Are nursery days and nursery discharges (for newborns) included as acute
inpatient services in the calculation of hospital incentives for the Medicare
and Medicaid Promoting Interoperability Programs?

Nursery days and discharges are not included as acute inpatient services because
they are not considered acute inpatient services based on the level of care provided
during a normal nursery stay. Pages 44460 and 44463 of the Stage 1 final rule preamble
clarify that for the Medicare reimbursement, the statutory language clearly restricts discharges
and inpatient-bed-days to those from the acute care portion of a hospital. This is
because of the definition of “eligible hospital” in section 1886(b)(6)(B) of
the Social Security Act. Page 44467 of the Stage 1 final rule explains that statutory parameters placed on Medicare incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicare is held to the same parameters as Medicaid,
the same limitations on counting inpatient-bed days and total discharges apply to Medicare hospital incentive calculations. To view the Stage 1 final rule for the Medicare and Medicaid Promoting Interoperability programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-21707.pdf.

If an eligible hospital or critical access hospital (CAH) has a rehabilitation unit
or a psychiatric unit that is part of the inpatient department and that falls
under Place of Service (POS) code 21, but that is excluded from the eligible
inpatient prospective payment system (IPPS), should patients from those units be included in the denominator for the measures of meaningful use objectives for the Medicare and Medicaid Promoting Interoperability Programs?

No, CMS specified in the final rule that the statutory definition of “hospital” used in the Promoting Interoperability Program does not apply to hospitals and hospital units excluded from IPPS, such as rehabilitation or psychiatric units (75 FR 44466). Therefore, patients treated in these units should not be included in the denominators of measures. If patients are treated in an eligible hospital or inpatient psychiatric unit but are also admitted to areas of the inpatient department that are part of the “observation (outpatient hospital)” then those patients and the actions taken for those patients outside of the inpatient rehabilitation or inpatient psychiatric units should be counted in the numerators and denominators for the meaningful use measures.

How should nursery days be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Promoting Interoperability Programs?

Nursery days are excluded from the calculation of hospital incentives because they are not considered inpatient-bed days based on the level of care provided during a normal nursery stay. Page 44467 of the Stage 1 final rule preamble explains that for the Medicare reimbursement, the statutory language clearly restricts discharges and inpatient-bed-days to those from the acute care portion of a hospital. This is because of the definition of “eligible hospital” in section 1886(b)(6)(B) of the Social Security Act. Page 44467 of the Stage 1 final rule explains that statutory parameters placed on Medicare incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicare is held to the same parameters as Medicaid, the same limitations on counting inpatient-bed days and total discharges apply to Medicare hospital incentive calculations. To view the Stage 1 final rule for the Medicare and Medicaid Promoting Interoperability programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-21707.pdf.

If an eligible professional (EP) sees a patient in a setting that does not have
certified electronic health record (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 for the Medicare and Medicaid Promoting Interoperability Programs?

Yes, CMS specified in the final rule that the statutory definition of “hospital” used in the Promoting Interoperability Program does not apply to hospitals and hospital units excluded from IPPS, such as rehabilitation or psychiatric units (75 FR 44466). Therefore, patients treated in these units should not be included in the denominators of measures. If patients are treated in an eligible hospital or inpatient psychiatric unit but are also admitted to areas of the inpatient department that are part of the “observation (outpatient hospital)” then those patients and the actions taken for those patients outside of the inpatient rehabilitation or inpatient psychiatric units should be counted in the numerators and denominators for the meaningful use measures.

How is hospital-based status determined for eligible professionals in the Medicare and Medicaid Promoting Interoperability Programs?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Covered professional services are physician fee schedule (PFS) services paid under Section 1848 of the Social Security Act. CMS uses PFS data from the Federal fiscal year immediately preceding the calendar year for which the Promoting Interoperability payment is made (that is, the “payment year”) to determine what percentage of covered professional services occurred in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The percentage determination is made based on total number, with each unit of a CPT billing code counting as a single service. States will use claim and/or encounter data (or equivalent data sources at the State's option) to make this determination for Medicaid. States may use data from either the prior fiscal or calendar year. For the Medicare Promoting Interoperability Program, EPs should contact their state Medicaid agency for more information.

Should patient encounters in an ambulatory surgical center (Place of Service 24) be included in the denominator for calculating that at least 50
percent or more of an eligible professional’s (EP’s) patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology?

Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period occurred at a practice/ location or practices/locations equipped with certified EHR technology. That is, eligible professionals must choose either the "Observation Services method" or the "All ED Visits method" to be used with all meaningful use 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. (77 FR 53986). Observation Services method should not be used to calculate the denominator of all meaningful use measures. Prior to attestation, eligible hospitals and CAHs must also indicate whether they used either the "Observation Services method" or the "All ED Visits method" to be used with all meaningful use 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. (77 FR 53986). Observation Services method should not be used to calculate the denominator of all meaningful use measures.
| 7815 | When combining meaningful use data from multiple locations equipped with Certified Electronic Health Records (EHR) technology, is it required to have a full meaningful use report from each location or is it acceptable to only collect denominator information from one or more locations? | An eligible provider (EP) must have accurate denominators for the meaningful use measures. If an EP is unable to access data from a location to determine whether a patient or action in the denominator should be included in the numerator for a given measure, the EP should be aware that this could negatively impact their performance on the measure, and the EP might not meet the required threshold for the measure. |
| 5259 | How should patients in swing beds be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Promoting Interoperability Programs? | A number of the meaningful use measures for eligible hospitals and CAHs require the denominator to be based on the number of unique patients admitted to the inpatient or emergency department during the EHR reporting period. Unique swing bed patients who receive inpatient care should be included in the denominators of meaningful use measures. However, if the eligible hospital or CAH's certified EHR technology cannot readily identify and include unique swing bed patients who have received inpatient care, those patients may be excluded from the calculations for the denominators of meaningful use measures. |