined by the New Jersey EHR Incentive Program as "one or more claims for the same patient for the same rendering physician for the same date of service (DOS)." This should be a count of unduplicated per patient, per date of service Medicaid fee-for-service and managed care encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services. The New Jersey EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count within the numerator. In other words, Eligible Professionals should count the following as one patient encounter: one-to-many claims for the same patient where the claim has the same DOS and the same rendering/attending

provider. All claims related to the actual "encounter" with the patient for the same date, same provider.

9.3.1.2 Eligibility Screen 1 – Service Setting

To determine if the majority of services were hospital-based; evaluate if 90 percent or more of services were performed in a hospital inpatient or emergency room setting. The following section aids in this process:

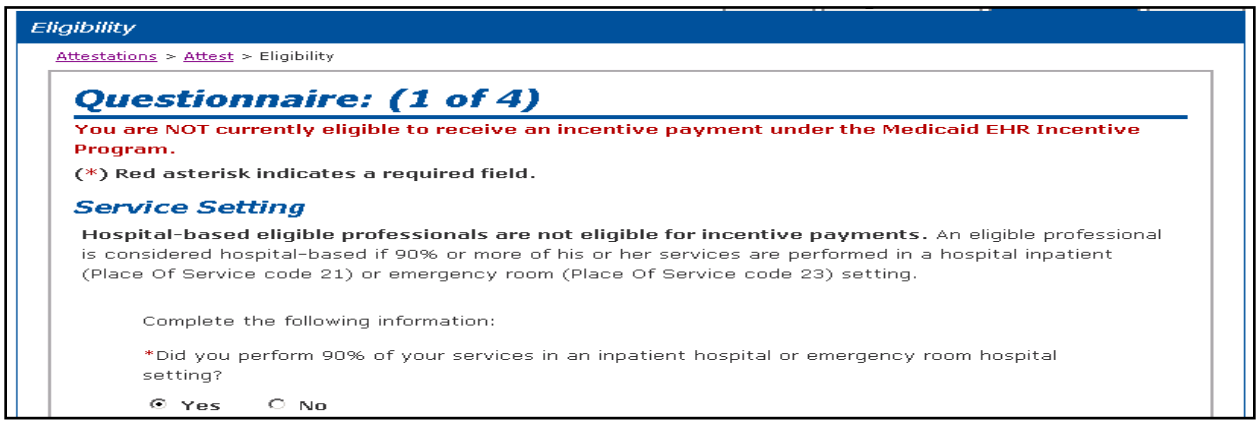


Figure 27 – Attestation Tab – Service Setting

2. Select YES if hospital-based, then select Save and Continue button.

    - Hospital-based providers are not eligible to receive the payments.
    - The application will display an error message, "You are NOT currently eligible to receive an incentive payment under the Medicaid EHR Incentive Program. " The Attestation Process is halted and the user will not be allowed to continue entering in information. The eligibility status is set to Ineligible.

3. Select NO if the provider is NOT hospital-based and select Save and Continue button.

    - The application will continue to the Eligibility Screen 2 – Volume Check question.

4. Select Previous Page button to display the Verify Registration page.

Regardless of the answer, after attestation submission and finalization (72 hrs after submittal) the system will validate the provider's attestation that they practice predominantly outside a hospital by checking the place of service for the

attesting provider's or the proxy's claims for the period specified within the system to validate Medicaid volume. If the providers are performing encounters in an inpatient or emergency room setting, the solution will PEND the attestation for further review. The Provider may then contact the Provider Services Help desk to review their attestation and work the PEND. The user will not be able to continue entering attestation data.

9.3.1.3 Eligibility Screen 2 – Volume Check

The purpose of this screen is to determine if the volume in the practice is eligible for the incentives.

In order to be eligible for the Medicaid EHR Incentive Program, the following conditions must be met:

- Eligible professionals (EPs) must meet eligible patient volume thresholds. For most professionals, this means a 30% eligible patient volume based on total patient encounters for the Attestation period.
- Pediatricians for the Attestation period
  - If Pediatricians have greater than 20% but less than a 30% eligible patient volume, their annual incentive cap is reduced to 2/3.
  - Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount they qualify for.

EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) and not did meet the EP 30% Medicaid patient volume threshold will be able to indicate volume and exclusions, which will be discussed with the Eligibility Screen 3 and 4.

9.3.1.3.1 Out of State Encounters

If the provider has significant Medicaid encounters from another state payer, then you may add the encounters from the other state or states to your in-state encounter count to achieve the required encounter volume. Entering out-of-state patient volume is optional at the discretion of the provider. The Volume page provides functionality to add and maintain out-of-state (OOS) volume counts. When an attestation with OOS entries is submitted, the attestation will be placed in a Pend status provided the in-state volume counts are validated. New Jersey Medicaid EHR Incentive Program staff will review the attestation to ensure the appropriate documentation was provided and also to review the documentation to determine if the attestation will be

accepted or rejected. The provider must obtain the counts from the out of state's Medicaid MMIS and be prepared to submit the following documentation:

- ❑ Certification on official letterhead from the State Medicaid agency declaring the numbers obtained were derived from the State's MMIS and are accurate.
- ❑ Report generated by the State Medicaid agency with the total Fee-for-Service and Managed Care Organization encounter count and reporting period.

Figure 28 – Attestation Tab – Medicaid Patient Volume

1. Enter the start date or end date of the EP's patient volume attestation period by typing in the date or selecting the calendar icon to the right of either box. The application will then automatically calculate the appropriate 90 day window for the provider's chosen attestation period.
2. Enter the number of Medicaid (Title XIX only) fee-for-service and managed care patient encounters for EP or proxy entity being used by the EP for the 90 day attestation period calculated at the top of the screen. The sum of these two numbers will be the numerator for the patient volume calculation.
    - Do not add commas. The application will insert commas, as needed, after entry.
3. Enter the total number of patient encounters for the EP or proxy entity being used by the EP for the 90 day attestation period calculated at the top of the screen. This amount will be the denominator for the EP's patient volume calculation.
    - Do not add commas. The application will insert commas, as needed, after entry.
4. Out of State Patient Volume (Optional)
    - This screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Instructions for each option follow this screen shot.

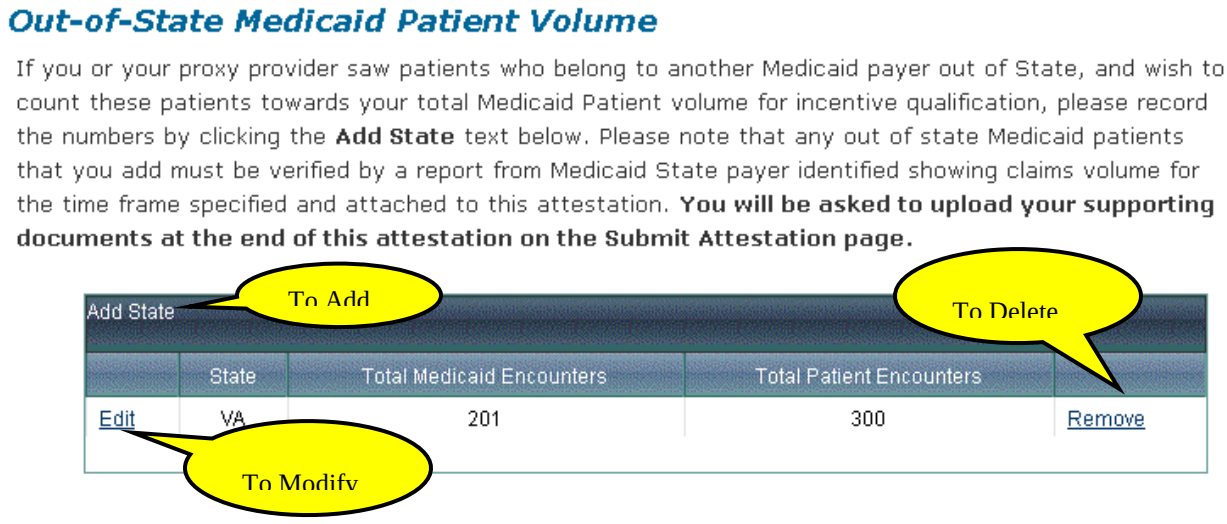


Figure 29 – Attestation Tab – Out-of-State Medicaid Patient Volume

❖ Select Add State to display the following screen.

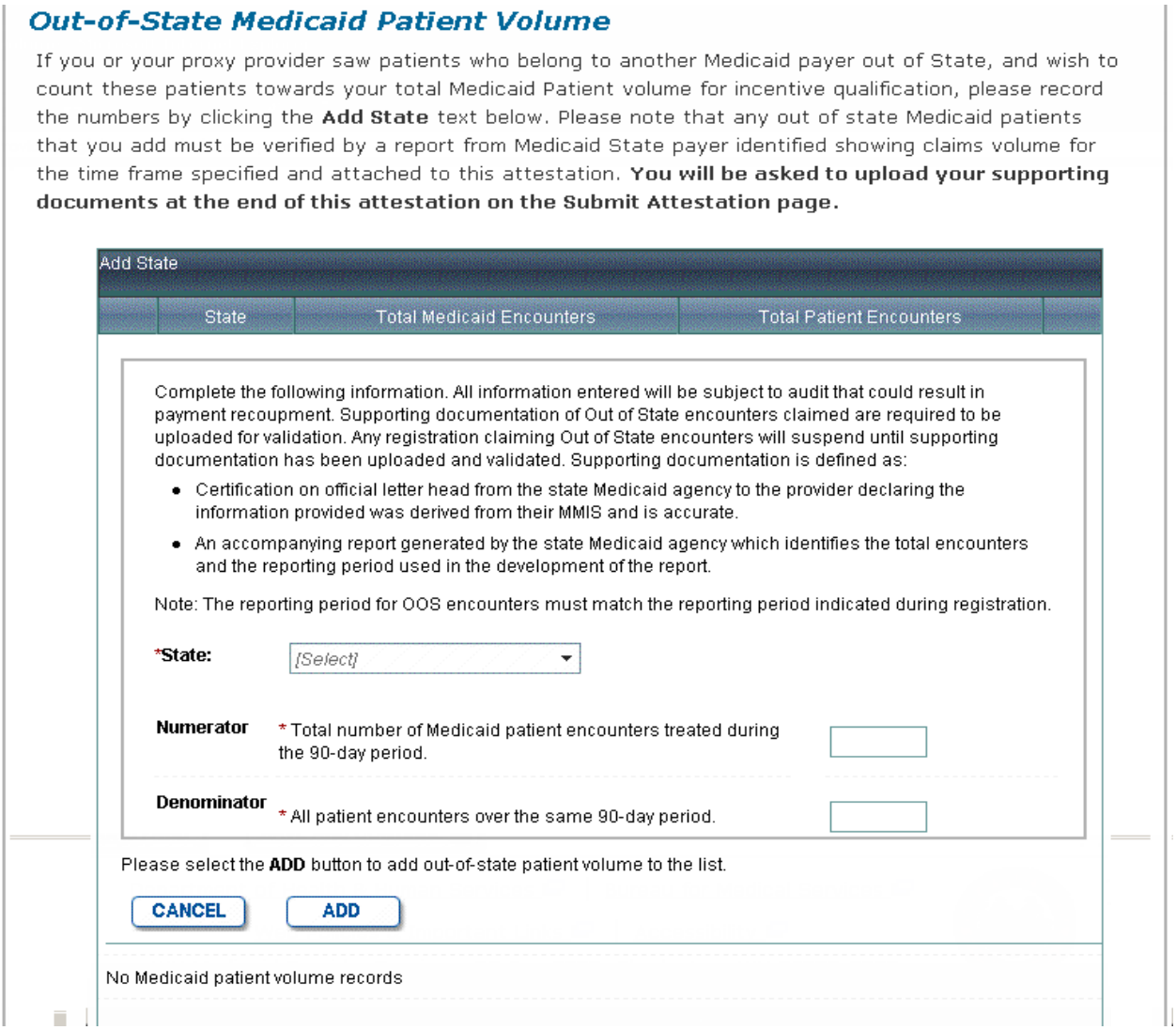


Figure 30 – Out-of-State Entry – Add/Edit Screen

- To Add Out of State entry
    1. Select Add State to display the screen above.
    2. Select a State from the drop down list.
    3. Enter encounters
    4. Enter in Denominator, which is the total patient encounters for the State
    5. Select Add button

To enter patient encounter information for additional states repeat steps 1-5.

- To modify an out of state entry:
    - Select **Edit**
    - The screen will display the selected out-of-state entry
    - Select **Update** button

- To delete and out of state entry
  - Select **Remove**
  - Verify the entry being deleted by responding to the question presented. If the provider does not meet the volume percentages listed above, then Volume Screen 3 will display.

If the eligible professional (EP) meets or exceeds the Medicaid patient volume required to receive a New Jersey EHR Incentive Program payment, the application will display the "Payment Calculation" page. Once the EP has completed and submitted their attestation for processing, their Medicaid patient volume information will be verified against the claims and encounter data available in NJMMIS. All information entered into the application is subject to post-payment audit.

If the eligible professional does not meet the required Medicaid patient threshold after entering all of their patient volume information, additional screens will appear presenting a possible alternative patient volume calculation.

9.3.1.3.2 Volume Screen 3 – Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Patient Volume

The purpose of this screen is to provide another opportunity to meet the eligibility volume for those providers practicing predominantly in an FQHC. The following is the volume criteria if the provider practiced at an FQHC or RHC:

Eligible professionals that perform 50% of more of their overall patient encounters over a six month period in an FQHC or RHC are eligible to use an alternative, "Needy Individual" patient volume calculation to become eligible to participate in the New Jersey EHR Incentive Program. Volume Screen 3 (shown below in Figure 36) asks the EP to provide the necessary information to determine if they are eligible to use the "Needy Individual" patient volume calculation

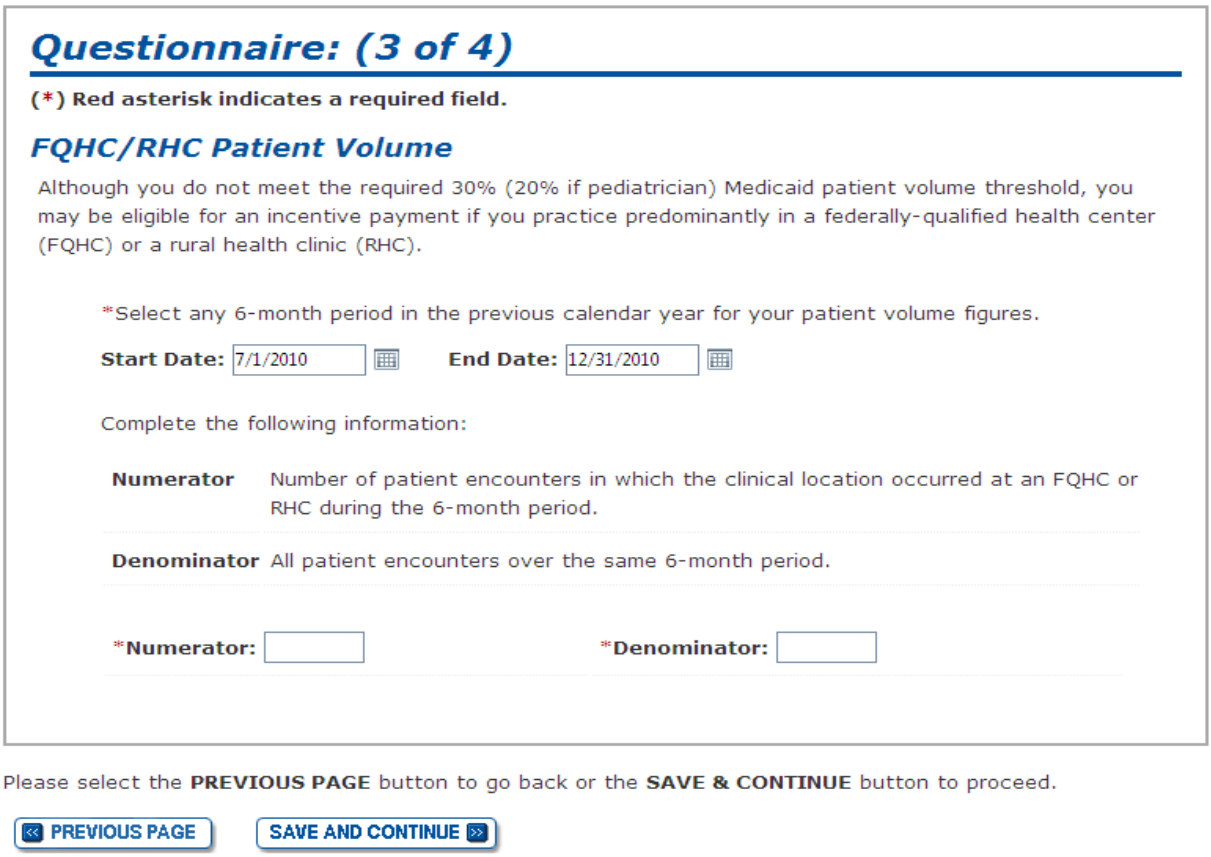


Figure 31 – Attestation Tab - FQHC/RHC Patient Volume

1. Enter the start date or end date by typing in the date or selecting the calendar icon to the right of either box. The system will automatically calculate the six month patient volume calculation period.
2. Enter the number of patient encounters performed by the EP at an FQHC or RHC in the six month period selected above. A patient encounter is defined as a unique patient, date-of-service, and place-of-service combination. This count must belong to the EP alone; no proxy entity measure (such as for a group practice or clinic) may be utilized when counting FQHC patient encounters. This will be the numerator used to determine if the EP practices predominantly in an FQHC.
    - Do not add commas. The application will insert commas, as needed, after entry.
3. Enter the total number of patient encounter performed by the EP over the six month period selected at the top of the screen. This count must belong to the EP alone; no proxy entity measure (such as a group practice or clinic) may be utilized when counting the total number of encounters. This will be the denominator used to determine if the EP practiced predominantly in an FQHC.
    - Do not add commas. The application will insert commas, as needed, after entry.

– Select **Save and Continue**.

The application will validate if all fields have data entered.

- If any field does not contain an entry, an error message will display. Please enter the appropriate data.

If all fields contain responses, the next action depends on the data entered.

- If the EP meets the 50% patient volume threshold needed to be considered to be "practicing predominantly" in an FQHC or RHC, the EP will proceed to Volume Screen 4.
- If the EP does not meet the 50% patient volume threshold needed to be considered to be "practicing predominantly" in an FQHC or RHC, then the EP will not be allowed to continue their attestation. If the EP has questions or needs assistance, please call the New Jersey Medicaid Provider Services Help Desk at (800) 776-6334 and select option 7 to speak with a New Jersey EHR Incentive Program representative.

9.3.1.3.3 Volume Screen 4 – Needy Patient Volume

Providers who practice predominantly in an FQHC or RHC are allowed to use criteria more inclusive "Needy Individual" patient volume measure to establish their eligibility for the EHR Incentive Program. An EP "practices predominantly" at an FQHC or an RHC when the clinical location for over 50% of his/her total patient encounters over a period of 6 months occur at an FQHC or RHC. Providers who practice in an FQHC or RHC but do not meet the "predominantly practicing" threshold can still qualify for an EHR Incentive Program payment using Medicaid (Title XIX only) patient volume previously discussed, but are not eligible to use the "Needy Individual" patient volume measure described in this section.

Needy Individual Encounters Defined

The New Jersey EHR Incentive Program defines a qualified patient encounter as a unique patient, date-of-service, and place-of-service combination, including inpatient, outpatient, and emergency room services. "Needy Individual" patient encounters include services rendered to an individual on any one day where any of the following are met:

- Medicaid (Title XIX) or the Children's Health Insurance Program (CHIP) (or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service;

- Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid all or part of the individual's premiums, co-payments, or cost-sharing;
- The services were furnished at no cost;
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

The EHR Incentive Program Attestation Application will run a report from the NJMMIS to validate the Medicaid and CHIP fee-for-service and managed care encounter amounts included in the numerator of the Needy Individual patient volume calculation. At the EP's option, out-of-state patient encounters meeting the four "Needy Individual" criteria above may be used to establish New Jersey EHR Incentive Program eligibility. All information entered into the EHR Incentive Program Attestation Application is subject to post-payment audit that could result in payment recoupment.

An example of the screen used to enter "Needy Individual" patient volume information is shown below in Figure 33, followed by instructions on how to complete the screen.

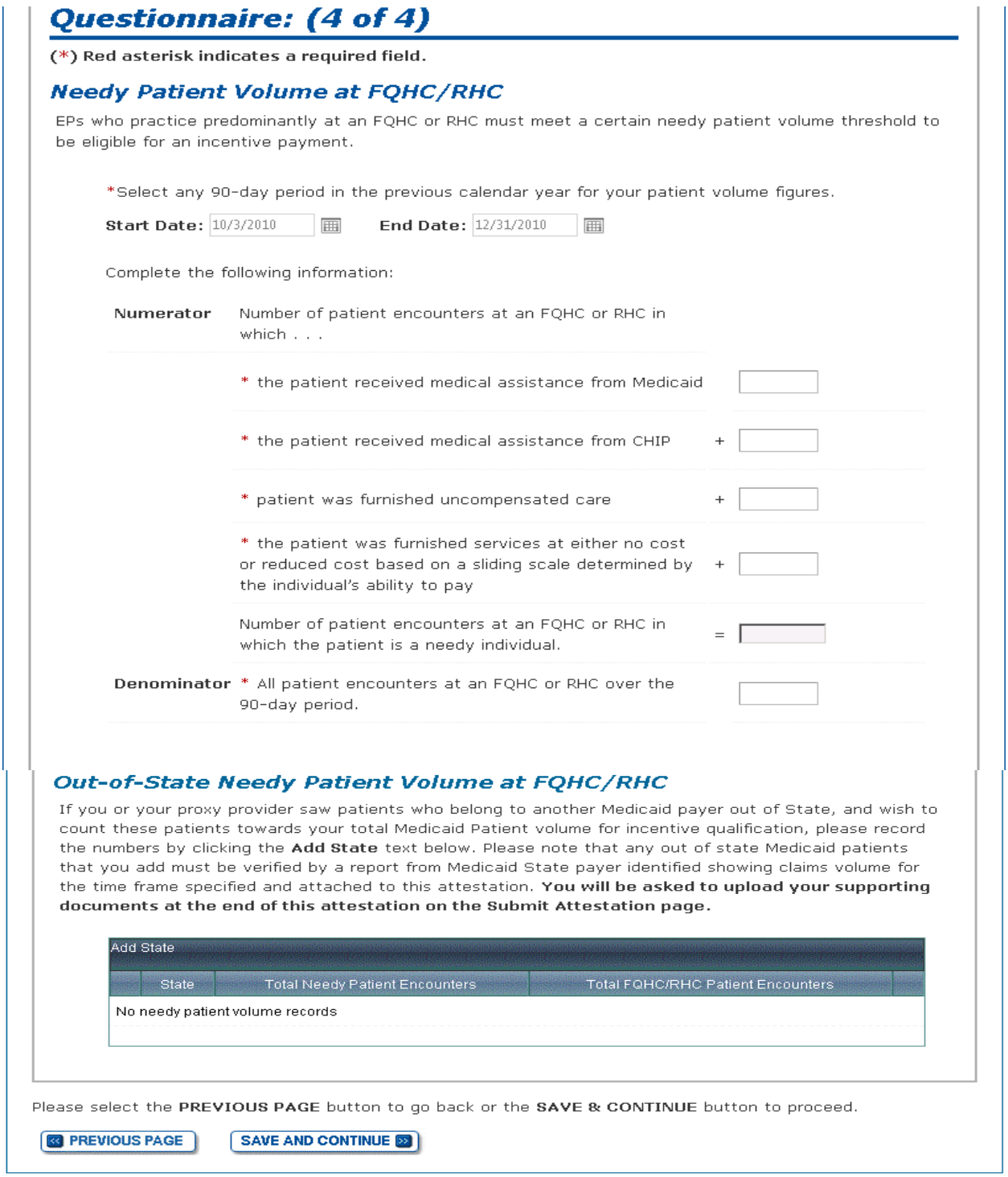


Figure 32 – Attestation Tab – Needy Patient Volume at FQHC/RHC

1. Enter the start date or end date of the EP's patient volume attestation period by typing in the date or selecting the calendar icon to the right of either box. The application will

then automatically calculate the appropriate 90-day window for the provider's chosen attestation period.

For the selected 90-day attestation period, enter the number of patient encounters that meet the criteria for each question.

2. Enter the number of patients served in an FQHC or RHC that received medical assistance from Medicaid. This amount includes the unique patient, date-of-service, and location of service combinations where Medicaid (Title XIX, fee-for-service or managed care) or Medicaid demonstration project under section 1115 of ARRA paid for part or all of the service or paid all or part of the premiums, co-payments, and/or cost sharing.
    - Do not add commas. The application will insert commas, as needed, after entry.
3. Enter the number of patients served in an FQHC or RHC that received CHIP assistance. This amount includes the unique patient, date-of-service, and location of service combinations where CHIP or a CHIP demonstration project under section 1115 of ARRA paid for part or all of the service or paid all or part of the premiums, co-payments, and/or cost sharing.
    - Do not add commas. The application will insert commas, as needed, after entry.
4. Enter the number of FQHC or RHC patients provided uncompensated care at an FQHC or RHC. This amount includes the unique patient, date-of-service, and location of service combinations for which the EP received no compensation.
    - Do not add commas. The application will insert commas, as needed, after entry.
5. Enter the number of FQHC or RHC patient encounters provided at either no cost or reduced cost based on the sliding scale determined by the individual's ability to pay. This amount includes the unique patient, date-of-service, and location of service combinations that meet the required criteria.
    - Do not add commas. System will format with commas after entry.
6. The application will generate the total number of "Needy Individual" encounters using the information entered in steps 1-5
7. Enter the Denominator. This amount is the total number of patient encounters the FQHC/RHC had for the specified time frame based on reports generated from an auditable source, such as practice management or EHR systems.
    - Do not add commas. System will format with commas after entry.

Out-of-State Entry (Optional)

The screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Each option's instructions are bulleted sections following this screen shot.

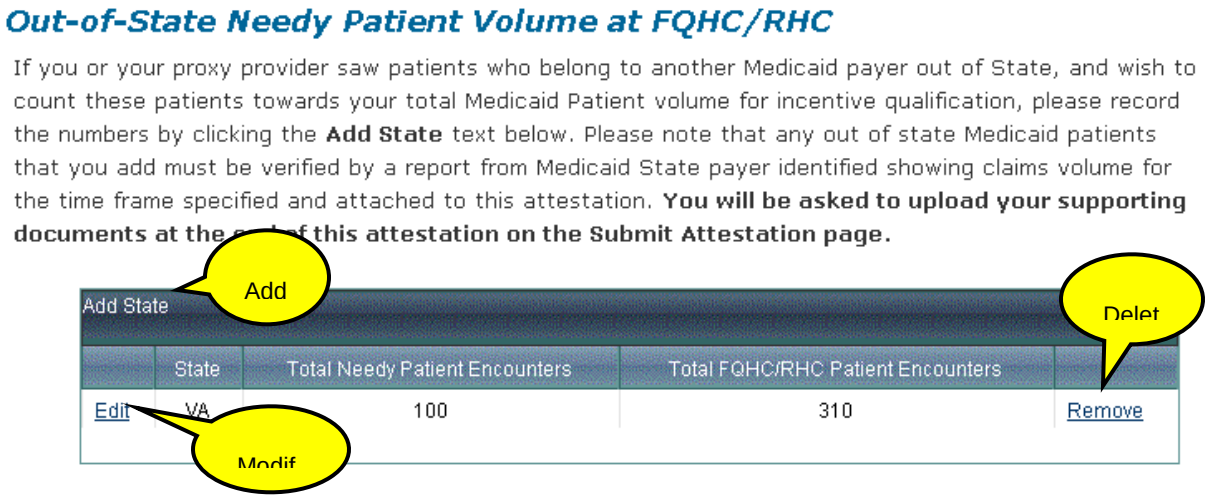


Figure 33 – Out-of-State FQHC/RHC Entry

- To Add
  - Select Add State to display the following screen.

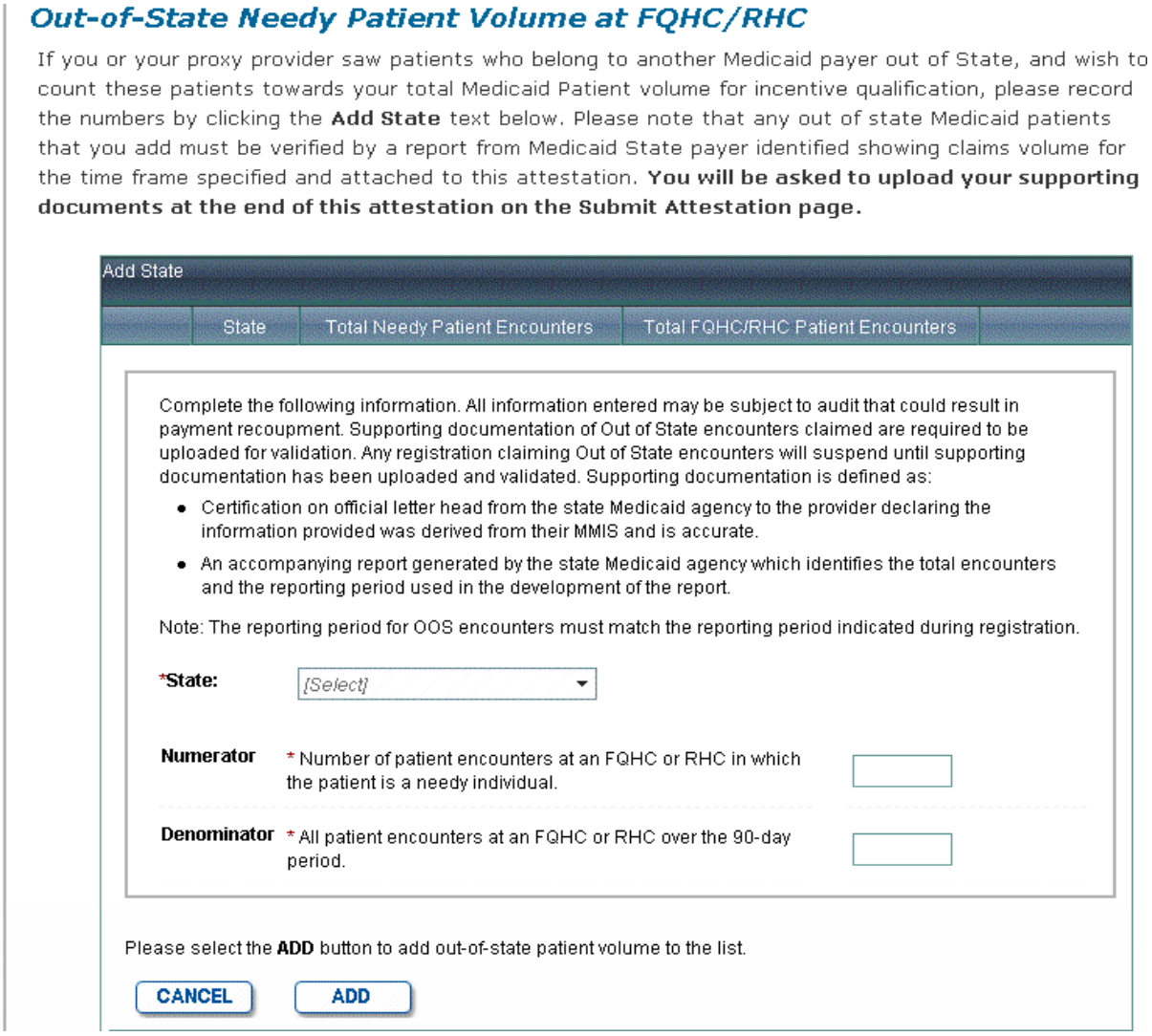


Figure 34 – Needy Out-of-state Patient Volume Entry/Edit Screen

- Enter in each value. (Definitions of each field may be found in the Needy Patient volume section above.)
- Select Add

❖ To Edit

1. Select Edit next to the state
2. The Out-of-State Patient Volume Entry screen displays with your entries
3. Modify the entries
4. Select Update

❖ To Delete

1. Select Delete on the desired state
2. Respond appropriately to the "Are you sure?" question

2. Select Save and Continue to save all changes.

The system validates if all fields have data entered.

- An error message displays if the user did not supply dates, numerator and a denominator. Please enter the appropriate data.
- If all fields have been answered AND THE ENTRIES MEET THE VOLUME PERCENTAGES, the Incentive Payment schedule screen displays.
- If the provider does not meet the volume percentages listed above, the provider is ineligible and will not be allowed to continue. Attestation status will state Attestation Not Allowed. Contact NJ Medicaid Provider Services Help Desk at 888-482-0793 option 8 for questions and assistance.

9.3.2 Attestation Payment

The payment schedule is a proposed schedule based on the answers provided in the Eligibility section. Once a completed attestation is submitted to the EHR Incentive Program Attestation Application, it will execute NJMMIS reports to validate the Medicaid and CHIP values entered during the attestation process. If the entered volume is not within a specified range of the NJMMIS reported data, the application will not approve the attestation for payment and will refer the attesting provider to the NJ Medicaid Provider Services Help Desk.

Pediatrician EHR Incentive Payments
(Between 20 – 29 Percent)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$14,167					
CY 2012	$5,667	$14,167				
CY 2013	$5,667	$5,667	$14,167			
CY 2014	$5,667	$5,667	$5,667	$14,167		
CY 2015	$5,667	$5,667	$5,667	$5,667	$14,167	
CY 2016	$5,665	$5,667	$5,667	$5,667	$5,667	$14,167
CY 2017		$5,665	$5,667	$5,667	$5,667	$5,667
CY 2018			$5,665	$5,667	$5,667	$5,667
CY 2019				$5,665	$5,667	$5,667
CY 2020					$5,665	$5,667
CY 2021						$5,665
TOTAL	$42,500	$42,500	$42,500	$42,500	$42,500	$42,500

Figure 35 – Pediatrician 20% Volume Payment Calendar

Calendar of Payments for Providers						
Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Figure 36 – Eligible Providers Payment Calendar

9.3.3 Certified EHR Technology

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) is the body that tests and certifies EHR systems. If the EHR system is approved, it is assigned a certification number. The web site below is the Certified Health IT Product List web site to look up EHR certification number or even to register an EHR. Please contact the Help Contacts listed on the Certified Health IT Product List web site if you have questions.

http://onc-chpl.force.com/ehrcert

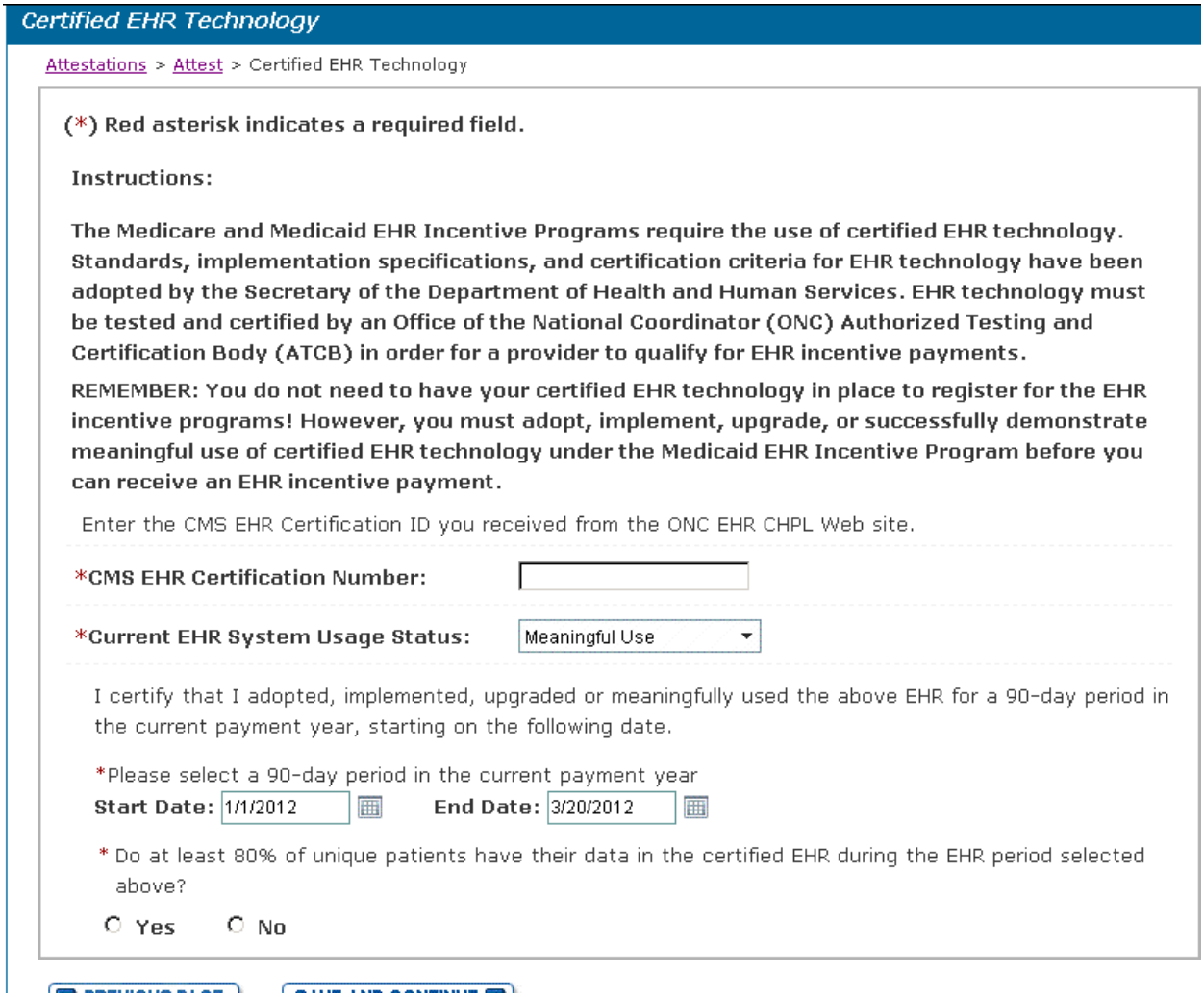


Figure 37 – Attestation Tab – Certified EHR Technology Page

2. Enter the EHR Certification number.
3. Select the option of Meaningful Use.
4. Select the 90-day period that the EHR system was adopted, implemented or upgraded.

