(iii) To capture and query information relevant to health care quality;
(iv) To exchange electronic health information with, and integrate such information from other sources;
(v) To protect the confidentiality, integrity, and availability of health information stored and exchanged; and
(3) Has been certified to the certification criteria adopted by the Secretary:
   (i) For at least one of the four criteria adopted at §170.314(a)(1), (a)(18), (a)(19), or (a)(20);
   (ii) At §170.314(a)(3);
   (iii) At §170.314(a)(5) through §170.314(a)(8);
   (iv) Both §170.314(b)(1) and (2); or, both §170.314(b)(8) and §170.314(h)(1); or §170.314(b)(1) and (2) combined with either §170.314(b)(8) or §170.314(h)(1), or both §170.314(b)(8) and §170.314(h)(1);
   (v) At §170.314(b)(7);
   (vi) At §170.314(c)(1) through §170.314(c)(3);
   (vii) At §170.314(d)(1) through §170.314(d)(8);
   (4) Has been certified to the certification criteria at §170.314(c)(1) and (2):
   (i) For no fewer than 9 clinical quality measures covering at least 3 domains from the set selected by CMS for eligible professionals, including at least 6 clinical quality measures from the recommended core set identified by CMS; or
   (ii) For no fewer than 16 clinical quality measures covering at least 3 domains from the set selected by CMS for eligible hospitals and critical access hospitals.

Effective Date Notes: 2. At 79 FR 54478, Sept. 11, 2014, §170.202 was amended by adding paragraph (d), effective Oct. 14, 2014. For the convenience of the user, the added text is set forth as follows:

§170.202 Transport standards.


§170.204 Functional standards.

The Secretary adopts the following functional standards:
(c) Clinical quality measure-by-measure data. Data Element Catalog, (incorporated by reference in §170.299).
§ 170.205


(d) Electronic submission to public health agencies for surveillance or reporting—(1) Standard. HL7 2.5.1 (incorporated by reference in §170.299).

(2) Standard. HL7 2.5.1 (incorporated by reference in §170.299).


The Secretary adopts the following code sets, terminology, and nomenclature as the vocabulary standards for the purpose of representing electronic health information:

(a) Problems—(1) Standard. The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.


(b) Procedures—(1) Standard. The code set specified at 45 CFR 162.1002(a)(2).


(c) Laboratory tests—(1) Standard. Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory (incorporated by reference in §170.299).

(2) Standard. Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.40, a universal code system for identifying laboratory and clinical observations produced by the Regenstrief Institute, Inc. (incorporated by reference in §170.299).

(3) Standard. The code set specified at 45 CFR 162.1002(a)(5).


(5) Standard. The code set specified at 45 CFR 162.1002(b)(3) for the indicated procedures or other actions taken.

(d) Medications—(1) Standard. Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.


(g) Preferred language. Standard. As specified by the Library of Congress, ISO 639-2 alpha-2 codes limited to those that also have a corresponding alpha-2 code in ISO 639-1. (incorporated by reference in §170.299).

(h) Smoking status. Standard. Smoking status must be coded in one of the following SNOMED CT® codes:

(1) Current every day smoker. 449668002

(2) Current some day smoker. 428041000124106

(3) Former smoker. 8517006

(4) Never smoker. 266919005

(5) Smoker, current status unknown. 266927001

(6) Unknown if ever smoked. 266927001