CMS Ambulatory Surgical Centers, as an institution, are not eligible for any of the CMS EHR Incentive programs. However, Eligible Professionals that provide services in these centers are. A look at how Eligible Providers can qualify for incentive payments.

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About the Author

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About HITECH Answers

HITECH Answers provides independent analysis on the many facets of the HITECH Act impacting adoption of certified EHR technology.

At the forefront of providing this analysis since April of 2009, HITECH Answers offers one of the most extensive online resources available to gain a complete understanding of how to achieve meaningful use and qualify for CMS EHR Incentive Programs.

Subject matter experts from leading organizations and institutions help contribute content to HITECH Answers including Centers for Medicare and Medicaid Services (CMS), Certification Commission for Health Information Technology (CCHIT), Wellspan Health, The American Academy of Professional Coders (AAPC), Oregon Health and Science University (OHSU), and the Health Story Project.

And likewise, HITECH Answers continues to be sought by leading health IT organizations for its subject matter experts, resources, research, and contributing articles. Some of those organizations are Medicare Part B News, QuantiaMD, AAPC, SURGistrategies, For The Record Magazine and Medical Economics.
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Introduction

In February of 2009 the American Recovery and Reinvestment Act (ARRA) of 2009 was signed into law by the federal government. Included in this law was the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Act allocated $19 Billion to the Department of Health and Human Services (HHS) to be administered by the Office of the National Coordinator (ONC) to fund the initiative to increase adoption of Electronic Health Records (EHR) by physicians and hospitals. The government firmly believes in the benefits of using electronic health records and is ready to invest federal resources to proliferate its use.

Under the provisions of the HITECH Act, a federal incentive program is made available to Eligible Professionals (EPs) who adopt an EHR and demonstrate their use in a meaningful way. The providers that are deemed eligible for the program can receive substantial incentives through either Medicare or Medicaid in the following manner:

- Under Medicare, they can receive up to $44,000.00 over a five (5) year period or
- Under Medicaid, they can receive up to $63,750.00 over a six (6) year period

Having an Electronic Health Records system in a medical practice is just one of the aspects of the HITECH incentives. Providers must ensure that the EHR system they implement and use meets the certification requirements for HITECH. They must also demonstrate “meaningful use,” or the ability to use the EHR to effectively support specific clinical activities. The requirements are organized around achieving a national health policy to:

- Improve quality, safety and efficiency and reduce health disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

The complete CMS EHR Incentive Program is separated into three different stages. Each one of the stages has its own deadlines, incentives and distinct requirements. In order to appreciate the full scope of the incentive program and the objectives of meaningful use, individual providers must be able to share data and information with other
organizations across the continuum of care. This will obviously require the development of various health information exchanges (HIE) that facilitate interaction and interoperability of health information technology (HIT) implementations in organizations and among many stakeholders.

Therefore, to qualify for any of the incentives that will be available during the life of the CMS incentive programs, physicians must be using “certified Electronic Health Records technology” in a “meaningful manner.” While the widespread use of EHRs in the United States is inevitable, it will be more beneficial for clinicians to obtain certified EHR technology as early as feasibly possible.
Eligible Professionals

You must be an Eligible Professional for Medicare or Medicaid to qualify for the incentive payments. You can determine your eligibility status by walking through this series of questions.

- Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?
  - Yes
    - You are not currently eligible to receive EHR Incentive payments under the Medicaid or Medicare EHR Incentive Programs.
  - No
    - You might qualify continue evaluation.

- Were at least 30% of your services furnished to Medicaid patients in an outpatient setting (20% requirement for pediatricians)?
  - Yes
    - Are you a: Physician, Nurse Practitioner (NP), Certified Nurse Mid-Wife (CNM), Dentist, Physician Assistant (PA) working in a Federally Qualified Health Center (FQHC), or rural health clinic (RHC) that is so led by a PA
      - Yes
        - If you adopt, implement, or upgrade to or successfully demonstrate meaningful use of certified EHR technology, you may be eligible to receive incentive payments under the MEDICAID Program.
      - No
        - You are not currently eligible to receive EHR Incentive payments under the Medicaid or Medicare EHR Incentive Programs.
  - No
    - You might qualify continue evaluation.