Respond to the 80% of patients records are in an EHR question:

- ❖ If answered No, attestation progress is not allowed

Type in dates or select a date via the Calendar function.

System will calculate the 90 days from the start or end date entered.

5. Select Save and Continue.

The system validates if all fields have data entered.

- Error message displays if the user did not:
  - Supply EHR Certification number
  - Select an option
  - Supply a 90 day start and end date
  - Enter the appropriate data
- If no errors occur, the Attestation Topic page displays. If all topics have been answered, the Submit button will be available.

9.4 Meaningful Use Core Measures

This section addresses the navigation of the Meaningful Use screens. Screen shots are displayed within the Meaningful Use Core Screenshots section.

CMS requires that providers attest to 15 defined "core" meaningful use criteria. The screen below lists the 15 questions currently required for Meaningful Use Stage 1 reporting for eligible providers.

Providers, please note that each MU question is required. The application will validate that all questions are completed during attestation, but does not validate that the questions meet the percentile required for meaningful use of an EHR system until after the questionnaire is submitted. At this point, the system will reject the meaningful use attestations for providers that do not meet the percentages required by each of the applicable meaningful use criteria.

Meaningful Use Core Measures

Attestations > Attest > Meaningful Use Core Measures

Questionnaire

Instructions:

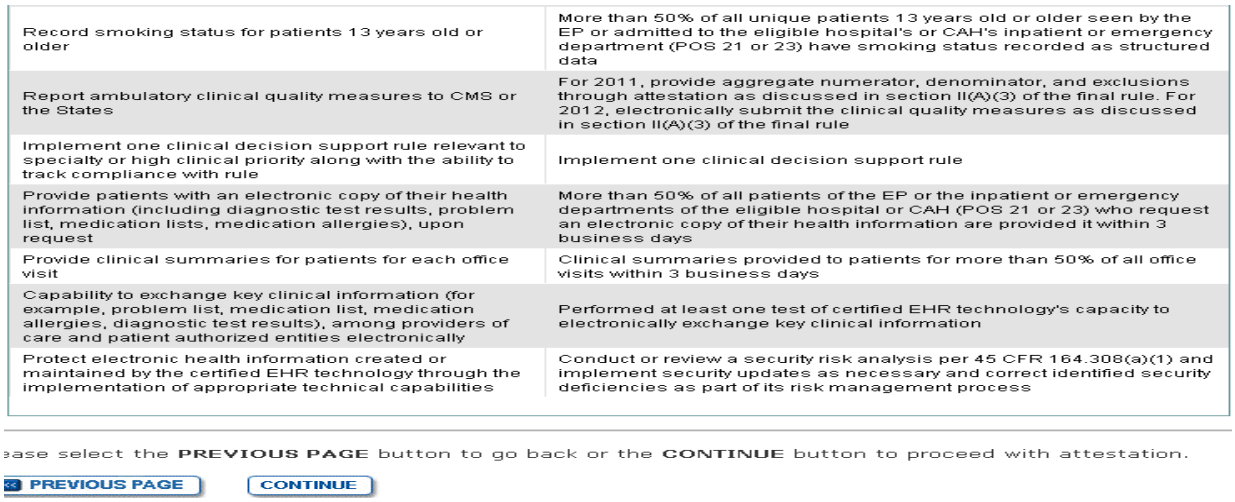
For eligible professionals, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, eligible professionals must report on 20 of these 25 meaningful use objectives.

- **There are 15 required core objectives.**
- **The remaining 5 objectives may be chosen from the list of 10 menu set objectives.**

In addition, eligible professionals must report on 6 total clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).

This attestation will begin with the 15 required core objectives listed below:

Objective	Measure
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data
Record demographics • preferred language • gender • race • ethnicity • date of birth	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data



Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
Report ambulatory clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of the final rule. For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of the final rule
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with rule	Implement one clinical decision support rule
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Figure 38 – Meaningful Use Core Objectives and Measures List

9.4.1 Meaningful Use Core Question General Workflow Functionality

Link to CMS definition

- Each meaningful use criteria screen has a link to the CMS definition for the applicable requirements and detail of each question for the provider to access and review the specific requirements for completing the numerator/denominator for each question and, if applicable, the criteria for being exempt from the particular meaningful use question.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not filled, the page will continue to display until required fields are corrected.
  - If required fields are filled, the next screen displays.

Previous Button

- Displays the previous screen.

9.5 Meaningful Use Menu Measures

CMS has defined ten meaningful use "menu" measures. CMS requires providers to attest to 5 of the 10 measures, including one public health measure. The meaningful use menu measures screenshots section displays the question for each menu measure. The following screen shots list the Meaningful Use Menu Measures questions.

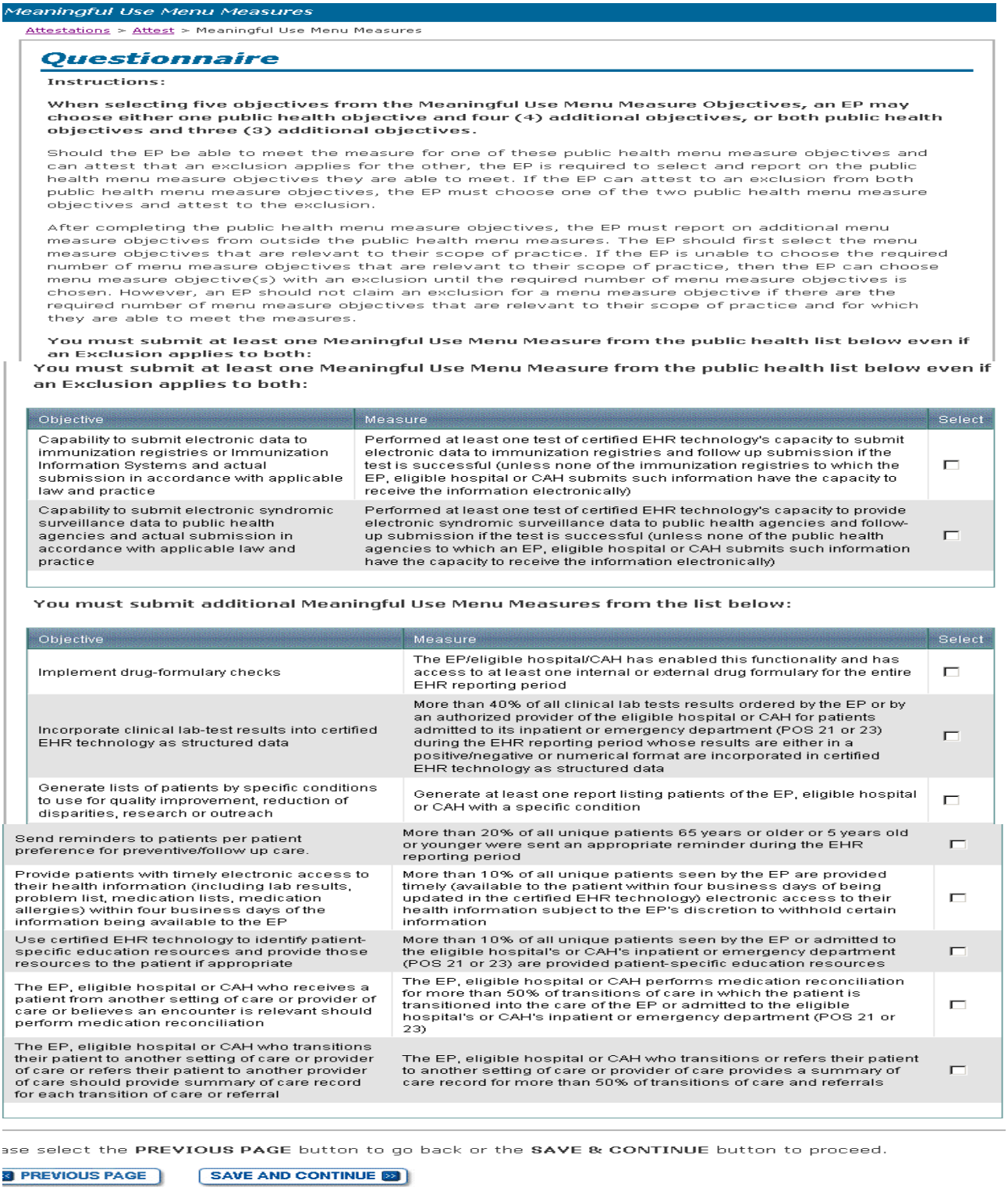


Figure 39 – Meaningful Use Menu Measure Question List

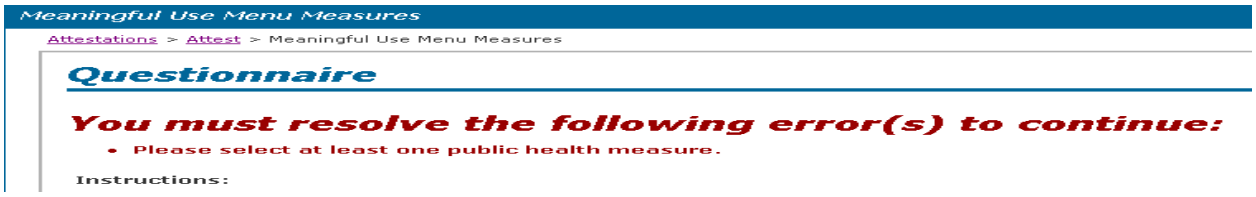
- User must select the public health question and remaining menu set questions they wish to respond to by clicking in the box under the SELECT column for each question.
- A checkmark indicates that you have selected that question. The application will allow you to select more than 5 questions.

Potential Error Messages on this Screen

The following are the error messages if the minimum requirements are not met:

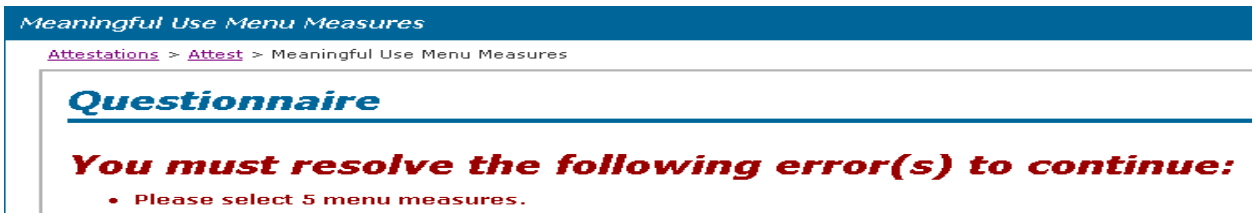
MESSAGE 1- User receives the following error and cannot continue attestation process until error is fixed.

- If user does not select any questions
- If user does not select any public health question



MESSAGE 2 - User receives the following error and cannot continue attestation process until error is fixed.

- Selects less than 5 items, which includes a public health question, the following error message displays.



Application Question Display for Menu Measures

The application will only display the questions that were selected. The navigation is the same as was outlined in the Meaningful Use Core section, as show again below.

The application will not validate if the required score has been met at the time of entry, it will only tell the user if the appropriate questions have been completed. **The validation of EHR usage percentiles is done after the attestation is submitted.**

9.5.1 Meaningful Use Question General Workflow Functionality

Link to CMS definition

- Each MU question screen has a link to its CMS definition in order to allow the provider to view the specific requirements for each objective's numerator and denominator and, if applicable, the requirements for exemption from the particular meaningful use objective.

Save and Continue Button

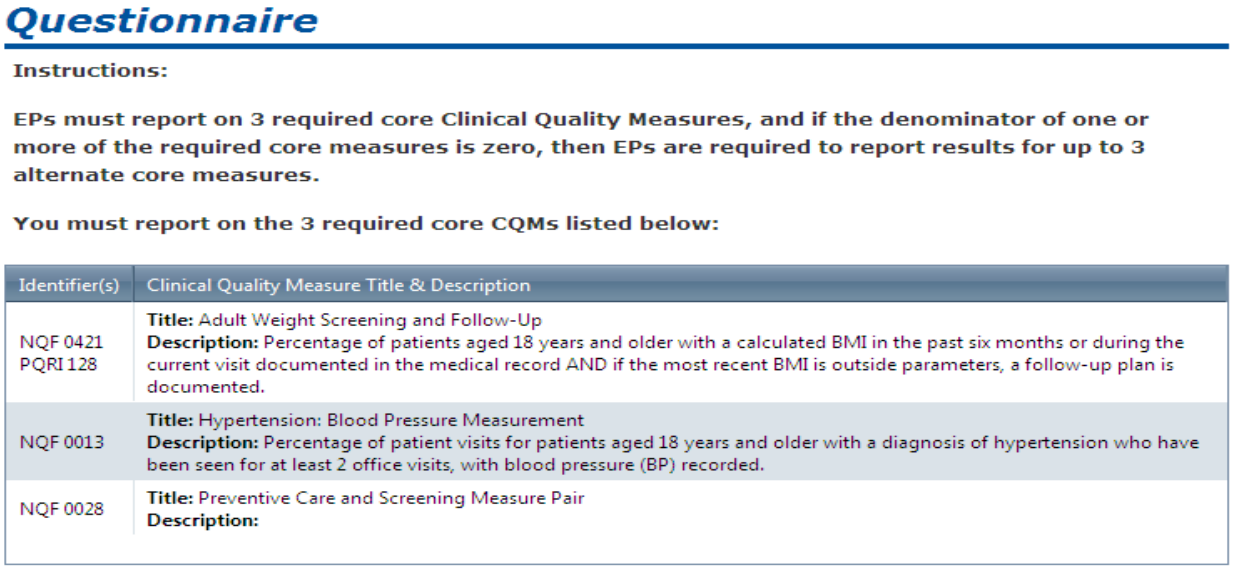
- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not filled, the page will continue to display until required fields are corrected.
  - If required fields are filled, the next screen displays.

Previous Button

- Displays the previous screen.

9.6 Clinical Quality Measures (CQM)

CMS requires that the provider report CQM from a combination of the following three "core" measures and three out of 38 additional CQM.



Questionnaire

Instructions:

EPs must report on 3 required core Clinical Quality Measures, and if the denominator of one or more of the required core measures is zero, then EPs are required to report results for up to 3 alternate core measures.

You must report on the 3 required core CQMs listed below:

Identifier(s)	Clinical Quality Measure Title & Description
NQF 0421 PQRI 128	**Title:** Adult Weight Screening and Follow-Up **Description:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
NQF 0013	**Title:** Hypertension: Blood Pressure Measurement **Description:** Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
NQF 0028	**Title:** Preventive Care and Screening Measure Pair **Description:**

Figure 40 – Clinical Quality Measure Core list

If the provider responds with a zero in the denominator in the above questions, the following questions requires a response.

Figure 41 – Additional Core Clinical Measures

The provider will need to select the remaining number of the required CQM count from thirty-eight questions. The following figure displays the list of questions. The individual question screen shots are displayed in the "Clinical Quality Measures – 38 Questions Screen Shots" section.

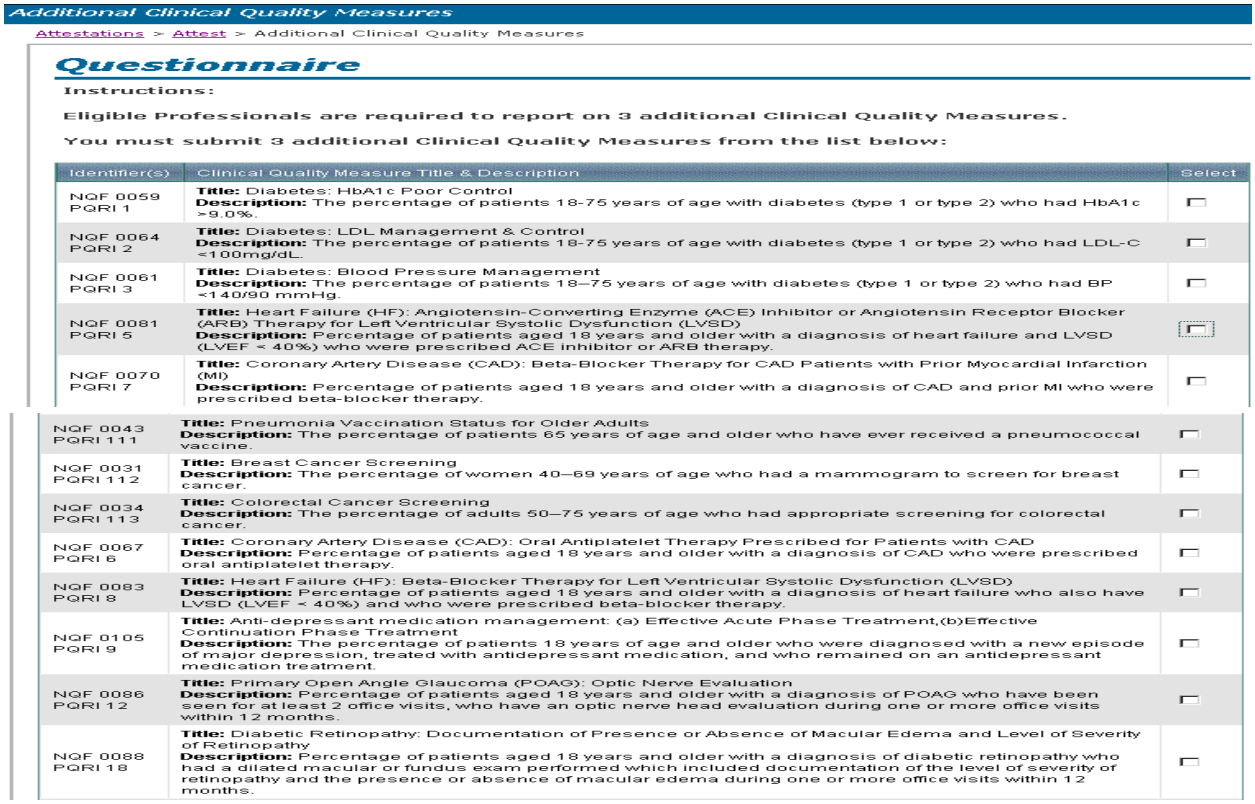


Figure 42 – Beginning of 38 CQMs

NQF 0089 PQRI 19	**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 on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	☐
NQF 0047 PQRI 53	**Title:** Asthma Pharmacologic Therapy **Description:** Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.	☐
NQF 0001 PQRI 64	**Title:** Asthma Assessment **Description:** Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	☐
NQF 0002 PQRI 66	**Title:** Appropriate Testing for Children with Pharyngitis **Description:** The percentage of children 2-18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	☐
NQF 0387 PQRI 71	**Title:** Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer **Description:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	☐
NQF 0385 PQRI 72	**Title:** Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients **Description:** Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	☐
NQF 0389 PQRI 102	**Title:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients **Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	☐
NQF 0027 PQRI 115	**Title:** Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies **Description:** The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	☐
NQF 0055 PQRI 117	**Title:** Diabetes: Eye Exam **Description:** The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	☐
NQF 0062 PQRI 119	**Title:** Diabetes: Urine Screening **Description:** The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.	☐
NQF 0056 PQRI 163	**Title:** Diabetes: Foot Exam **Description:** The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	☐
NQF 0074 PQRI 197	**Title:** Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol **Description:** Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	☐
NQF 0084 PQRI 200	**Title:** Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation **Description:** Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	☐
NQF 0073 PQRI 201	**Title:** Ischemic Vascular Disease (IVD): Blood Pressure Management **Description:** The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1– November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).	☐
NQF 0068 PQRI 204	**Title:** Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic **Description:** The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.	☐
NQF 0004	**Title:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement **Description:** The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	☐
NQF 0012	**Title:** Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) **Description:** Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit.	☐
NQF 0014	**Title:** Prenatal Care: Anti-D Immune Globulin **Description:** Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.	☐
NQF 0018	**Title:** Controlling High Blood Pressure **Description:** The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	☐
NQF 0032	**Title:** Cervical Cancer Screening **Description:** The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	☐
NQF 0033	**Title:** Chlamydia Screening for Women **Description:** The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	☐
NQF 0036	**Title:** Use of Appropriate Medications for Asthma **Description:** The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).	☐
NQF 0052	**Title:** Low Back Pain: Use of Imaging Studies **Description:** The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.	☐
NQF 0075	**Title:** Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control **Description:** The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1– November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.	☐
NQF 0575	**Title:** Diabetes: HbA1c Control < 8% **Description:** The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.	☐

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Figure 43 – Remaining 38 CQMs List

9.6.1 Clinical Quality Measures Meaningful Use Question General Workflow Functionality

To complete the CQM section, you must select a minimum of three CQMs out of a choice of 38 questions. The individual questions are displayed with the 38 CQMs section. The navigation is the same as was outlined in the Meaningful Use Core and Menu Measures section, but are repeated below.

Potential Error Messages on this Screen

The following are the error messages if the minimum numver of requirements are not met:

MESSAGE 1- User did not select three questions receives the following error and cannot continue attestation process until error is fixed.

You must resolve the following error(s) to continue:

- Please select 3 Additional Clinical Quality Measures.

MESSAGE 2 - User selected only one question receives the following error and cannot continue attestation process until error is fixed.

You must resolve the following error(s) to continue:

- Please select 2 more Additional Clinical Quality Measures.

MESSAGE 2 - User selecting only two questions receives the following error and cannot continue attestation process until error is fixed.

You must resolve the following error(s) to continue:

- Please select 1 more Additional Clinical Quality Measure.

Application Question Display for Menu Measures

Link to CMS definition

- Each MU question screen has a link to its CMS definition in order to allow the provider to view the specific requirements for each objective's numerator and denominator and, if applicable, the requirements for exemption from the particular meaningful use objective.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

- Displays the previous screen

9.7 Submit Attestation and Payment Status

The Submit Attestation button remains disabled if the eligibility checks failed or not all required questions have been answered. If the eligibility checks passed and all required questions are answered, then the Submit Attestation button is available. On selection of the Submit Attestation button, the following screen displays:

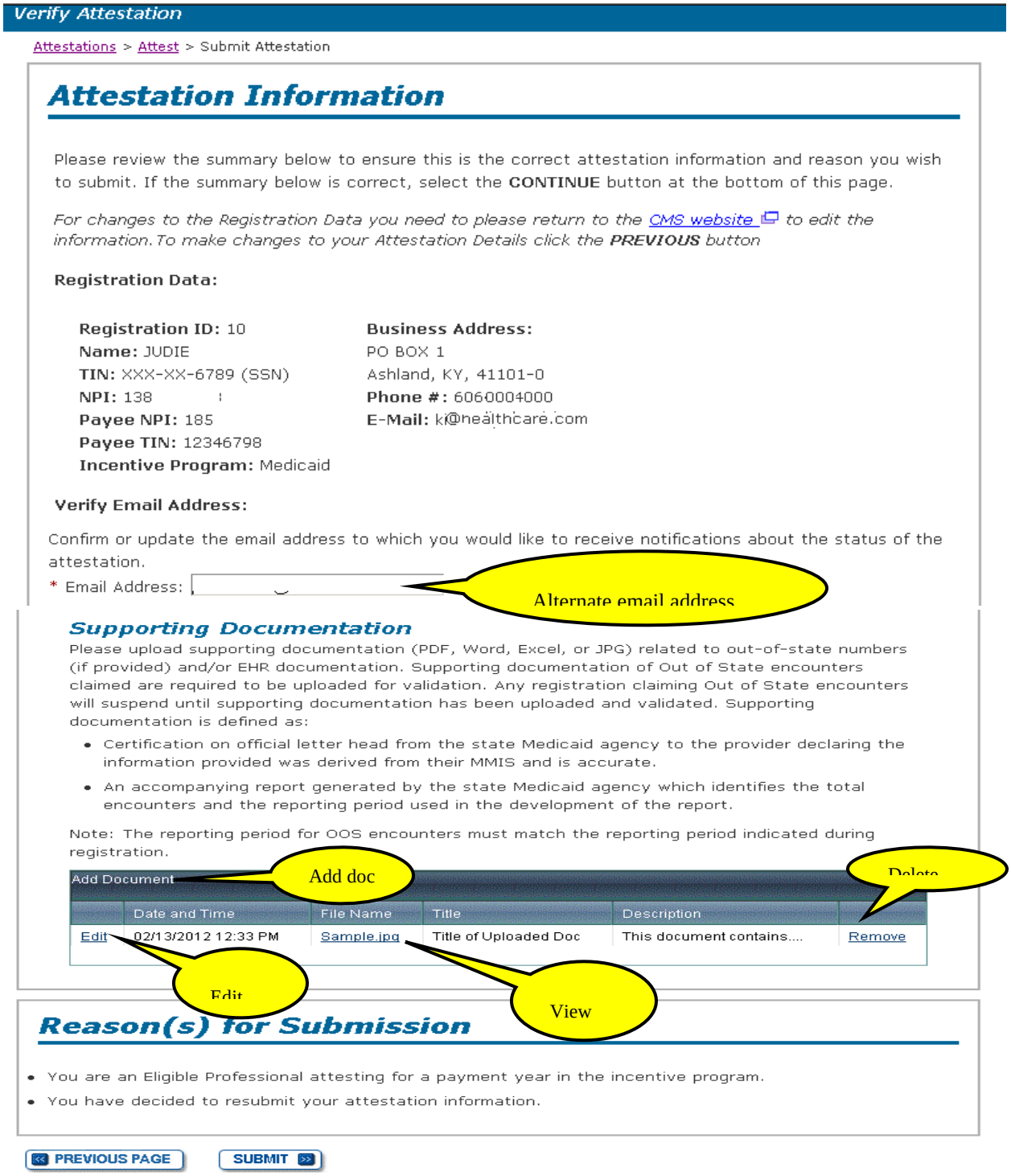


Figure 44 – Attestation Tab – Submit Attestation Check Email Address

Enter an email address if the one listed in the "Email Address" field is incorrect.

9.8 Supporting Documentation

Documents may be in the form of PDF, Jpeg, Excel, and Word files 4 megabytes or smaller. Section 3 of this document lists required documentation. If you have entered Out-of-State encounters, you are required to upload two documents, which are a certification letter that volumes are from the state's MMIS and the report from the state's MMIS department.

- To Add Document
  1. Select Add Document to display the following screen

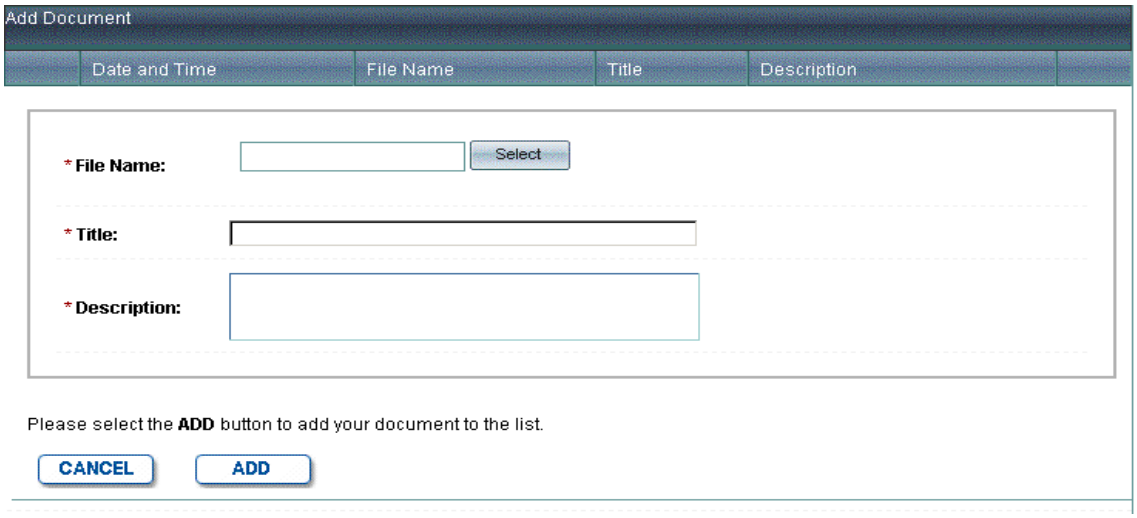


Figure 45 - Supporting Documentation – Add Screen

- Select File to upload from your computer
- Select the Select button
- On Files window, navigate through your computer and select the file to upload,
- Select Ok.
- Document name displays in the File Name box.

2. Enter in Title
3. Enter in Description of file
4. Select Add

- To add more files, Repeat Steps.

- To Edit Document

    1. Select Edit next to the desired document
    2. The Supporting Documentation – Add screen displays with Update and Cancel buttons instead.
    3. Modify the information
    4. Select Update

To Delete Document

1. Select Delete next to the desired document
2. Answer "Are you sure?" question appropriately

Select Submit button. This displays the Successful Submission screen. An example is below.

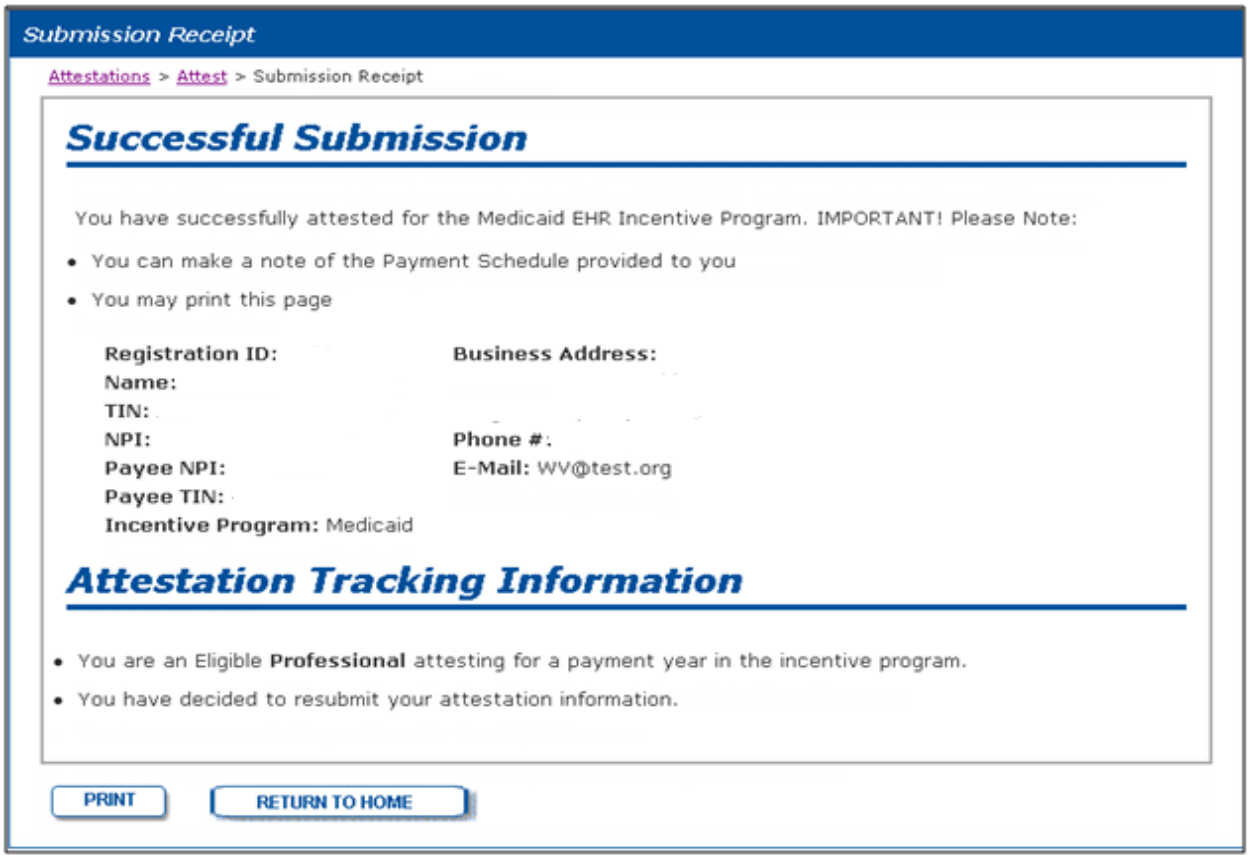


Figure 46 – Attestation Tab - Submission Receipt Window

Upon the successful submission of the uploaded documents, the attestation entry process is completed. The New Jersey EHR Incentive Program provides 72 hours to make changes. If changes are made during the initial 72 hour period, a new 72 hour period will begin. Once no

changes are made to an attestation for 72 hours, the EHR Incentive Program Attestation Application will execute its final eligibility checks. These include validating that the Medicaid and CHIP patient encounter amounts entered by the EP are within a reasonable range of the fee-for-service claim and managed care encounter volume stored in the NJMMIS and querying the CMS NLR to determine if the attesting EP has already received an EHR Incentive Program payment from Medicare or another state's Medicaid EHR Incentive Program. This processing will take some time to complete, and incentive payments will not be sent immediately after submitting a completed attestation.

After the eligibility and payment checks are executed, the New Jersey EHR Incentive Program will send the EP an e-mail with their current attestation status. If an eligibility or payment error has occurred during the initial data verification process and assistance is needed, please contact the NJ Medicaid Provider Services Help Desk at (800) 776-6334, option 7.

The EHR Incentive Program Attestation Application will describe the attestation errors. Alternatively, EPs can log in to the application and select the "Status" tab to display their current attestation status.

10. Status Grid

The table lists the attestation status that may occur.

