**Carve-Out**

A carve-out is a group of services that are not covered under the primary contract, but are addressed under a separate agreement. For instance, a practice may have a contract with a payer whereby all services will be reimbursed to the practice at a specific percentage of Medicare. There may also be a carve-out, whereby 10 procedures are paid at a contracted dollar rate, not a percentage of Medicare.

**Assignment**

Accepting assignment means that:

1. you will accept as payment in full the allowed amount established by the payer (Medicare or any other payer you are contracted with) and
2. the payment will be sent directly to the provider for services rendered.

Providers may accept assignment on a case-by-case basis unless they are contracted with the payer, in which case they usually are participating with the payer and accept assignment.

**Dear Mary Pat: How Do I**
Handle Chart Audit Requests From Payers?

When a payer or health plan calls your practice and requests records or requests an on-site visit to review charts, follow this guideline:

1. Be professional at all times. Audits can be nerve-wracking and can be a drain on internal resources, but there is always something to be learned from the process.

2. Ask for the request in writing, to include the names of the patients whose charts will be accessed, the dates of service covered under the audit, the name of the auditor, the specific reason for the audit, what the result from the audit will entail (warnings, sanctions, grading, etc.) and if the result will be published in any form anywhere. Request that the specific information culled from the audit be shared with your practice in an usable form.

3. Review your contract with the payer for any language related to the payer’s rights to access information, the description of the information, and any payment due to the practice for the labor and resources used in producing the records. Check with your state insurance laws for any information regarding such requests. Note that Medicare Advantage plans do not have contracts with practices, so you do have the right to charge for the labor and resources necessary to produce records.

4. When the information arrives from the payer, confirm that the patients named in the audit have records in your practice.

5. If the explanation for the audit is unclear, request more in-depth information in writing.
6. Review records or charts requested by the payer and be sure to remove any documentation that does not specifically refer to the dates being included in the audit. Do not give the entire chart to the auditor.

7. For practices with EMRs, print the appropriate documentation for the auditor if they request an on-site visit. Do not give the entire chart to the auditor.

8. If you are satisfied that all requirements are being met by the payer, schedule the audit, or arrange for records to be sent. If coming on-site, arrange for a quiet place for the auditor to review records, preferably close to you so you can observe, answer questions and ask questions.

9. Analyze the feedback received to improve any areas needed and document your effort as a part of your compliance plan. Have all practice employees sign off on any compliance plan updates.

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**Chart Audit Request Management**

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7. Review records or charts requested by the payer and be sure to remove any documentation that does not specifically refer to the dates being included in the audit. Do not give the entire chart to the auditor.

8. For practices with EMRs, print the appropriate documentation for the auditor if they request an on-site visit. Do not give the auditor access the system, as their permission to review records is limited.

9. Analyze the feedback received to improve any areas needed and document your effort as a part of your compliance plan. Have all practice employees sign off
Ten Reasons Why (Some) Physicians Aren’t Rushing to Adopt EMRs

1. Everyone is waiting for the other shoe to drop on Medicare payments.
2. Private practices may not have the in-house expertise to implement an EMR and may not be able to afford a consultant (although some states are receiving grants to help practices – check your state’s grant here.)
3. There is a lot of confusion on the parts of Meaningful Use that have been clarified and of course, on those that haven’t.
4. Administrators are distracted by RAC, PECOS, HIPAA, PQRI, eRx and RCM.
5. Some practices have spent years avoiding Medicare and Medicaid patients and now don’t have the patient numbers to participate.
6. Everyone and their uncle is selling an EMR – who can tell the long-timers who are about to be bought from the short-timers who might last forever?
7. Physicians are worried about the drop in production that (some say) happens when a practice launches an EMR.
8. There seems to be as many horror stories as there are success stories with EMRs.
9. Practices that are affiliated with a hospital are nervous about tying themselves to the hospital in such a serious way as hopping on their EMR package.
10. Because two practices can have absolutely opposite experiences with the same EMR, no one can find consistent recommendations for any single product. (It’s not the product, it’s the implementation!)

11. Bonus Reason: lots of people are confused about how to qualify for the ARRA money (read my post about this [here.])

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The Healthcare Bill, Rage, Concierge Practices, Cuts, Claims and Don Berwick (Yes!)

