Eligible Professional Meaningful Use Core Measures Measure 12 of 15

Stage 1

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Electronic Copy of Health Information	
Objective	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.
Measure	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.
Exclusion	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

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Definition of Terms

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
- EXCLUSION: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this

requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- When responding to patient requests for information, the EP should accommodate patient requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524, Access of individuals to protected health information. HIPAA contains requirements for providing patients copies of their health information.
- Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, this would include the elements listed in the ONC final rule at 45 CFR 170.304(f) for EPs and 45 CFR 170.306(d) for eligible hospitals and CAHs as required for EHR technology to become certified.
- An EP may withhold information from the electronic copy of a patient's health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.
- An EP should provide a patient with all of the health information they have available electronically, subject to withholding as described in the HIPAA Privacy Rule, as specified at in 45 CFR 164.524.
- Form and format should be human readable and comply with the HIPAA Privacy Rule, as specified at 45 CFR 164.524(c). The media could be any electronic form such as patient portal, PHR, CD, USB fob, etc. EPs are expected to make reasonable accommodations for patient preference as outlined in 45 CFR 164.522(b).
- The charging of fees for this information is governed by the HIPAA Privacy Rule at 45 CFR 164.524(c)(4) (which only permits HIPAA covered entities to charge an individual a reasonable, cost-based fee for a copy of the individual's health information).
- If provision of the copy involves the mailing of physical electronic media, then it would need to be mailed by at least the third business day following the request of the patient or their agents.
- Third-Party Requests: Only specific third-party requests for information are included in the denominator. Providing the copy to a family member or patient's authorized representative consistent with federal and state law may substitute for a disclosure of the information to the patient and count in the numerator. A request from the same would count in the denominator. All other third-party requests are not included in the numerator or the denominator.

Related Meaningful Use FAQs

To see the FAQs, click the New ID # hyperlinks below, or visit the CMS FAQ web page at https://questions.cms.gov/ and enter the New ID # into the Search Box, clicking the "FAQ #" option to view the answer to the FAQ. (Or you can enter the OLD # into the Search Box and click the "Text" option.)

- 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)? ***New ID #2935**, Old ID #10269*
- What information must an EP, eligible hospital 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"? ***New ID #3305**, Old ID #10663*
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? ***New ID #2813**, Old ID #10095*
- For EPs who see patients in both inpatient and outpatient settings, and where certified EHR technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings? ***New ID #2765**, Old ID #10068*
- If an EP is unable to meet the measure of a meaningful use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective? ***New ID #2883**, Old ID #10151*
- Should patient encounters in an ambulatory surgical center be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at practices/locations equipped with certified EHR technology? ***New ID #3065**, Old ID #10466*
- If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures? ***New ID #3077**, Old ID #10475*

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§170.304(f) Electronic copy of health information	Enable a user to create an electronic copy of a patient’s clinical information, including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in: (1) Human readable format; and (2) On electronic media or through some other electronic means in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: (A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); (B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and (C) Medications. The standard specified in §170.207(d).

§170.302(n) Automated measure calculation	For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

Standards Criteria	
Patient summary record	• §170.205(a)(1) - HL7 CDA Release 2, CCD. Implementation specifications: HITSP Summary Documents Using HL7 CCD Component HITSP/C32. • §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.
Problems	• §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. • §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version.
Laboratory test results	• §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.
Medication	• §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

Related Certification FAQs

Click on the green numbers to view the answer to the FAQ.

- The "electronic copy of health information" certification criteria (45 CFR 170.304(f) and 45 CFR 170.306(d)) each require that Certified EHR Technology "enable a user to create an electronic copy of a patient's clinical information… in: (1) Human readable format; and (2) On electronic media or through some other electronic means…." Is there more than one way to demonstrate compliance with these certification criteria? ***9-10-019-1***