Provider Screen Status	Admin Portal Attestation Status	Description - Provider
Attestation Not Allowed	Attestation Not Allowed	Provider's registration did not pass the inital eligibility check.
Attestation Not Started	Attestation Not Started	Provider's registration has processed successful; but the provider has not yet logged into the PIP solution and begun their attestation
Attestation In Progress	Attestation In Progress	Provider has opened their attestation and is actively editing it.
Submitted	Submitted	This status appears after submission for 48 hrs till final provider eligibility check is run. Provider can cancel an attestation and re-edit it for 2 days after submission prior to it being "finalized"
Pended	Pended	Provider sees "Pended"
Provider has failed final Elig check • POS Error • Volume error • Pay hold error	Resubmit	Provider sees "Resubmit" and the appropriate reason message for the eligibility error
Accepted	Accepted	Provider will see their attestation on the Status tab. The status will be Accepted
• Locked for Payment • Excluded from payment	Locked For Payment Excluded From Payment	Attestation remains on the Status tab only. Waiting for payment validation from NLR

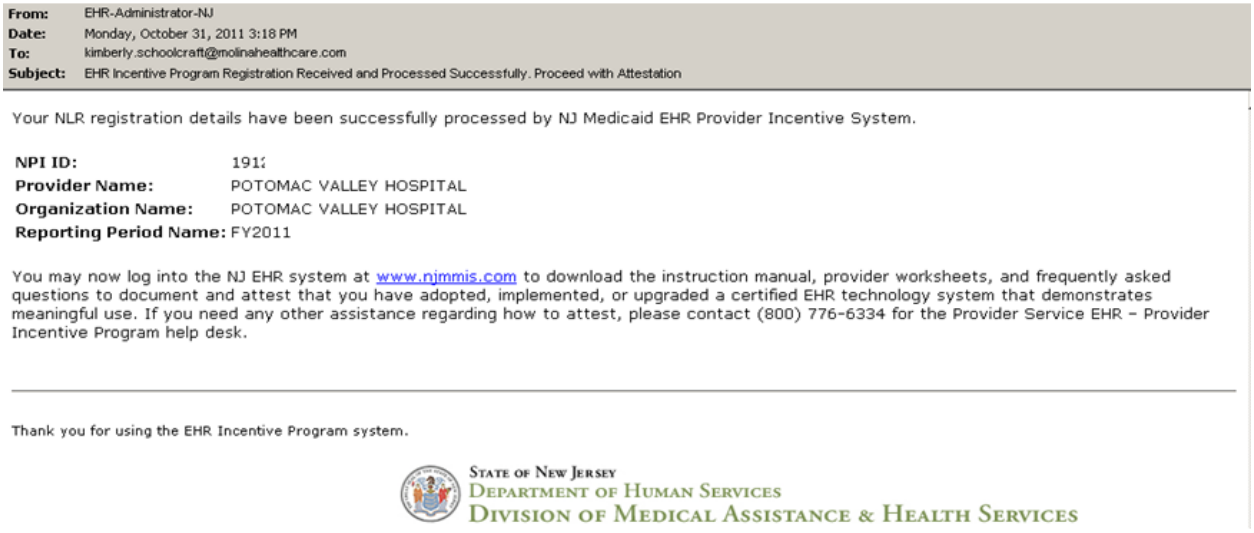
Figure 47 – Attestation Status

11. Successful Registration with CMS Email

After registering with CMS, it may take 48 hours before this message is received.

- The delay is for CMS processing registration and sending them to the appropriate State repository. The Provider Portal application will have the registration in this State repository and process registration. The Provider Portal application checks that the provider is a valid provider type and has active enrollment in Medicaid.

When this message is received, log into the Provider Portal to register and attest for this provider.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com
Subject: EHR Incentive Program Registration Received and Processed Successfully. Proceed with Attestation

Your NLR registration details have been successfully processed by NJ Medicaid EHR Provider Incentive System.

NPI ID: 191[illegible]
Provider Name: POTOMAC VALLEY HOSPITAL
Organization Name: POTOMAC VALLEY HOSPITAL
Reporting Period Name: FY2011

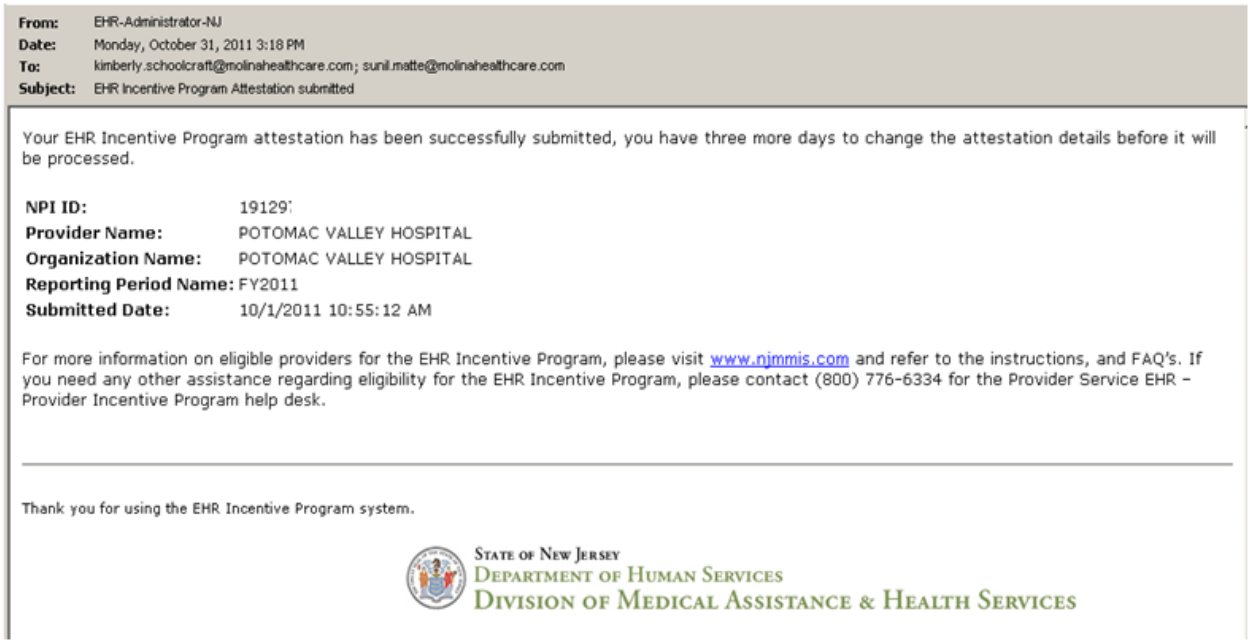
You may now log into the NJ EHR system at www.njmmis.com to download the instruction manual, provider worksheets, and frequently asked questions to document and attest that you have adopted, implemented, or upgraded a certified EHR technology system that demonstrates meaningful use. If you need any other assistance regarding how to attest, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

12. Submitted Attestation Email

This email is sent after submitting the attestation. The system will wait two days to provide time for modifications. After the two days have passed, the system will execute the final edits.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation submitted

Your EHR Incentive Program attestation has been successfully submitted, you have three more days to change the attestation details before it will be processed.

NPI ID:	19129
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Submitted Date:	10/1/2011 10:55:12 AM

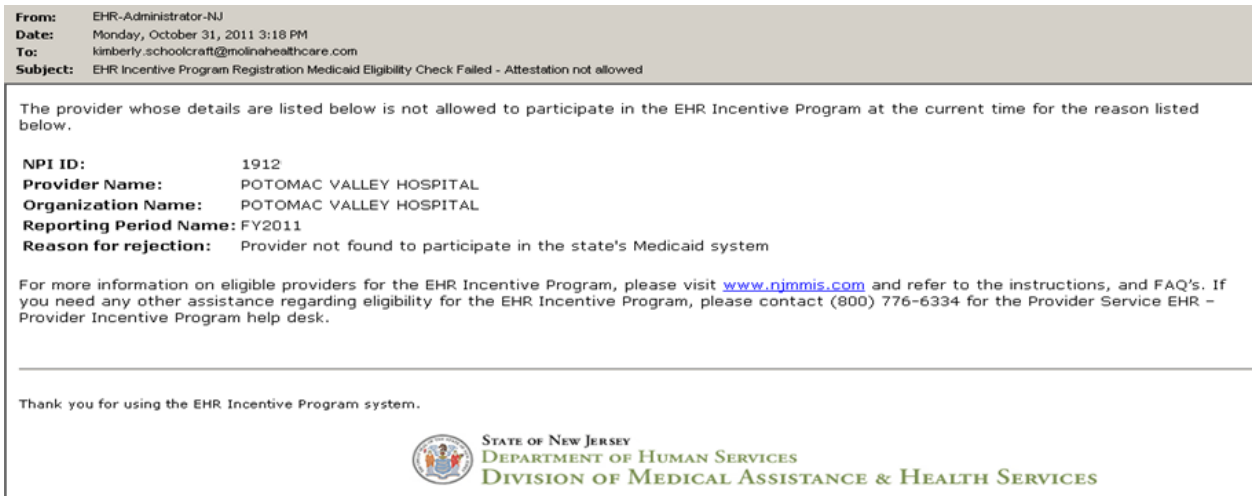
For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

13. Error Occurred When Processing Registration Email

When the registration arrives from the NLR to the application, validation of the provider is required. This email occurs if the provider does not exist in the MMIS.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com
Subject: EHR Incentive Program Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the EHR Incentive Program at the current time for the reason listed below.

NPI ID:	1912
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Reason for rejection:	Provider not found to participate in the state's Medicaid system

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

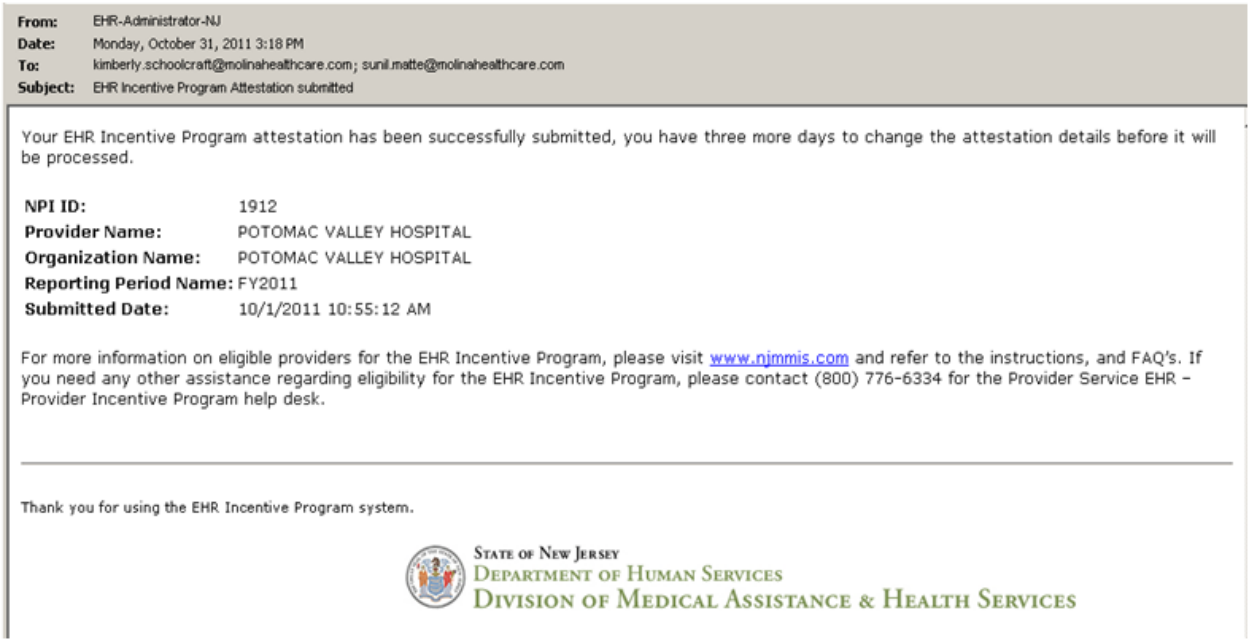
Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

14. Attestation Accepted Email

This email is sent when either one of the two scenarios occur:

- The 48 hour time span that allowed for changes has expired. The attestation is no longer accessible for changes within the application. The attestation details will be sent to the NLR to check if any payments have been made for the attesting provider.
- BMS has reviewed the failed attestation details and found that the attestation is acceptable. BMS set the status to an accepted status. The attestations details will be sent to the NLR to check if any payments have been made for the attesting provider.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation submitted

Your EHR Incentive Program attestation has been successfully submitted, you have three more days to change the attestation details before it will be processed.

NPI ID:	1912
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Submitted Date:	10/1/2011 10:55:12 AM

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

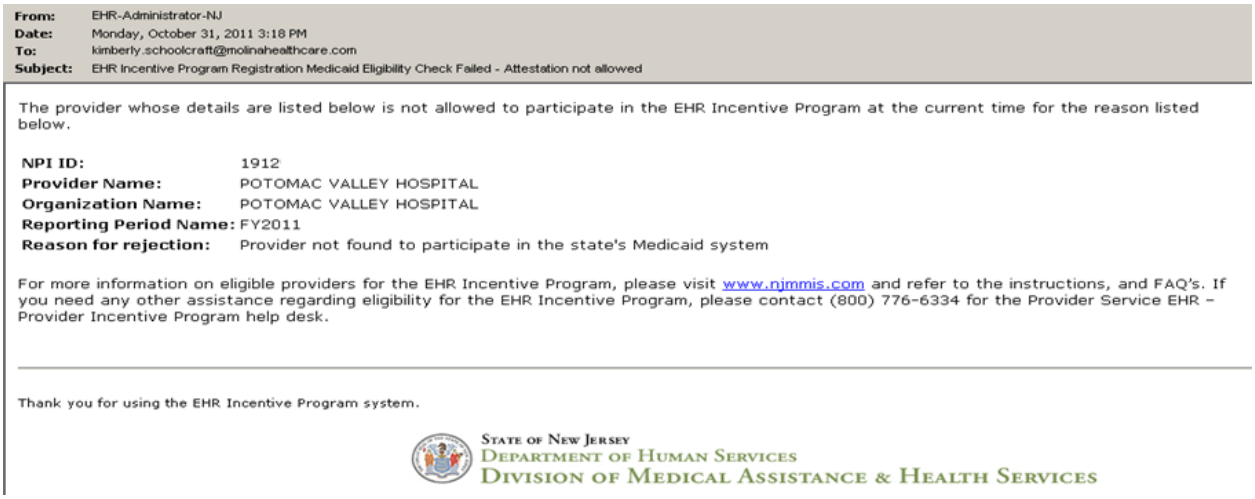
Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

15. Error Occurred While Processing Registration – Medicaid Enrollment Failed Email

The following checks are made when an attestation is received from the NLR. The email below displays all the possible error messages for the following checks:

- Check if the provider is enrolled in Medicaid program during the attestation period.
- Check if the provider type that was selected when registering on the CMS site matches the provider type on the provider's enrollment record.
- Check if the payee NPI entered when registering on the CMS site is found when validating the attesting provider's payees on the Medicaid record.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com
Subject: EHR Incentive Program Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the EHR Incentive Program at the current time for the reason listed below.

NPI ID: 1912
Provider Name: POTOMAC VALLEY HOSPITAL
Organization Name: POTOMAC VALLEY HOSPITAL
Reporting Period Name: FY2011
Reason for rejection: Provider not found to participate in the state's Medicaid system

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

16. Attestation Error – Practice Predominately in a Hospital Setting Email

Claims checks are part of the processing. If it was found that the provider practiced predominately in a hospital, the attestation is ineligible and the email is sent.

From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR incentive program due to the below reason.

NPI ID: 19125
Provider Name: POTOMAC VALLEY HOSPITAL
Organization Name: POTOMAC VALLEY HOSPITAL
Reporting Period Name: FY2011
Submitted Date: 10/1/2011 10:55:12 AM
Reason for rejection: Provider has no Medicaid claims in the State's Medicaid system

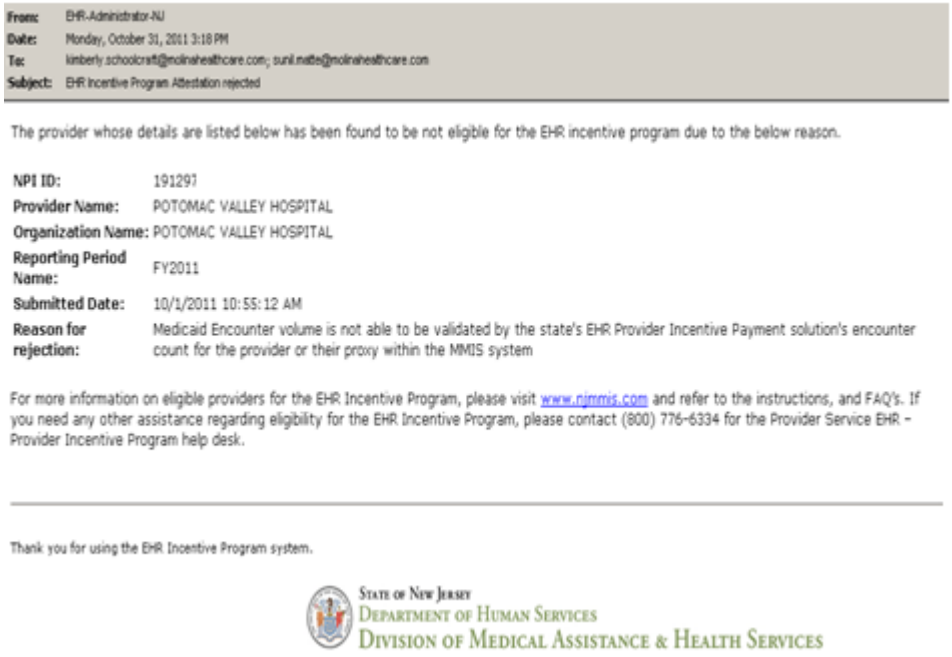
For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

17. Attestation Error – Medicaid Claims Count Failed Email

The solution will check the provider's Medicaid claims that were submitted during the attestation period. If there were no claims found for the attestation period, the following email will be sent.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.mathe@molinahealthcare.com
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR incentive program due to the below reason.

NPI ID:	191297
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Submitted Date:	10/1/2011 10:55:12 AM
Reason for rejection:	Medicaid Encounter volume is not able to be validated by the state's EHR Provider Incentive Payment solution's encounter count for the provider or their proxy within the MMIS system

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

If the solution found that claims counts could not be validated, then the following email is sent.

From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR incentive program due to the below reason.

NPI ID:	191297
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Submitted Date:	10/1/2011 10:55:12 AM
Reason for rejection:	Medicaid Encounter volume is not able to be validated by the state's EHR Provider Incentive Payment solution's encounter count for the provider or their proxy within the MMIS system

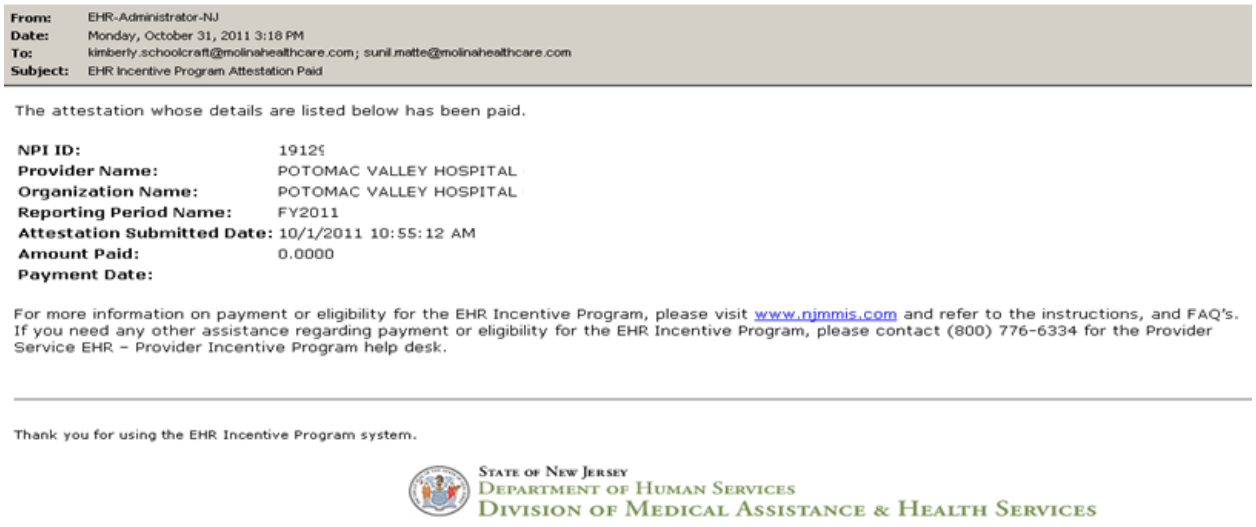
For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR - Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

18. Attestation Paid Email

If final eligibility checks pass and no payment issues occurred, an email is sent indicating that payment is approved and being processed. The payment will continue with additional processing, so payment arrival will take a few days.



From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation Paid

The attestation whose details are listed below has been paid.

NPI ID:	19129
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Attestation Submitted Date:	10/1/2011 10:55:12 AM
Amount Paid:	0.0000
Payment Date:	

For more information on payment or eligibility for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding payment or eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

19. Attestation Payment Denied Email

If final eligibility checks did not pass and payment issues occurred, an email indicating denial is sent. The Medicaid Provider Services staff at 888-483-0793 may be able to address questions.

From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation payment not processed by MMIS

The attestation whose details are listed below has been denied payment.

NPI ID: 19129'
Provider Name: POTOMAC VALLEY HOSPITAL '
Organization Name: POTOMAC VALLEY HOSPITAL '
Reporting Period Name: FY2011
Submitted Date: 10/1/2011 10:55:12 AM

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

20. Attestation Payment Denied – Pay Hold Found

Payment is denied if the provider is on pay hold and this email is sent if it is found.

From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.natte@molinahealthcare.com
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR incentive program due to the below reason.

NPI ID:	19129
Provider Name:	POTOMAC VALLEY HOSPITAL
Organization Name:	POTOMAC VALLEY HOSPITAL
Reporting Period Name:	FY2011
Submitted Date:	10/1/2011 10:55:12 AM
Reason for rejection:	Provider is on a pay hold and not eligible for payment at this time

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR - Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

21. Attestation Excluded from Payment Email

This email indicates that CMS already has a payment on record from this provider. Please contact the CMS NLR for questions and concerns.

From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation excluded from payment

The attestation whose details are listed below has been excluded from payment by CMS due to a record of duplicate payment for Medicaid attestation in this State or another State during the current attestation period. If you think your payment is not duplicated at the national level, please work with the NLR to resolve.

NPI ID: 1912!
Provider Name: POTOMAC VALLEY HOSPITAL
Organization Name: POTOMAC VALLEY HOSPITAL
Reporting Period Name: FY2011
Attestation Submitted Date: 10/1/2011 10:55:12 AM

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

Provider Incentive Program Help Desk.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

22. Attestation Rejected Email

NJ Medicaid and NJ Medicaid Provider Services staff have the ability to review attestation and reject a submitted attestation. When the attestation is rejected, an email is sent to notify the user of the status change. To find out more information, please contact the Medicaid Provider Services staff at (800) 776-6334 and have your seven digit New Jersey Medicaid provider ID number.

From: EHR-Administrator-NJ
Date: Monday, October 31, 2011 3:18 PM
To: kimberly.schoolcraft@molinahealthcare.com; sunil.matte@molinahealthcare.com
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR incentive program due to the below reason.

NPI ID: 19125
Provider Name: POTOMAC VALLEY HOSPITAL
Organization Name: POTOMAC VALLEY HOSPITAL
Reporting Period Name: FY2011
Submitted Date: 10/1/2011 10:55:12 AM
Reason for rejection: Provider has no Medicaid claims in the State's Medicaid system

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

23. Attestation Pended for Out-of-State Entries

If a submitted attestation has passed volume checks and has out-of-state entries, the attestation will be pended. The NJ Medicaid and NJ Medicaid Provider Services staff will review the required documentation and determine if the attestation is acceptable. The following email indicates that the attestation was pended. To find out more information, please contact the Medicaid Provider Services staff at (800) 776-6334 and have your seven digit New Jersey Medicaid provider ID number.

From: EHR-Administrator-NJ
Date: Tuesday, July 03, 2012
To: Provider@email.com
Subject: EHR Incentive Program Attestation rejected

The attestation whose details are listed below is being reviewed by the state.

NPI ID: 19
Provider Name: Provider Name
Organization Name:
Reporting Period Name: FY2011
Submitted Date: 10/1/2011 10:55:12 AM
Reason for pending review: Attestation contains Out of State Patient volumes

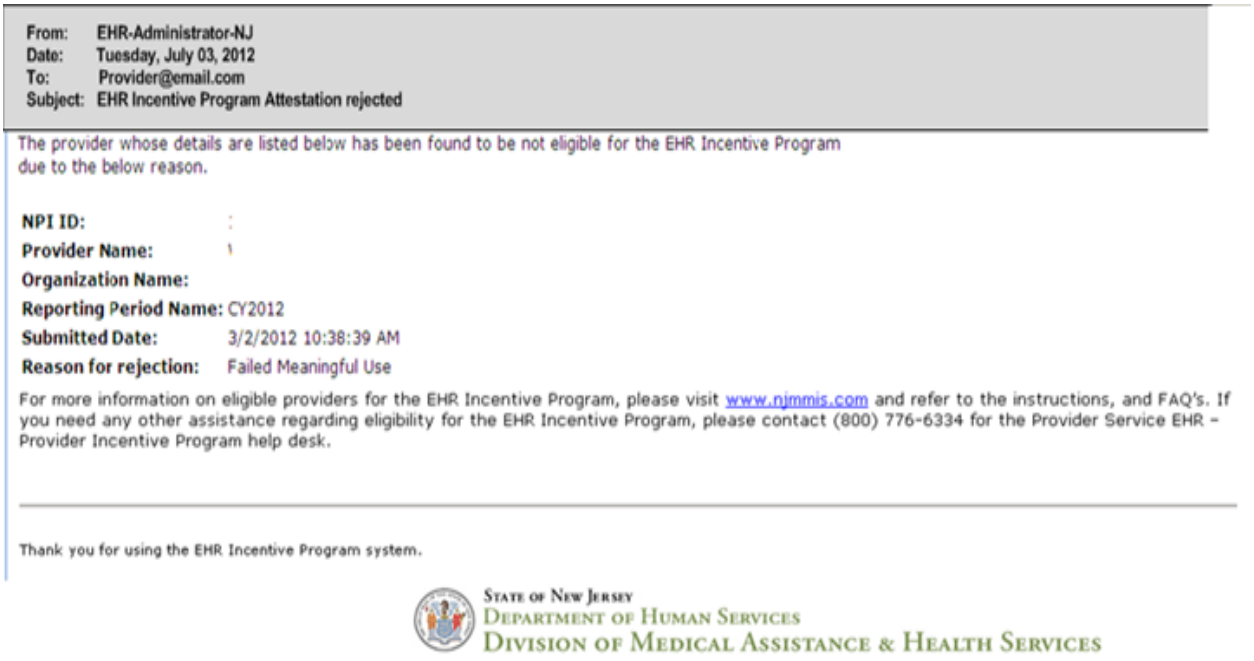
For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the EHR Incentive Program system.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

24. Attestation Failed Meaningful Use

After the provider attestation passes the volume check and payment checks, the application will validate that the Meaningful Use Core and Menu Measures responses meet or exceed the required response. If the user failed one or more questions, the following email will be sent to notify that Meaningful Use failed:



From: EHR-Administrator-NJ
Date: Tuesday, July 03, 2012
To: Provider@email.com
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR Incentive Program due to the below reason.

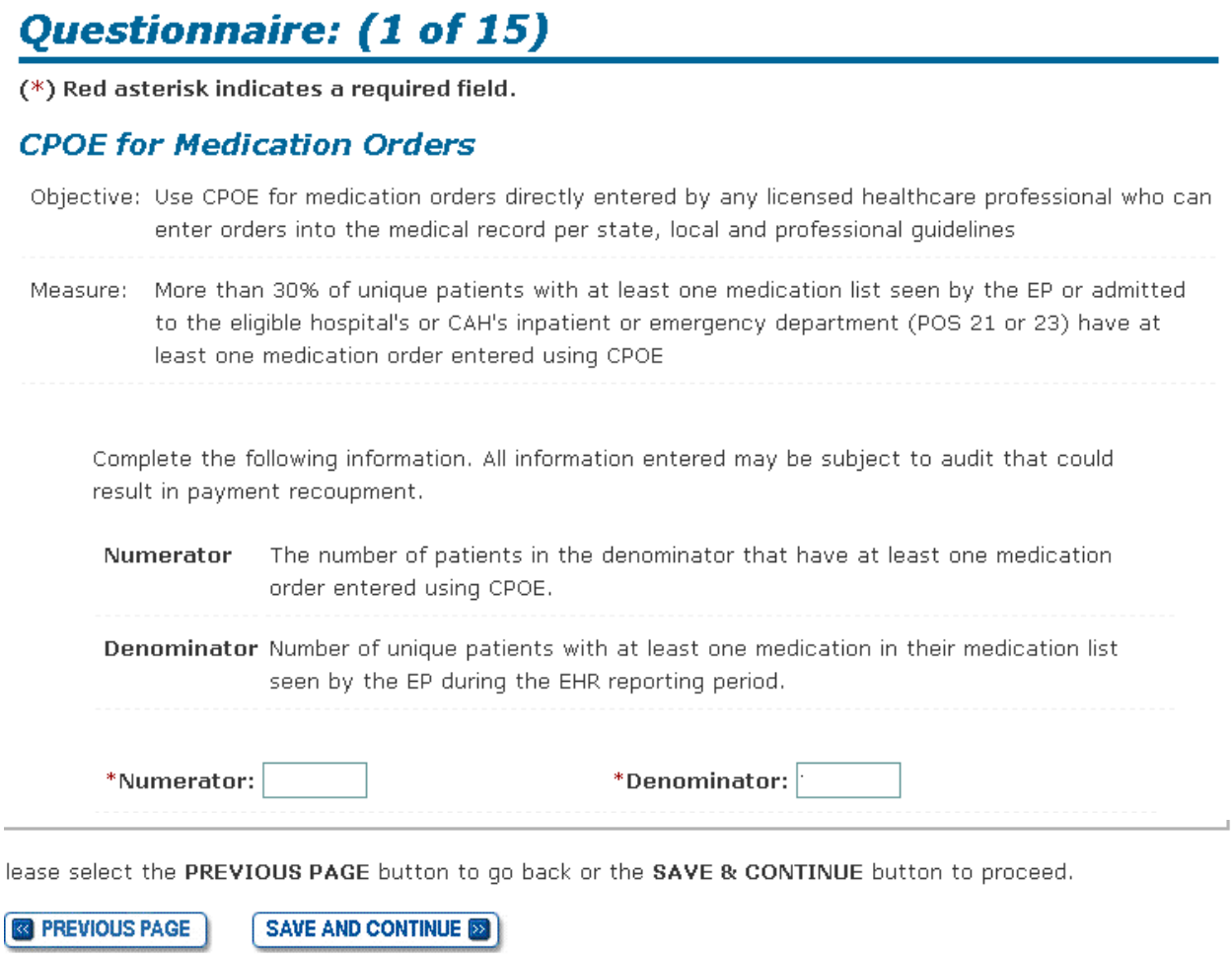
NPI ID:
Provider Name:
Organization Name:
Reporting Period Name: CY2012
Submitted Date: 3/2/2012 10:38:39 AM
Reason for rejection: Failed Meaningful Use

For more information on eligible providers for the EHR Incentive Program, please visit www.njmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR Incentive Program, please contact (800) 776-6334 for the Provider Service EHR – Provider Incentive Program help desk.

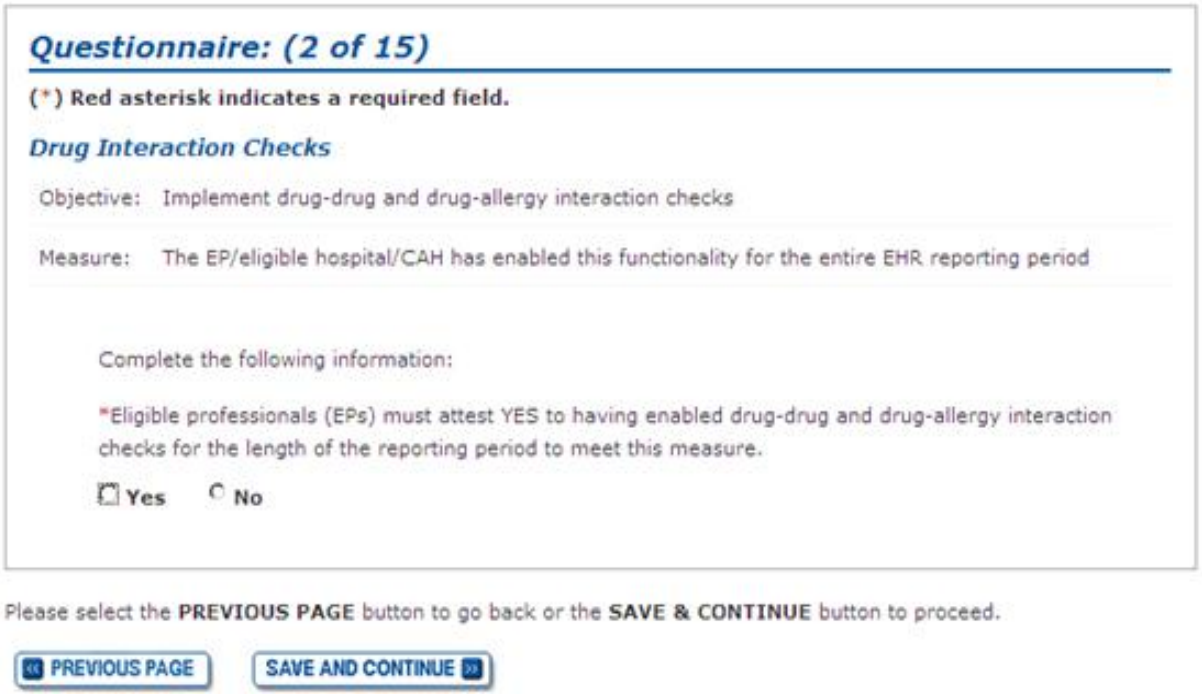
Thank you for using the EHR Incentive Program system.

