

Eligible Hospital and Critical Access Hospital

Meaningful Use Core Measures

Measure 8 of 16

Stage 2

Date issued: November, 2014

Clinical Lab-Test Results	
Objective	Incorporate clinical lab test results into Certified EHR Technology as structured data.
Measure	More than 55 percent of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data.
Exclusion	No exclusion.

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information
- Certification and Standards Criteria

Definition of Terms

Admitted to the Emergency Department – There are two methods for calculating ED admissions for the denominators for measures associated with Stage 2 of Meaningful Use objectives. [Find out more in this FAQ.](#)

Attestation Requirements

DENOMINATOR / NUMERATOR / THRESHOLD

DENOMINATOR: Number of lab tests ordered during the EHR reporting period by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.

NUMERATOR: Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.

THRESHOLD: The resulting percentage must be more than 55 percent in order for an EP, eligible hospital, or CAH to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to labs ordered for those patients whose records are maintained using certified EHR technology.

- Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The eligible hospital or CAH is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
- Lab results are not limited to any specific type of laboratory or to any specific type of lab test.
- Provided the lab result is recorded as structured data and uses the standards above, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to be counted in the numerator.
- The Medicare and Medicaid EHR Incentive Programs do not specify the use of code set standards in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory, for the entry of structured data for this measure and made this a requirement for EHR technology to be certified.
- In order to meet this objective and measure, an eligible hospital or CAH must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(5), (g)(1), and (g)(2).

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*	
§ 170.314(b)(5) Incorporate lab tests & values/results	<ul style="list-style-type: none"> (i) Receive results. <ul style="list-style-type: none"> (A) Ambulatory setting only. <ul style="list-style-type: none"> 1) Electronically receive and incorporate clinical laboratory tests and values/results in accordance with the standard specified in § 170.205(j) and, at a minimum, the version of the standard specified in § 170.207(c)(2). 2) Electronically display the tests and values/results received in human readable format. (B) Inpatient setting only. Electronically receive clinical laboratory tests and values/results in a structured format and electronically display such tests and values/results in human readable format. (ii) Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (iii) Electronically attribute, associate, or link a laboratory test and value/result with a laboratory order or patient record.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.205(j) Electronic incorporation and transmission of lab results	HL7 Version 2.5.1 Implementation Guide: S&I Framework Lab Results Interface, (incorporated by reference in § 170.299).
§ 170.207(c)(2) Laboratory tests	Logical Observation Identifiers Names and Codes (LOINC) Database version 2.40, June 2012, a universal code system for identifying laboratory and clinical observations produced by the Regenstrief Institute, Inc. (incorporated by reference in § 170.299).