Preliminary ARRA IFR Stage 1 Criteria - EHR Technology for Eligible Providers		
	Criteria	**Standards Compliance**
COMPONENT A: COMPUTER PHYSICIAN ORDER ENTRY		
IFR.EP.A.1	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; and 4. Provider referrals.	
COMPONENT B: DRUG DECISION SUPPORT		
IFR.EP.B.1	1. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and CPOE.	
IFR.EP.B.2	2. Enable a user to electronically check if drugs are in a formulary or preferred drug list in accordance with the standard specified in Table 2A row 2.	Table 2A row 2 Applicable Part D standard required by law (i.e., NCPDP Formulary & Benefits Standard 1.0)
IFR.EP.B.3	3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking.	
IFR.EP.B.4	4. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	
COMPONENT C: PROBLEM LIST		
IFR.EP.C.1	Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standards specified in Table 2A row 1.	Table 2A row 1 Applicable HIPAA code set required by law (i.e.,ICD-9-CM); or SNOMED CT®
COMPONENT D: ELECTRONIC PRESCRIBING		
IFR.EP.D.1	Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards specified in Table 2A row 3.	Table 2A row 3 Applicable Part D standard required by law (e.g., NCPDP SCRIPT 8.1) or NCPDP SCRIPT 8.1 and NCPDP SCRIPT 10.6 Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+
COMPONENT E: MEDICATION LIST		
IFR.EP.E.1	Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standard specified in Table 2A row 1.	Table 2A row 1 Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+
COMPONENT F: MEDICATION ALLERGY LIST		
IFR.EP.F.1	Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care (i.e., over multiple office visits).	
COMPONENT G: DEMOGRAPHICS		

IFR.EP.G.1	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.	
COMPONENT H: ADVANCE DIRECTIVES		
	No criterion (dropped from MU)	
COMPONENT I: VITAL SIGNS		
IFR.EP.I.1	1. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse.	
IFR.EP.I.2	2. Automatically calculate and display body mass index (BMI) based on a patient's height and weight.	
IFR.EP.I.3	3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2-20 years old.	
COMPONENT J: SMOKING STATUS		
IFR.EP.J.1	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to: current smoker, former smoker, or never smoked.	
COMPONENT K: LAB TEST RESULTS		
IFR.EP.K.1	1. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format.	
IFR.EP.K.2	2. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes.	
IFR.EP.K.3	3. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).6 (1) For positive patient identification, either the patient's name or identification number, or a unique patient identifier and identification number. (2) The name and address of the laboratory location where the test was performed. (3) The test report date. (4) The test performed. (5) Specimen source, when appropriate. (6) The test result and, if applicable, the units of measurement or interpretation, or both. (7) Any information regarding the condition and disposition of specimens that do not meet the laboratory's criteria for acceptability.	
IFR.EP.K.4	4. Enable a user to electronically update a patient's record based upon received laboratory test results.	
COMPONENT L: PATIENT LISTS		
IFR.EP.L.1	Enable a user to electronically select, sort, retrieve, and output a list of patients and patients' clinical information, based on user-defined demographic data, medication list, and specific conditions.	
COMPONENT M: CMS QUALITY REPORTING		
IFR.EP.M.1	1. Calculate and electronically display quality measure results as specified by CMS or states. 2. Enable a user to electronically submit calculated quality measures in accordance with the standard specified of PQRI 2008 XML.	Table 2A row 5 CMS PQRI 2008 Registry XML Specification#,+
COMPONENT N: PATIENT REMINDERS		
IFR.EP.N.1	Electronically generate, upon request, a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.	
COMPONENT O: CLINICAL DECISION RULE		
IFR.EP.O.1	1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list.	
IFR.EP.O.2	2. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade.	
IFR.EP.O.3	3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	

