

# Eligible Professional Core Measure Frequently Asked Questions

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## CPOE for Medication Orders

1. How should an EP who orders 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?

The CPOE measure is structured to minimize reporting burden. 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. An EP who:

- a. Prescribes more than 100 medications during the EHR reporting period;
- b. Maintains medication lists that include medications that they did not order; and
- c. 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 EPs 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.

2. Who can enter medication orders in order to meet the measure for the CPOE meaningful use objective? 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. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.

3. To meet the meaningful use objective for CPOE, should EPs include hospital-based observation patients 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.

4. Is the physician the only person who can enter information in the EHR in order to qualify for the EHR Incentive Programs?

No. The Final Rule for the Medicare and Medicaid EHR incentive programs, specifies that in order to meet the meaningful use objective for computerized provider order entry (CPOE) for medication orders, any licensed healthcare professional can enter orders into the medical record per state, local, and professional guidelines. The remaining meaningful use objectives do not specify any requirement for who must enter information.

5. What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? There are 15 measures for EPs and 14 measures for eligible hospitals that require the collection of data to calculate a percentage, which will be the basis 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: one 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; and a second group 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. Table 3 in the Medicare and Medicaid EHR Incentive programs final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation. To view the final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

6. 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? In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the clinic setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs.
7. 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? Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs 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.
8. 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? Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all Places of Service (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).
9. 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? Yes, an EP may include patients seen in locations without certified EHR technology in the numerators and denominators of meaningful use measures if the patients' information is entered into certified EHR technology at another practice location. However, EPs should be aware that it is unlikely that they will be able to include such patients in the numerator for the measure of the "use computerized provider order entry (CPOE)" objective or for the e-prescribing measure. As we explain in FAQ #10134, CPOE must be entered by someone who can 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. Because information for patients seen in locations without certified EHR technology will be transcribed at a later date into the certified EHR system, it is unlikely that CPOE could occur before any action is taken on the order. For the e-prescribing measure, it is unlikely that EPs will be able to electronically transmit prescriptions for patients in locations without certified EHR technology.

## Drug Interaction Checks

1. 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 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 eligible hospitals must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks. We would not have listed these core requirements as separate measures, nor required that EPs and hospitals meet all core objectives and measures listed in the regulation, had we intended for them to be met simultaneously.

## Maintain Problem List

1. To meet the meaningful use objective "maintain an up-to-date problem list of current and active diagnoses," are EPs, eligible hospitals, and CAHs required to use ICD-9 or SNOMED-CT®?  
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 the Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses." However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 and SNOMED-CT® as a standard for the entry of structured data in certified EHR technology. Therefore, EPs, eligible hospitals, 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.
2. How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?  
All cases where the EP and the patient have an actual physical encounter with the patient in which they render any service to the patient should be included in the denominator as seen by the EP. Also a patient seen through telemedicine would still count as a patient "seen by the EP." However, in cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures. For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all meaningful use measures that include patients "seen by the EP." EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies as least some of the services they render for patients as "seen by the EP" and this policy must be consistent for the entire EHR reporting period and across meaningful use measures that involve patients "seen by the EP" -- otherwise, these EPs would not be able to satisfy meaningful use, as they would have denominators of zero for some measures.
3. When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?  
The EP can include or not include those patients in their denominator at their discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (NPs and certain physician assistants (PA)), patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

## e-Prescribing (eRx)

1. Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing meaningful use objective?

The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing (eRx) for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at [http://www.deadiversion.usdoj.gov/schedules/orangebook/e\\_cs\\_sched.pdf](http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf)). Any prescription not subject to these restrictions would be a permissible prescription. Although DOJ recently published an Interim Final Rule that allows the electronic prescribing of these substances, we were unable to incorporate these recent guidelines into the Medicare and Medicaid EHR Incentive Programs. Therefore, the determination of whether a prescription is a "permissible prescription" for purposes of the eRx meaningful use objective should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010, when the notice of proposed rulemaking was published in the Federal Register.

2. In order to satisfy the meaningful use objective for electronic prescribing, 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?

The meaningful use measure for e-prescribing is the electronic transmission of 40 percent of all permissible prescriptions. 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.

3. For the meaningful use objective of "generate and transmit prescriptions electronically," how should the numerator and denominator be calculated?

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 measure of this objective, 40 percent of all permissible prescriptions written by the EP must be generated and transmitted electronically according to the applicable certification criteria and associated standards adopted for certified EHR technology as specified by the Office of the National Coordinator for Health IT (ONC).