HEALTHCARE BILL IMPACT ON INDIVIDUALS AND RAGE

A number of people asked me about the impact of health reform on them as individuals. Here is a great story from the [Atlanta Journal-Constitution](http://www.atlantajournalconstitution.com) that takes specific examples of individuals and families and speculates on how the new bill(s) will impact them.

For 2010, the changes are minimal:

- Dependent children may be covered by their parents’ health insurance policies until age 26.
- A high-risk insurance pool will open for people with
pre-existing conditions who have been uninsured for six months.

- In 2011 Medicare will pay for an annual checkup, and deductibles and co-payments for many preventive services and screenings will be eliminated. The Medicare prescription drug doughnut hole will gradually narrow every year until it is eliminated in 2020. People in the “doughnut hole” could receive a $250 rebate this year.

I have to say that I’ve been dumbfounded by the fury raised over the passage of the new healthcare legislation. I realize that the bills separate people into winners (uninsured, providers with uncompensated charity care, patients with pre-existing conditions, Medicare patients, providers who see Medicaid patients, families with adult children, etc.) and losers (companies who have to pony up more money for their retired employees, insurance companies, illegal immigrants, high wage earners, etc.), but this story placed the fury into a different perspective for me. It’s a good read.

CONCIERGE PRACTICES

What does healthcare reform mean for the physician practice? Many are predicting the rise of concierge practices (also called boutique medicine, retainer practices, VIP medicine and cash practices) as physicians find they cannot survive if their patient population is predominantly Medicare, Medicaid and uninsured patients. Concierge practices fall into two categories:

- The first operates on an insurance+ model, which means that the practice accepts and files the insurance for the patient, but also requires an additional out-of-pocket fee of anywhere from $1500 to $1800 per year to be a patient of the practice. The fee is to cover services that Medicare and commercial insurance do not, such as physicals, phone consultations, wellness
counseling and patient education.

- The second operates on a strictly cash basis and the practice does not accept or file any insurance for the patient. The patient pays a flat fee per year for care (usually in the $5,000 to $15,000 range) and all primary care is provided for that amount. The patient still needs to carry insurance for prescriptions, hospital services and sub-specialist services. Imagine being a manager in this type of practice – no preauthorizations, no insurance department, no eligibility checking, no refunds...

Concierge medicine has not been around that long, but it is growing in popularity by leaps and bounds. The first acknowledged concierge practice was formed in 1996 in the Pacific Northwest. In 2002, CMS (Centers for Medicare and Medicaid) published a memo stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. In 2003, the Department of Health and Human Services ruled that concierge medical practices are not illegal. Today, there are approximately 5,000 physicians using the concierge model in the United States today.

**MEDICARE CUTS, MEDICARE CLAIMS AND DON BERWICK**

Shortly after all the shouting and voting on healthcare reform was over, Congress recessed for two weeks leaving the controversy over the 21.5% cuts required by the SGR formula still unsettled. CMS has advised the MACs to again hold claims for services provided from April 1 to April 10 to give Congress a chance to get back to work and back to voting for an additional delay (or not) for the cuts. If the cuts are allowed to stand, many physicians will start making their own cuts by minimizing the number of Medicare and Medicaid patients they will see.

Amidst this craziness, a voice of sanity is heard and it is
Donald Berwick, MD, current President of the Institute for Healthcare Improvement (IHI) and probable Obama pick for the head of CMS. If you don’t know Don Berwick or the IHI, click [here](#) to read an interview with him about the IHI’s “100,000 Lives Campaign” or watch the video below of him speaking about the dimensions of quality. Good stuff!

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**NCCI (National Correct Coding Initiative)**

The CMS (Centers for Medicare and Medicaid Services) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the [National Correct Coding Initiative Coding Policy Manual for Medicare Services](#) (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs (Fiscal Intermediaries) as a general reference tool that explains the rationale for NCCI edits.

Carriers implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.

More information from CMS [here](#).
Historic Votes on H.R. 3590 and H.R. 4872 Usher In Healthcare Reform

As I write this Sunday night I am listening to the US House of Representatives’ discussion/posturing prior to a ‘yes” or “no” vote for the Senate’s healthcare reform bill H. R. 3590. I don’t usually listen to CNN Live, but I want to remember this moment as I think it is the beginning of significant change in healthcare.