- Did you practice predominantly in a Federally Qualified Health Center or Rural Health Clinic with a 30% needy individual patient volume threshold? Section 1903(t)(3)(F) of the Act defines needy individuals as individuals meeting any of the following three criteria: 1. They are receiving medical assistance from Medicaid or the Children’s Health Insurance Program (CHIP) 2. They are furnished uncompensated care by the provider 3. They are furnished services at either no cost or reduced cost based on a sliding scale.
o Yes
  ▪ Are you a: Physician, Nurse Practitioner (NP), Certified Nurse Mid-Wife (CNM), Dentist, Physician Assistant (PA) working in a Federally Qualified Health Center (FQHC), or rural health clinic (RHC) that is so led by a PA
    • Yes
      o If you adopt, implement, or upgrade to or successfully demonstrate meaningful use of certified EHR technology, you may be eligible to receive incentive payments under the MEDICAID Program.
    • No
      o You are not currently eligible to receive EHR Incentive payments under the Medicaid or Medicare EHR Incentive Programs.
  o No
    ▪ You might qualify continue evaluation

Do you treat Medicare patients?
  o No
    ▪ You are not currently eligible to receive EHR Incentive payments under the Medicaid or Medicare EHR Incentive Programs.
  o Yes
    ▪ Are you a: Doctor of Medicine or Osteopathy, Doctor of Dental Surgery or Dental Medicine, Doctor of Podiatric Medicine, Doctor of Optometry, Chiropractor
      • No
        o You are not currently eligible to receive EHR Incentive payments under the Medicaid or Medicare EHR Incentive Programs.
      • Yes
        o If you successfully demonstrate meaningful use you may be eligible to receive incentive payments under the MEDICARE Program
EHR Incentive Programs

Medicare and Medicaid both have incentive programs administered through CMS for EHR adoption. The Medicare program includes both Medicare Fee-For-Service and Medicare Advantage providers. The Medicaid program includes Medicaid providers but the State’s participation is voluntary and not all States have established a program. Although, it is unlikely that there will be any State that will not participate.

Under the Fee-for-Service Medicare program, the first year payment incentive amount is equal to 75 percent or $18,000 (whichever is smaller) of an EP’s Medicare physician fee schedule (MPFS) allowed charges. To be eligible for the maximum 2011 or 2012 incentives, the EP would need to have an annual amount of $24,000 in Medicare claims. Maximum program incentives are obtained by starting in 2011 or 2012. If you become a meaningful user after 2012 you will receive incentive money but you will not be able to obtain the maximum program amount.

A Medicare Advantage EP potential incentive is not based on the Fee-for-Service basis but rather their participation in a MA organization. The incentive payments go to the MA organization, not the individual EPs.

The Medicaid program is not based on allowable fees or participation but rather patient thresholds. EPs must meet Medicaid patient volumes of 20% or 30% depending on what type of provider you are and where you provide services.

An EP can only participate in one program at a time. During the life of the incentive program an EP may switch programs only one time. EPs eligible to receive EHR incentive payments under either Medicare or Medicaid will maximize their payments by choosing the Medicaid EHR Incentive Program. EPs who choose the Medicaid program can only participate in one State’s program even if they see patients from multiple states.
CMS EHR Incentive Program and Other CMS Programs

CMS has other incentive programs in both Medicare and Medicaid. There is potential participation in both the CMS EHR Incentive programs and other established programs.