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

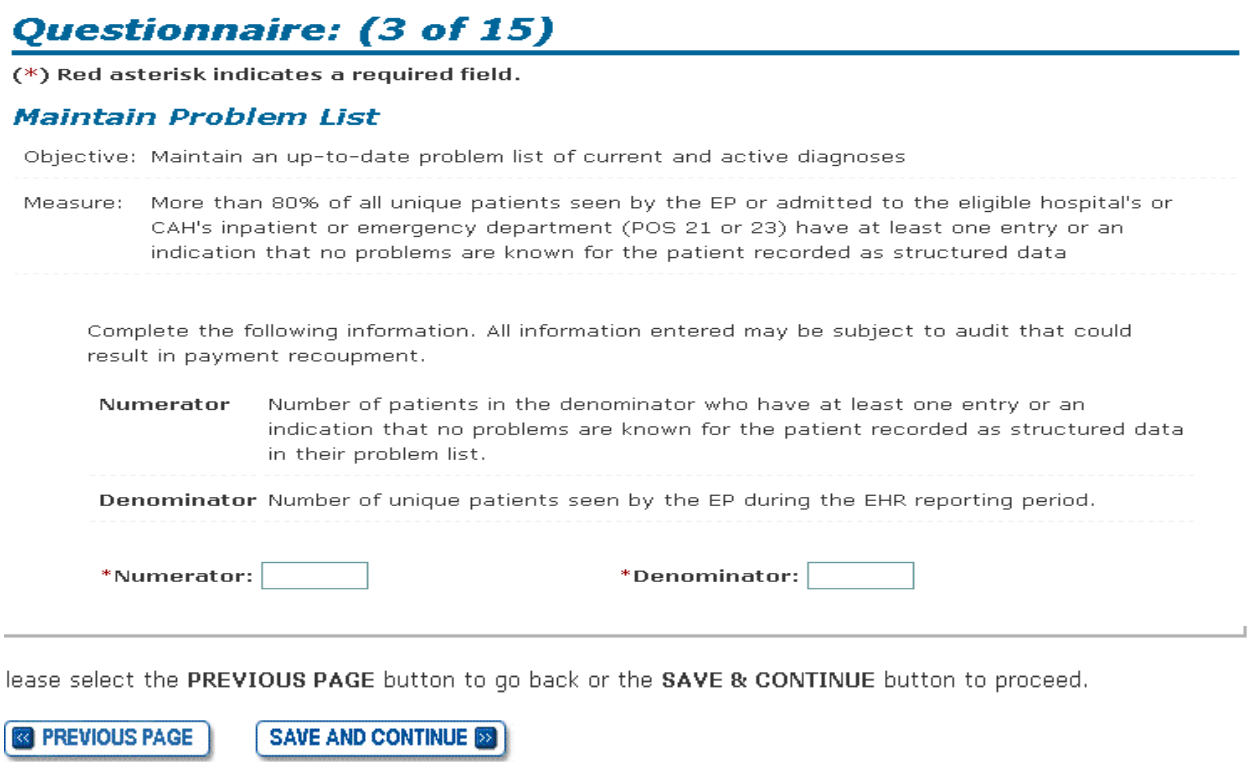
25. Meaningful Use Core Measures Screen Shots



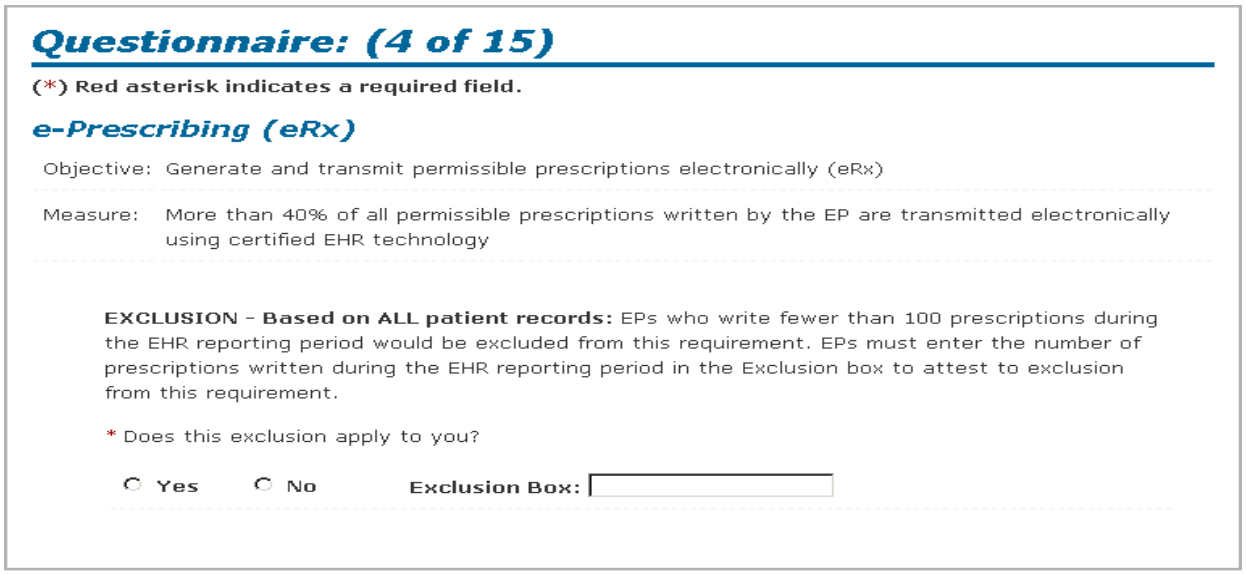
Meaningful Use Core Question 1 – CPOE for Medication Orders



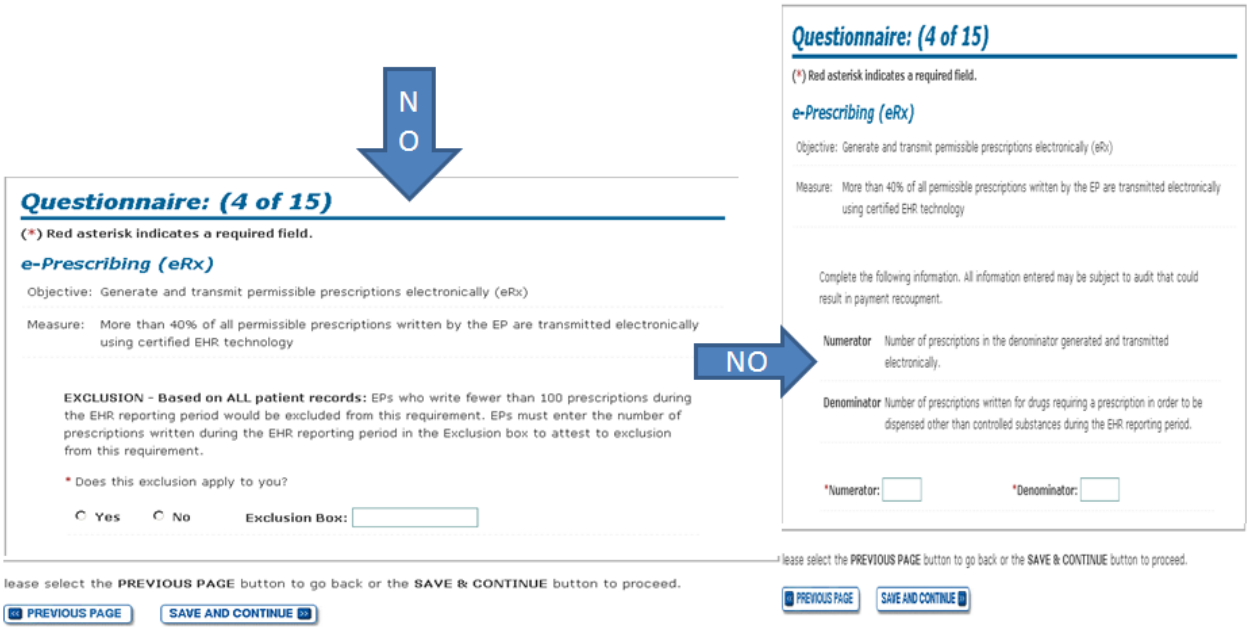
Meaningful Use Core Question 2 – Drug Interaction Checks



Meaningful Use Core Question 3 – Maintain Problem List



Meaningful Use Core Question 4 – e-Prescribing



Meaningful Use Core Question 4 – Answered No to Exclusions

Questionnaire: (5 of 15)

(*) Red asterisk indicates a required field.

Active Medication List

Objective: Maintain active medication list

Measure: More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data

Complete the following information. All information entered may be subject to audit that could result in payment recoupment.

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

*Numerator: *Denominator:

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Meaningful Use Core Question 5 – Active Medication List

Questionnaire: (6 of 15)

(*) Red asterisk indicates a required field.

Medication Allergy List

Objective: Maintain active medication allergy list

Measure: More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data

Complete the following information. All information entered may be subject to audit that could result in payment recoupment.

Numerator	Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Denominator	Number of unique patients seen by the EP during the EHR reporting period.

*Numerator: *Denominator:

lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Meaningful Use Core Question 6 – Medication Allergy List

Questionnaire: (7 of 15)

(*) Red asterisk indicates a required field.

Record Demographics

Objective: Record demographics

- preferred language
- gender
- race
- ethnicity
- date of birth

Measure: More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data

Complete the following information. All information entered may be subject to audit that could result in payment recoupment.

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

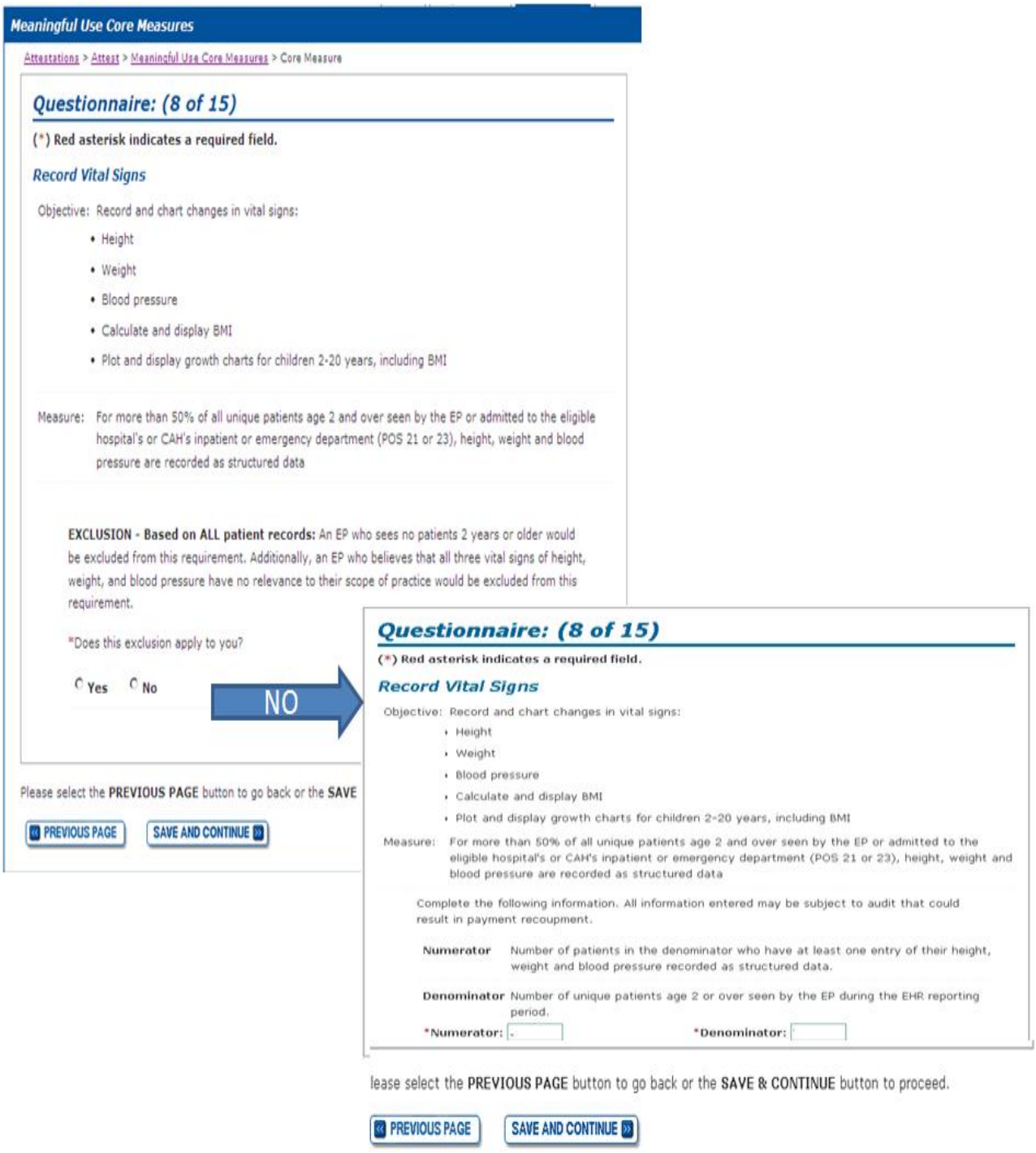
Denominator Number of unique patients seen by the EP during the EHR reporting period.

*Numerator: *Denominator:

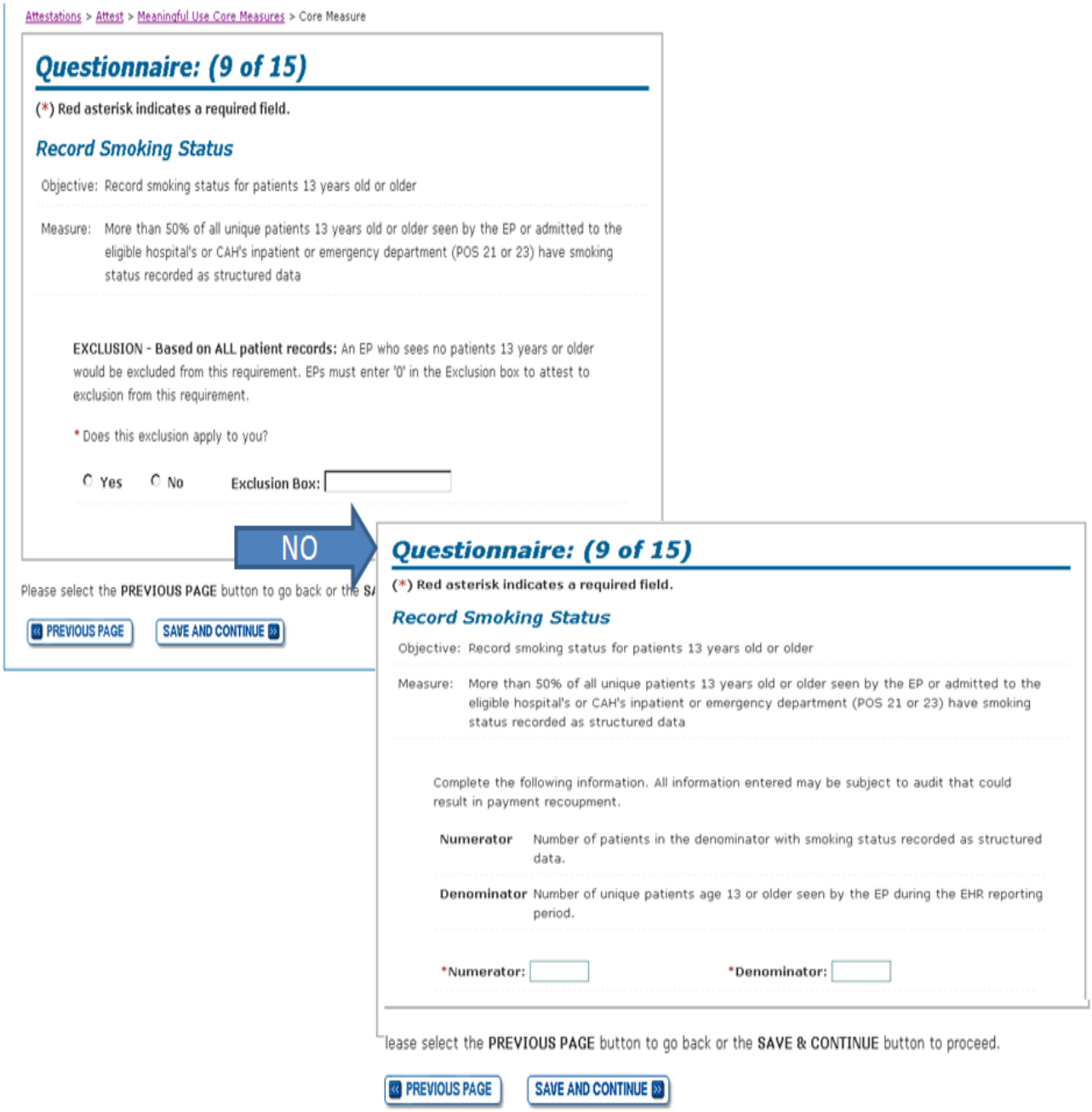
lease select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

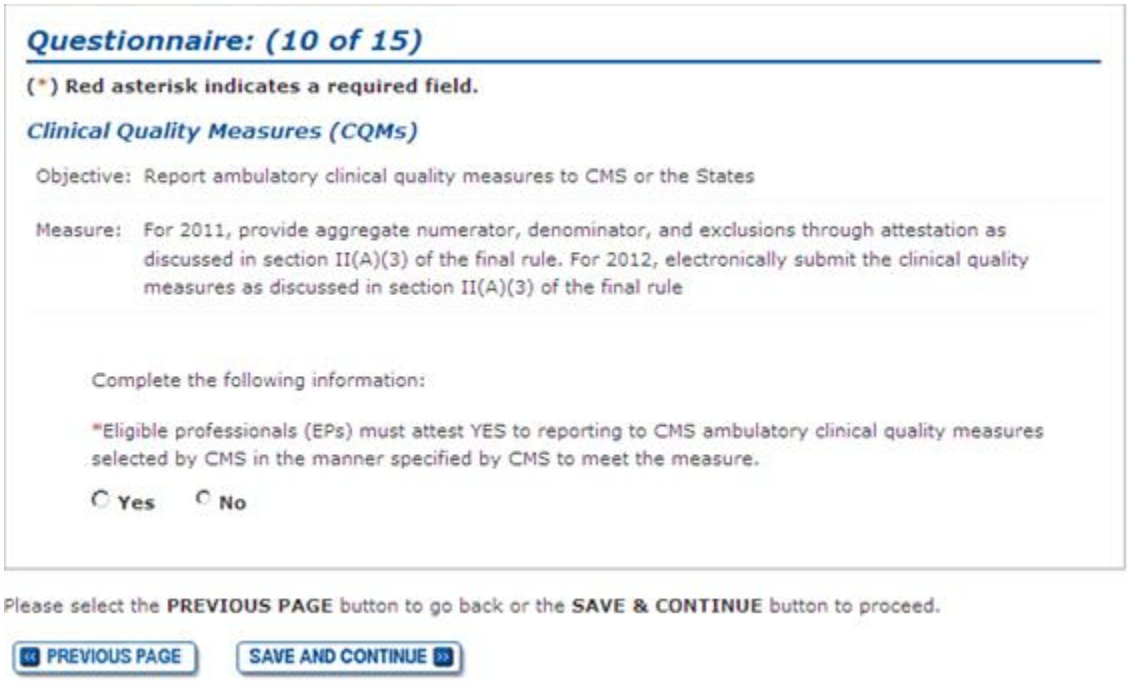
Meaningful Use Core Question 7 – Record Demographics



Meaningful Use Core Question 8 - Record Vital Signs and Answer No to Exclusion

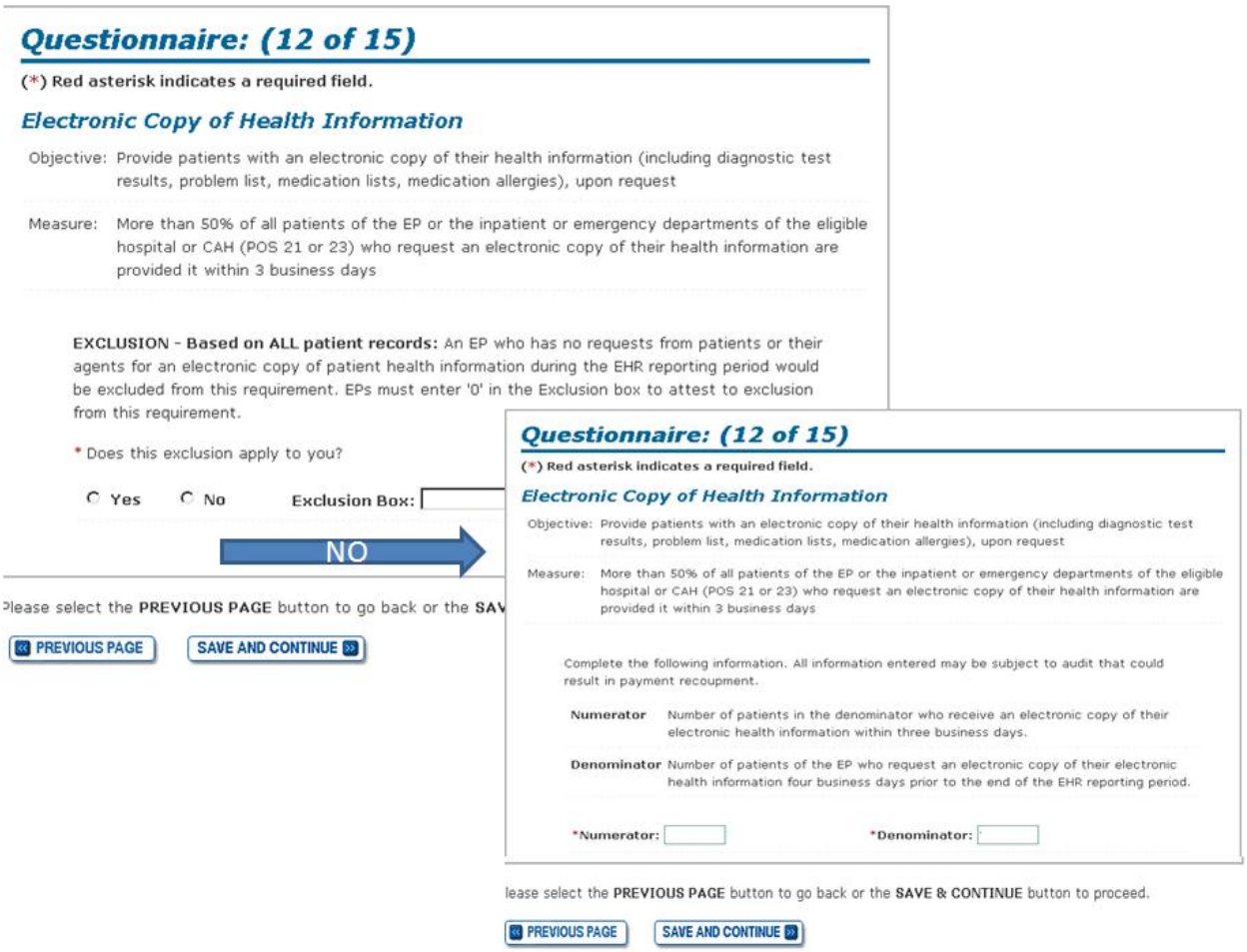


Meaningful Use Core Question 9 – Record Smoking Status and Answer No to Exclusion

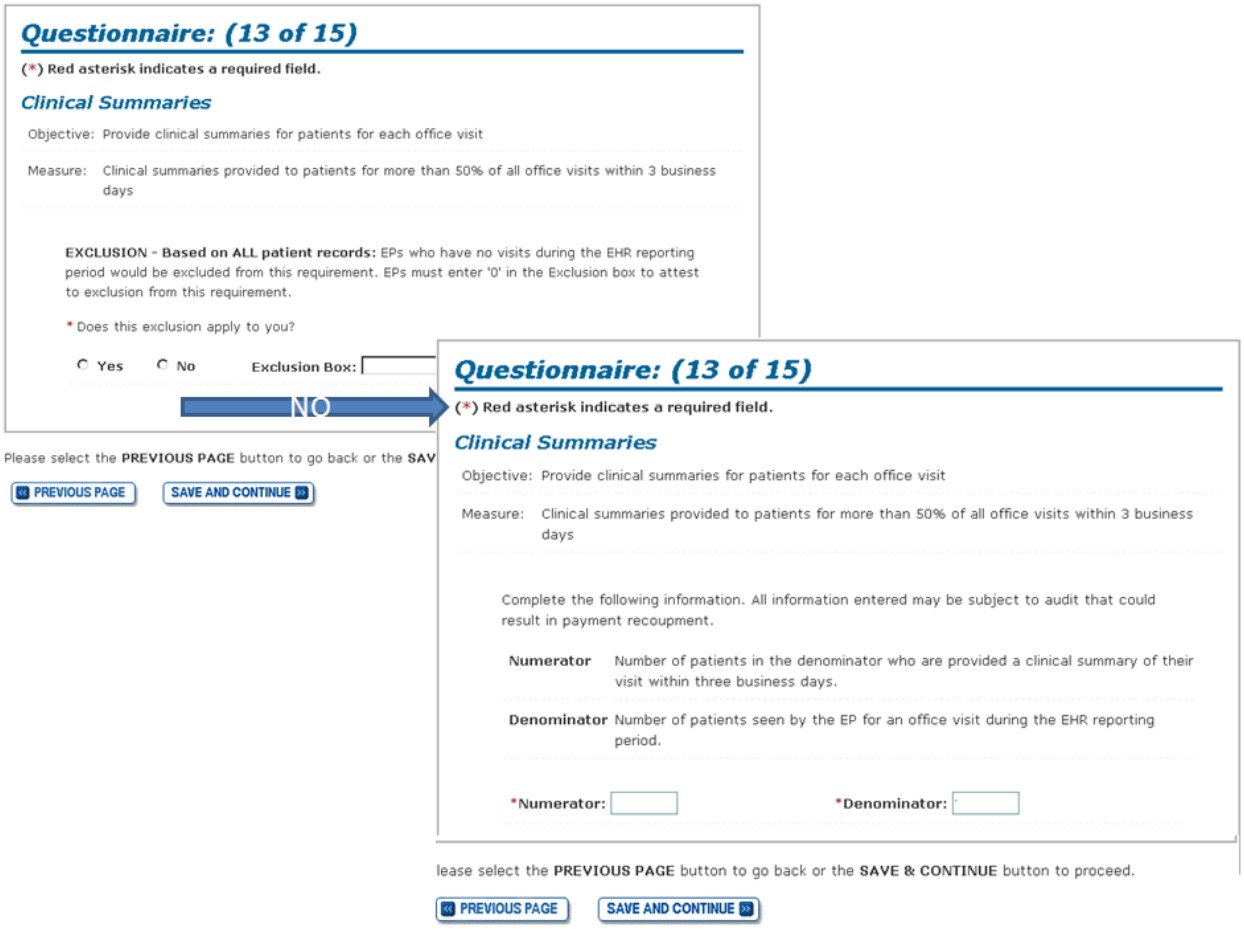


Meaningful Use Core Question 10 – Clinical Quality Measures (CQMs)

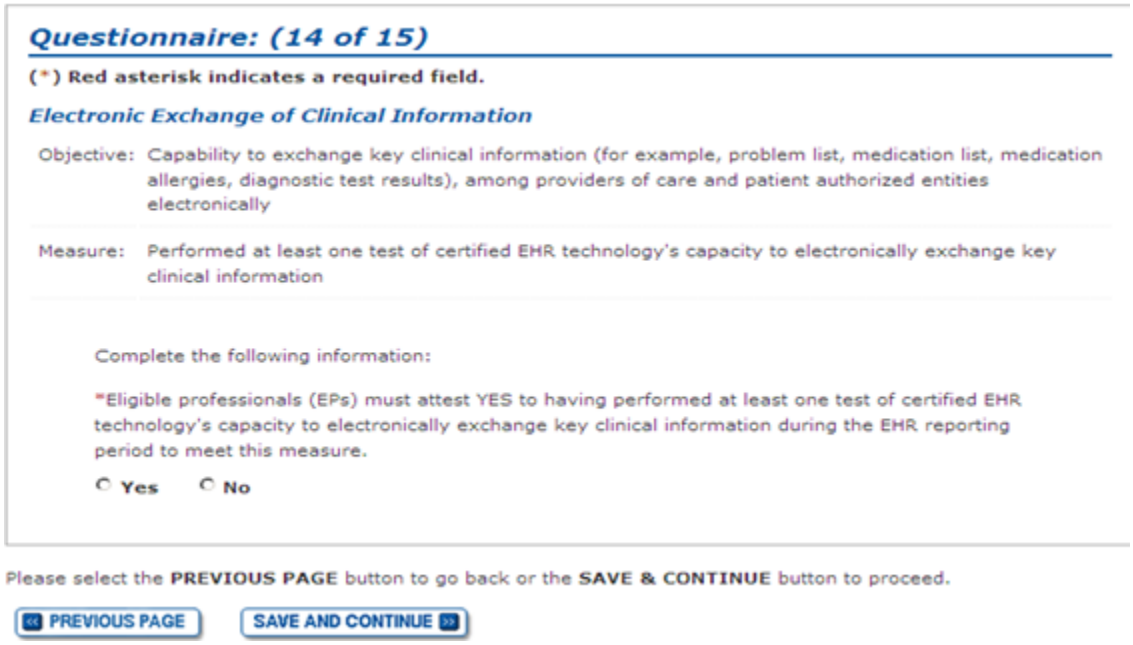
Meaningful Use Core Question 11 – Clinical Decision Support Rule



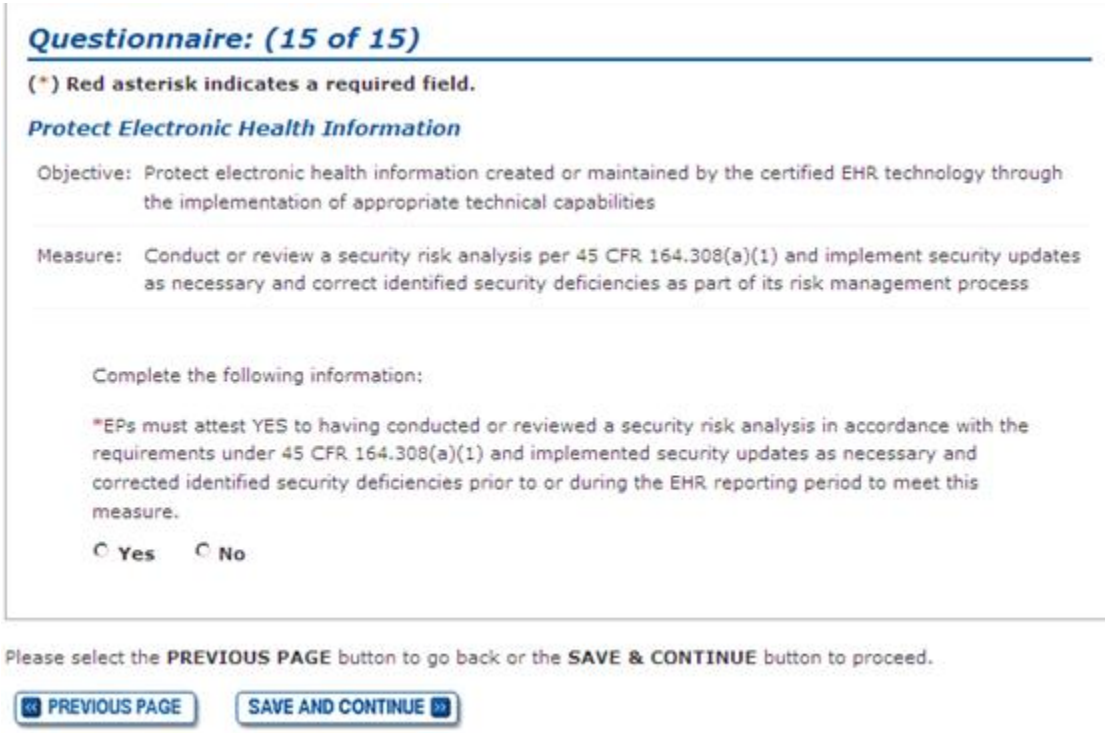
Meaningful Use Core Question 12 – Electronic Copy of Health Information and Answer No to Exclusion



Meaningful Use Core Question 13 – Clinical Summaries and Answer No to Exclusion



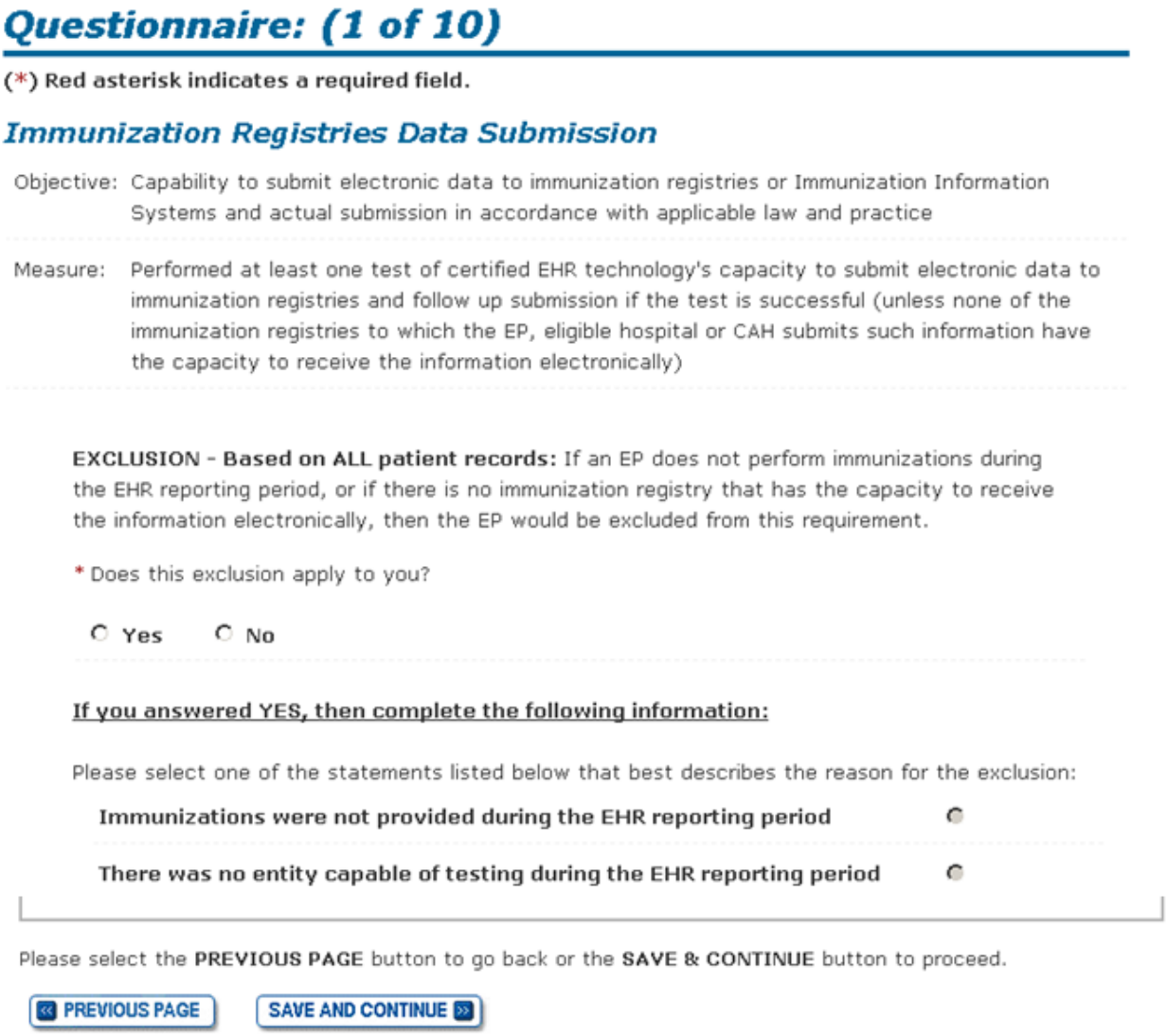
Meaningful Use Core Question 14 – Electronic Exchange of Clinical Information



Meaningful Use Core Question 15 – Protect Electronic Health Information

26. Meaningful Use Menu Measures Screen Shots

CMS requires that a minimum of five "menu set" questions are selected. All ten questions' screen shots are displayed. The application will only display the questions that are selected by the user.



Meaningful Use Menu Measures Question 1 – Immunization Registries Data Submission

Answered No from previous

Questionnaire: (1 of 10)

(*) Red asterisk indicates a required field.

munization Registries Data Submission

e: Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice

re: Performed at least one test of certified EHR technology's capacity to submit electronic data t immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)

Complete the following information:

*EPs must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless non of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.

