



Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures Measure 3 of 13

Stage 1 (2013 Definition)
Last Updated: April 2013

| Maintain Problem List | |
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| Objective | Maintain an up-to-date problem list of current and active diagnoses. |
| Measure | More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) 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
- Related Meaningful Use FAQs
- Certification and Standards Criteria

Definition of Terms

Admitted to the Emergency Department – There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the “Observation Services method” or the “All ED Visits method” to be used with all measures. Providers cannot calculate the denominator of some measures using the “Observation Services method,” while using the “All ED Visits method” for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators.

Observation Services method. The denominator should include the following visits to the ED:

- The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use
- The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator.

All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

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 admitted to an eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) 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 eligible hospital or CAH. This knowledge could be ascertained from previous records, transfer of information from other providers, or querying the patient.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients admitted to an eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) 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 eligible hospital or CAH to meet this measure.

Additional Information

- 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, eligible hospitals and CAHs 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 structured data in certified EHR technology in order to meet the measure for this objective.

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.)

- 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®?
[New ID #2881](#), [Old ID #10150](#)
- Does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients? [New ID #3067](#), [Old ID #10468](#)
- If an eligible hospital or CAH has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and that bills under Place of Service (POS) code 21, but that is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of meaningful use objectives?
[New ID #3213](#), [Old ID #10591](#)
- How should patients in swing beds be counted in the denominators of meaningful use measures for eligible hospitals and CAHs? [New ID #3259](#), [Old ID# 10640](#)

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 | |
|---|---|
| §170.302(c) Maintain up-to-date problem list | <p>Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with:</p> <p>(1) The standard specified in §170.207(a)(1); or (2) At a minimum, the version of the standard specified in §170.207(a)(2).</p> |
| §170.302(n) Automated measure calculation | <p>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.</p> |
| Standards Criteria | |
| Problems | <ul style="list-style-type: none"> ▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. |