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Electronic Health Information Export

Maximus 1.0

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Product Name and Version:

Maximus 1.0

Electronic Health Information Export

1. Single Patient Export

Maximus allows a user to export electronic health information (EHI) for a single patient at any time without developer assistance using the below mentioned file format.

2. Multi-Patient Export

Maximus can export all the data for a patient population in our standardized format explained below.

3. File Formats

For a standards-based way of health information exchange, we are using the following options:

A. CCD/C-CDA documents

Maximus supports bulk export of HL7 CCDA xml files which comply to US Core Data for Interoperability (USCDI), Version 1 requirements.
The specifications for the CCDA can be obtained from the HL7 website:

– Health Level 7 (HL7) Implementation Guide for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 (US Realm) Draft Standard for Trial Use July 2012

– HL7® Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1 August 2015, June 2019 (with Errata)

– HL7® CDA R2 IG: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 2, October 2019, IBR approved for § 170.205(a)(5)

B. FHIR bulk data access

Maximus also supports HL7® Version 4.0.1 FHIR® Release 4, October 30, 2019, FHIR® US Core Implementation Guide STU V3.1.1, HL7 FHIR Bulk Data export. Please refer 170.315(g)(10) SmartOnFHIR API Documentation.PDF for the API Specifications.
https://documents.maximus.care/

4. Patient Demographics & Insurance

Excel Format

This file offers a comprehensive view of demographics and insurance details structured for clarity and ease of access.

5. Appointments

Excel Format

This file offers a comprehensive view of all future appointment details, structured for clarity and ease of access.

6. Documents (Scanned Documents like PDF, JPG, PNG File Formats)

This includes signed progress notes, available lab results, radiology reports, and any other scanned or uploaded document in the patient's record.

Organizational Structure: All these documents are sorted and indexed within the respective patient chart number folders. If there are specific categories or types for these documents (e.g., Lab Reports, Radiology, Scanned Receipts, etc.), they will reside in their respective category subfolder within the primary patient folder.