Maintain Problem List	
Objective	Maintain an up-to-date problem list of current and active diagnoses.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion	No exclusion.

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information

Definition of Terms

Problem List – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

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.

Up-to-date – The term ''up-to-date'' means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information

- The Medicare and Medicaid EHR Incentive Programs do not specify the use of ICD-9 or SNOMED-CT® in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 or SNOMED-CT® for the entry of structured data for this measure and made this a requirement for EHR technology to be certified. Therefore, EPs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® as a basis for the entry of structured data into certified EHR technology in order to meet the measure for this objective.
- For patients with no current or active diagnoses, an entry must still be made to the problem list indicating that no problems are known.
- An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances.
- The initial diagnosis can be recorded in lay terms and later converted to standard structured data or can be initially entered using standard structured data.

Related FAQs

- **#10150** - To meet the meaningful use objective "maintain an up-to-date problem list of current and active diagnoses," are EPs, eligible hospitals, and CAHs required to use ICD-9 or SNOMED-CT®?
- **#10664** - How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?
- **#10665** - When a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?
- **#10466** - 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?
- **#10475** - 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?