Eligible Hospital and Critical Access Hospital Meaningful Use Menu Set Measures
Measure 3 of 10

Stage 1 (2014 Definition)
Last updated: May 2014

Clinical Lab Test Results	
Objective	Incorporate clinical lab test results into EHR as structured data.
Measure	More than 40 percent of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion	No exclusion.

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Definition of Terms

Admitted to the Emergency Department – There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators.

Observation Services method. The denominator should include the following visits to the ED:

- The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use

- The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare

Benefit Policy Manual, Chapter 6, Section 20.6. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator.

All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of lab tests ordered during the EHR reporting period by authorized providers of the eligible hospital or CAH for patients admitted to an eligible hospital'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.

- NUMERATOR: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an 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.
- 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.
- 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.

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 laboratory tests and values/results	(i) Receive results. (A) Ambulatory setting only. (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.

*Additional certification criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.

Standards Criteria	
§170.205(j)	HL7 Version 2.5.1. Implementation Guide: S&I Framework Lab Results Interface
§170.207(c)(2)	LOINC® version 2.40, June 2012, a universal code system for identifying laboratory and clinical observations produced by the Regenstrief Institute, Inc.