I’m not sure what this change will be, but many things that have been status quo for healthcare during my career might change almost beyond recognition by the time I retire. This, I think, is a good thing. I don’t think the current system is bad, but I sure think it could be better. As with any change, there will be good things, bad things, and unintended good and bad things. It should be fascinating.

Discussion has now timed out and the representatives are voting; 216 votes are needed to pass. The vote has just been announced (10:45 p.m.) and it is 219 Yeas to 210 Nays and the bill is passed! The next step is for it to be signed into law by President Obama, which might happen tonight or tomorrow.

Now the representatives are voting on H.R. 4872 – “The Health Care and Education Affordability Reconciliation Act of 2010” which contains fixes to H.R. 3590 that have been negotiated
between the two chambers. The bill has just passed (11:37 p.m.) with 220 Yeas and 211 Nays! 4872 will now go to the Senate for a vote which some are predicting will pass as early as Tuesday.

President Obama spoke from the White House after the votes and said “Tonight we answered the call of history.” The passage of these bills has been compared to the passage of Medicare in 1965 and the passage of Social Security in 1935.

Here are details of both bills.

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**Details on H.R. 3590 “~”~Patient Protection and Affordable Care Act’’**

**Cost:** $940 billion over ten years.

**Deficit:** Would reduce the deficit by $143 billion over the first ten years. Would reduce the deficit by $1.2 trillion dollars in the second ten years.

**Coverage:** Would expand coverage to 32 million Americans who are currently uninsured.

**Health Insurance Exchanges:**

- The uninsured and self-employed would be able to purchase insurance through state-based exchanges with subsidies available to individuals and families with income between the 133 percent and 400 percent of poverty level.
- Separate exchanges would be created for small businesses to purchase coverage – effective 2014.
- Funding available to states to establish exchanges within one year of enactment and until January 1, 2015.

**Subsidies:** Individuals and families who make between 100 percent – 400 percent of the Federal Poverty Level (FPL) and
want to purchase their own health insurance on an exchange are eligible for subsidies. They cannot be eligible for Medicare, Medicaid and cannot be covered by an employer. Eligible buyers receive premium credits and there is a cap for how much they have to contribute to their premiums on a sliding scale. Federal Poverty Level for family of four is $22,050.

### Paying for the Plan:

- **Medicare Payroll tax on investment income** – Starting in 2012, the Medicare Payroll Tax will be expanded to include unearned income. That will be a 3.8 percent tax on investment income for families making more than $250,000 per year ($200,000 for individuals).
- **Excise Tax** – Beginning in 2018, insurance companies will pay a 40 percent excise tax on so-called “Cadillac” high-end insurance plans worth over $27,500 for families ($10,200 for individuals). Dental and vision plans are exempt and will not be counted in the total cost of a family’s plan.
- **Tanning Tax** – 10 percent excise tax on indoor tanning services.

### Medicare:

- Closes the Medicare prescription drug “donut hole” by 2020. Seniors who hit the donut hole by 2010 will receive a $250 rebate.
- Beginning in 2011, seniors in the gap will receive a 50 percent discount on brand name drugs. The bill also includes $500 billion in Medicare cuts over the next decade.

### Medicaid:

Expands Medicaid to include 133 percent of federal poverty level which is $29,327 for a family of four.

- Requires states to expand Medicaid to include childless adults starting in 2014.
- Federal Government pays 100 percent of costs for
covering newly eligible individuals through 2016.
- Illegal immigrants are not eligible for Medicaid.

Insurance Reforms:

- Six months after enactment, insurance companies can no longer deny children coverage based on a preexisting condition.
- Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions.
- Insurance companies must allow children to stay on their parent’s insurance plans through age 26.

Abortion:

- The bill segregates private insurance premium funds from taxpayer funds. Individuals would have to pay for abortion coverage by making two separate payments, private funds would have to be kept in a separate account from federal and taxpayer funds.
- No health care plan would be required to offer abortion coverage. States could pass legislation choosing to opt out of offering abortion coverage through the exchange.