- Medicare Physician Quality Reporting Initiative (PQRI) – the physician is eligible for the CMS Electronic Health Records Incentive Program if they are also eligible under the provisions of the Incentive Program (See Who is Eligible under the 2 Programs (Medicare and Medicaid))
- Medicare Electronic Health Record Demonstration (EHR Demo) – the physician is eligible for the CMS Electronic Health Records Incentive Program if they are also eligible under the provisions of the Incentive Program (See Who is Eligible under the 2 Programs (Medicare and Medicaid))
- Medicare Care Management Performance Demonstration (MCMP) – the physician is eligible if the practice is eligible under the provisions of the Incentive Program
- Electronic Prescribing (eRx) Incentive Program – If the EP chooses to participate in the Medicare Electronic Health Records Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously in the same program year. If the EP chooses to participate in the Medicaid Electronic Health Records Incentive Program, he or she can participate in the Medicare eRx Incentive Program simultaneously
Certified Technology

The Office of the National Coordinator (ONC) has created a certification process to ensure that the users of electronic health information technology will be using systems that meet the identified standards for security, interoperability, and functionality. Therefore, ONC has established a program to review and approve entities as Authorized Testing and Certifying Bodies (ACTBs). These ACTBs will certify vendor products to ensure that the EHR software is able to demonstrate the required functionality for the various Stages of meaningful use. The current ONC-ACTBs are operating under the final rule issued on January 7, 2011, Establishment of the Permanent Certification Program for Health Information Technology. To become an ONC-ACTB, organizations must apply and met stringent requirements for testing technology. A list of current ACTBs can be found on the ONC web site.

Once a product has successfully been tested and receives certification from an ONC-ACTB, it will be listed on the ONC Certified HIT Products List (CHPL) site. You will also use this site to obtain attestation information on your certified EHR.
Registration for the CMS EHR Incentive Program

On January 3, 2011 enrollment for the CMS EHR Incentive Program began. All Eligible Professionals and eligible hospitals are encouraged to register now. You do not have to have a certified EHR system purchased or implemented to register for the program. You will however need your certified system implemented and functioning to attest to the 90 day reporting. Medicaid enrollment will be handled by the individual states. The enrollment web site with complete instructions for registering and Medicaid state updates can be found on the CMS EHR Incentive Program web site.

To Participate in the Incentive Programs

All providers who wish to participate in the Incentive Programs must:

- Be eligible under the provisions of one of the Incentive Programs
- Register via the CMS EHR Incentive Program web site
- Be enrolled in Medicare Fee-for-Service (FFS), Medicare Advantage (MA), or Medicaid (FFS or Managed Care)
- Have a National Provider Identifier (NPI)
- Use ONC-Authenticated Testing and Certification Body (ATCB) Certified Technology
- Be enrolled in Medicare’s Provider Enrollment, Chain, and Ownership System (PECOS)

Registration Requirements Include the Following

- Name of the Eligible Professional (EP)
- National Provider Identifier (NPI)
- Business Address and Business Phone
- Taxpayer Identification Number (TIN) to which the provider would like the Incentive Payments made, this can be the EP’s TIN or the entity to which they wish to reassign their incentive payment
- Selection of either the Medicare or Medicaid program for the EP
- State Selection for Medicaid Providers
Attestation for the CMS EHR Incentive Program

On April 18, 2011 web-based attestation for the CMS Medicare EHR Incentive Program began. The enrollment web site with complete instructions for attestation is located on the CMS EHR Incentive Program web site.

During the online attestation process EPs will attest to a minimum of 90 consecutive days of meeting the appropriate meaningful use objectives with Certified Technology. Data that must be reported will include numerator, denominator, and any potential allowable exclusions to specific objectives. In addition, it will be necessary to document the selection and reporting of specific Clinical Quality Measures. The specific numerators and denominators that are to be reported will be obtained from the EHR, the EPs workflow process, or a combination of the two. It is important to understand how the EHR documents and reports meaningful use data in order for you to provide it accurately during attestation. The acquisition of this information has the potential to be the most problematic portion of the attestation process. If necessary, look to your EHR vendor for clarification and guidance on obtaining the meaningful use data that must be reported on an EP by the EP, not practice wide, basis.

