IDAHO MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM:
OBJECTIVES & CLINICAL QUALITY MEASURES (CQM)
FREQUENTLY ASKED QUESTIONS

Questions	Answers
What do the numerators and denominators mean in measures that are required to demonstrate meaningful use?	There are 13 measures for eligible professionals (EP) and 14 measures for eligible hospitals (EH) that require the collection of data to calculate a percentage to be used for determining if the Meaningful Use objective was met according to a minimum threshold for that objective. Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: 1. Where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using Certified EHR Technology. 2. Where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using Certified EHR Technology. This grouping is designed to reduce the burden on providers.
How should EPs select menu objectives for the Medicare and Medicaid EHR Incentive Programs?	All EPs participating in Stage 1 of the EHR Incentive Programs are required to report on a total of five meaningful use objectives from the menu set of 10. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. Idaho doesn't currently accept syndromic surveillance from EPs, so they must select the public health objective for immunizations. If an EP can be excluded from the public health menu objective, they should claim the exclusion and report on four additional menu objectives from outside the public health menu set. Each EP should select menu objectives that are relevant to their scope of practice and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice.

Questions	Answers
If an EP is unable to meet the measure of a Meaningful Use objective because it is outside the scope of the practice, will the EP be excluded from meeting the measure of that objective?	Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when CMS regulations specifically provide for an exclusion. An EP may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.
Do specialty providers have to meet all of the meaningful use or can they ignore the objectives that are not relevant to their scope of practice?	For EPs who participate in the Medicare and Medicaid EHR Incentive Programs, there are a total of 23 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 13 required core objectives. The remaining five objectives may be chosen from the list of 10 menu set objectives. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, they can claim that exclusion during attestation. However, if an exclusion is not provided, or if the EP does not meet the criteria for an existing exclusion, then they must meet the measure of the objective in order to successfully demonstrate meaningful use and receive an EHR incentive payment. Failure to meet the measure of an objective or to qualify for an exclusion for the objective, will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.
My practice does not typically collect information on any of the core, alternate core, and additional clinical quality measures (CQM) listed in the Final Rule on the Medicare and Medicaid EHR Incentive Programs. Do I need to report on CQMs for which I do not have any data?	Eligible professionals are not excluded from reporting CQMs, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. For the core measures, if the EP reports a zero for the core measure denominator, then they must report results for up to three alternate core measures (potentially reporting on all six core or alternate core measures). For the menu set measures, the Centers for Medicare and Medicaid Services (CMS) expects the EP to report on measures which do not have a denominator of zero. If none of the measures in the menu set applies to the EP, then they must report on three measures, reporting a denominator of zero, and then attest that the remainder of the menu set measures have a value of zero in the denominator.

Questions	Answers
	As CMS stated in the final rule (75 FR 44409-10): "The expectation is that the EHR will automatically report on each core clinical quality measure, and when one or more of the core measures has a denominator of zero then the alternate core measure(s) will be reported. If all six of the CQMs in Table 7 have zeros for the denominators (this would imply that the EPs patient population is not addressed by these measures), then the EP is still required to report on three additional clinical measures of their choosing from Table 6 in this final rule. In regard to the three additional CQMs, if the EP reports zero values, then for the remaining CQMs in Table 6 (other than the core and alternate core measures) the EP will have to attest that all of the other CQMs calculated by the certified EH Certified EHR Technology R technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional CQMs (other than the core and alternate core measures) in Table 6." *Note: in 2014, there are no longer Core, Alternate and Additional CQMs. CQMs have changed to 9 out of 65 CQMs that must come from 3 of the 6 domains.
If multiple EPs are using the same Certified EHR Technology across several physical locations, can a single test serve to meet the measures of these objectives?	No. If multiple EPs are using the same Certified EHR Technology in different physical locations/settings (e.g., different practice locations), there must be a single test performed for each physical location/setting. This is true even if the Certified EHR Technology that is used in the different physical locations is connected to the same server. The purpose of this testing is to demonstrate that the information can be transferred from where it was created (the physical location and setting of the EP or group of EPs) to another provider of care, patient-authorized entity, or public health agency. While we understand that several different physical locations and settings may send this information through a central server or on mostly the same path, there may be some degree of variation in the path of transmission or the infrastructure involved.
I am an EP for whom none of the core, alternate core, or additional CQMs adopted for the Medicare and Medicaid EHR incentive	In the event that none of the 44 CQMs apply to an EP's patient population, the EP is still required to report a zero for the denominators for all six of the core and alternate core CQMs. If all of the remaining 38 CQMs included in Table 6 of the final rule do not apply to the EP, then they are still required to report on