**Separately, anti-abortion Democrats worked out language with the White House on an executive order that would state that no federal funds can be used to pay for abortions except in the case of rape, incest or health of the mother. [Read more here]**

Individual Mandate: In 2014, everyone must purchase health insurance or face a $695 annual fine. There are some exceptions for low-income people.

Employer Mandate: Technically, there is no employer mandate. Employers with more than 50 employees must provide health insurance or pay a fine of $2000 per worker each year if any worker receives federal subsidies to purchase health insurance. Fines applied to entire number of employees minus some allowances.
Immigration: Illegal immigrants will not be allowed to buy health insurance in the exchanges – even if they pay completely with their own money.

Details on H.R. 4872 – “The Health Care and Education Affordability Reconciliation Act of 2010” (fixes to 3590)

COST: $940 billion over 10 years, according to the Congressional Budget Office.

HOW MANY COVERED: 32 million uninsured. Major coverage expansion begins in 2014. When fully phased in, 95 percent of eligible Americans would have coverage, compared with 83 percent today.

INSURANCE MANDATE: Almost everyone is required to be insured or else pay a fine. There is an exemption for low-income people. Mandate takes effect in 2014.

INSURANCE MARKET REFORMS: Major consumer safeguards take effect in 2014. Insurers prohibited from denying coverage to people with medical problems or charging them more. Higher premiums for women would be banned. Starting this year, insurers would be forbidden from placing lifetime dollar limits on policies, and from denying coverage to children because of pre-existing medical problems. Parents would be able to keep older kids on their policies up to age 26. A new high-risk pool would offer coverage to uninsured people with medical problems until 2014, when the coverage expansion goes into high gear.

MEDICAID: Expands the federal-state Medicaid insurance program for the poor to cover people with incomes up to 133 percent of the federal poverty level, $29,327 a year for a family of four. Childless adults would be covered for the first time, starting in 2014. The federal government would pay 100 percent of the tab for covering newly eligible individuals through
2016. A special deal that would have given Nebraska 100 percent federal financing for newly eligible Medicaid recipients in perpetuity is eliminated. A different, one-time deal negotiated by Democratic Sen. Mary Landrieu for her state, Louisiana, worth as much as $300 million, remains.

**TAXES:** Dramatically scales back a Senate-passed tax on high-cost insurance plans that was opposed by House Democrats and labor unions. The tax would be delayed until 2018, and the thresholds at which it is imposed would be $10,200 for individuals and $27,500 for families. To make up for the lost revenue, the bill applies an increased Medicare payroll tax to investment income as well as wages for individuals making more than $200,000, or married couples above $250,000. The tax on investment income would be 3.8 percent.

**PRESCRIPTION DRUGS:** Gradually closes the “doughnut hole” coverage gap in the Medicare prescription drug benefit that seniors fall into once they have spent $2,830. Seniors who hit the gap this year will receive a $250 rebate. Beginning in 2011, seniors in the gap receive a discount on brand name drugs, initially 50 percent off. When the gap is completely eliminated in 2020, seniors will still be responsible for 25 percent of the cost of their medications until Medicare’s catastrophic coverage kicks in.

**EMPLOYER RESPONSIBILITY:** As in the Senate bill, businesses are not required to offer coverage. Instead, employers are hit with a fee if the government subsidizes their workers’ coverage. The $2,000-per-employee fee would be assessed on the company’s entire workforce, minus an allowance. Companies with 50 or fewer workers are exempt from the requirement. Part-time workers are included in the calculations, counting two part-timers as one full-time worker.

**SUBSIDIES:** The proposal provides more generous tax credits for purchasing insurance than the original Senate bill did. The aid is available on a sliding scale for households making up
to four times the federal poverty level, $88,200 for a family of four. Premiums for a family of four making $44,000 would be capped at around 6 percent of income.

**HOW YOU CHOOSE YOUR HEALTH INSURANCE:** Small businesses, the self-employed and the uninsured could pick a plan offered through new state-based purchasing pools called exchanges, opening for business in 2014. The exchanges would offer the same kind of purchasing power that employees of big companies benefit from. People working for medium-to-large firms would not see major changes. But if they lose their jobs or strike out on their own, they may be eligible for subsidized coverage through the exchange.