CMS will provide ongoing clarification on the attestation process through webinars, FAQs, and User Guides to help assist in understanding and preparing for attestation. After online reporting of the core, menu, quality measures immediate submission is available which will reveal whether it was successful and details of each of the reported measures. Upon notification of complete and successful submission, the EP is qualified to receive an incentive from the CMS EHR Incentive Program.
Meaningful Use and the Eligible Professional

The CMS Final Rule specifies the initial criteria that EPs must meet to demonstrate meaningful use and qualify for incentive payments. For EPs, there are a total of 25 meaningful use objectives. To qualify for the incentive, the EP must meet 20 of these 25 objectives. The objectives are further divided into core and menu sets. The 15 core objectives are required while the remaining 10 menu objectives have options to defer 5.

Each objective has a corresponding measure and possible exclusion. The objective describes what the EP is required to do. The measure details the amount the EP must do. The exclusion outlines if any the reason an EP does not have to do the objective.

The objectives are measured by either affirmation or calculation. Objectives specifically state how they should be measured. When attesting to an objective measured by affirmation the EP will merely state they did do the objective or they did not, yes or no. Objectives that require calculation are percentage based. The objective is successfully met by demonstrating at least the percentage required. The percentage is obtained by a calculation of a denominator and a numerator. The denominator is either those patients whose records are maintained using certified EHR technology or all patients seen or admitted during the EHR reporting period regardless of whether their records are kept using certified EHR technology. Objectives clearly state which denominator can be used. The numerators are actions or subsets of patients seen or admitted during the EHR reporting period, only including patients or actions taken on behalf of those patients, whose records are kept using certified EHR technology. When the numerator is divided by the denominator the percentage is calculated.

The CMS rule outlines a phased and flexible approach to implement the requirements for demonstrating meaningful use. This approach initially establishes criteria for meaningful use based on currently available technological capabilities and providers’ practice experience. CMS will also establish graduated criteria for demonstrating meaningful use through future rulemaking, consistent with anticipated developments in technology and providers’ capabilities. EPs must demonstrate meaningful use of Certified Complete EHR Technology for a minimum of 90 consecutive days in their initial year, and full years subsequently.

Meaningful Use is separated into three stages. Stage 1 went into effect on January 1, 2011, to be replaced by Stage 2 in 2013, and then Stage 3 in 2015. Stage 1 has been fully defined, whereas Stages 2 is in the recommendation stage and 3 has not yet been defined.
Meaningful Use and Ambulatory Surgical Centers

What is an Ambulatory Surgical Center (ASC)?

According to CMS regulatory definitions, an Ambulatory Surgical Center or ASC means any distinct entity that:

- operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization
- has an agreement with CMS to participate in Medicare as an ASC
- and meets the conditions set forth in subparts B and C of 42 C.F.R. Part 416 – Ambulatory Surgical Services

CMS further defines the ASC on its web site in the Certification & Compliance section. An ASC must be certified and approved to enter into a written agreement with CMS. Participation as an ASC is limited to any distinct entity that operates exclusively for purposes of providing surgical services to patients not requiring hospitalization and whose expected stay in the ASC does not exceed 24 hours. An unanticipated medical circumstance may arise that would require an ASC patient to stay in the ASC longer than 24 hours, but such situations should be rare.

The regulatory definition of an ASC does not allow the ASC and another entity, such as an adjacent physician's office, to mix functions and operations in a common space during concurrent or overlapping hours of operations. CMS does permit two different Medicare-participating ASCs to use the same physical space, so long as they are temporally separated. That is, the two facilities must have entirely separate operations, records, etc., and may not be open at the same time.

However, ASCs are not permitted to share space, even when temporally separated, with a hospital, e.g., a hospital outpatient surgery department, or with a Medicare-participating Independent Diagnostic Testing Facility (IDTF). Certain radiology services that are reasonable and necessary and integral to covered surgical procedures may be provided by an ASC; it is not necessary for the ASC to also participate in Medicare as an IDTF for these services to be covered.
Participation in the Federal ASC program requires a Certification from CMS. You must have this certification to contract with other payers for facility fees. CMS administers the ASC program but each State, through their Health Departments, has jurisdiction over the program. Forty-three states have requirements of ASC licenses to operate. This license is then a requirement for the federal certification.