COMPONENT P: PROGRESS NOTE		
	No criterion (dropped from MU)	
COMPONENT Q: INSURANCE ELIGIBILITY		
IFR.EP.Q.1	Enable a user to electronically record and display patients' insurance eligibility, and submit insurance eligibility queries to public or private payers and receive an eligibility response in accordance with the applicable standards specified in Table 2A row 4.	Table 2A row 4 Applicable HIPAA transaction standards required by law
COMPONENT R: ELECTRONIC CLAIMS SUBMISSION		
IFR.EP.R.1	Enable a user to electronically submit claims to public or private payers in accordance with the applicable standards specified in Table 2A row 4.	Table 2A row 4 Applicable HIPAA transaction standards required by law
COMPONENT S: PATIENT ELECTRONIC COPY OF HEALTH INFORMATION		
IFR.EP.S.1	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, medication allergy list, immunizations, and procedures in: 1) human readable format; and 2) accordance with the standards specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.	Table 2A row 1 Patient Summary Record: HL7 CDA R2 CCD Level 2 or ASTM CCR • Problem List: Applicable HIPAA code set required by law (i.e.,ICD-9-CM); or SNOMED CT® •Medication List: Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+ •Medication Allergy List: No standard adopted at this time. •Procedures: Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4®) •Vital Signs: No standard adopted at this time. •Units of Measure: No standard adopted at this time. •Lab Orders and Results: LOINC® when LOINC® codes have been received from a laboratory
COMPONENT T: PATIENT ELECTRONIC ACCESS TO HEALTH INFORMATION		
IFR.EP.T.1	Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	
COMPONENT U: PATIENT-SPECIFIC EDUCATIONAL RESOURCES		
	No criterion (dropped from MU)	
COMPONENT V: PATIENT CLINICAL SUMMARY		

IFR.EP.V.1	1. Enable a user to provide clinical summaries to patients (in paper or electronic form) for each office visit that include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations. 2. If the clinical summary is provided electronically (i.e., not printed), it must be provided in: 1) human readable format; and 2) accordance with the standards specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.	Table 2A row 1 Patient Summary Record: HL7 CDA R2 CCD Level 2 or ASTM CCR • Problem List: Applicable HIPAA code set required by law (i.e.,ICD-9-CM); or SNOMED CT® •Medication List: Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+ •Medication Allergy List: No standard adopted at this time. •Procedures: Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4®) •Vital Signs: No standard adopted at this time. •Units of Measure: No standard adopted at this time. •Lab Orders and Results: LOINC® when LOINC® codes have been received from a laboratory
COMPONENT W: EXCHANGE CLINICAL INFORMATION		
IFR.EP.W.1	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row1, displaying it in human readable format. 2. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations and procedures in accordance with the standards specified in Table 2A row 1.	Table 2A row 1 Patient Summary Record: HL7 CDA R2 CCD Level 2 or ASTM CCR • Problem List: Applicable HIPAA code set required by law (i.e.,ICD-9-CM); or SNOMED CT® •Medication List: Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+ •Medication Allergy List: No standard adopted at this time. •Procedures: Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4®) •Vital Signs: No standard adopted at this time. •Units of Measure: No standard adopted at this time. •Lab Orders and Results: LOINC® when LOINC® codes have been received from a laboratory
COMPONENT X: MEDICATION RECONCILIATION		
IFR.EP.X.1	Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.	
COMPONENT Y: IMMUNIZATION REGISTRIES		
IFR.EP.Y.1	Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards specified in Table 2A row 8 or in accordance with the applicable state-designated standard format	Table 2A row 8 HL7 2.3.1 or HL7 2.5.1
COMPONENT Z: REPORTABLE LAB SUBMISSION		
	No criteria in this domain	
COMPONENT AA: ELECTRONIC SYNDROMIC SURVEILLANCE		

IFR.EP.AA.1	Electronically record, retrieve, and transmit syndrome-based (e.g., influenza like illness) public health surveillance information to public health agencies in accordance with the standards specified in Table 2A row 7.	Table 2A row 7 HL7 2.3.1 or HL7 2.5.1