ONC has released an FAQ stating that "with respect to the capability a Complete EHR or EHR Module must demonstrate in order to be certified to the certification criterion adopted at 170.304(b), a Complete EHR or EHR Module must be capable of electronically transmitting prescriptions to external recipients according to NCPDP SCRIPT 8.1 or 10.6 in addition to the adopted vocabulary standard for medications (45 CFR 170.207(d))." Given such FAQ, prescriptions transmitted electronically within an organization (the same legal entity) would not need to use these NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology.

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," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/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.

## Record Vital Signs 2011

1. 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 2 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.

2. In recording height as part of the core meaningful use objective "Recording vital signs" for EPs, eligible hospitals, and 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.

## Clinical Quality Measures (CQMs)

1. 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?

An eligible professional (EP) is not excluded from reporting core clinical quality measures. However, zero is an acceptable value to report for the denominator of a clinical quality measure if there is no patient population within the EHR to whom that clinical quality measure 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). We refer readers to pp. 44409-10 of the preamble to our final rule for our discussion of this issue.

2. Can I use the electronic specifications for CQMs to satisfy both the PQRS and the EHR Incentive Programs? No. Each program has specific specifications for reporting. In the future CMS expects to harmonize specifications between PQRS (formerly known as the Physician Quality Reporting Initiative, or PQRI) and the Medicare and Medicaid EHR Incentive Programs. Therefore if a provider is reporting under the PQRI EHR program, they must refer to the PQRS EHR specifications found at [http://www.cms.gov/PQRI/20\\_AlternativeReportingMechanisms.asp](http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp). Providers are required to report using the specifications for clinical quality measures found at [http://www.cms.gov/QualityMeasures/03\\_ElectronicSpecifications.asp#TopOfPage](http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage).

3. I am an EP for whom none of the core, alternate core, or additional CQMs adopted for the EHR Incentive Programs apply. Am I exempt from reporting on all CQMs? In the event that none of the 44 clinical quality measures applies 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 clinical quality measures. If all of the remaining 44 clinical quality measures included in Table 6 of our final rule do not apply to the EP, then the EP is still required to report on at least three of the additional clinical quality measures of their choosing from Table 6 of the final rule (other than the six core/alternative core measures). If the EP reports zero values for these three additional, menu-set clinical quality measures, then for the remaining menu-set clinical quality measures, the EP will also have to attest that all the other menu-set quality measures calculated by the certified EHR technology have a value of zero in the denominator. In other words, the EP is required to try to find at least three measures in the menu set for which the denominator is other than zero. If s/he cannot, then the EP must still choose three menu-set measures on which to report. S/he 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 menu-set measures 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.

4. 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 clinical quality measures is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core clinical quality measures. If the denominator values for all three of the alternate core clinical quality measures is also '0,' an EP still needs to report on 3 additional clinical quality measures. Zero is an acceptable denominator provided that this value was produced by certified EHR technology. Please see question number 10144 for a discussion of zero denominator reporting in the menu set.

5. My practice does not typically collect information on any of the core, alternate core, and additional CQMs listed in the Final Rule on the EHR Incentive Programs. Do I need to report on CQMs for which I do not have any data? EPs are not excluded from reporting clinical quality measures, 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 the EP must report results for up to three alternate core measures (potentially reporting on all 6 core/alternate core measures). For the menu-set measures, we expect 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 the EP must report on three of such 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. As we 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 clinical quality measures 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 clinical quality measures, if the EP reports zero values, then for the remaining clinical quality measures in Table 6 (other than the core and alternate core measures) the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures) in Table 6."
6. Can EPs use CQMs from the alternate core set to meet the requirement of reporting three additional measures? No, if EPs report data on all three clinical quality measures from the core set, they would not report on any from the alternate core set. The three additional clinical quality measures must come from Table 6 of the final rule (75 FR 44398-44408), excluding those clinical quality measures included in either the core set or the alternate core set.
7. If a provider feeds data from certified EHR technology to a data warehouse, can the provider report on meaningful use objectives and clinical quality measures from the data warehouse?  
To be a meaningful EHR user a provider must do three things:
- Have complete certified EHR technology for all meaningful use objectives either through a complete EHR or a combination of modules; and
  - Meet 20 measures (19 for eligible hospitals and CAHs), including all of the core and five (5) menu-set measures associated with the objectives (unless excluded). Core measures include reporting clinical quality measures.
  - Use the capabilities and standards of certified EHR technology in meeting the measure of each objective

If the conditions above are met and data is transferred from the certified EHR technology to a data warehouse, the provider can use information from the data warehouse to report on Meaningful Use objectives and clinical quality measures. However, in order to report calculated clinical quality measures, the data warehouse may need to be certified. The Office of the National Coordinator of Health Information Technology has addressed the issue of certification of a data warehouse in the following Frequently Asked Question:

<http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3163&PageID=20775>.