**Patients and Encounters**

CMS clearly defines the terms unique patient and patient encounter. They are not used interchangeably and must be considered when calculating patient volume thresholds and measures. CMS chose to use “unique patient” over “patient encounter” in measuring objectives related to patient’s medical records. It was assumed that not all of the information would need to be updated or needed by the EP at every patient encounter.

**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.

**Patient Encounter**
- Face-to-face meeting between patient and EP
- Results in a billable claim

**Medicaid Encounters**
- Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service; or
- Services rendered on any one day to an individual for where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing.
Relevant Encounter

- EP performs a medication reconciliation due to new medication or long gaps in time between encounters
- Other reasons determined appropriate and judged to be so by the EP

What does it take to meet the EHR Incentive requirements in an ASC?

Ambulatory surgical centers as an institutional facility are not eligible for EHR incentive payments. Institutional facilities under Medicare are subsection (d) hospitals and critical access hospitals (CAH). Institutional facilities under Medicaid are acute care hospitals, which include CAHs and cancer hospitals, and children’s hospitals. These definitions are statutory and the law did not give discretion for the Secretary of HHS to expand or alter them.

Even though ASCs are not eligible for incentive payments, Eligible Professionals (EPs) that perform services in ambulatory surgical centers are eligible for CMS EHR incentive payments. The EP must meet all objectives using certified technology for a reporting period of 90 consecutive days. The certified technology must be certified for eligible professionals. Using EHRs in ASCs that are hospital based and have certified technology for eligible hospitals and not eligible professionals is not an acceptable demonstration of meaningful use for EPs. But most physicians that provide services in ASCs also provide additional services at other facilities or might even provide services at another ASC. EPs that provide services in more than one location must still meet the threshold of 50 percent of their patient encounters being documented in a certified EHR. This requirement can be met by seeing patients at one or many locations, including Ambulatory Surgical Centers. CMS clearly states the patient encounters in the ASC count toward the percentage threshold:

“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).”
Objectives that use measures based on percentages are requiring that a certain amount of an EPs patients are included in the action. Denominators are derived from either those patients whose records are maintained using certified EHR technology or all patients seen or admitted during the EHR reporting period regardless of whether their records are kept using certified EHR technology. For EPs that provide services in more than one location they must determine what patients are correctly counted in the denominator. First, it is obvious that EPs may not have access to certified EHRs at all locations which they provide services. So measures should be limited to actions taken at the locations which have a certified EHR.

EHR Incentive payments are paid directly to the EP in a single consolidated annual payment. Payments will be made as soon as the EP has attested and reached the threshold for maximum payment. EPs can attest to meaningful use before they have reached the $24,000 threshold. All payments will be made to the EP unless the EP has a valid contractual arrangement which allows the entity or facility to bill for the providers services and the EP has reassigned the incentive payment to that entity. EPs cannot reassign their incentive payments to more than one employer or entity. The EPs enrollment information will disclose if the EP belongs to more than one practice by the association of their NPI. If the EP is associated with more than one entity the EP must select one TIN to receive the incentive payment.
The Medicare EHR Incentive Program and the ASC

EPs that have chosen to participate in the Medicare EHR Incentive program and provide services in an ASC must meet all the EP requirements already discussed along with specific requirements relating only to Medicare.

CMS Medicare EHR incentive payments are subject to an annual limit equal to 75 percent of the EP’s Medicare Physician Fee Schedule (MPFS) allowable charges billed. Charges must be submitted not later than two months after the end of the calendar year to be included in the calculation of charges billed. Charges are the total of the individual EP no matter how many different physical locations they were billed.

Medicare Advantage EPs must meet these additional requirements, hourly thresholds, and patient volume thresholds.

- Furnish, on average, at least 20 hours a week of patient-care services and be employed by the Qualifying MA Organization, or
- Furnish, on average, at least 20 hours a week of patient care services and be employed by, or be a partner of, an entity that through contract with the Qualifying MA Organization furnishes at least 80% of the entity’s Medicare patient care services to enrollees of the Qualifying MA Organization, and
- 80% of Provider services are provided to enrollees of the MAO
The Medicaid EHR Incentive Program and the ASC

EPs that have chosen to participate in the Medicaid EHR Incentive program and provide services in an ASC must meet all the EP requirements already discussed along with specific requirements relating only to Medicaid.