Questions	Answers
programs apply. Am I exempt from reporting on all CQMs?	at least three of the additional CQMs of their choosing from Table 6 of the final rule (other than the six core or alternative core measures). If the EP reports zero values for these three additional CQMs, then for the remaining CQMs, the they will also have to attest that all the other CQM's calculated by the Certified EHR Technology have a value of zero in the denominator. The EP is required to find at least three measures in the CQMs for which the denominator is other than zero. If they can't, then they must still choose three CQMs on which to report. The provider may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other CQMs calculated by the Certified EHR Technology have a value of zero in the denominator. A zero report in the menu set is not sufficient without such accompanying attestation. We refer readers to page 44410 of the preamble to the final rule. *Note: in 2014, there are no longer Core, Alternate and Additional CQMs. CQMs have changed to 9 out of 65 CQMs that must come from 3 of the 6 domains.
One of the measures for the core set of CQMs for EPs is not applicable for my patient population. Am I excluded from reporting that measure for the Medicaid EHR Incentive Programs?	An EP is not excluded from reporting core CQMs. However, zero is an acceptable value to report for the denominator of a CQM if there is no patient population within the EHR to whom that CQM applies. If an EP reports a zero denominator for one of the core measures, then the EP is required to report results for up to three alternate core measures (possibly reporting denominators of 0 for all three alternate core measures). *Note: in 2014, there are no longer Core, Alternate and Additional CQMs. CQMs have changed to 9 out of 65 CQMs that must come from 3 of the 6 domains.
If the denominators for all three of the core CQMs are zero, do I have to report on the additional CQMs for EPs?	If the denominator value for all three of the core CQMs is zero, an EP must report a zero denominator for all such core measures, and then must also report on all three alternate core CQMs. If the denominator values for all three alternate core CQMs is also zero, an EP still needs to report on three additional CQMs. Zero is an acceptable denominator, provided that this value was produced by Certified EHR Technology. *Note: in 2014, there are no longer Core, Alternate and Additional CQMs. CQMs have changed to 9 out of 65 CQMs that must come from 3 of the 6

Questions	Answers
	domains.
For EHs and CAHs, will the CQM results be calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program (formerly known as Reporting Hospital Quality Data for Annual Payment Update program)?	No. For all CQMs reported for the Medicare and Medicaid EHR Incentive Programs, the certified EHR must report the numerator, denominator, and exclusion results. Providers will report their aggregate results for CQMs during attestation to CMS or the states.
Can EPs use CQMs from the alternate core set to meet the requirement of reporting three additional objectives?	No. If EPs report data on all three CQMs from the core set, they would not report on any from the alternate core set. The three additional CQMs must come from Table 6 of the final rule (75 FR 44398-44408), excluding those CQMs included in either the core set or the alternate core set. *Note: in 2014, there are no longer Core, Alternate and Additional CQMs. CQMs have changed to 9 out of 65 CQMs that must come from 3 of the 6 domains.
Who do I contact to suggest adding or deleting a code on a clinical quality measure (CQM) or to suggest other CQM improvements?	Please contact the measure steward (the entity responsible for maintaining and updating a clinical quality measure) if you have suggestions or comments for improving the measure, comments regarding the measure's scientific, or medical soundness and applicability. You may also contact them if you would like to add specific vocabulary taxonomies or codes to the measure that may be appropriate for the measure population. The measure steward for each CQM is identified in the electronic specifications and in CMS's July 28, 2010, final rule (see 75 FR 44398-44420, Tables 6, 7, and 10).
Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) meaningful use objective and when must these medication orders be entered?	Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can enter the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order.
How should an EP who orders	The CPOE measure is structured to help minimize the reporting burden.