8. If the certified EHR technology possessed by an EP generates zero denominators for all CQMs in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating? No, the EP is not responsible for determining the status of CQMs that their certified EHR technology is not capable of calculating. The certification criterion for ambulatory CQMs sets a minimum threshold in order for the certification criterion to be met. An EHR technology must be certified to the 6 core CQMs (3 core and 3 alternate core CQMs in Table 7 of the final rule) and at least 3 CQMs from the additional set (Table 6 of the final rule). In the final rule, we stated that it was our expectation that EPs would seek out certified EHR technologies that include and were certified for CQMs relevant to their scope of practice. In later stages of meaningful use and the corresponding certification

requirements, we will seek to address situations where an EP does not obtain certified EHR technology that would enable the EP to report on CQMs that are relevant to their practice.

9. If certified EHR technology possessed by an EP includes the ability to calculate CQMs from the additional set that are not indicated by the EHR developer or on the CHPL as tested and certified by an ONC-ATCB, can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation?

Yes, the EP can submit results for CQMs in the additional set (Table 6 of the final rule) calculated by certified EHR technology, even if those CQMs were not individually tested and certified by an ONC-ATCB. We expect to revisit CQM requirements in more detail for later stages of meaningful use as well as the corresponding certification requirements.

## Electronic Copy of Health Information

1. 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.

2. 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"?

In our final rule, we 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, eligible hospital or CAH.

We encourage all providers to meet patient's request for information with all of the information that the patient requests and meets the description above. However, if the provider's certified EHR technology cannot provide all of patient requested information within the 3 business day timeline, a minimum level of information is defined in the certification process. 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, eligible hospital or CAH that provides these four elements within 3 business days of the patient request in the specified standards meets the measure associated with this objective. Again, we encourage all providers to continue to work with patients to provide information patients may request above and beyond these four elements.

## Electronic Exchange of Clinical Information

1. For the meaningful use objective of "capability to exchange key clinical information," does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective?

No, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats to exchange key clinical information would not utilize the certification capability of certified EHR technology to electronically transmit the information, and therefore would not meet the measure of this objective.

For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for EPs and 45 CFR 170.306(f) for eligible hospitals and CAHs). We expect that this information would be exchanged in structured electronic format when available (e.g., drug or clinical lab data); however, where the information is available only in unstructured electronic formats (e.g., free text or scanned images), the exchange of unstructured information would satisfy this measure. For more information about electronic exchange of key clinical information, please refer to the following FAQ: [http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10270/kw/10270](http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270).

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of the summary of care record is not a requirement but an option. To satisfy the measure of the "provide a summary of care record for each transition of care" objective, a provider is permitted to send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver. In this case, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats could satisfy the measure of this objective.

2. For the meaningful use objective of "capability to exchange key clinical information," what forms of electronic transmission can be used to meet the measure of the objective?
- For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for eligible professionals and 45 CFR 170.306(f) for eligible hospitals and critical access hospitals). There are many acceptable transmission methods for conducting a test of the electronic exchange of key clinical information with providers of care and patient authorized entities (see FAQ #10270) To meet the measure of this objective a provider must:

- 1) use certified EHR technology to generate a continuity of care document (CCD)/continuity of care record (CCR), and
- 2) electronically transmit the CCD/CCR.

To complete step 2, an eligible professional, eligible hospital, or critical access hospital may use any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.) regardless of whether it was included by an EHR technology developer as part of the certified EHR technology in the eligible professional's, eligible hospital's, or critical access hospital's possession.

Please note that the use of USB, CD-ROM, or other physical media or electronic fax would not meet the measure of this objective and has been addressed in another FAQ (see FAQ #10638) If the test involves the transmission of actual patient information, all current privacy and security regulations must be met.

3. To meet the meaningful use objective "capability to exchange key clinical information," can different providers of care (e.g. physicians, hospitals, etc.) share EHR technology and successfully meet this objective?
- In order to meet this objective, clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology or organizations that are part of the same legal entity, since no actual exchange of clinical information would take place in these latter instances. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. It is possible for different legal entities to meet this objective by using separate instances of the same certified EHR technology (e.g. both entities using separate license of the same program), subject to the following limitations:

- A different legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.
- In order to be distinct certified EHR technology, each instance of certified EHR technology must be able to be certified and operate independently from all others. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.
- The exchange of key clinical information requires that the eligible professional, eligible hospital, or critical access hospital (CAH) must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.