When establishing Medicaid patient volume thresholds, EP must have a minimum of 30 percent of all patient encounters attributable to Medicaid over any continuous, representative 90-day period within the most recent calendar year prior to reporting. Exceptions to this are Pediatricians and Medicaid EPs practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). Pediatrician’s minimum is only 20 percent and the other EPs must have a minimum of 30 percent attributed to “needy individuals”. Needy individuals are defined as having any one of the following criteria:

1. Individual is receiving financial assistance from Medicaid or the Children’s Health Insurance Program (CHIP)
2. Individual received uncompensated care by the EP
3. Individual received services at no cost or reduced cost based on an ability to pay sliding scale

States have two options on how EP will calculate Medicaid volume or propose to CMS an alternative methodology. This proposed option would have to have CMS approval before implementing. The CMS final rule outlines the two options for calculating Medicaid volume.

1. Using as the numerator the EPs total number of Medicaid patient encounters in any representative continuous 90-day period in the preceding calendar year and the denominator is all patient encounters for the same EP over the same 90-day period. \[\text{Total (Medicaid) patient encounters in any representative continuous 90-day period in the preceding calendar year/ Total patient encounters in that same 90-day period} \] * 100

2. Using as the numerator the EP’s total number of Medicaid patients assigned through a Medicaid managed care panel, medical or health home program panel, or similar provider structure with capitation and/or case assignment, plus all other Medicaid encounters for that EP. The assignment must be current within the 90-day period and we will consider as a proxy for this an encounter with any patient on the panel within the previous calendar year prior to the
representative 90-day period when the patient was on the panel. The
denominator is all patients assigned to the EP for the same 90-day period, also
with whom the provider had at least one encounter in the prior calendar year as
a proxy, as well as any other unduplicated Medicaid encounters during the
representative 90-day period. \[
\frac{[\text{Total (Medicaid) patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{Unduplicated (Medicaid) encounters in the same 90-day period}]}{[\text{Total patients assigned to the provider in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]} \times 100
\]

EPs that provide Medicaid services in more than one location may choose one or more
of the locations in order to calculate patient volume. One of these locations can be an
ASC. The calculation does not have to include all the locations the EP provides service.
However, at least one of the locations that has a certified EHR and the EP is
demonstrating meaningful use should be included in the EPs patient volume.
Definitions

An **ASC service** means facility services that are furnished in an ASC.

**Covered surgical procedures** means those surgical and other medical procedures that meet the criteria specified in §416.65 and are published by CMS in the Federal Register.

**Facility services** means services that are furnished in connection with covered surgical procedures performed in an ASC, or in a hospital on an outpatient basis.

**A hospital-based eligible professional (EP)** is defined as an EP who furnishes 90% or more of their services in either inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

**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.

**Place of Service Codes (POS) and Definitions**

(Rev. 1869; Issued: 12-11-10; Effective/Implementation Date: 03-11-10)

POS codes from the national POS code set in terms of HIPAA compliance.

11 **Office** – **Payment rate = Non facility**

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

17 **Walk-in Retail Health Clinic (No later than May 1, 2010)** – **Payment rate = Non facility**

A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
20 Urgent Care Facility (January 1, 2003) – Payment rate = Non facility
Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 Inpatient Hospital – Payment rate = Facility
A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital – Payment rate = Facility
A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room-Hospital – Payment rate = Facility
A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center – Payment rate = Facility
A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

50 Federally Qualified Health Center – Payment rate = Non facility
A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

72 Rural Health Clinic – Payment rate = Non facility
A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
Resources

CMS EHR Incentive Programs site
Go to the site

Office of the National Coordinator (ONC) Health IT site
Got to the site

ONC Certified HIT Product List (CHPL)
Go to the site

HITECHAnswers.net
Go to the site

Electronic Code of Federal Regulations
Title 42: Public Health - PART 416 Ambulatory Surgical Services
View the document