Questions	Answers
medications infrequently calculate the measure for the CPOE objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?	However, if all of the following conditions are met it can also create a unique situation that could prevent an EP from successfully demonstrating meaningful use. If any of the following apply, the EP may be unable to meet the reporting measure: • Prescribes more than 100 medications during the EHR reporting period • Maintains medication lists that include medications that they did not order • Orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period In these circumstances, an EP may be both unable to meet this measure and unable to qualify for the exclusion. In the unique situation where all three criteria listed above apply, an EP may limit their denominator to only those patients for whom the EP has previously ordered medication, if they so choose. EPs who do not meet the three criteria listed above must still base their calculation on the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period regardless of who ordered the medication or medications in the patient's medication list.
To meet the meaningful use objective "CPOE", should EPs include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure?	If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include those patients seen in locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the "use computerized provider order entry (CPOE)" objective.
How should EPs count CPOE measures that are subsequently recorded using the CPOE function of Certified EHR Technology by a licensed healthcare professional or certified medical assistant? **e.g. in perioperative settings and**	We agree that in some situations it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under their direct supervision. Therefore, in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant

Questions	Answers
emergent situations, medications and diagnostic studies are sometimes initiated by the provider without a formal order or an order is given by someone under direct supervision of the provider immediately following a verbal order and before any record of the order is created.	to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
What information must an EP provide in order to meet the measure of the meaningful use objective for "provide a clinical summary for patients for each office visit"?	In CMS' final rule "clinical summary" is defined as: an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to: • The patient name • Provider's office contact information • Date and location of visit • An updated medication list • Updated vitals • Reason(s) for visit • Procedures and other instructions based on clinical discussions that took place during the office visit • Any updates to a problem list immunizations or medications administered during visit • Summary of topics covered/considered during visit • Time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled • List of other appointments and tests that the patient needs to schedule with contact information • Recommended patient decision aids • Laboratory and other diagnostic test orders • Test/laboratory results (if received before 24 hours after visit), and symptoms

Questions	Answers
	The EP must include all of the above that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology can't populate all of the above fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)): • Problem List • Diagnostic Test Results • Medication List • Medication Allergy List This answer applies to clinical summaries generated by certified EHR technology for electronic or paper dissemination. Also, if one form of dissemination (paper or electronic) has a more limited set of fields than the other, this does not serve as a limit on the other form. For example, certified EHR technology may be capable of populating a clinical summary with a greater number of data elements when the clinical summary is provided to the patient electronically than when the clinical summary is printed on paper. When the clinical summary in this example is provided electronically, it should include all of the above elements that can be populated by the certified EHR technology. The clinical summary would not be limited by the data elements that are capable of being displayed on a paper printout.
For the meaningful use objective of "provide summary care record for each transition of care or referral", should transitions of care between EPs within the same practice who share certified EHR technology be included in the numerator or denominator of the measure?	No. Patients who transition between EPs within the same practice and who share the same certified EHR technology should not be included in the numerator or denominator of the measure of this objective. Since these transitions occur within the same practice between EPs who share certified EHR technology, they do not meet the definition of transition of care as the movement of a patient from one setting of care (e.g., hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility, etc.) to another. Also, because EPs sharing the same certified EHR technology already have complete access to the patient's electronic record, providing a summary of care document would serve no purpose. Therefore these patients should be excluded from the calculation of this measure.

