PLACE OF SERVICE		
FAQ Number	**Question**	**Answer**
2843	A number of measures for Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs) include patients admitted to the Emergency Department (ED). Which ED patients should be included in the denominators of these measures for the Medicare and Medicaid Promoting Interoperability Programs?	There are two methods for calculating ED admissions for the denominators for measures associated with 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 (77 FR 53984). Observation Services method. When using this method, the denominator should include the following visits to the ED: The patients who are admitted to the inpatient department (Place of Service (POS) 21) either directly or through the emergency department. The patients who are initially presented to the emergency department (POS 23) and receive observation services. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. 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.
2991	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?	No, nursery days and discharges are not included in inpatient bed-day or discharge counts in calculating hospital incentives. We exclude nursery days and discharges because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay. Pages 44450 and 44453 of the Stage 1 final rule preamble explain that for the Medicare calculation, 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(n)(6)(B) of the Social Security Act. Page 44497 of the Stage 1 final rule explains that statutory parameters placed on Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicaid is held to the same parameters as Medicare, the same limitations on counting inpatient bed-days and total discharges apply to Medicaid 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/2010-17207.pdf".
3213	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 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 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 44448). Therefore, patients treated in these units should not be included in the denominators of measures. If patients are treated in either an inpatient rehabilitation or inpatient psychiatric unit but are also admitted to areas of the inpatient department that are part of the "subsection (d) 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.
3261	How should nursery day patients 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. In addition, nursery day patients should not be included in the denominators of meaningful use measures. However, if the eligible hospital or critical access hospital's (CAH's) certified EHR technology cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of meaningful use measures.
3077	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?	Starting in 2013, an EP must have access to Certified EHR Technology at a location in order to include patients seen in locations in the determination of whether they meet the threshold of 50% of patient encounters at locations equipped with Certified EHR Technology to be eligible for the Promoting Interoperability Program. However, if the EP meets this threshold and also includes information on patient encounters at locations where they do not have access to Certified EHR Technology, information about those encounters can be included when calculating the numerators and denominators for the meaningful use measures. For information about the patient encounters threshold, please see FAQ 3215.
2765	For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified electronic health record (EHR) technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?	In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the outpatient setting, since this setting is where they are eligible to receive Promoting Interoperability incentive payments.
3061	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 of Medicare allowed services for which the EP was reimbursed, with each unit of a CPT billing code counting as a single service. States will use claims 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 Medicaid Promoting Interoperability Program, EPs should contact their state Medicaid agency for more information.
3065	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 at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all Places of Service (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).
7811	If an eligible provider (EP) practices at an outpatient location, a location other than an inpatient (place of service 21) or emergency department (place of service 23), and that location is only equipped with Certified Electronic Health Records (EHR) Technology certified to the criteria applicable to an inpatient setting, must the EP include that location in their meaningful use calculations?	No, this location is not equipped with Certified EHR Technology with all the capabilities necessary for an EP to satisfy the meaningful use objectives and measures. Accordingly, this location (like all outpatient locations) would be in the denominator of the calculation to determine whether the EP's outpatient encounters meet the 50 percent threshold, but not in the numerator as the location is not equipped with Certified EHR Technology. Also the location would not be included in the calculations of the EP's meaningful use measures in either the denominator or the numerator. However, an EP can consider the location equipped with Certified EHR Technology if they have access to Certified EHR Technology certified to the criteria applicable to an ambulatory setting, which fills the gaps between inpatient and ambulatory. FAQ#3077 explains access to Certified EHR Technology. If the EP chooses to equip the location with Certified EHR Technology with the applicable criteria, the EP must then include that location in all calculations including both the 50 percent threshold calculation and the meaningful use measures calculations.
3067	For the Medicare and Medicaid Promoting Interoperability Programs, 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?	For the hospital meaningful use objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to an inpatient department (POS 21) and all patients admitted to an emergency department (POS 23). If the eligible hospital elects to use the alternate method for calculating emergency department patients, as detailed in FAQ #2843 the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures.
3609	For the Medicare and Medicaid Promoting Interoperability Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?	EPs, eligible hospitals, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. For objectives that require an action to be taken on behalf of a percentage of "unique patients," EPs, eligible hospitals, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all meaningful use objectives. Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators whenever applicable in order to provide accurate numbers. To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

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.
3259	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.