○ Yes ○ No

If you performed at least one test, then complete the following information:

Enter the name of the immunization registry used:

Was the test successful? ○ Yes ○ No

If the test was successful, then complete the following information:

Date (MM/DD/YY):

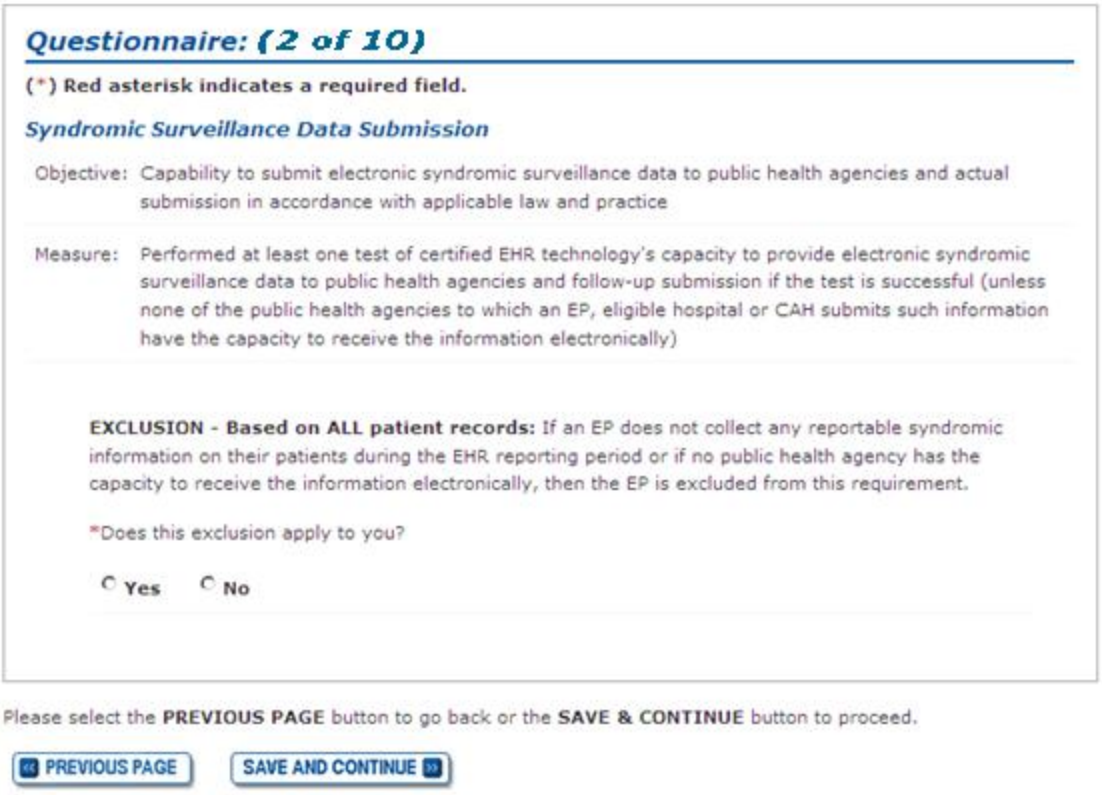
Time (HH:MM AM/PM): *(Example: 09:15 PM)*

Was a follow-up submission done? ○ Yes ○ No

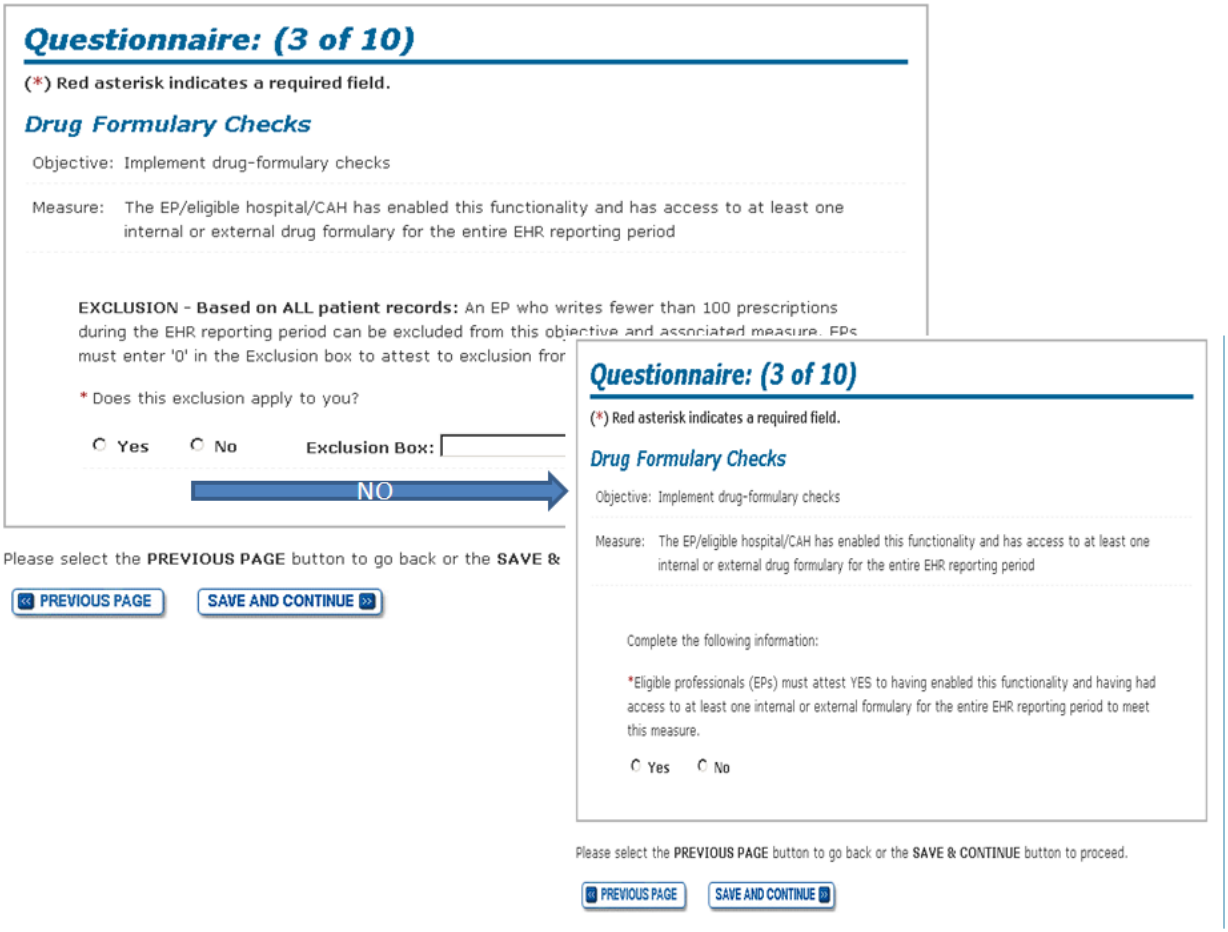
Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

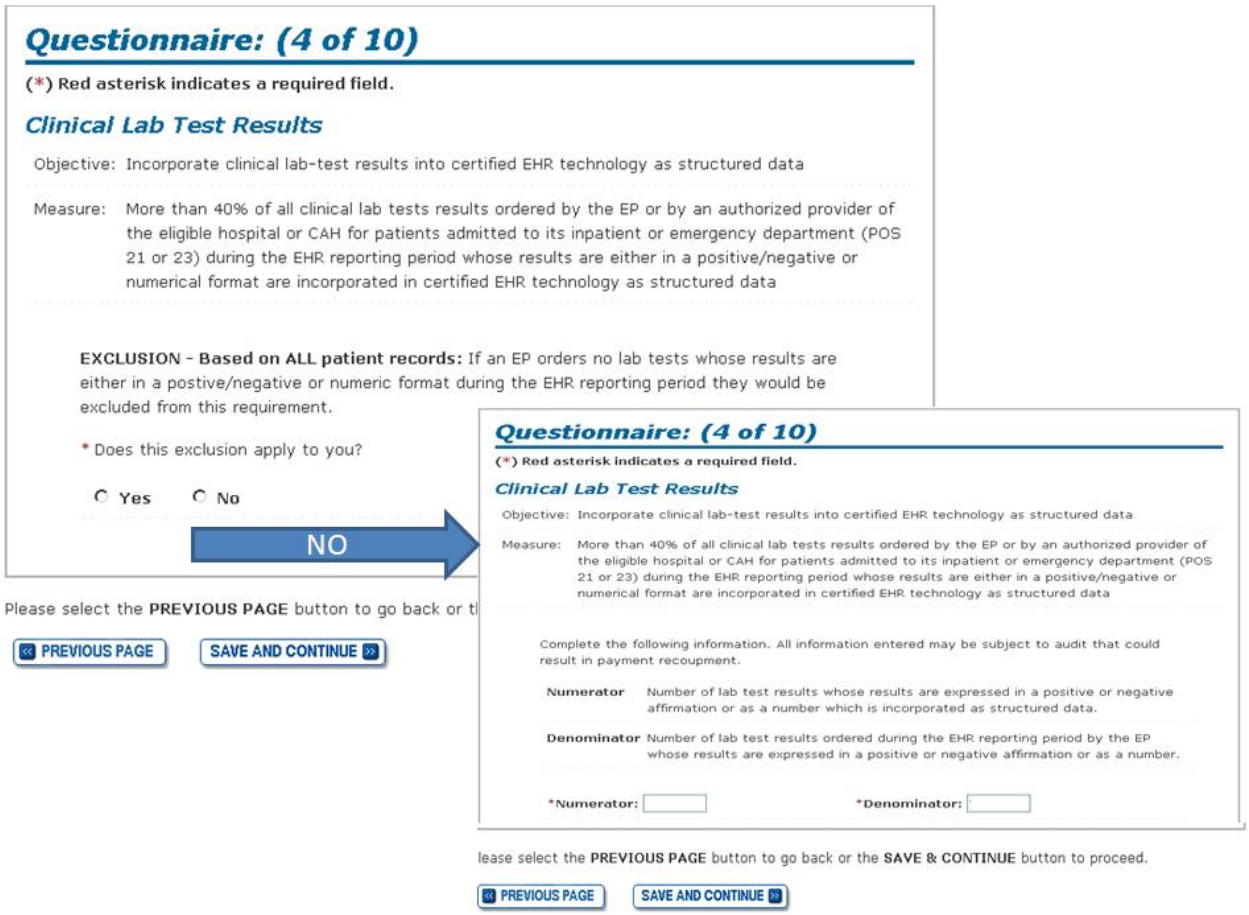
Meaningful Use Menu Measures Question 1 – Immunization Registries Answered No to Exclusion



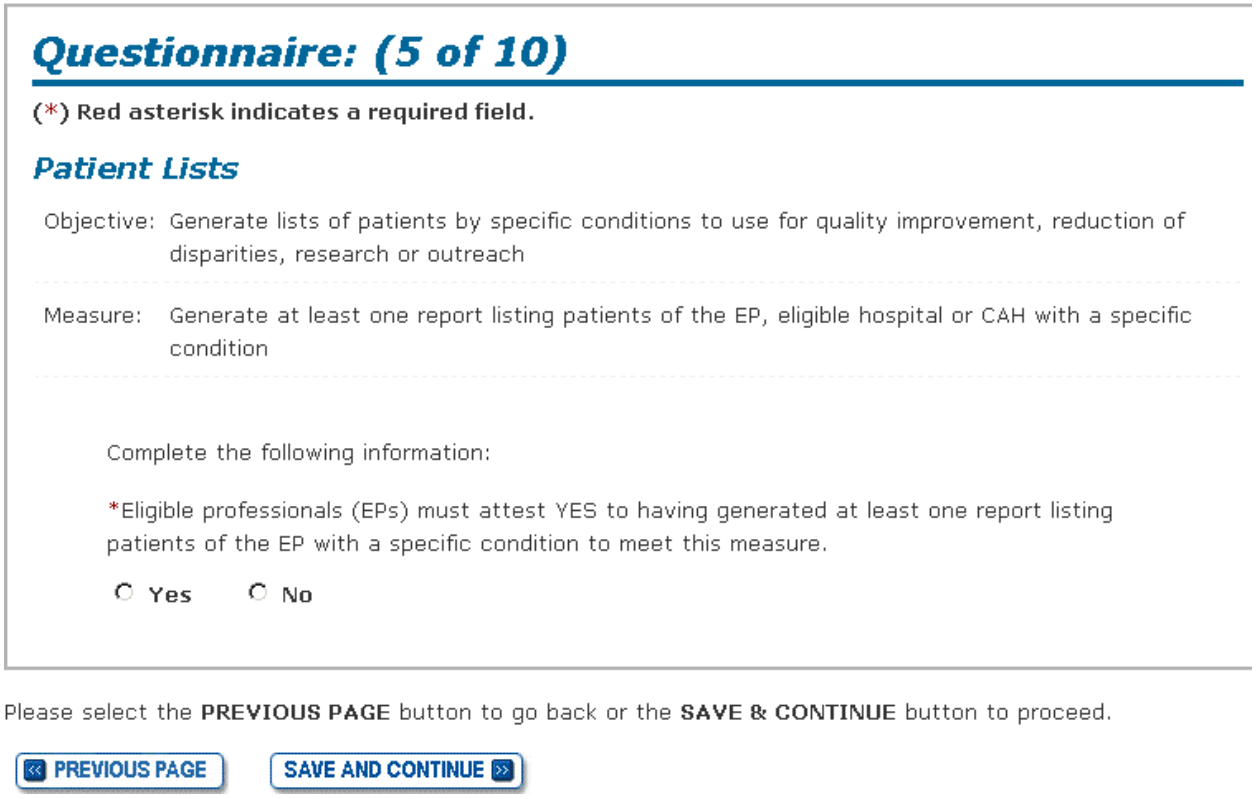
Meaningful Use Menu Measures Question 2 – Syndromic Surveillance Data Submission



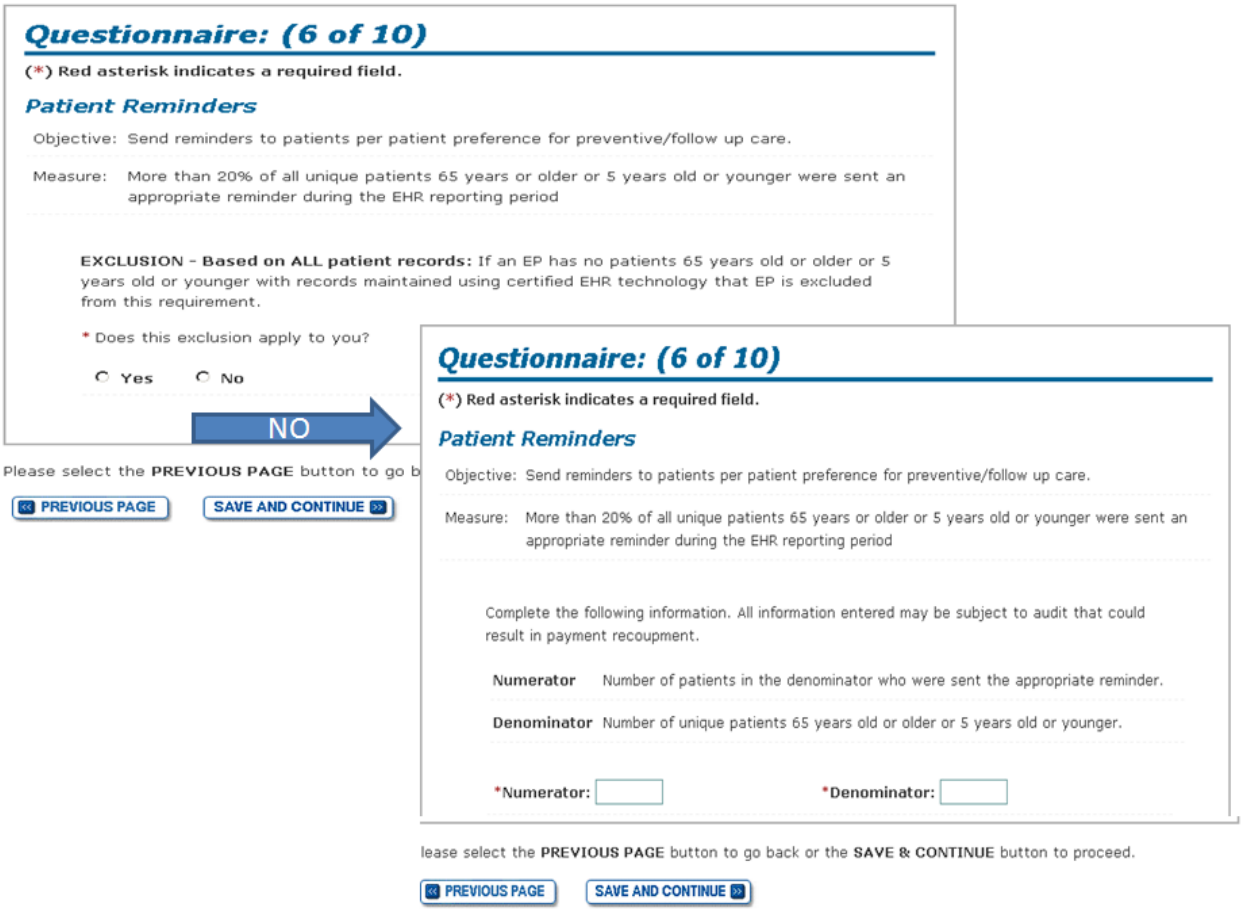
Meaningful Use Menu Measure Question 3 – Drug Formulary Checks and Answer No to Exclusion



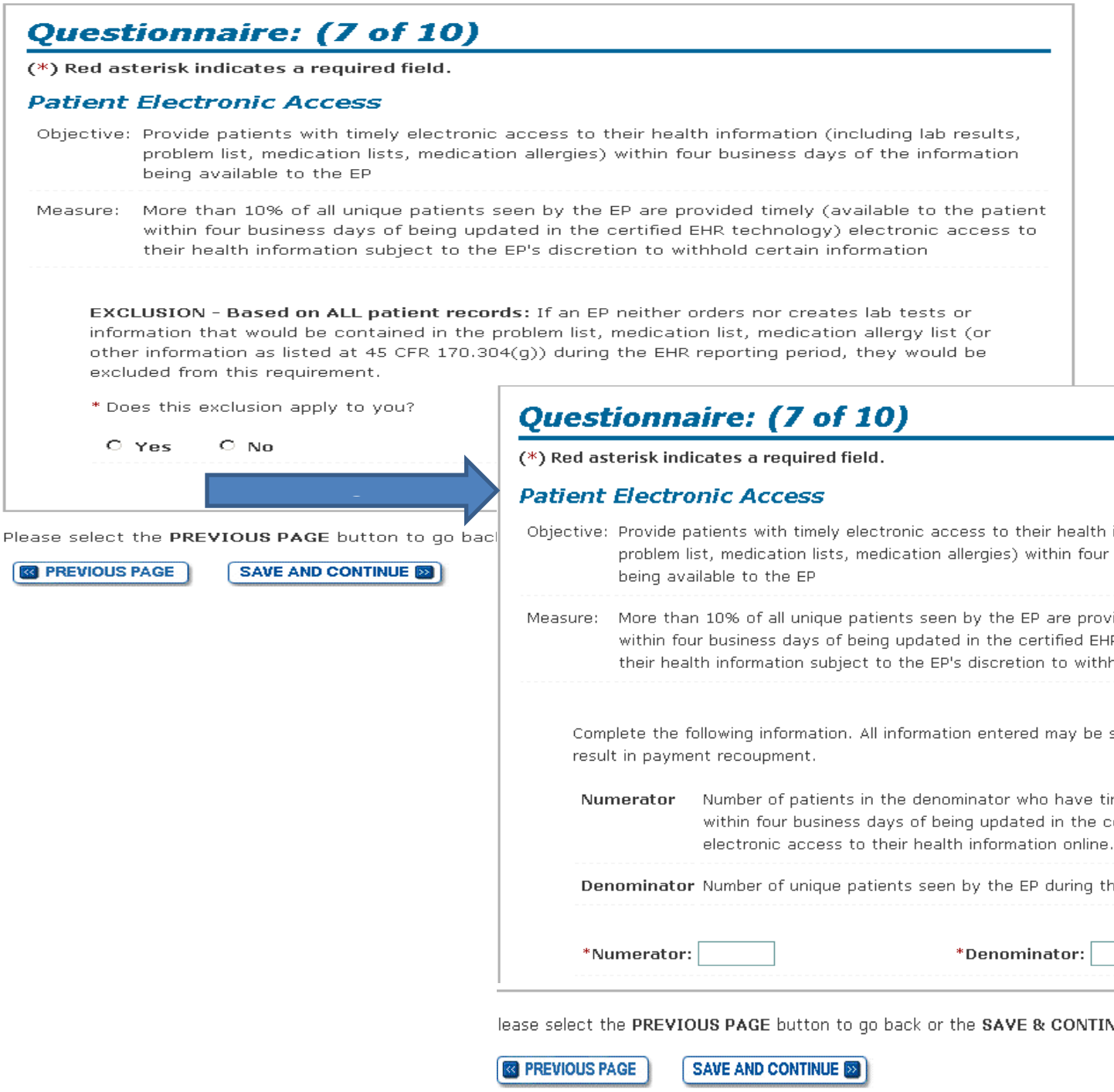
Meaningful Use Menu Measure Question 4 – Clinical Lab Test Results and Answer No to Exclusion



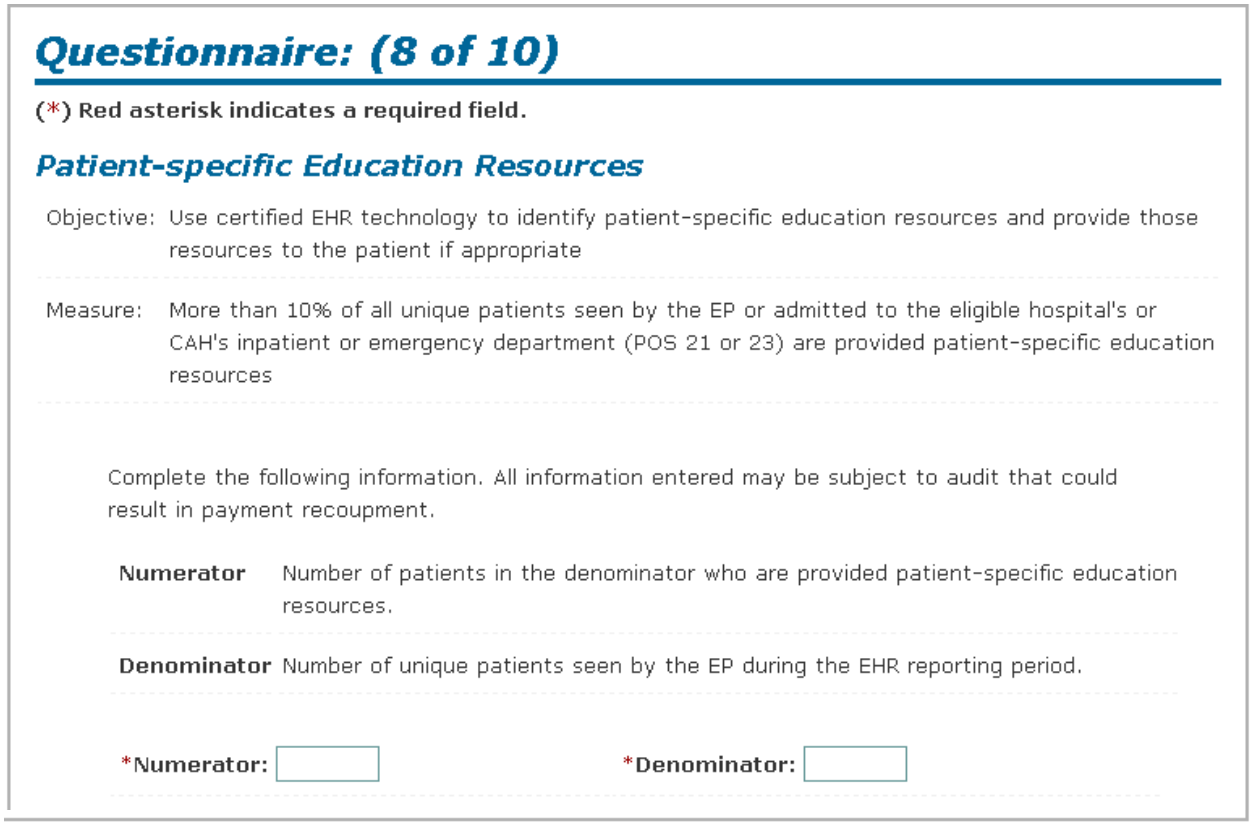
Meaningful Use Menu Measures Question 5 – Patient Lists



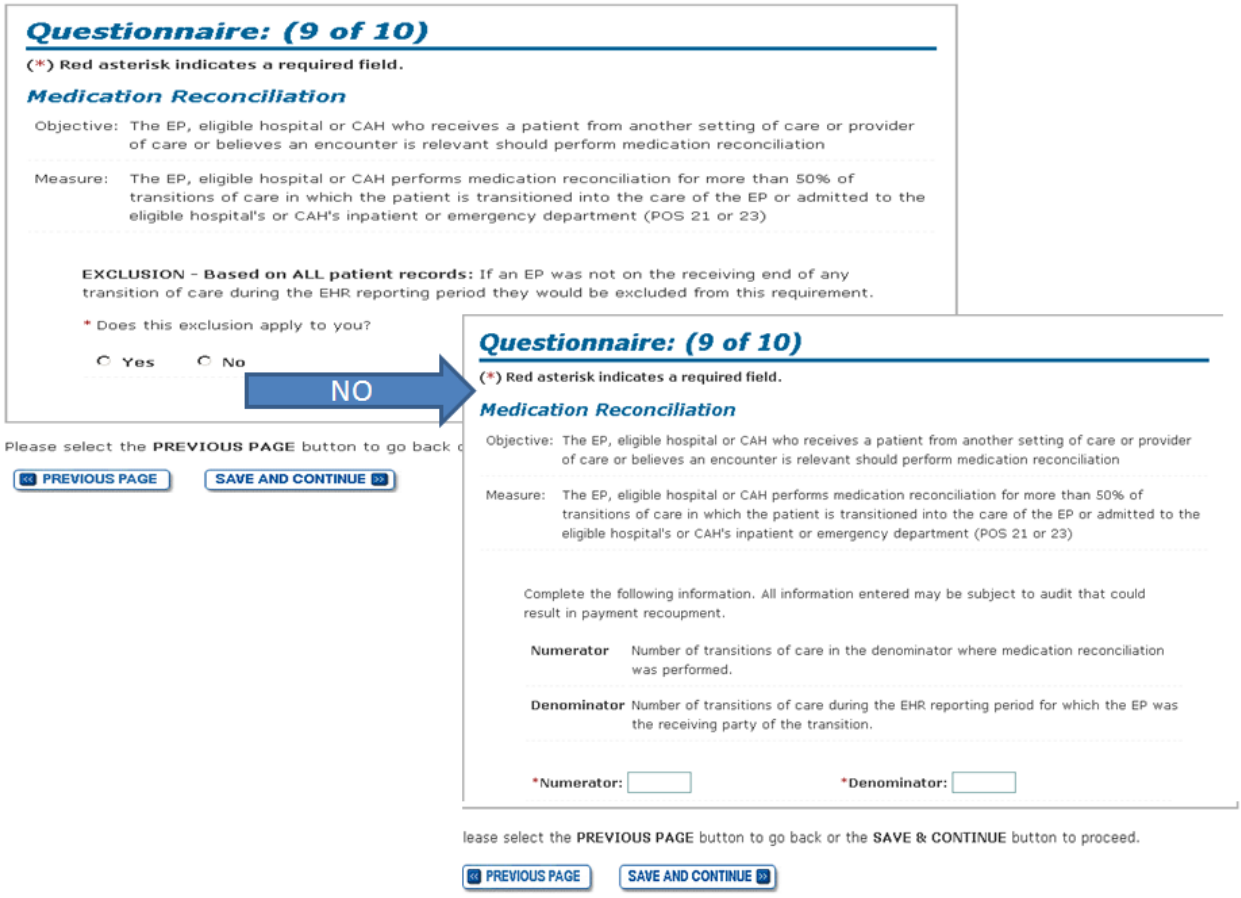
Meaningful Use Menu Measures Question 6 – Patient Reminders and Answer No to Exclusion



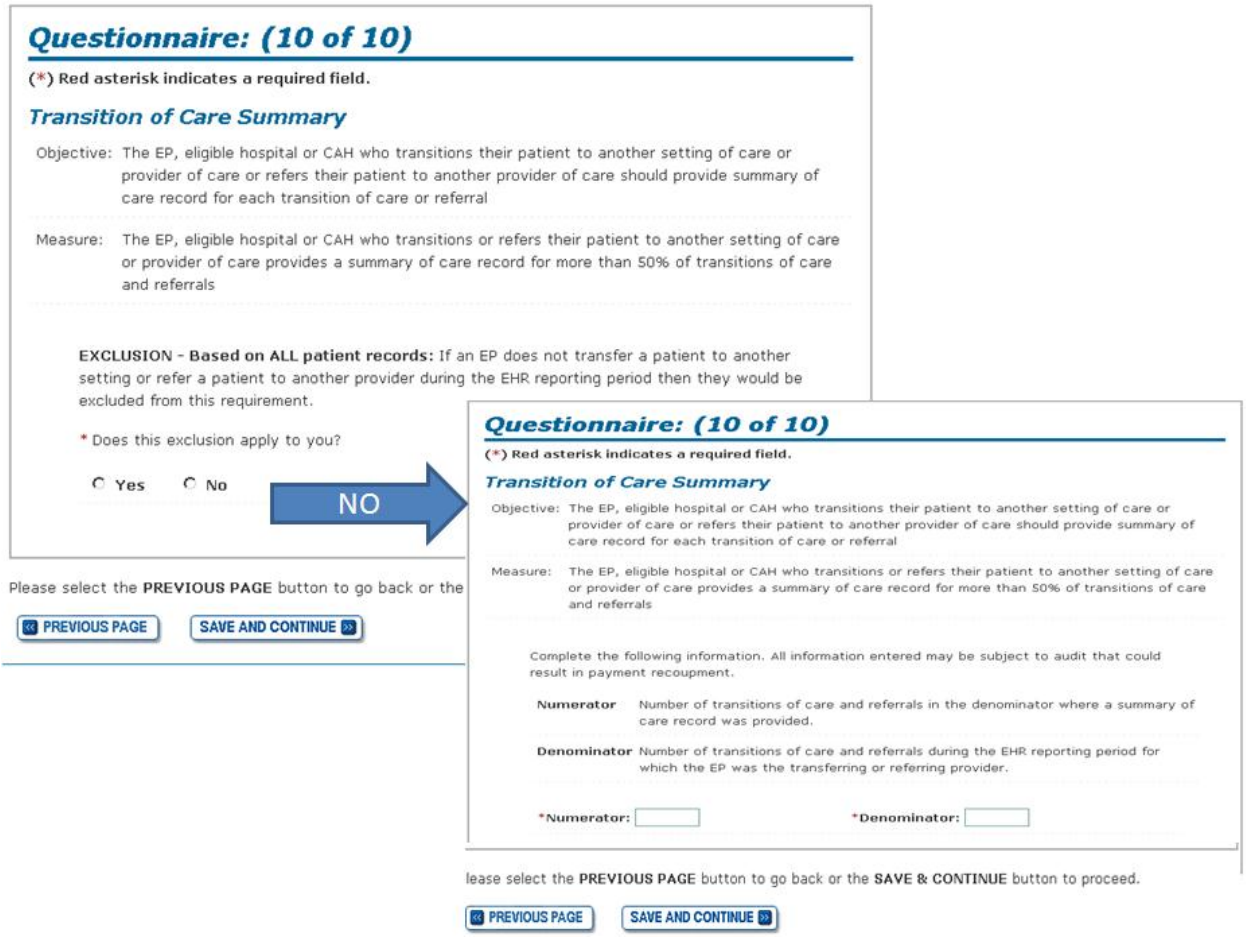
Meaningful Use Menu Measures Question 7 – Patient Electronic Access and Answer No to Exclusion



Meaningful Use Menu Measure Question 8 – Patient-specific Education Resources



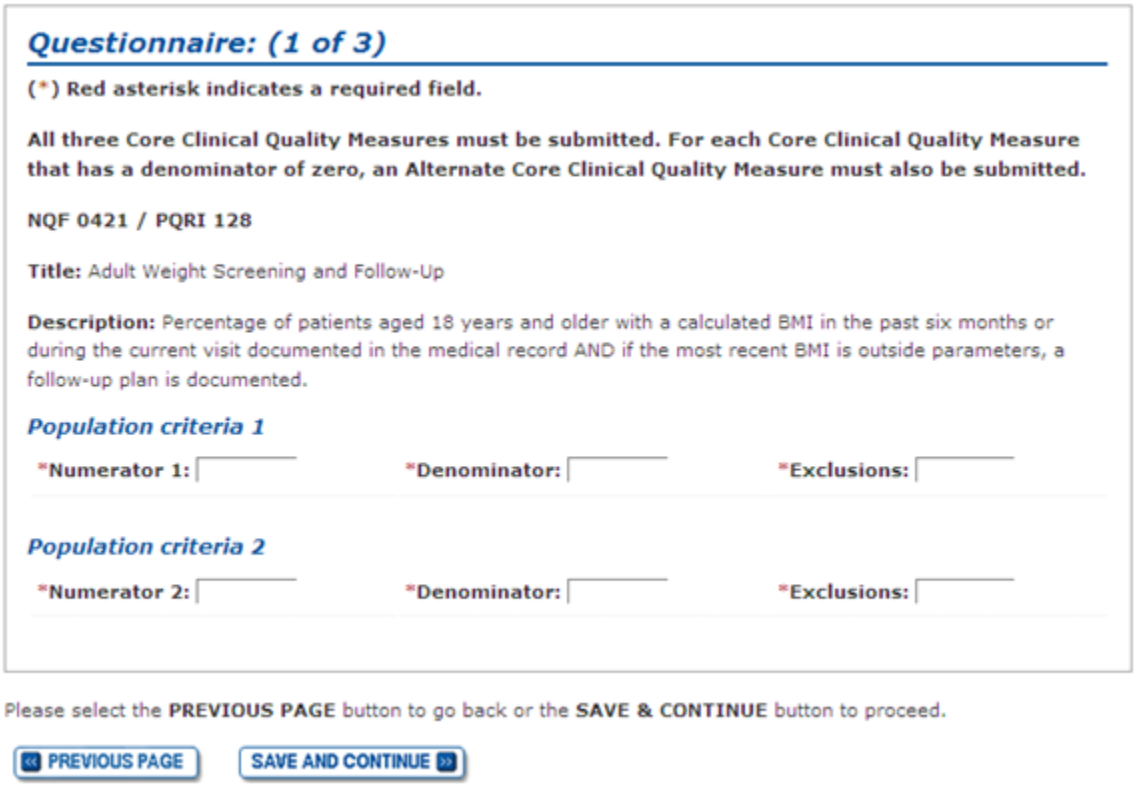
Meaningful Use Menu Measure Question 9 – Medication Reconciliation and Answer No to Exclusion



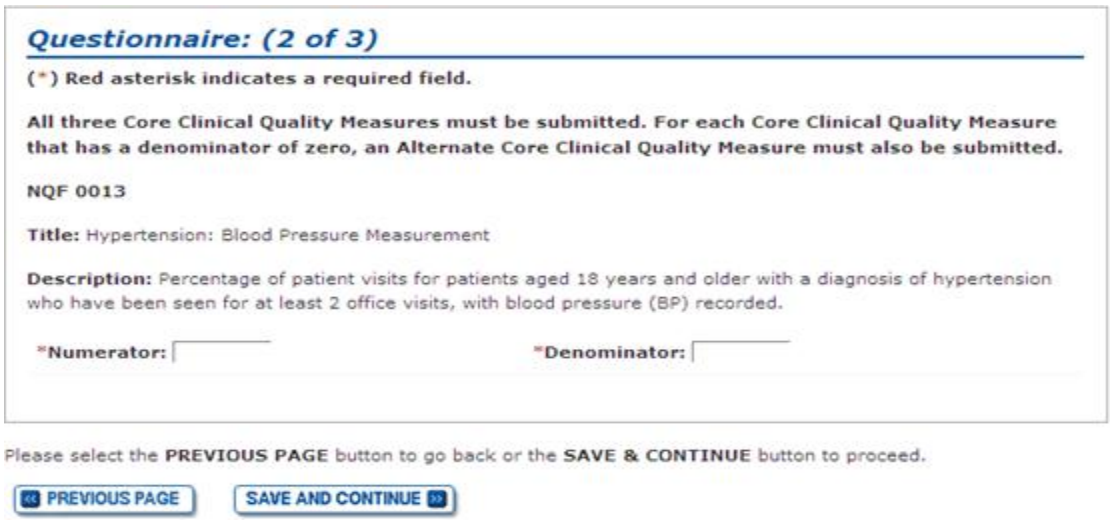
Meaningful Use Menu Measure Question 10 – Transition of Care Summary and Answer No to Exclusion

27. Clinical Quality Measures Screen Shots

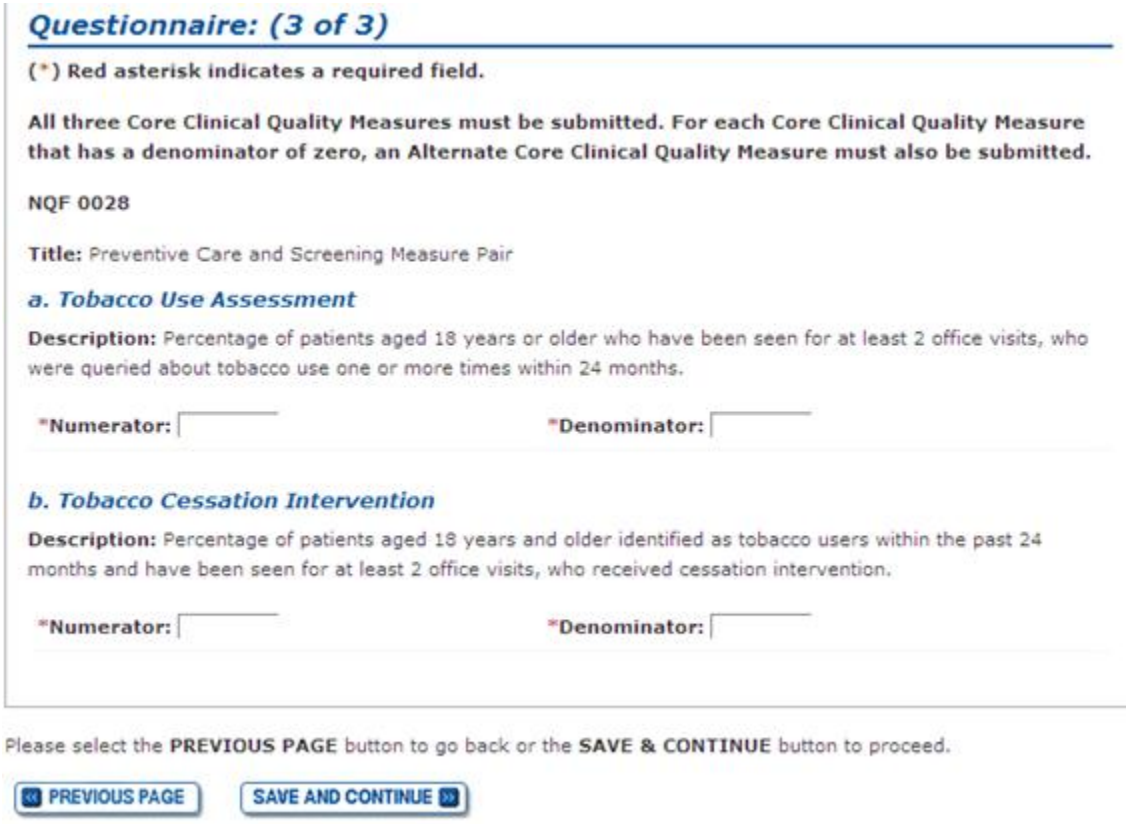
Below are screen shots for the three core CQMs with a required response:



Clinical Quality Measures Question 1 – Adult Weight Screening and Follow up

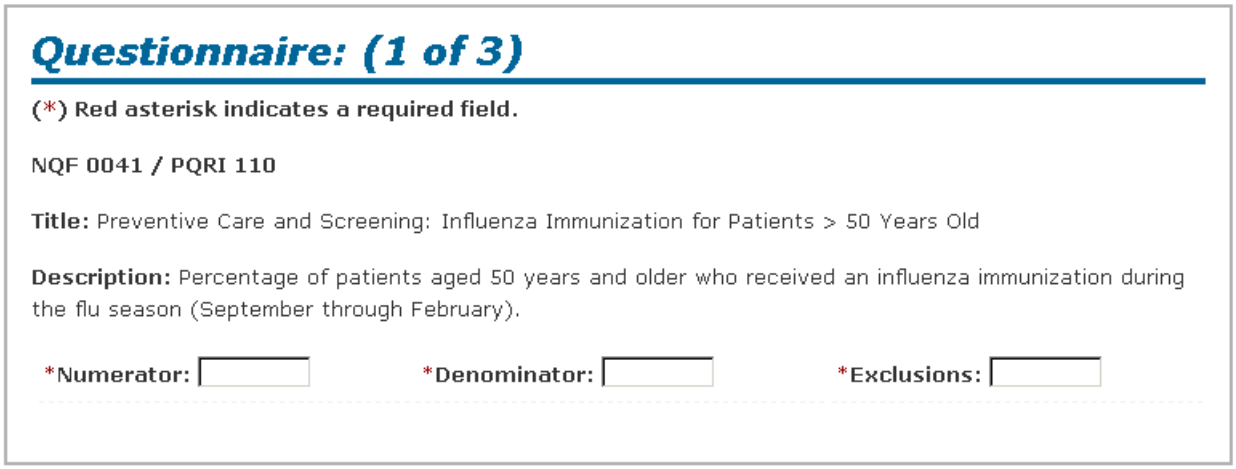


Clinical Quality Measure Question 2 – Hypertension: Blood Pressure Measurement

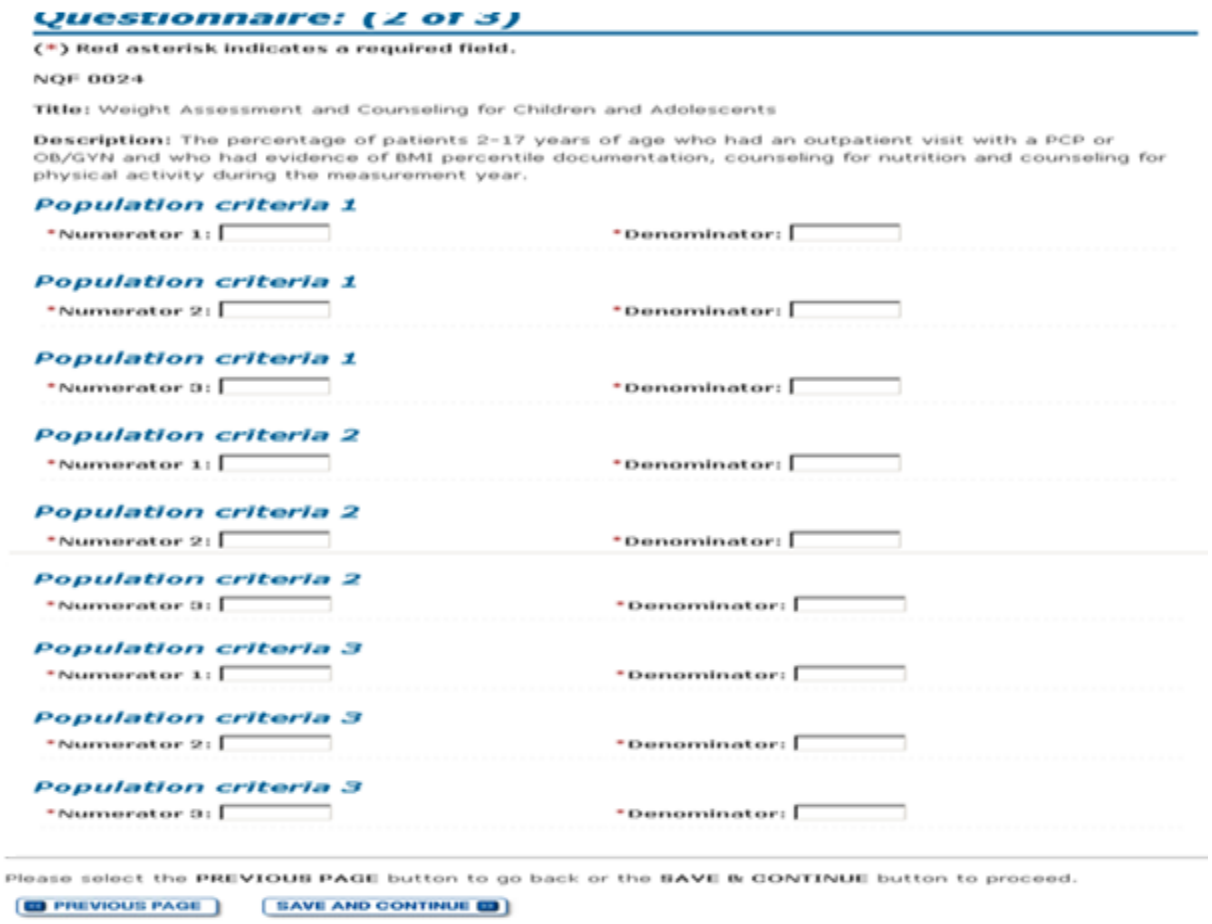


Clinical Quality Measure Question 3 – Preventive Care and Screening Measure Pair

If the denominator of the questions above is zero, then the following questions will require a response. Below are the screen shots for the questions:



Clinical Quality Measure Question 1 if denominator is 0- Preventive Care and Screening: Influenza Immunization for Patients > 50 years old


Questionnaire: (2 of 3)

(*) Red asterisk indicates a required field.

NQF 0024

Title: Weight Assessment and Counseling for Children and Adolescents

Description: The percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Population criteria 1
*Numerator 1: *Denominator:

Population criteria 1
*Numerator 2: *Denominator:

Population criteria 1
*Numerator 3: *Denominator:

Population criteria 2
*Numerator 1: *Denominator:

Population criteria 2
*Numerator 2: *Denominator:

Population criteria 2
*Numerator 3: *Denominator:

Population criteria 3
*Numerator 1: *Denominator:

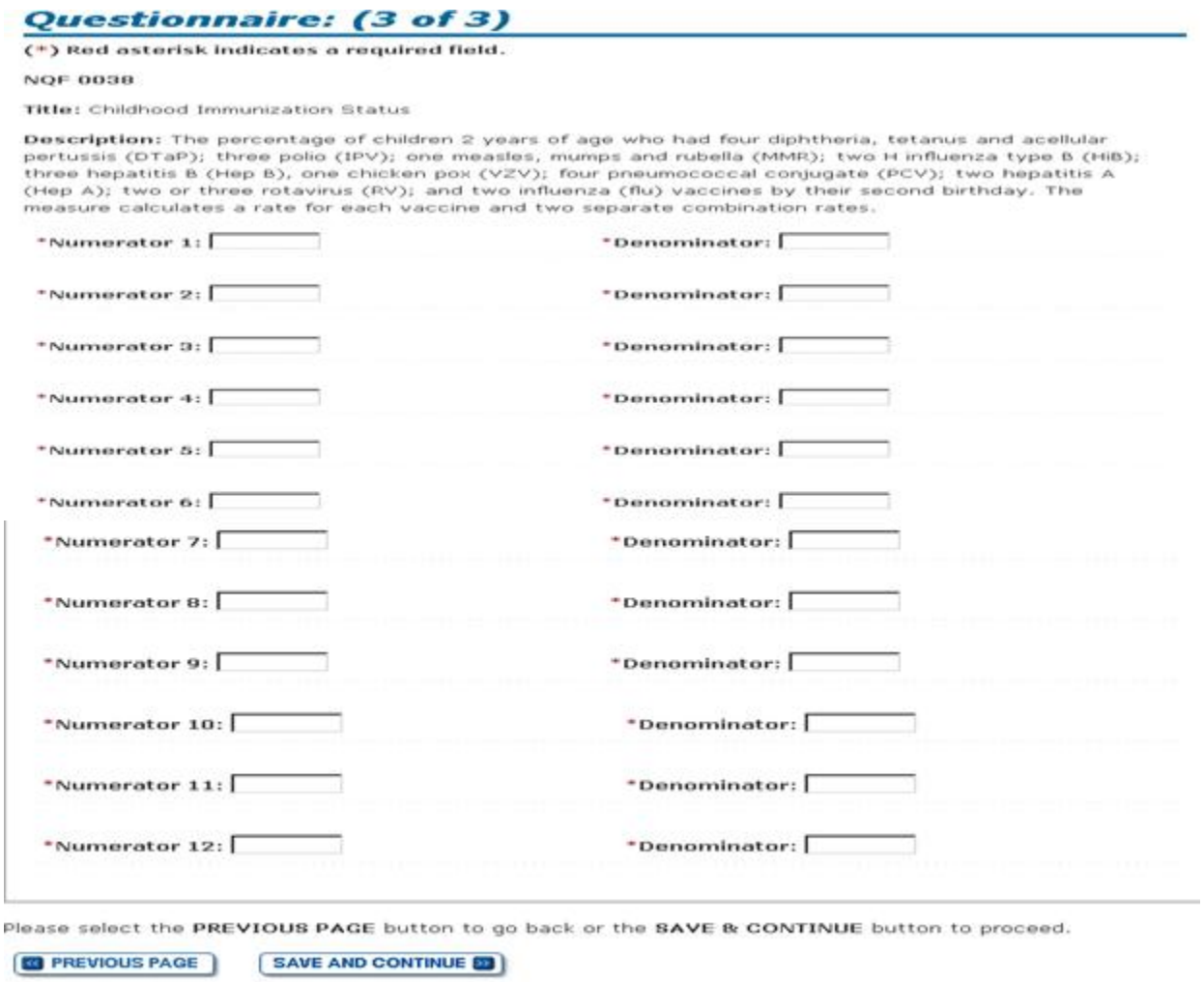
Population criteria 3
*Numerator 2: *Denominator:

Population criteria 3
*Numerator 3: *Denominator:

Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.

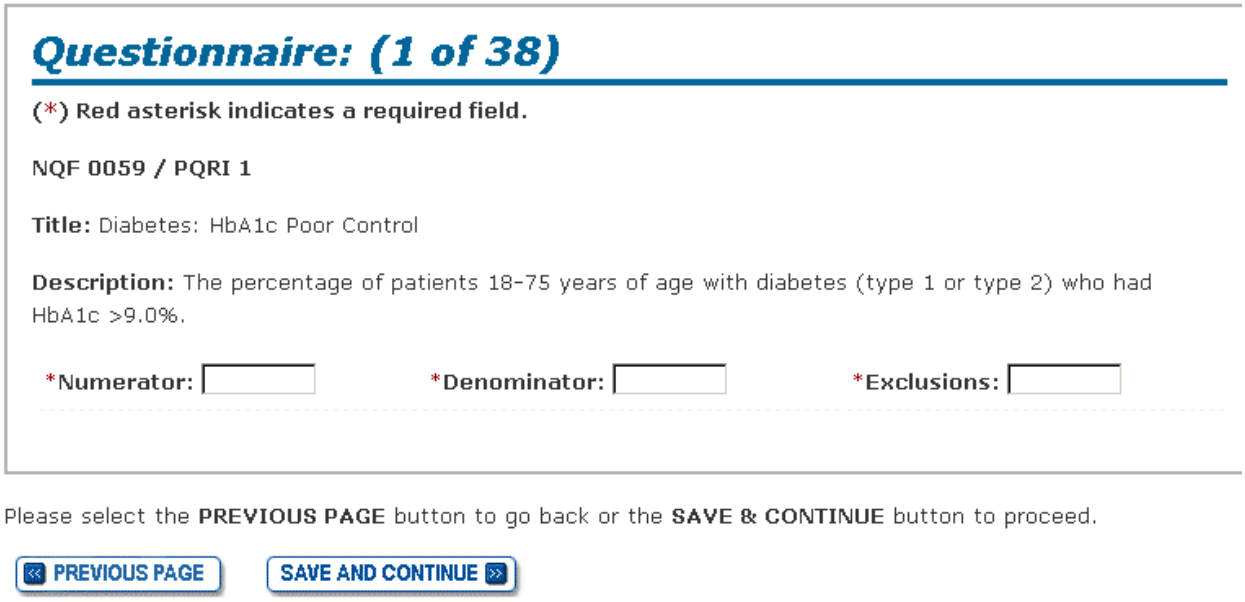
PREVIOUS PAGE SAVE AND CONTINUE

Clinical Quality Measure Question 2 if denominator is 0 – Weight Assessment and Counseling for Children and Adolescents

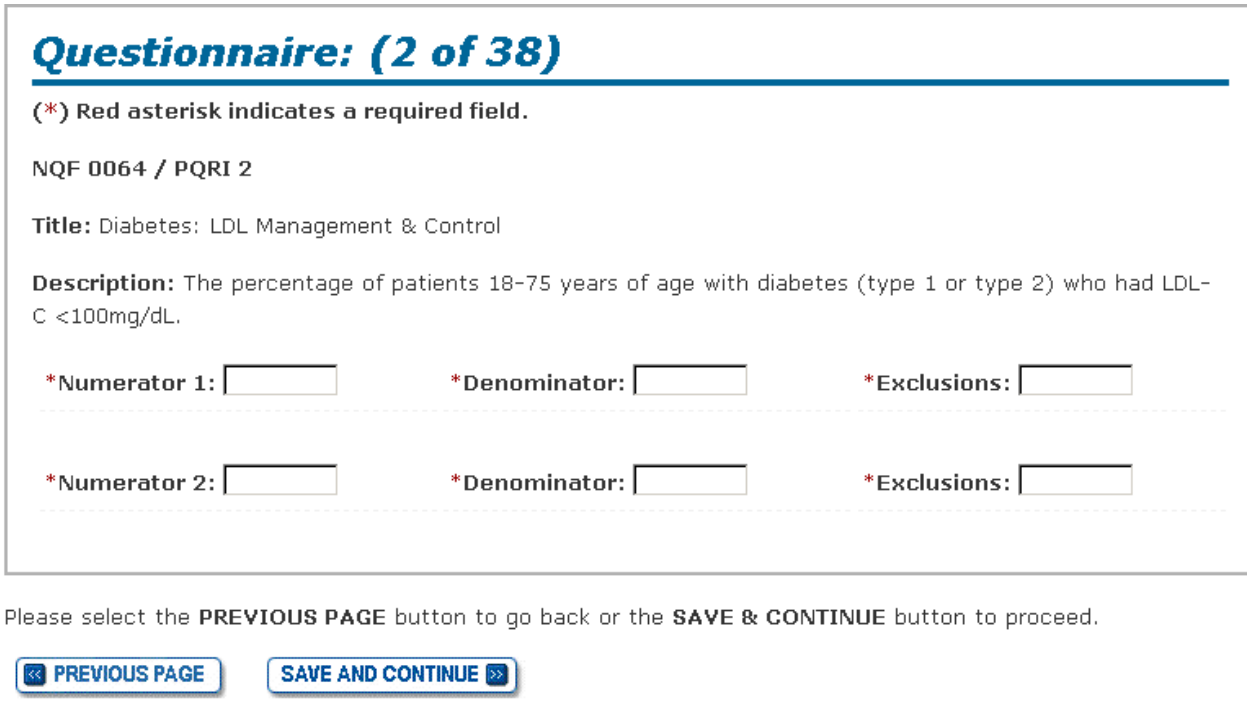


Clinical Quality Measure Question 3 if denominator is 0 – Childhood Immunization Status

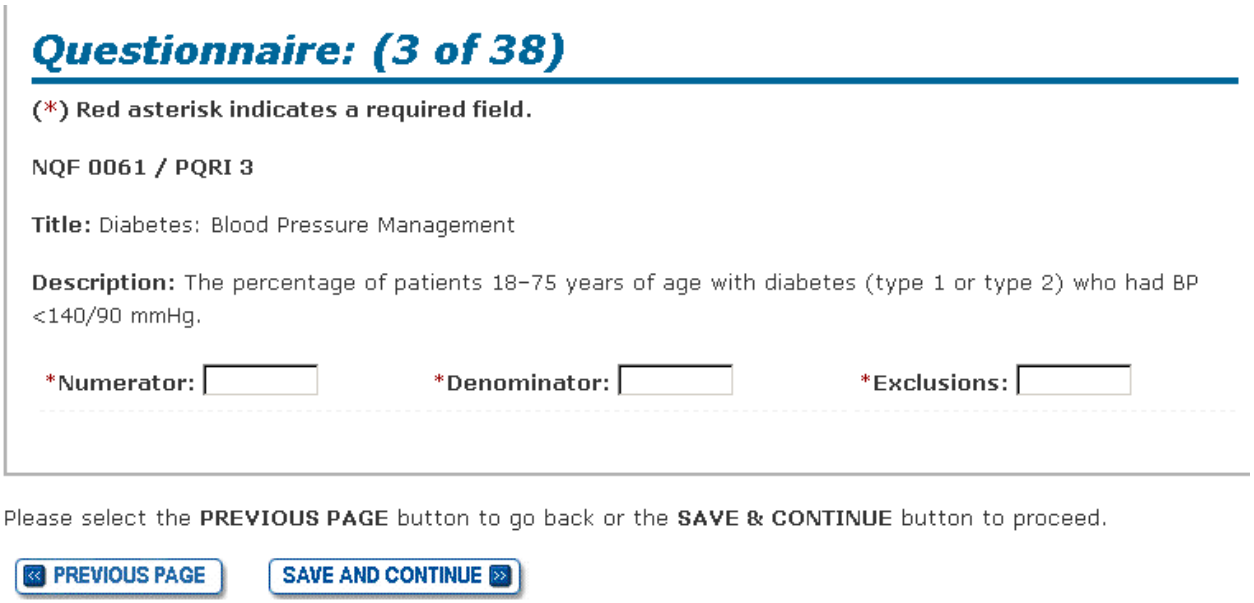
The following screen shots show the 38 CQMs that are available for selection. To meet meaningful use, at least three of these questions must be selected.



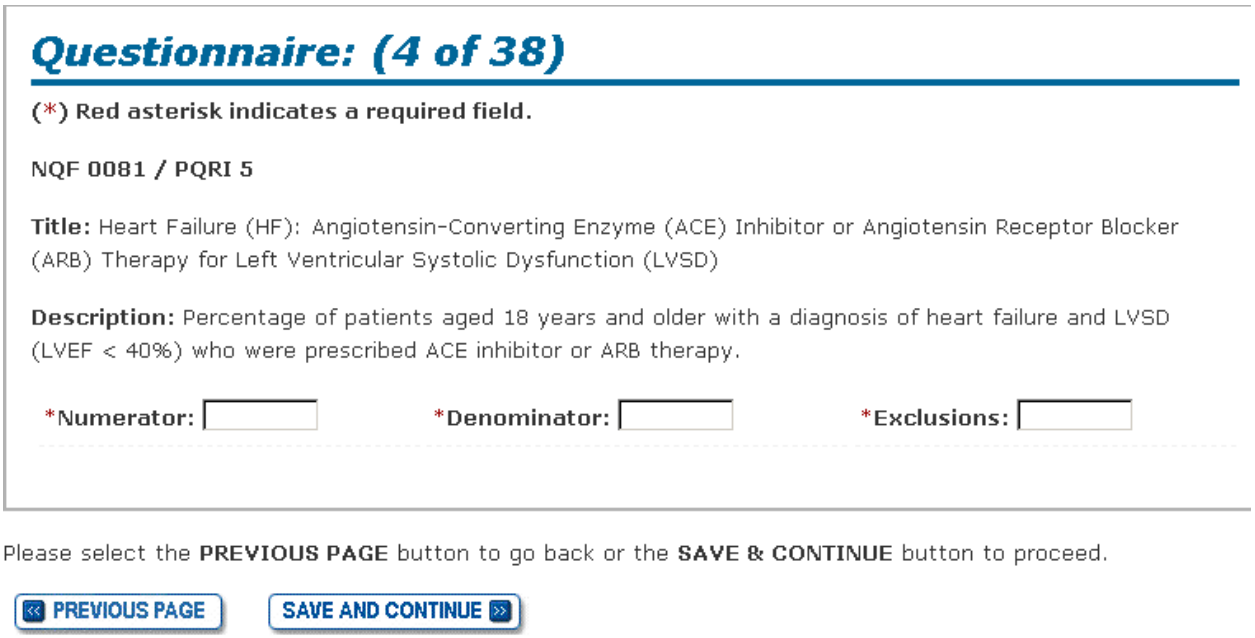
Clinical Quality Measure Question 1 – Diabetes: HbA1c Poor Control



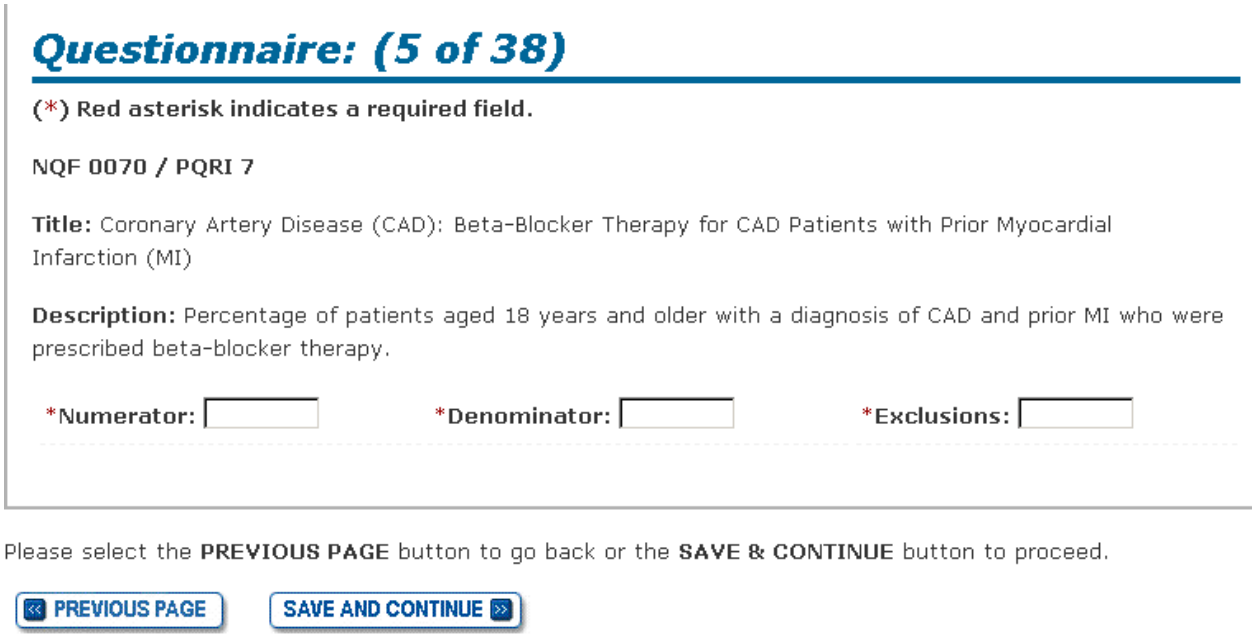
Clinical Quality Measure Question 2 – Diabetes: LDL Management & Control



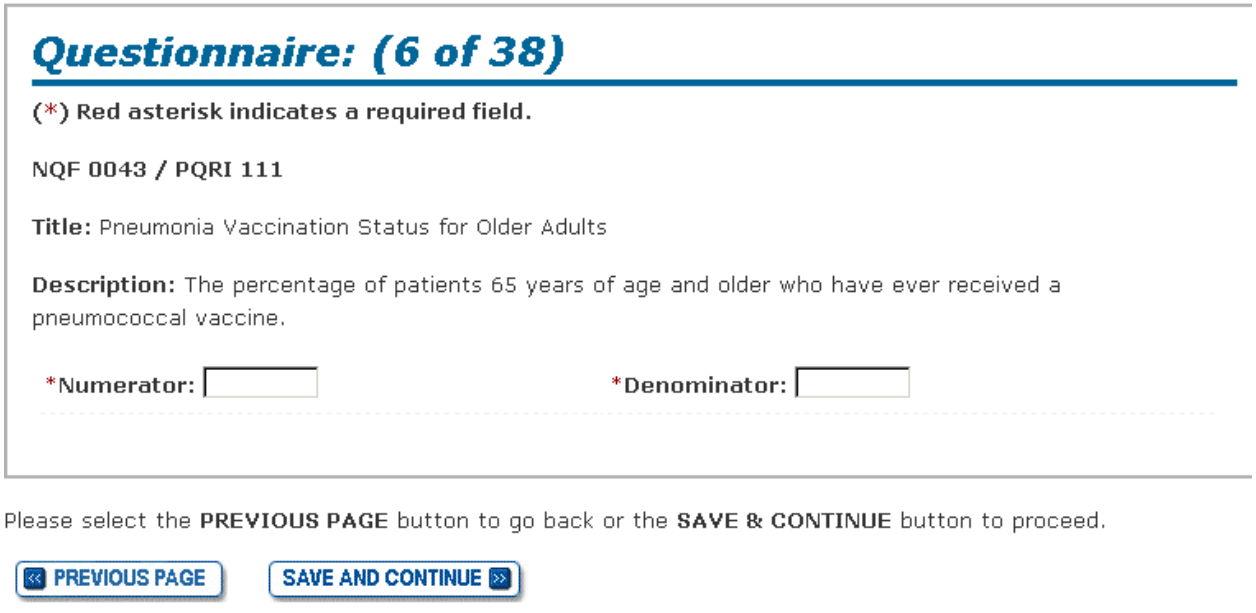
Clinical Quality Measure Question 3 – Diabetes: Blood Pressure Management



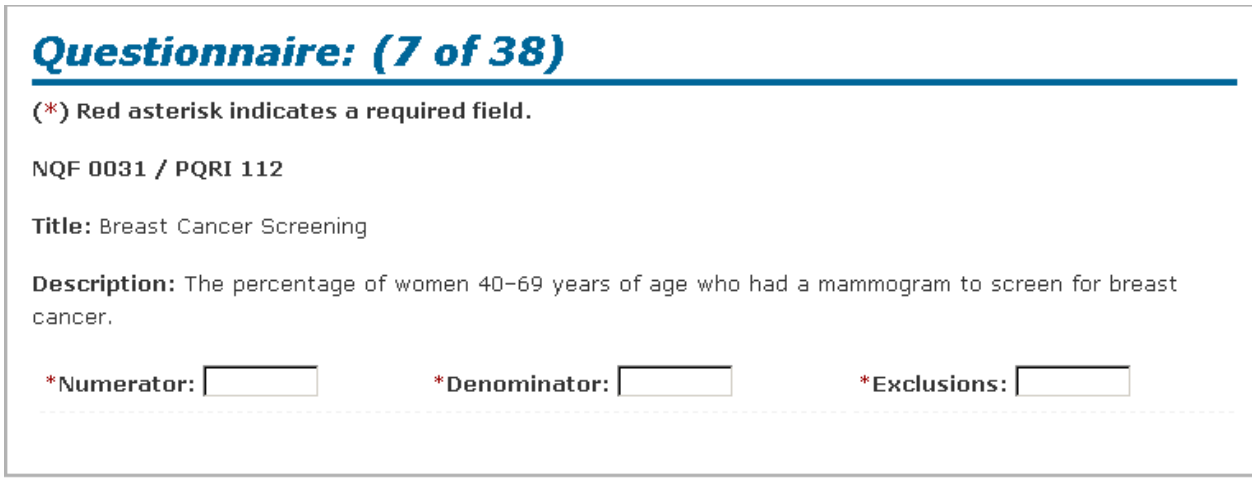
Clinical Quality Measure Question 4 – HF: ACE Inhibitor or ARB for LVSD



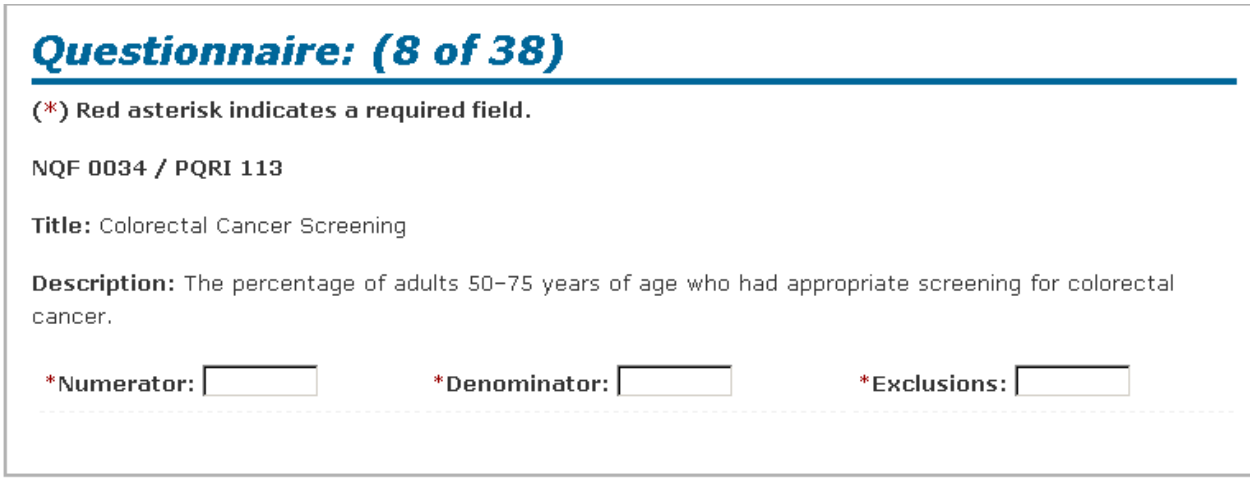
Clinical Quality Measure Question 5 – CAD: Beta-blocker Therapy for CAD patients with MI



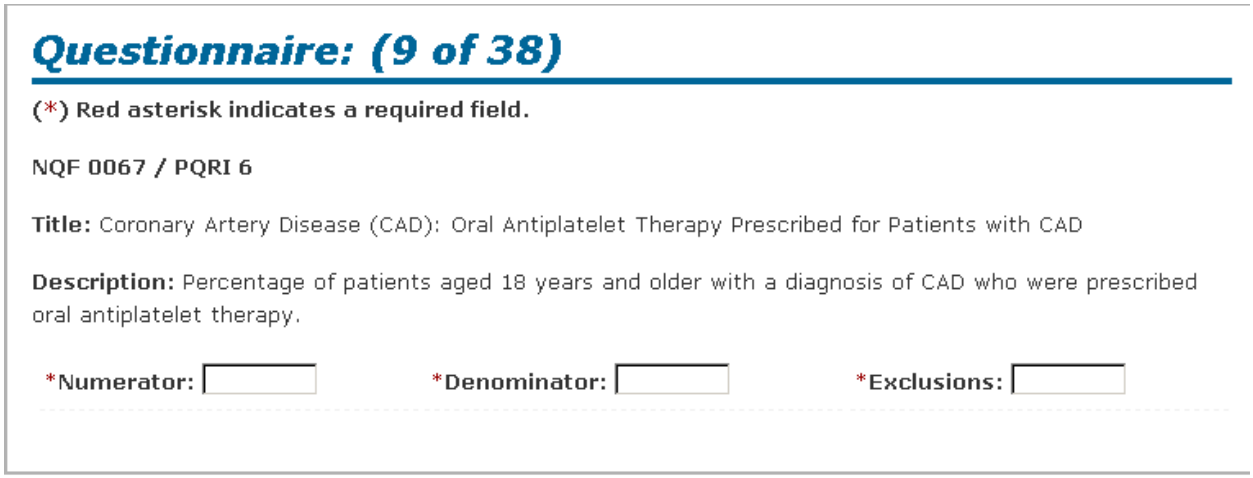
Clinical Quality Measure Question 6 – Pneumonia Vaccination Status for Older Adults



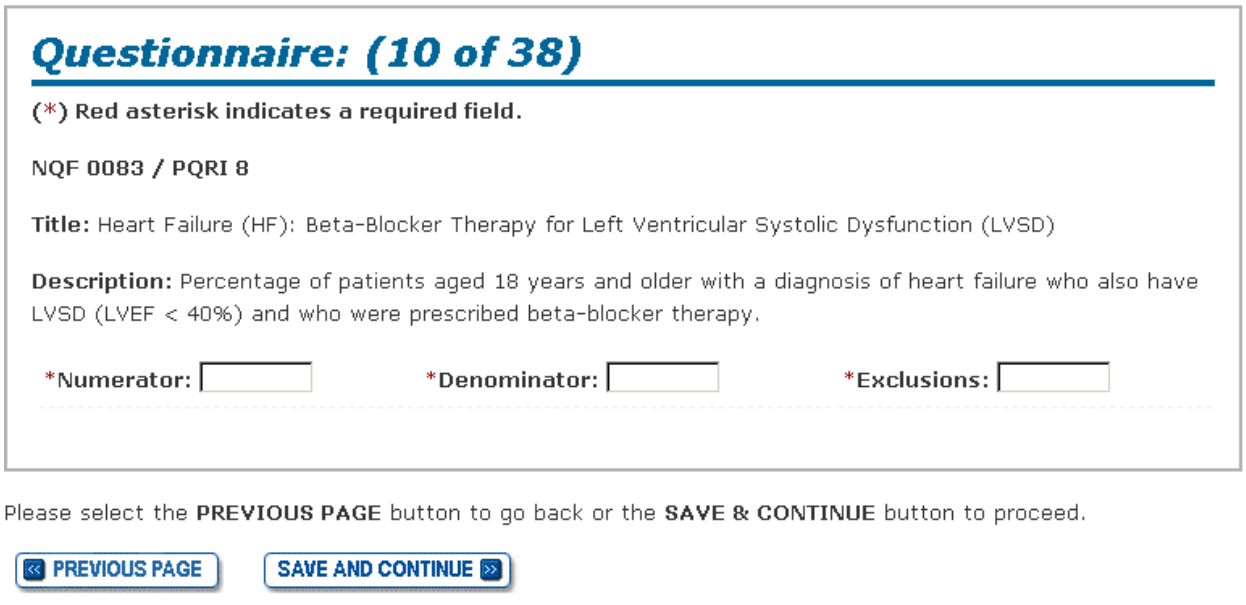
Clinical Quality Measure Question 7 – Breast Cancer Screening



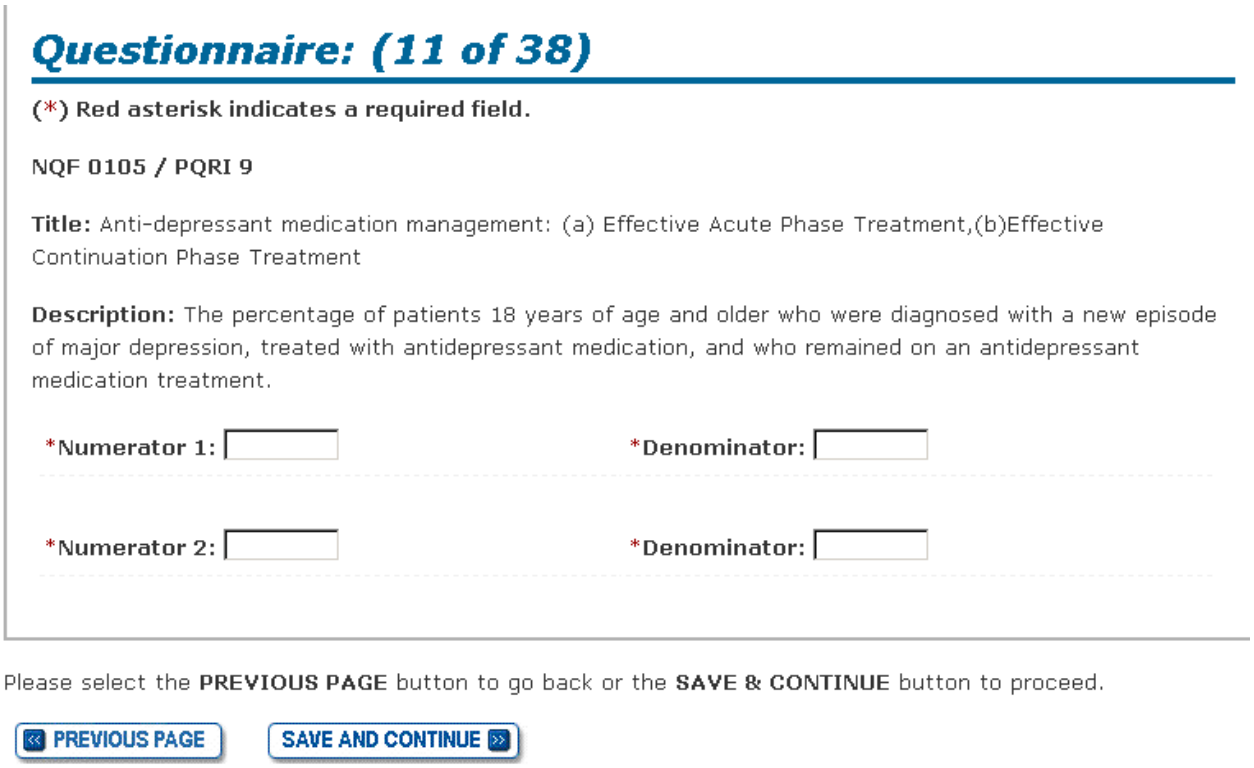
Clinical Quality Measure Question 8 – Colorectal Cancer Screening



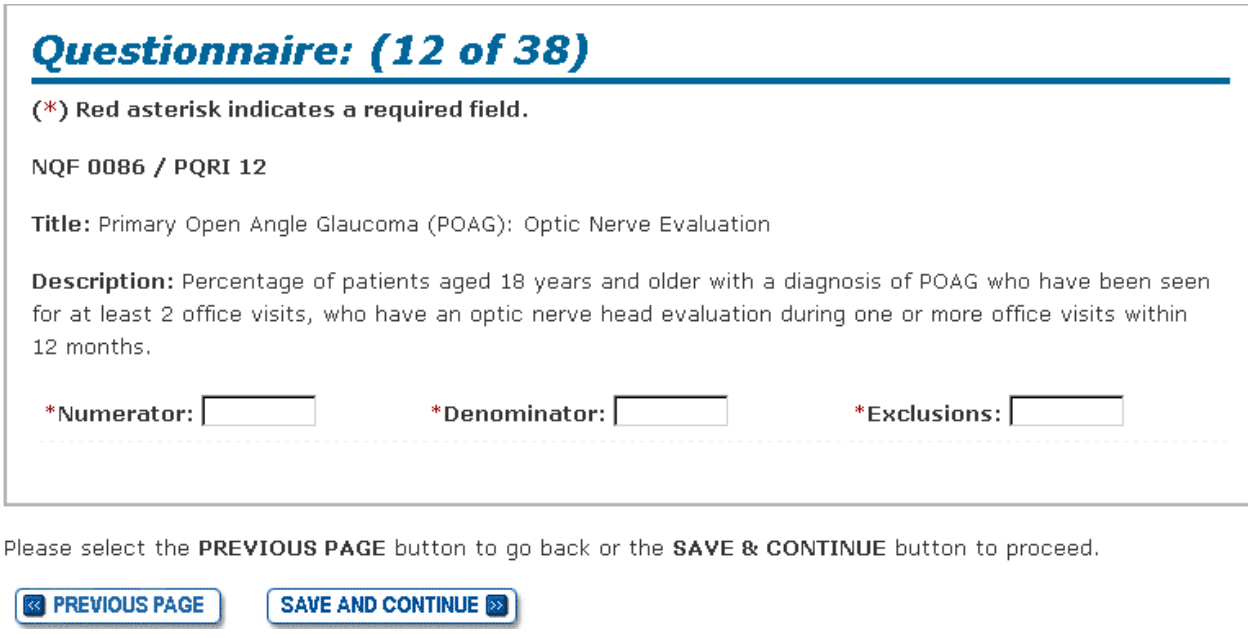
Clinical Quality Measure Question 9 – CAD: Oral Antiplatelet Therapy



Clinical Quality Measure Question 10 – HF: Beta-blocker Therapy for LVSD



Clinical Quality Measure Question 11 – Anti-depressant medication management



Clinical Quality Measure Question 12 – POAG: Optic Nerve Evaluation

Questionnaire: (13 of 38)

(*) Red asterisk indicates a required field.