Questions	Answers
For meaningful use objectives that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public health agencies, can the EP, EH or CAH conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives?	Yes. It is acceptable to conduct a test of information exchange from a test environment or test domain of certified EHR technology in order to satisfy the measures of the objective for "capability to exchange key clinical information" or any of the public health objectives (e.g., immunization registry, syndromic surveillance, or reportable lab results. However, it is important to note that in order to meet the objective for "capability to exchange key clinical information," the provider must conduct the test with another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information or transfers of information through means that do not reach another provider of care (e.g., "dummy" websites that exist solely for providers to send information) are not acceptable to satisfy this objective. Similarly, to meet any of the public health objectives, the provider's test must involve the actual submission of information to public health agencies, and follow up submission is required if the test is successful. Please note that some public health agencies will not allow providers to submit test information about fictional patients. Providers submitting information to public health agencies that do not allow test information must submit actual patient information as a test in order to satisfy the measures of these objectives. Note: The objective "capability to exchange key clinical information" was removed.
To meet the Stage 1 public health meaningful use objectives "submitting information to an immunization registry or reporting lab results to a public health agency" does a provider have to send information directly from their certified EHR technology to the appropriate receiving entity or can they use an intermediary such as a health information exchange (HIE) or	The CMS recognizes that there are a variety of methods in which the exchange of public health information could take place. In order to promote the submission of public health information to appropriate entities, CMS do not seek to limit or define the receiving capacities of said entities. In order to satisfy the public health meaningful use objectives, a provider must conduct one test of information exchange according to the following criteria: • The information required for the public health meaningful use objective must originate from the provider's certified EHR technology • The information sent from the provider's certified EHR technology must be formatted according to the standards and implementation

Questions	Answers
another third-party software vendor?	specifications associated with the public health meaningful use objective If an intermediary performs a capability specified in an adopted certification criterion and a provider intends to use the capability the intermediary provides to satisfy a correlated meaningful use requirement (submission to public health according to adopted standards), the capability provided by the intermediary would need to be certified as an EHR Module (see ONC FAQ 18 for more information).
Will the requirement that EPs and EHs choose at least one public health objective among the meaningful use measures still apply to those states that ask CMS for approval to change the definition of meaningful use? That is, if a state wants to require immunization reporting, is the provider still required to choose another public health objective or does the new meaningful use definition in that state supersede the general definition?	If the state requires any of the public health measures as core measures for the Medicaid EHR Incentive Program, then that would fulfill the EP requirement to select at least one public health measure. If the EP meets the exclusion criteria for any of the public health measures that a state has moved to the core set, with CMS approval, they would still have to select at least one public health measure from the menu set. Note: Immunization reporting has been moved from the menu objectives to the core objectives and will meet the requirement for public health reporting.
Can the drug-drug and drug-allergy interaction alerts of my EHR also be used to meet the meaningful use objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs?	No. The drug-drug and drug-allergy checks and the implementation of one clinical decision support rule are separate core meaningful use objectives. EPs and EHs must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks. CMS would not have listed these core requirements as separate measures, nor required that EPs and EHs meet all core objectives and measures listed in the regulation, had they intended for them to be met simultaneously.
To meet the Meaningful Use objective "maintain an up-to-	The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs do not specify the use of ICD-9 and SNOMED-CT® to meet the measure for

Questions	Answers
date problem list of current and active diagnoses" for the Medicare and Medicaid EHR Incentive Programs, are EPs, EHs, and CAHs required to use ICD-9 or SNOMED-CT®?	the Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses." However, ONC has adopted ICD-9 and SNOMED-CT® as a standard for the entry of structured data in certified EHR technology. Therefore, EPs, EHs, and CAHs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® in order to meet the measure for this objective.
For the meaningful use objective to "record and chart changes in vital signs" can an EP claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three?	An exclusion for this objective is provided only for EPs who either see no patients two years or older, or who believe that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. If an EP believes that one or two of these vital signs are relevant to their scope of practice, then they must record all three vital signs in order to meet the measure of this objective and successfully demonstrate meaningful use.
In recording height as part of the core Meaningful Use objective "Recording vital signs" for EPs, EHs, CAHs, how should providers account for patients who are too sick or otherwise cannot be measured safely?	In cases where taking an actual height measurement is inappropriate, self-reported or estimated height can be used.
What lab tests should be included in the denominator of the measure for the "incorporate clinical lab-test results" objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	For the "incorporate clinical lab-test results" objective, the denominator consists of the number of lab tests ordered during the EHR reporting period by the EP (or authorized providers of the EH or CAH for patients admitted to an EH's or CAH's inpatient or emergency department (POS 21 and 23) whose results are expressed in a positive or negative affirmation or as a number. Providers may limit the denominator to only those lab tests that were ordered during the EHR reporting period and for which results were received during the same EHR reporting period.
One of the menu set Meaningful Use objectives requires EPs, EHs	The only requirement to meet the measure of this objective is that more than 40 percent of all clinical lab tests results ordered during the EHR reporting are

