Eligible Professional Meaningful Use Core Measures Measure 1 of 14

Stage 1

Last updated: April 2013

CPOE for Medication Orders	
Objective	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
Measure	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. Optional Alternate: More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Table of Contents

Definition of Terms

Computerized Provider Order Entry (CPOE) – CPOE entails the provider's use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator that have at least one medication order entered using CPOE.

OPTIONAL NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of medication orders created by the EP during the EHR reporting period
- NUMERATOR: Number of medication orders in the denominator entered using CPOE.

The resulting percentage (Numerator ÷ Denominator) must be more than 30 percent in order for an EP to meet this measure.

EXCLUSION

- EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

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.
- Any licensed healthcare professionals can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE 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 the CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order.
- Electronic transmittal of the medication order to the pharmacy, laboratory, or diagnostic imaging center is not a requirement for meeting the measure of this objective. However, a separate objective (EPCMU 04) addresses the electronic transmittal of prescriptions and is a requirement for EPs to meet Meaningful Use.
- This specification sheet has been updated to reflect the applicable Stage 1 provisions in the Stage 2 Meaningful Use Final Rule, published on September 4, 2012.

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.)

- 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? ***New ID #3257**, Old #10639*
- Who can enter medication orders in order to meet the measure for the CPOE meaningful use objective? When must these medication orders be entered? ***New ID #2851**, Old #10134*
- 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? ***New ID #3057**, Old #10462*
- Is the physician the only person who can enter information in the EHR in order to qualify for the EHR Incentive Programs? ***New ID #2771**, Old #10071*
- What do the numerators and denominators mean in measures that are required to demonstrate meaningful use? ***New ID #2813**, Old #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 #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 #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 #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 #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(a) Computerized provider order entry	Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types: (1) Medications; (2) Laboratory; and (3) Radiology/imaging.

§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
N/A

Related Certification FAQs

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

- I've selected a certified Complete EHR [or certified EHR Module] from EHR technology developer XYZ. I prefer the certified CPOE EHR Module designed by EHR technology developer ABC over the CPOE capability included in EHR technology developer XYZ's Complete EHR. Can I use duplicative or overlapping certified capabilities of different certified EHR technologies without jeopardizing my ability to meaningfully use Certified EHR Technology? ***9-10-014-1***