NQF 0088 / PQRI 18

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.

*Numerator: *Denominator: *Exclusions:

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Clinical Quality Measure Question 13 – Diabetic Retinopathy: Documentation

Questionnaire: (14 of 38)

(*) Red asterisk indicates a required field.

NQF 0089 / PQRI 19

Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

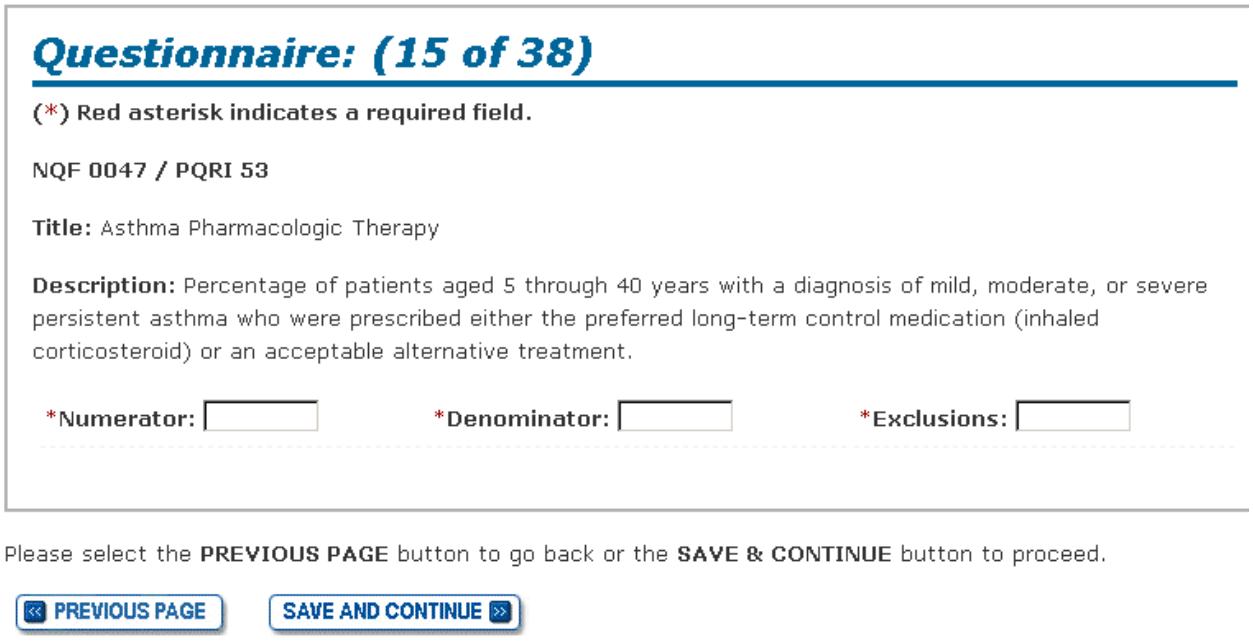
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

*Numerator: *Denominator: *Exclusions:

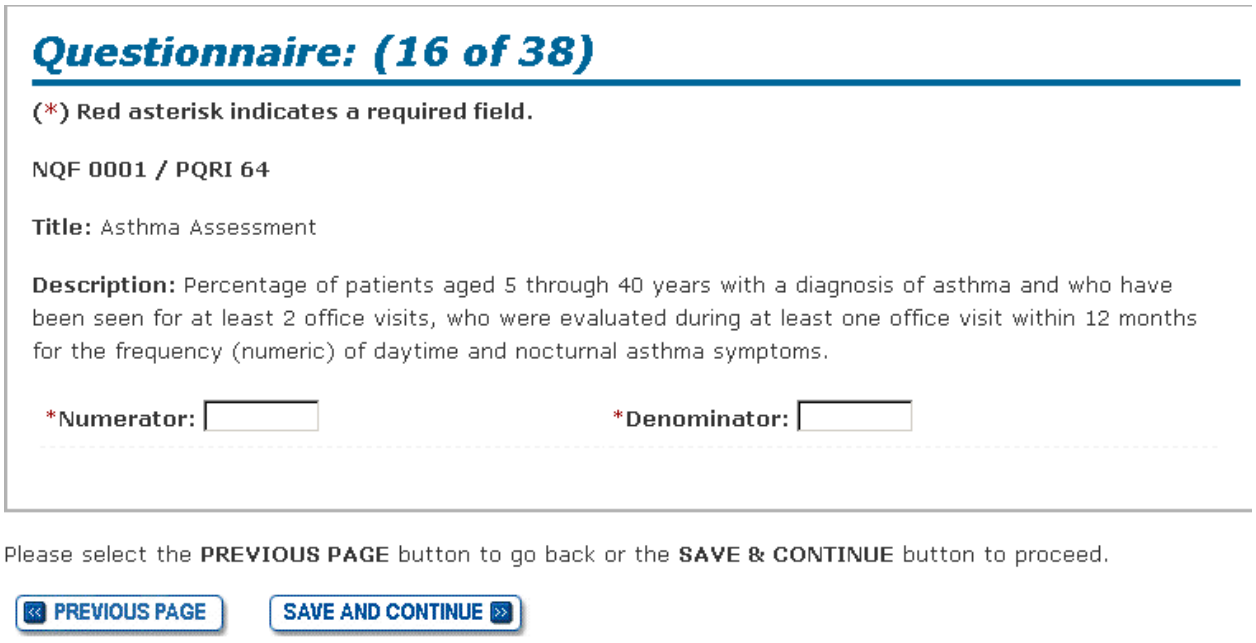
Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

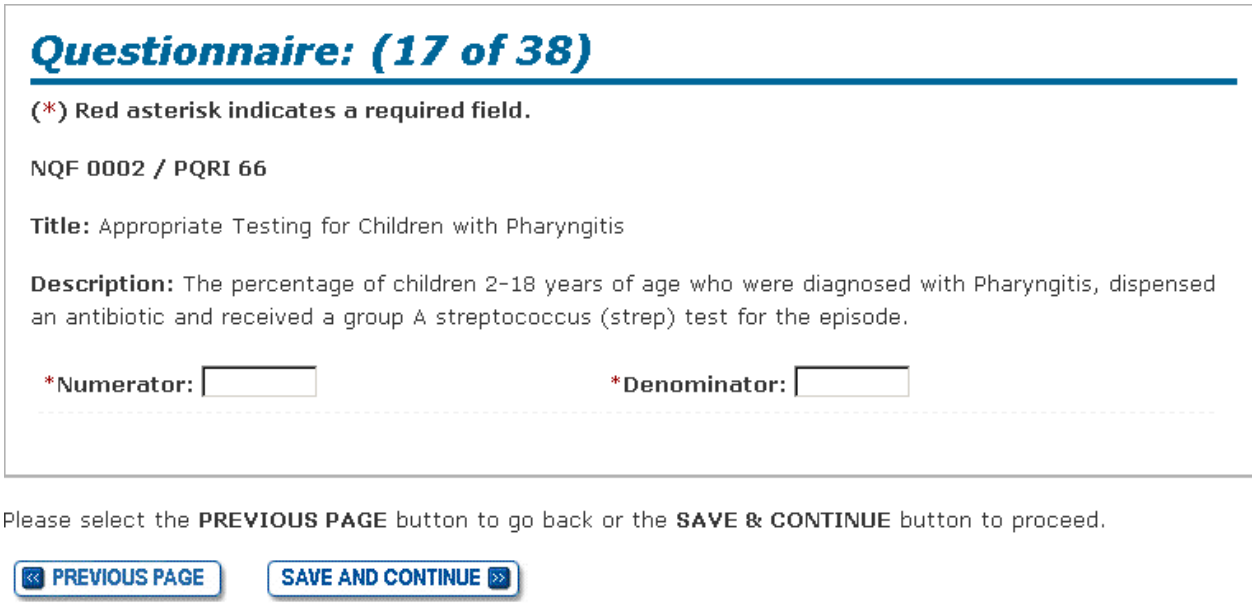
Clinical Quality Measure Question 14 – Diabetic Retinopathy: Communication



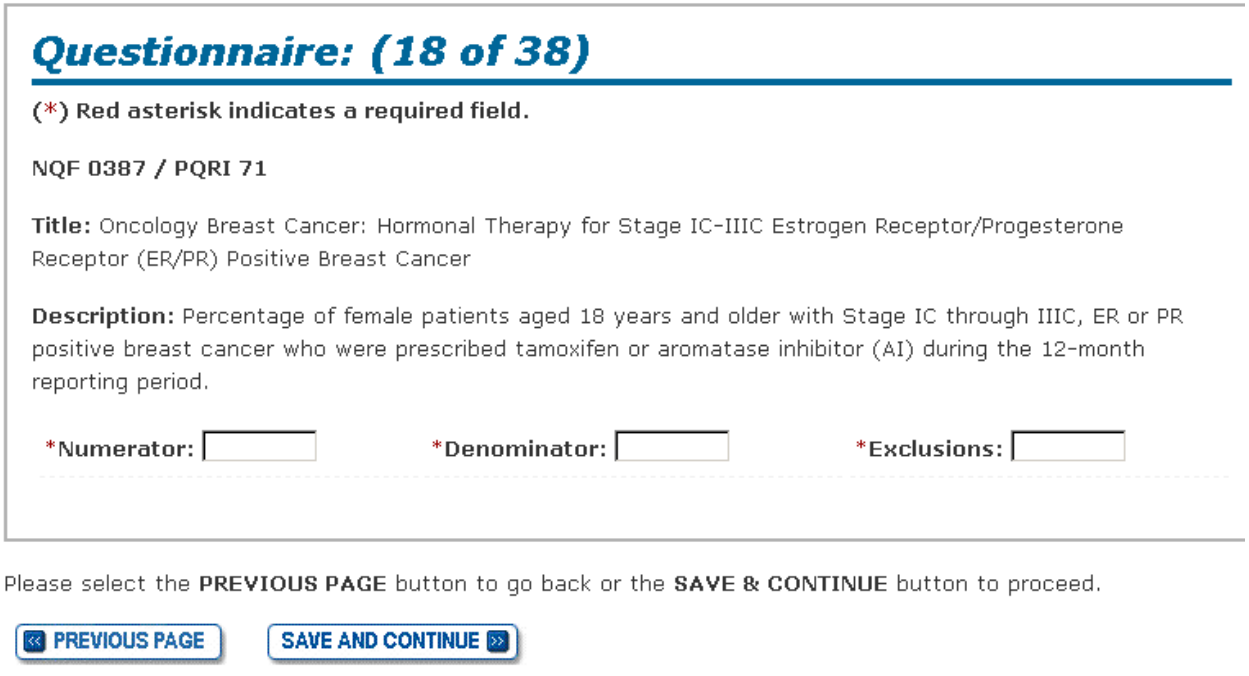
Clinical Quality Measure Question 15 – Asthma Pharmacologic Therapy



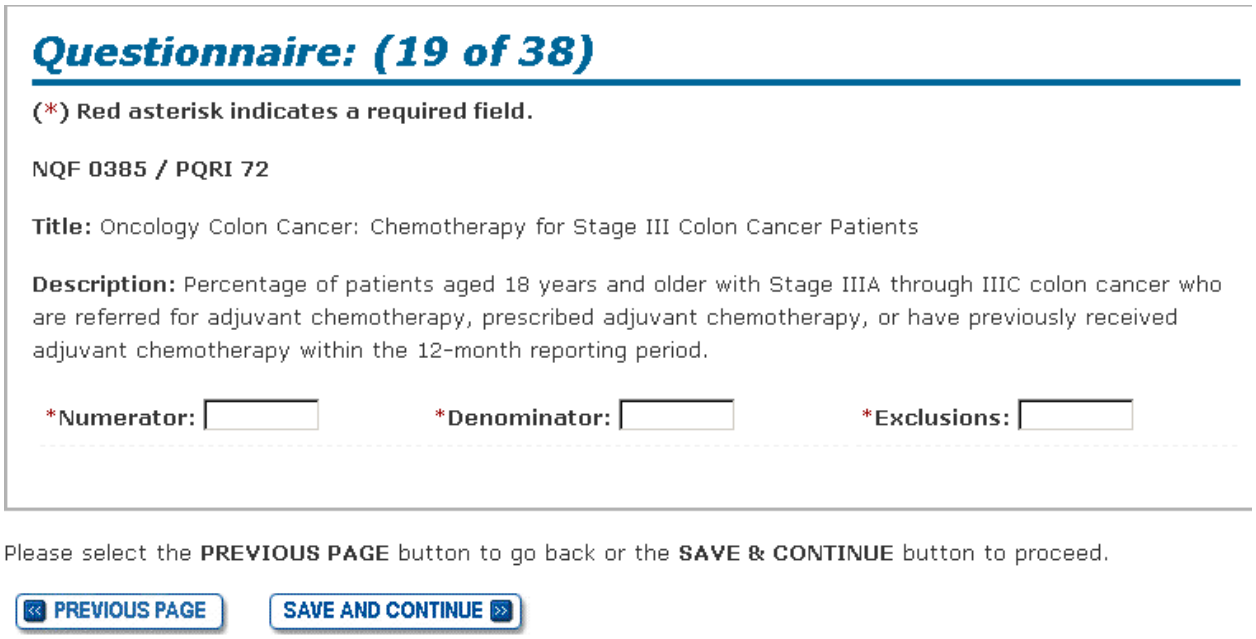
Clinical Quality Measure Question 16 – Asthma Assessment



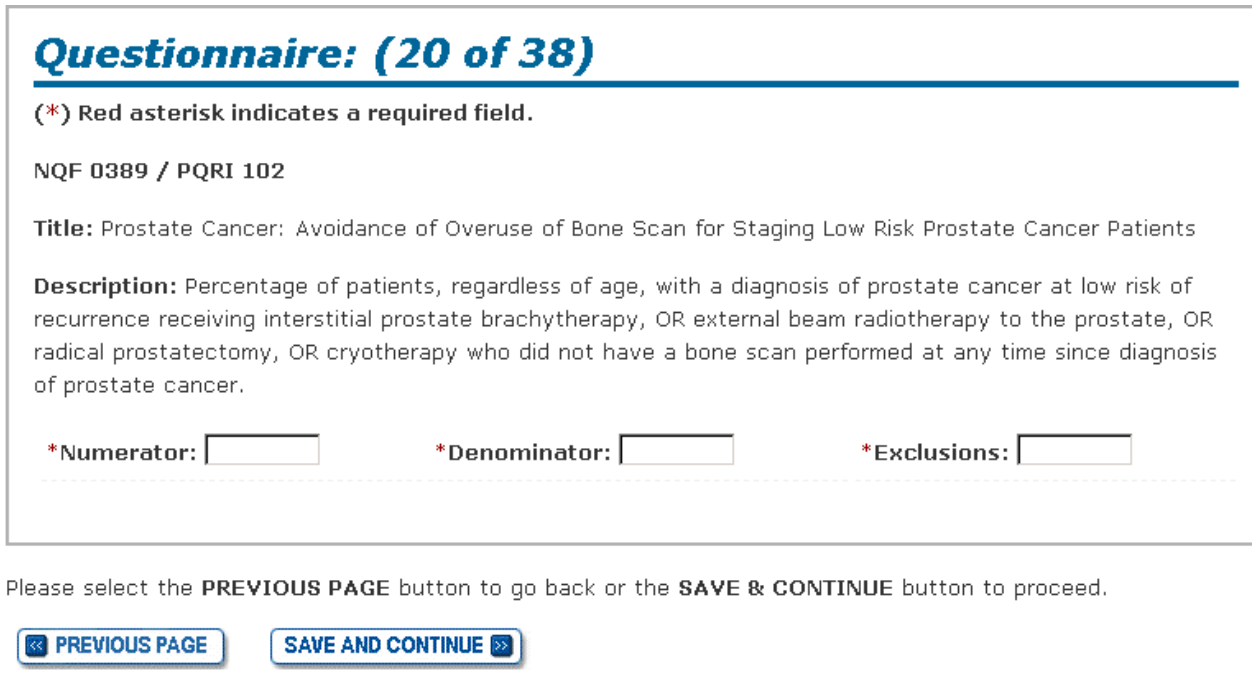
Clinical Quality Measure Question 17 – Appropriate Testing for Children for Pharyngitis



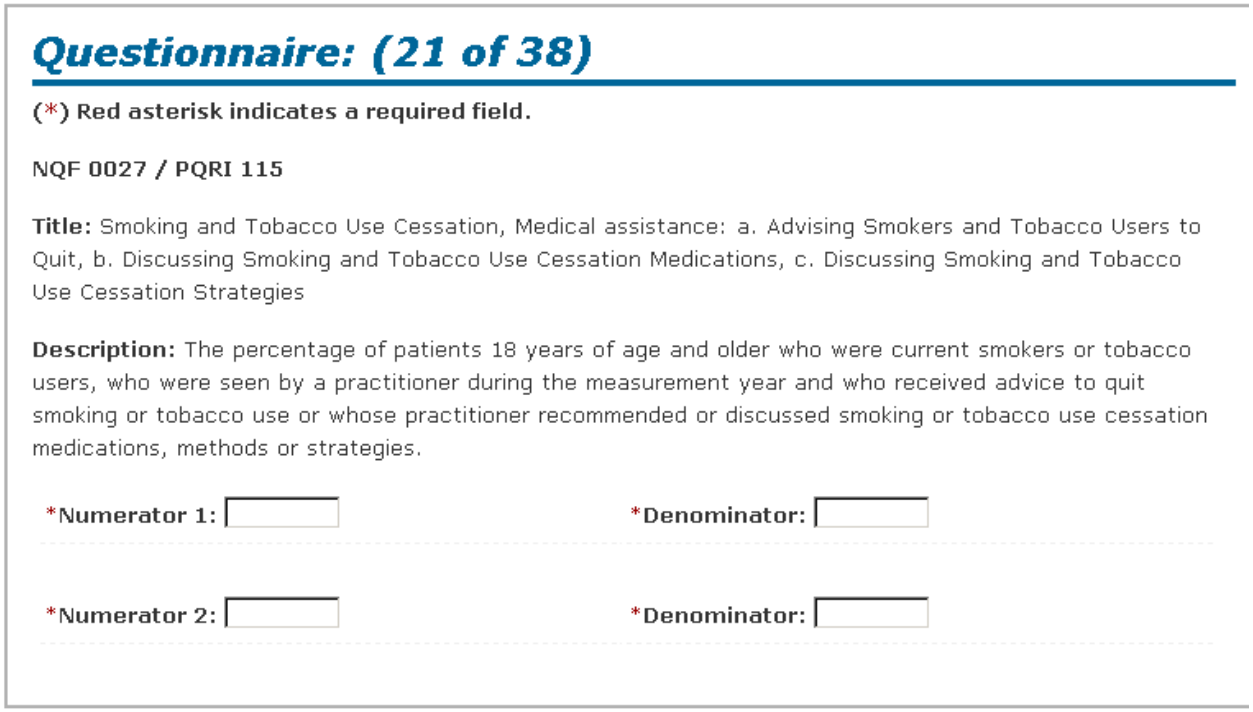
Clinical Quality Measure Question 18 – Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC



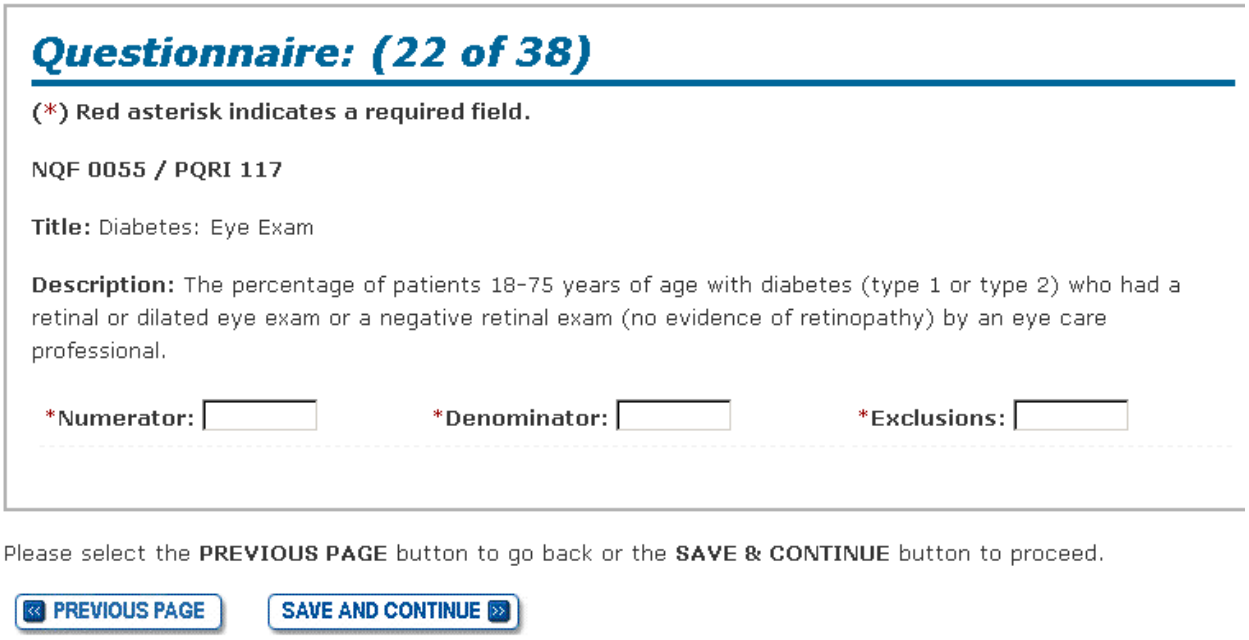
Clinical Quality Measure Question 19 – Oncology Colon Cancer: Chemotherapy for Stage III



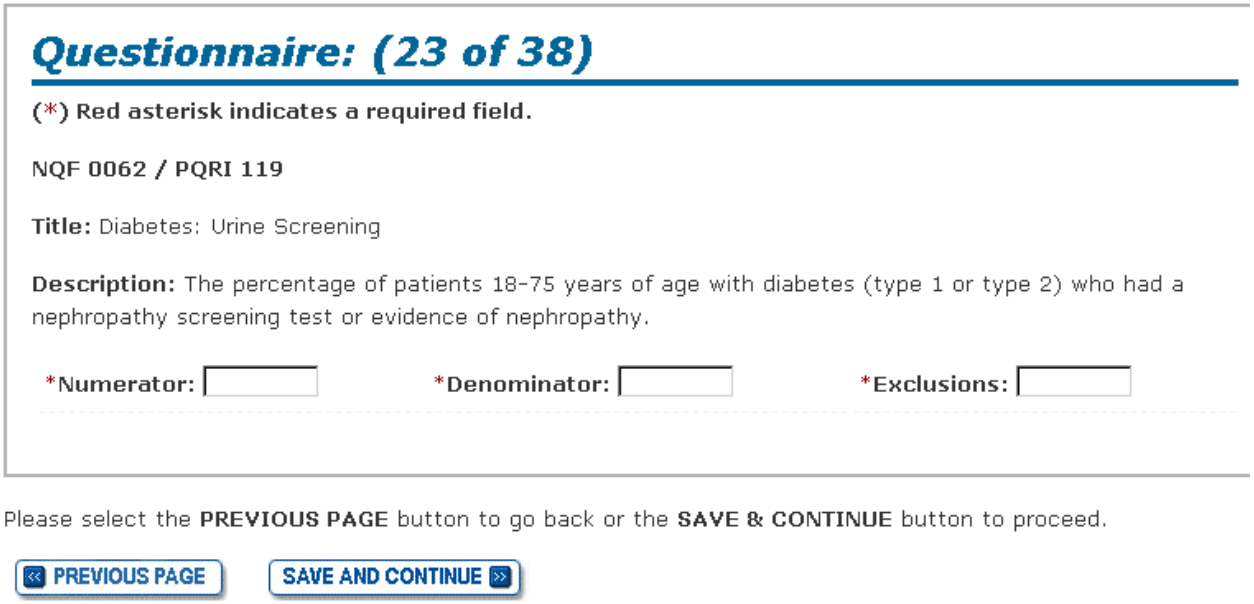
Clinical Quality Measure Question 20 – Prostate Cancer: Avoidance of Overuse of Bone Scan



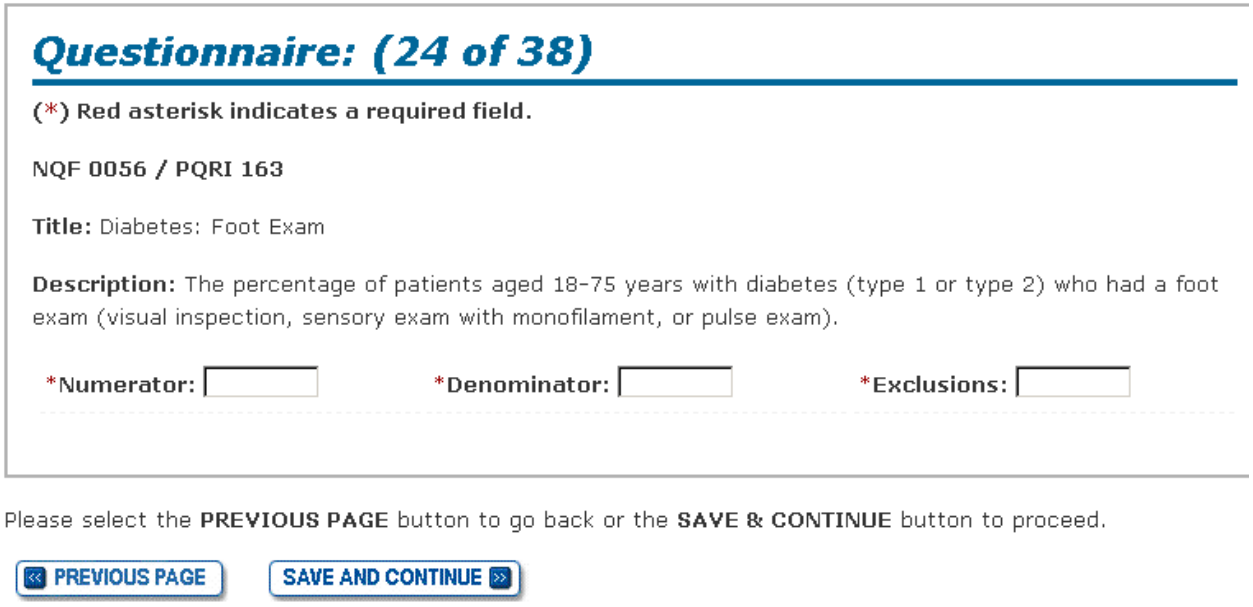
Clinical Quality Measures Question 21 – Smoking & Tobacco Use Cessation, Medical assistance



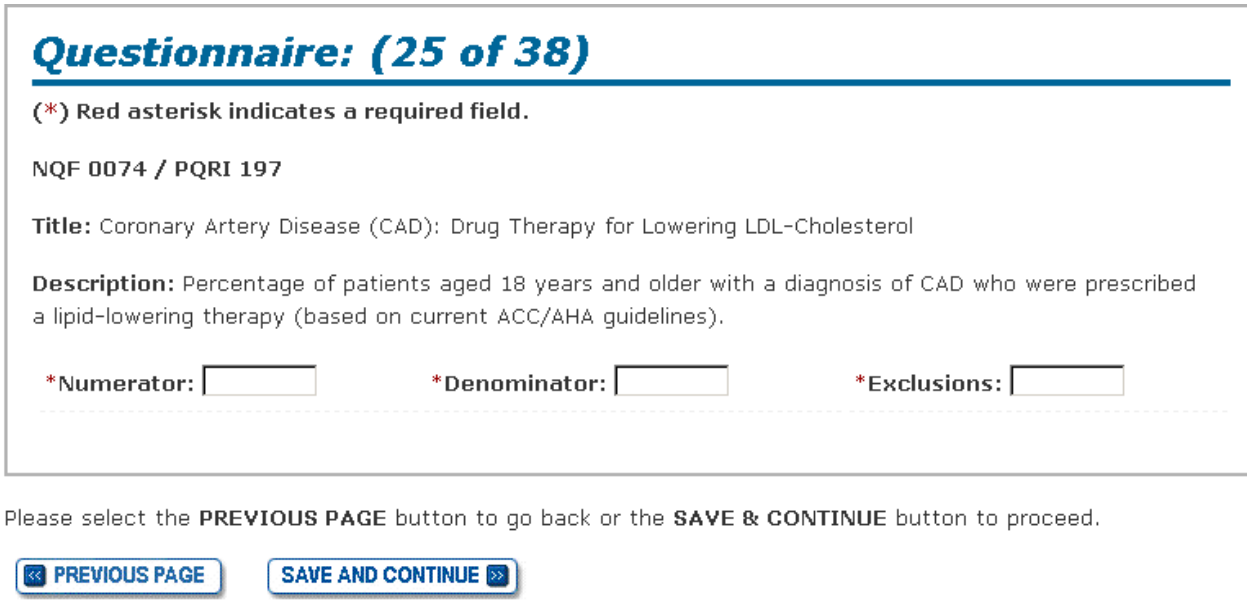
Clinical Quality Measures Question 22 – Diabetes: Eye Exam



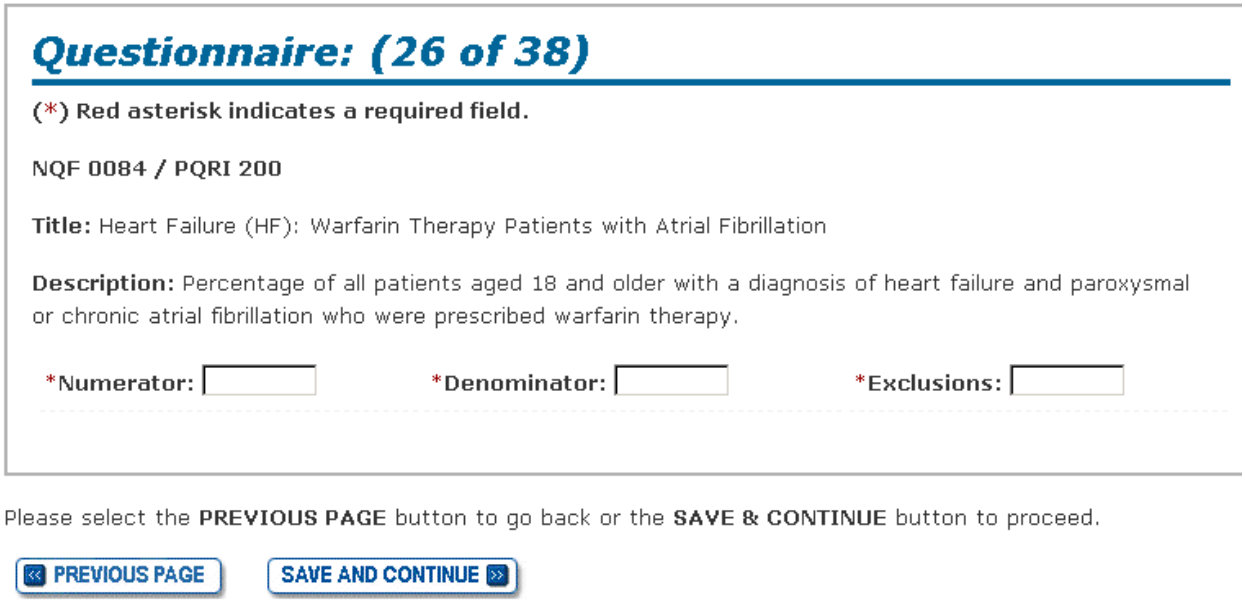
Clinical Quality Measure Question 23 – Diabetes: Urine Screening