Questions	Answers
and CAHs to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test in order to count a structured lab result in the numerator for the measure of this objective?	incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective in the Medicare and Medicaid EHR Incentive Programs.
For the "Incorporate clinical lab-test results" menu objective, how should a provider attest if the numerator displayed by their certified EHR technology is larger than the denominator?	A provider's certified EHR technology might return a numerator larger than the denominator if the EHR does not match lab orders to results on a one-for-one basis or if the EHR records a panel that returns multiple lab results as a single order within the system. However, the CMS EHR Incentive Programs Attestation System will not allow an EP, EH, or CAH to input a numerator that is greater than the denominator. In the case where your certified EHR technology reports a numerator larger than the denominator, you should input a numerator equal to your denominator in the Attestation System. However, notwithstanding the numerator and denominator values that are entered into the Attestation System, a provider must actually surpass the 40 percent threshold to meet the measure of this objective. You should maintain documentation regarding the numerator and denominator values generated by your certified EHR technology and, in the event of an audit, be prepared to demonstrate that you satisfied the percentage threshold for this measure.
To meet the meaningful use objective "use Certified EHR Technology to identify patient-specific resources and provide those resources to the patient" does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?	In the patient-specific education resources objective, education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

Questions	Answers
What information must an EP, EH or CAH provide in order to meet the measure of the meaningful use objective for "provide patients with an electronic copy of their health information"?	In CMS' final rule, they limited the information that must be provided electronically to that information that exists electronically in or accessible from the certified EHR technology and is maintained by or on behalf of the EP, EH or CAH. If the provider's certified EHR technology cannot provide all of the patient-requested information within the three business day timeline, a minimum level of information (defined in the certification process) should be provided. All EHR technology is certified for the purposes of this program (according to §170.304(f)) to provide: • Problem List • Diagnostic Test Results • Medication List • Medication Allergy List An EP, EH or CAH that provides these four elements within three business days of the patient request in the specified standards meets the measure associated with this objective.
To meet the meaningful use objective "provide patients with an electronic copy of their health information", how should the numerator and denominator be calculated for patients who see multiple EPs in the same practice (e.g., in a multi-specialty group practice)?	If the request for an electronic copy of their health information is made by a patient to a specific EP, then the patient should be counted in the numerator and denominator for that specific EP. If the patient makes a request for an electronic copy of their health information that is not to a specific EP (e.g., by request to the practice's administrative staff), then the patient should be counted in the numerators and denominators for all EPs with whom the patient has had an office visit.
For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)", how should the numerator and denominator be	The denominator for this objective consists of the number of prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, during the EHR reporting period. The numerator consists of the number of prescriptions in the denominator generated and transmitted electronically using certified EHR technology. In order to meet the

Questions	Answers
calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?	measure of this objective, more than 40 percent of all permissible prescriptions written by the EP must be generated and transmitted electronically. The EP would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," CMS considers the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
Do controlled substances qualify as "permissible prescriptions" for meeting the eRx meaningful use?	The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing for controlled substances in Schedule II-V. Any prescription not subject to these restrictions would be a permissible prescription.
In order to satisfy the Meaningful Use objective for eRx, can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy? Should these transactions be included in the numerator for the measure of this objective?	If the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to either a pharmacy or an intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator.
For the meaningful use objective of "record demographics" what documentation is required when recording the preliminary cause of death in the event of mortality?	All EHs and CAHs must record in the patient's EHR the clinical impression and preliminary assessment of the cause of death. No further documentation is required. This measure does not require the cause of death to be updated if the case is referred to the Department of Health or coroner's office.
For the CQMs ED-1, ED-2, and Stroke-4, how should EHs and	The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency

Questions	Answers
CAHs define an Emergency Department patient since the UB-04 data set referred to in the Healthcare Information Technology Standards Panel (HITSP) specifications no longer provides this information?	Department. See the data element specification (page 1-146) to be used for ED-1, ED-2, and Stroke-4.

Comment [Shannon T1]: Identify Acronym