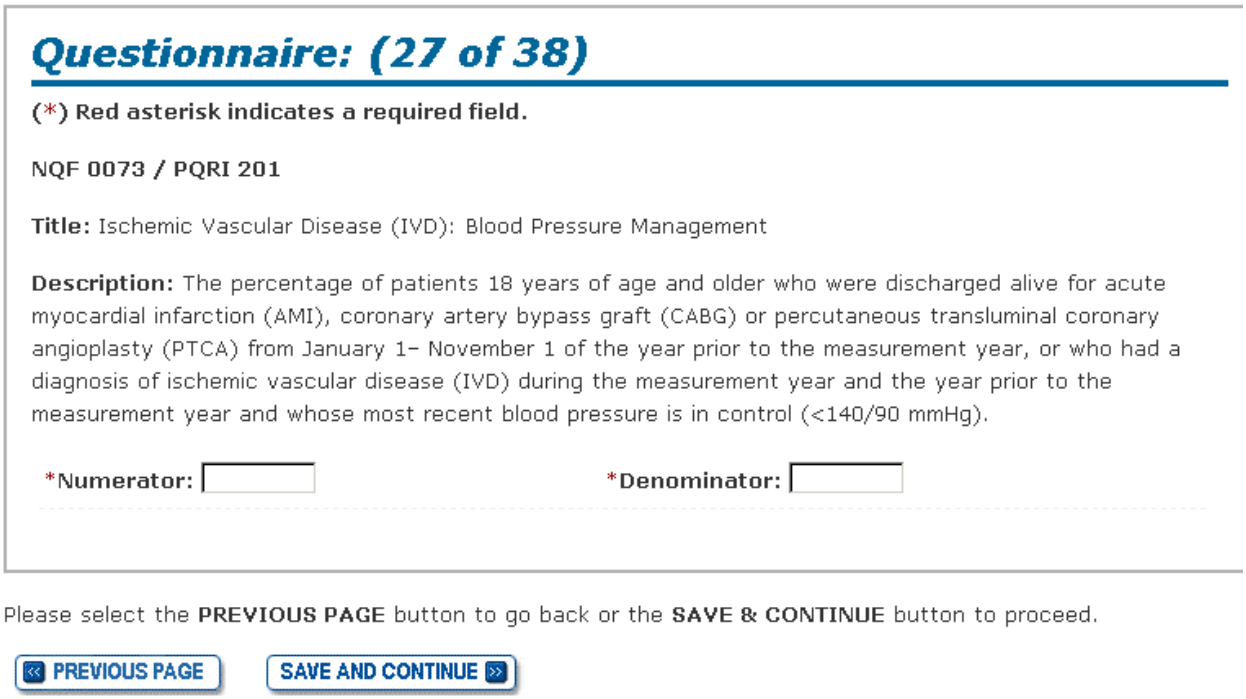
Clinical Quality Measure Question 24 – Diabetes: Foot Exam



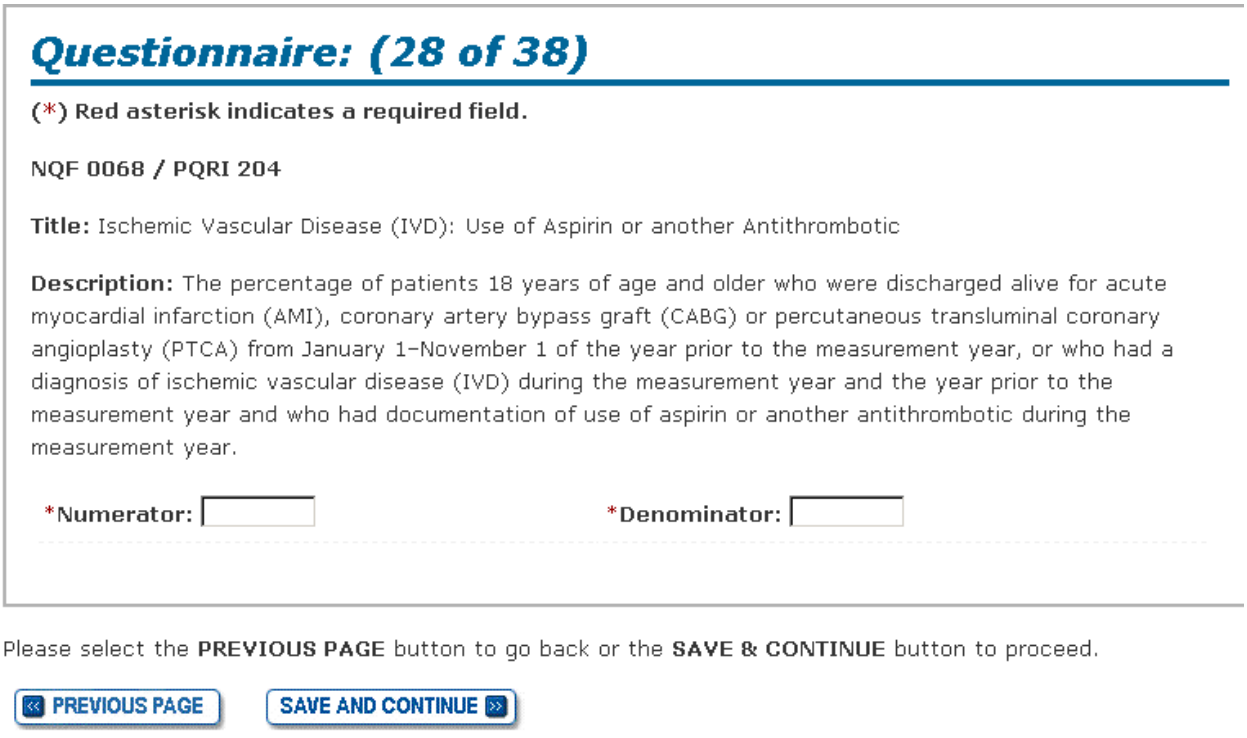
Clinical Quality Measure Question 25 – CAD: Drug Therapy for Lowering LDL-Cholesterol



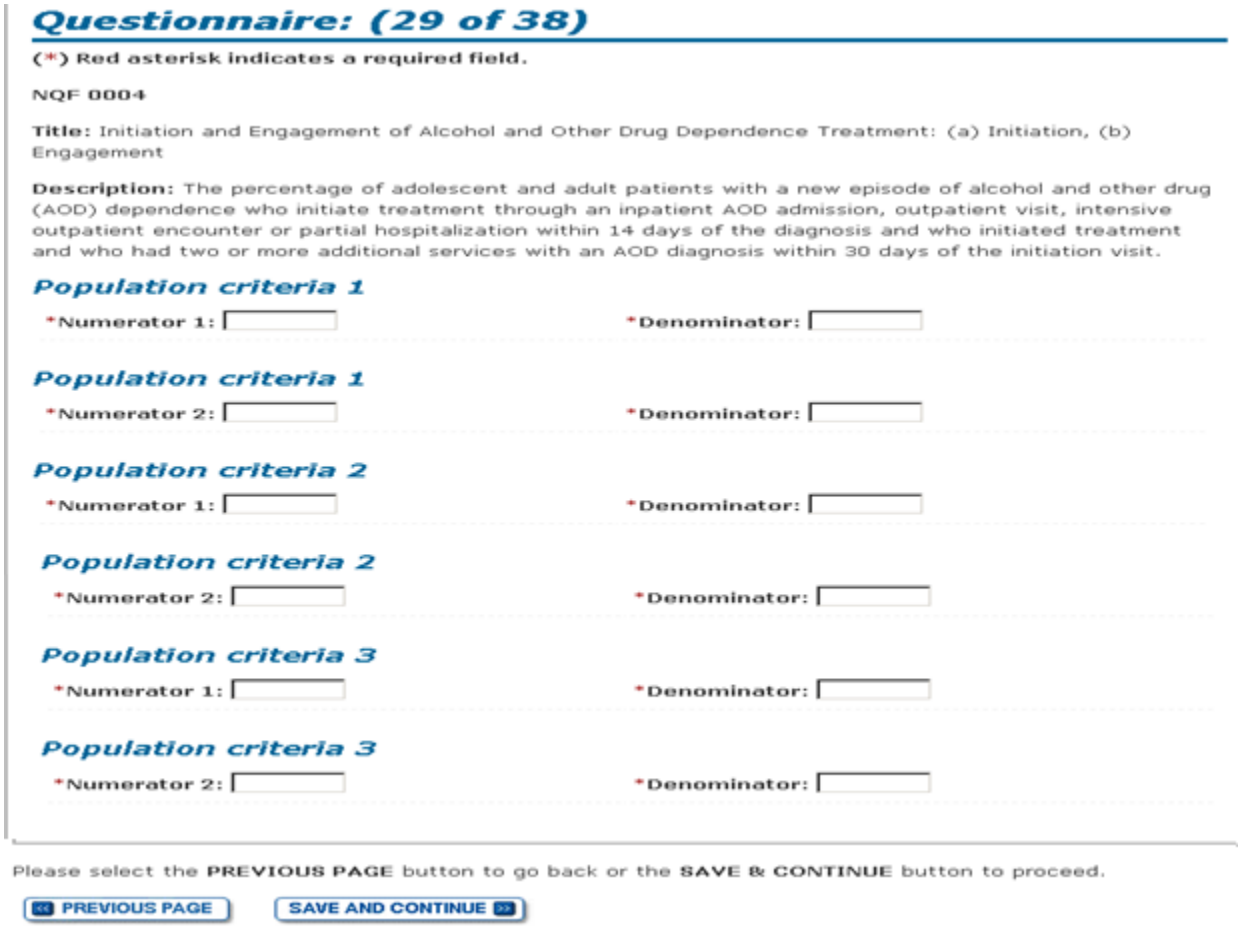
Clinical Quality Measure Question 26 – Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation



Clinical Quality Measure Question 27 – IVD: Blood Pressure Management



Clinical Quality Measure Question 28 – IVD: Use of Aspirin or another Antithrombotic



Questionnaire: (29 of 38)

(*) Red asterisk indicates a required field.

NQF 0004

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

Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Population criteria 1

*Numerator 1: *Denominator:

Population criteria 1

*Numerator 2: *Denominator:

Population criteria 2

*Numerator 1: *Denominator:

Population criteria 2

*Numerator 2: *Denominator:

Population criteria 3

*Numerator 1: *Denominator:

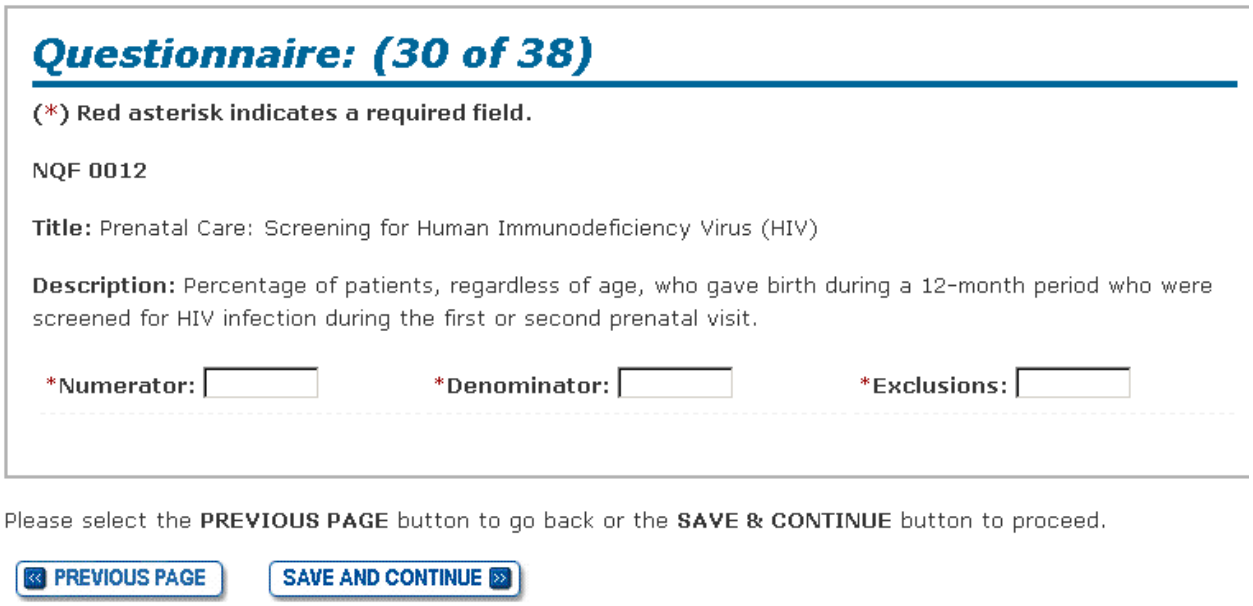
Population criteria 3

*Numerator 2: *Denominator:

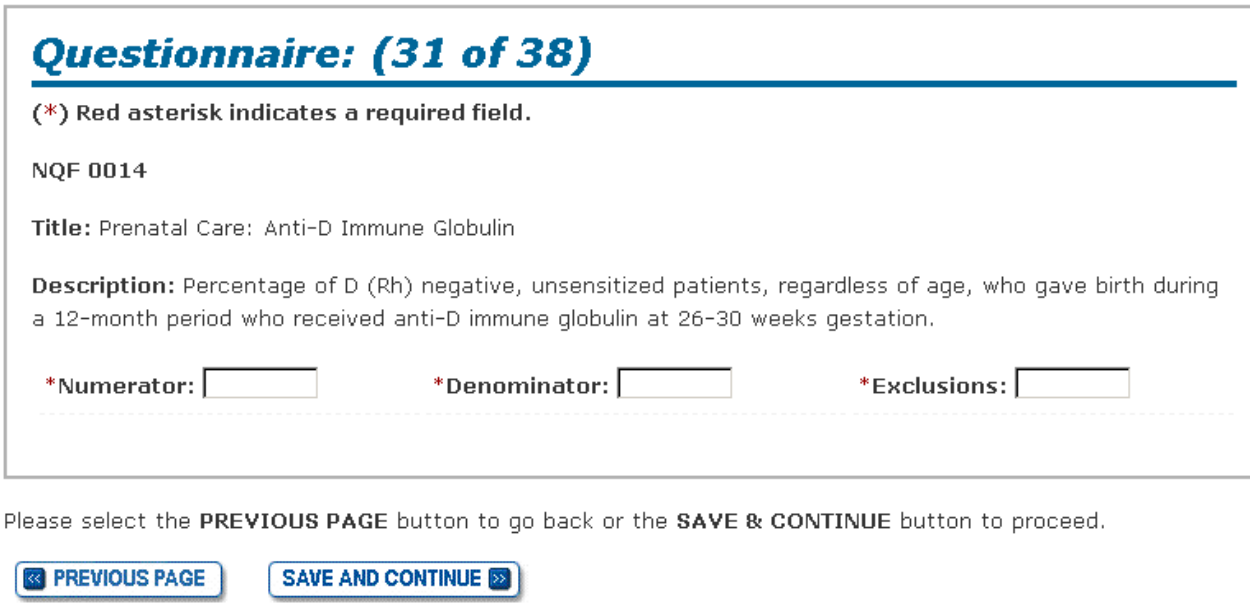
Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

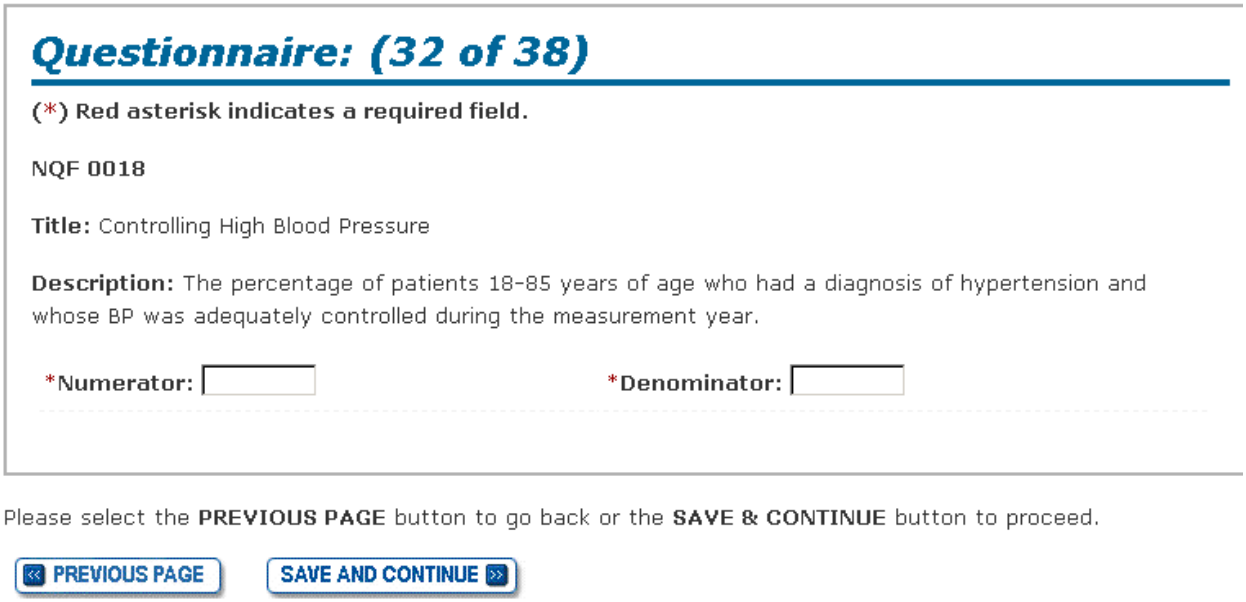
Clinical Quality Measure Question 29 – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment



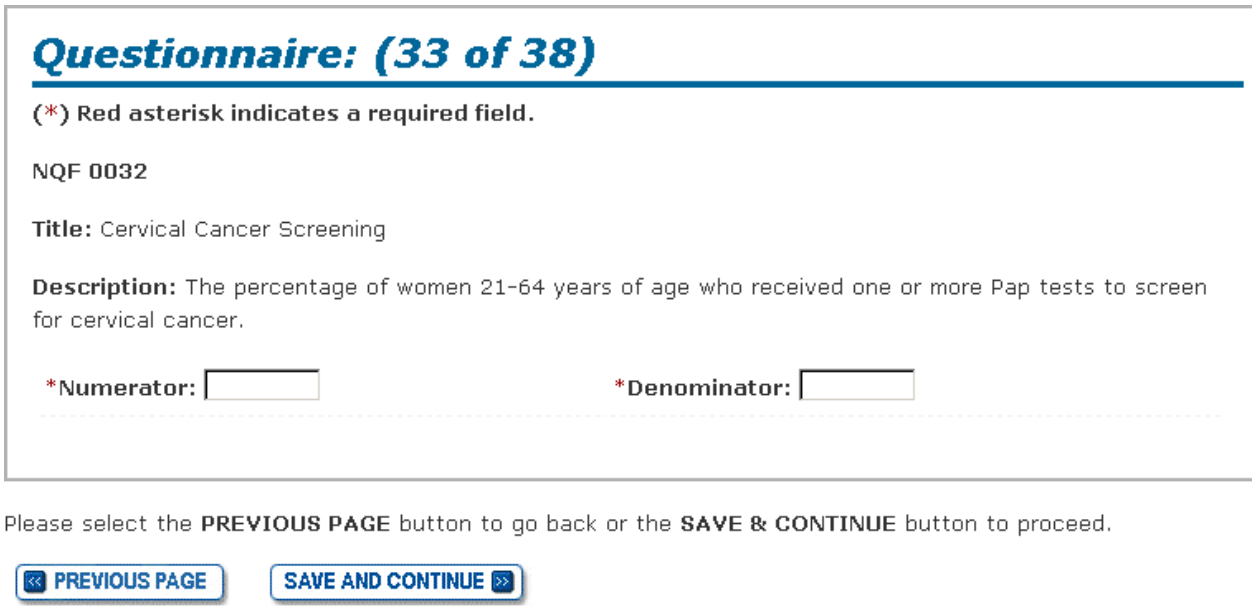
Clinical Quality Measure Question 30 – Prenatal Care: Screening for HIV



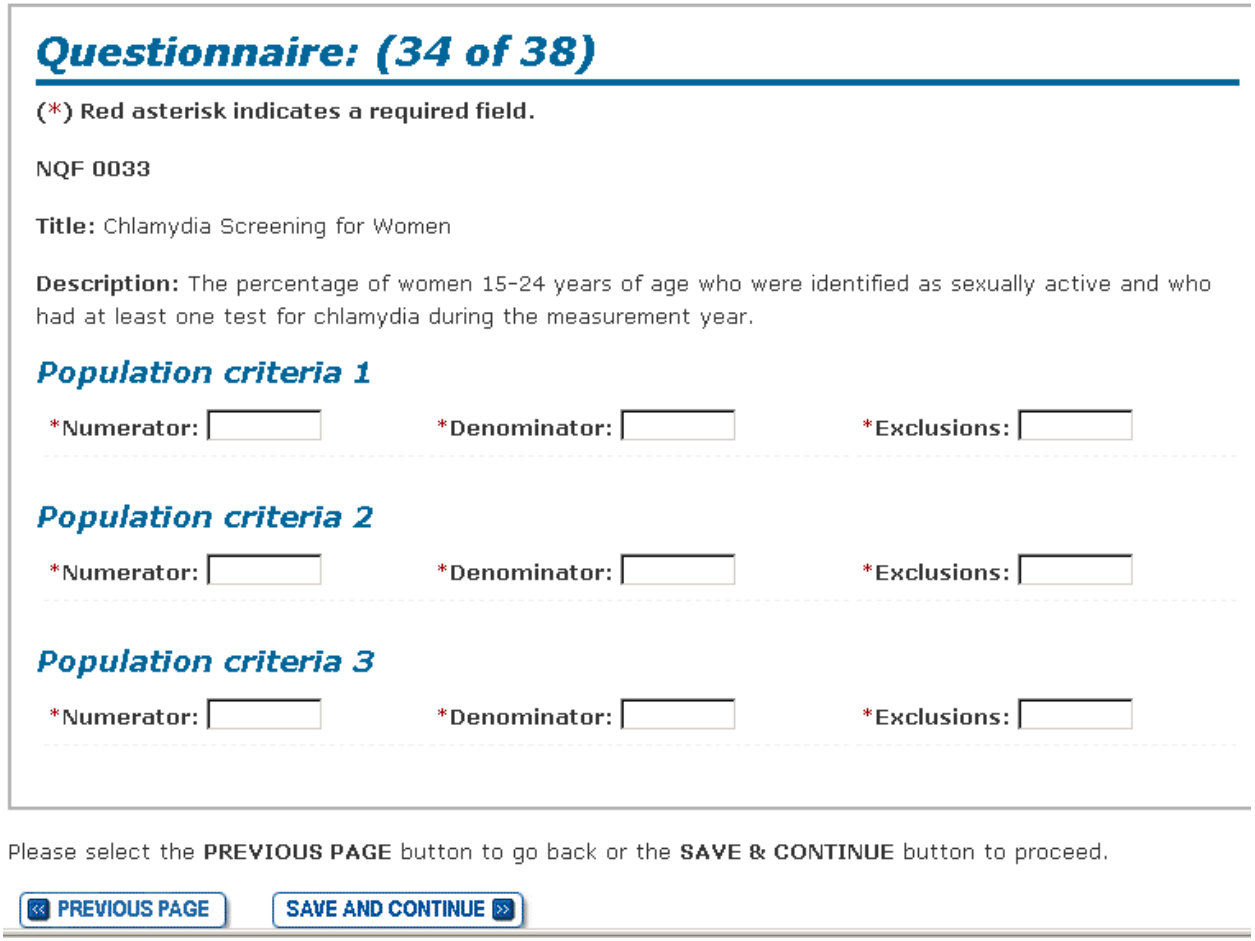
Clinical Quality Measure Question 31 – Prenatal Care: Anti-D Immune Globulin



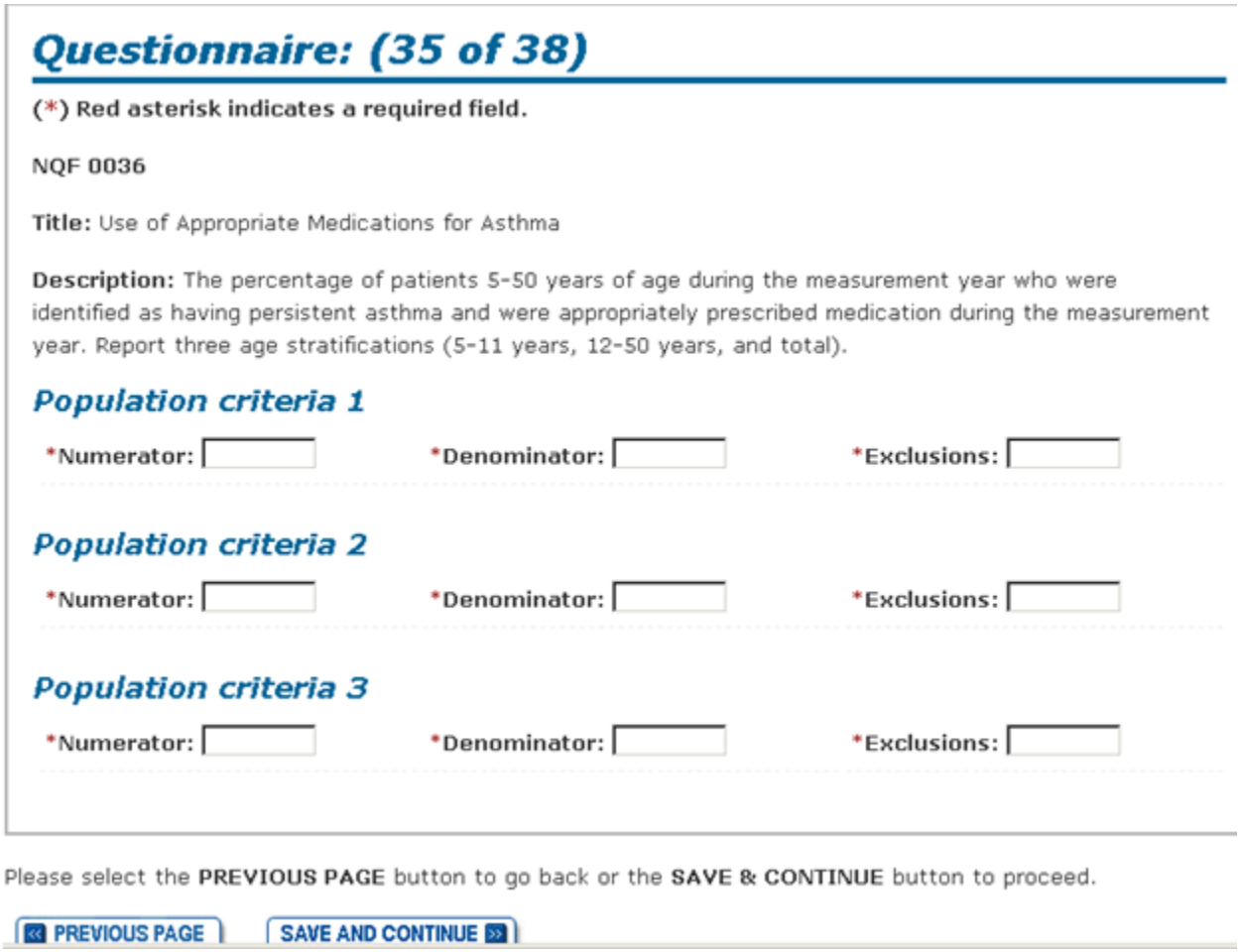
Clinical Quality Measure Question 32 – Controlling High Blood Pressure



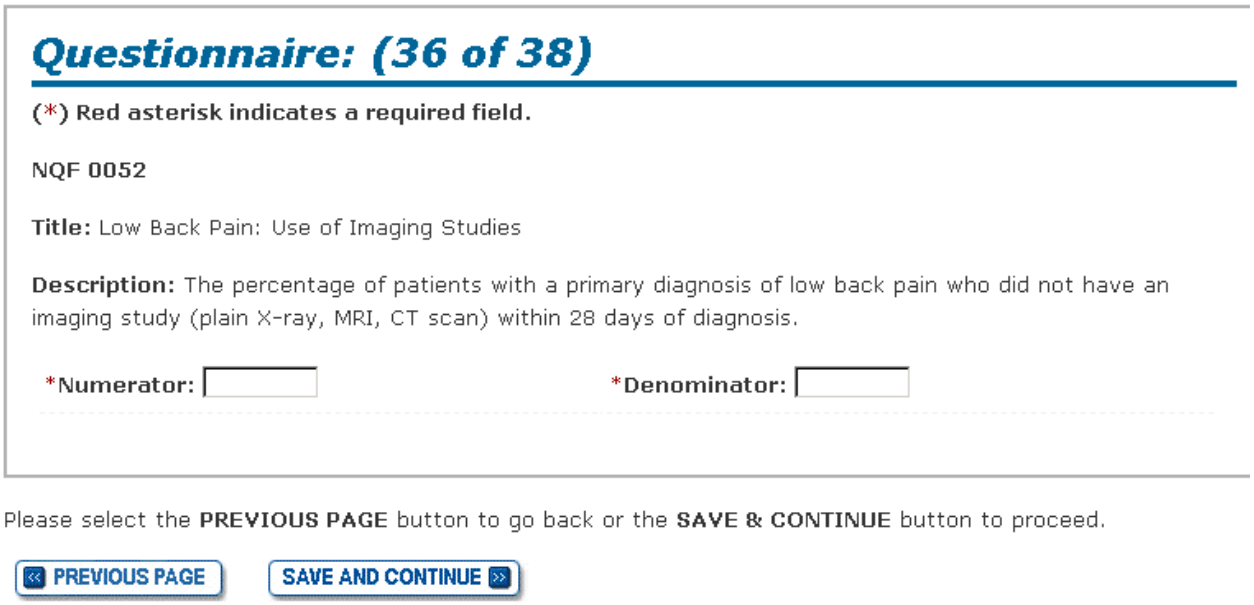
Clinical Quality Measure Question 33 – Cervical Cancer Screening



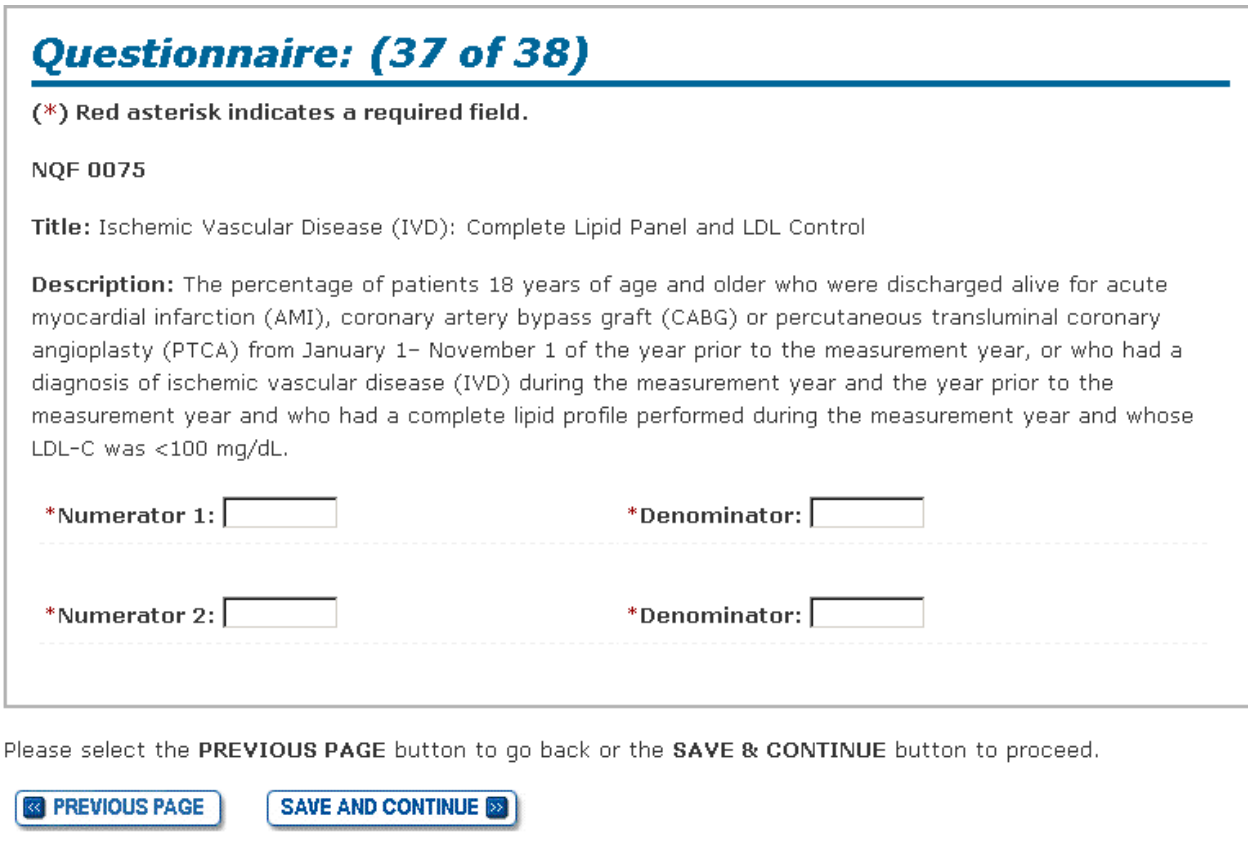
Clinical Quality Measure Question 34 – Chlamydia Screening for Women



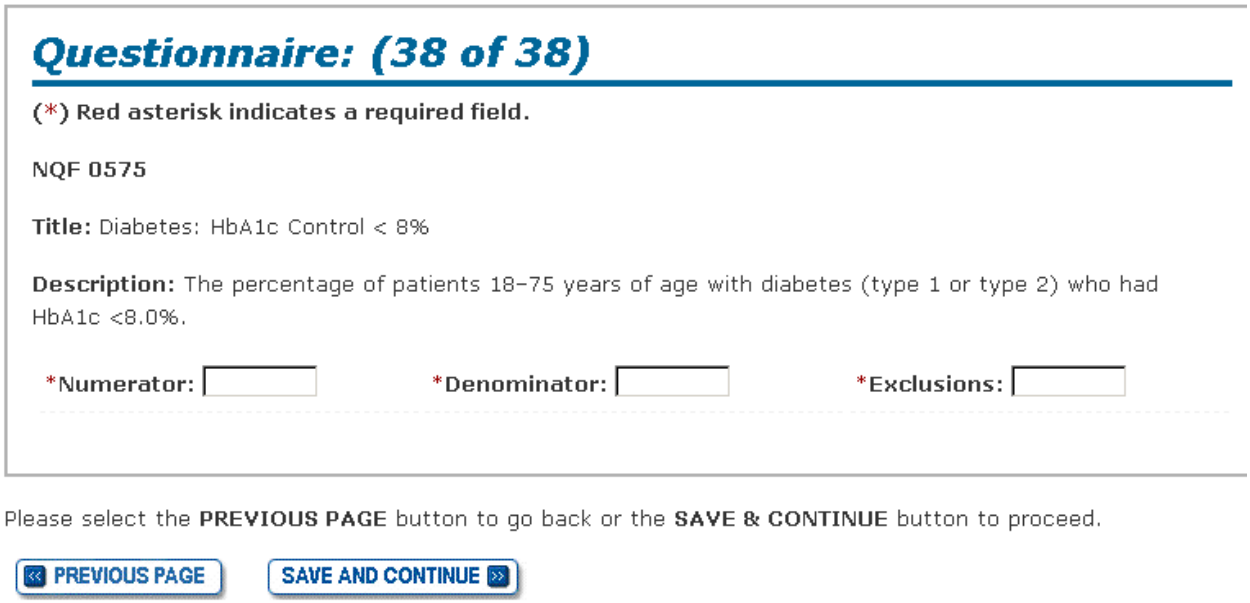
Clinical Quality Measure Question 35 – Use of Appropriate Medications for Asthma



Clinical Quality Measure Question 36 – Low Back Pain: Use of Imaging Studies



Clinical Quality Measure Question 37 – Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control



Clinical Quality Measure Question 38 – Diabetes: HbA1c Control < 8%