**GOVERNMENT-RUN PLAN:** No government-run insurance plan. People purchasing coverage through the new insurance exchanges would have the option of signing up for national plans overseen by the federal office that manages the health plans available to members of Congress. Those plans would be private, but one would have to be nonprofit.

**ABORTION:** The proposal keeps the abortion provision in the Senate bill. Abortion opponents disagree on whether restrictions on taxpayer funding go far enough. The bill tries to maintain a strict separation between taxpayer dollars and private premiums that would pay for abortion coverage. No health plan would be required to cover abortion. In plans that do cover abortion, policyholders would have to pay for it separately, and that money would have to be kept in a separate account from taxpayer money. States could ban abortion coverage in plans offered through the exchange. Exceptions would be made for cases of rape, incest and danger to the life of the mother.

**STUDENT LOAN OVERHAUL:** Requires the government to originate student loans, closing out a role for banks and other private lenders who charge a fee. The savings "projected to be more than $60 billion over a decade" are plowed into higher Pell
Grants for needy college students and increased support for historically black colleges.

**MEDICARE:** Extends Medicare’s solvency by at least nine years and reduces the rate of its growth by 1.4 percent, while closing the doughnut hole for seniors, meaning there will no longer be a gap in coverage of medication.

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**FAQ on HITECH, Meaningful Use, Eligible Providers, and the Stimulus Money**

NOTE: Read my latest post on how to register and attest for the EHR Incentive Programs [here](#).

**Where Did the Idea of Meaningful Use of Electronic Medical Records Come From?**

The American Recovery and Reinvestment Act of 2009 was signed by President Obama on February 17, 2009. The Law includes the Health Information Technology for Economic and Clinical Health Act or the HITECH Act. The HITECH Act establishes programs under Medicare and Medicaid to provide incentive payments for the Meaningful Use of Certified Electronic Health Records technology.

The goal of the HITECH legislation is to improve healthcare outcomes, to facilitate access to care and to simplify care. It is believed that the installation of electronic health records in medical practices is only the beginning. The goals of HITECH will be met when the EHR is used in a meaningful way.
What is Meaningful Use (MU)?

There are three identified components of Stage I Meaningful Use. They are:

1. Use of a certified EHR in a meaningful manner such as e-prescribing.
2. Use of Certified EHR Technology for the exchange of health information (exchange data with other providers or business partners such labs or pharmacies)
3. Use of Certified EHR Technology to submit clinical quality and other measures.

The first stage of Meaningful Use is capturing and sharing the data. Meaningful Use Stage II is advanced clinical processes and Stage III is starting to look Meaningful Use of an EHR in the context of improved healthcare outcomes.

There are 25 specific criteria for MU Stage I listed in this article in Healthcare IT News:

[1] Objective: Use CPOE (Computerized Physician Order Entry)
Measure: CPOE is used for at least 80 percent of all orders

Measure: The EP (Eligible Provider) has enabled this functionality

[3] Objective: Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®
Measure: At least 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.

[4] Objective: Generate and transmit permissible prescriptions electronically (eRx).
Measure: At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using
certified EHR technology.

Measure: At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data.

Measure: At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient has no medication allergies) recorded as structured data.

Measure: At least 80 percent of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data.

[8] Objective: Record and chart changes in vital signs. 
Measure: For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.

[9] Objective: Record smoking status for patients 13 years old or older 
Measure: At least 80 percent of all unique patients 13 years old or older seen by the EP “smoking status” recorded

[10] Objective: Incorporate clinical lab-test results into EHR as structured data. 
Measure: At least 50 percent of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

[11] Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of
disparities, research, and outreach.
Measure: Generate at least one report listing patients of the EP with a specific condition.

Measure: For 2011, an EP would provide the aggregate numerator and denominator through attestation as discussed in section II.A.3 of this proposed rule. For 2012, an EP would electronically submit the measures are discussed in section II.A.3. of this proposed rule.

[13] Objective: Send reminders to patients per patient preference for preventive/ follow-up care
Measure: Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 and over

[14] Objective: Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules
Measure: Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II.A.3.

[15] Objective: Check insurance eligibility electronically from public and private payers
Measure: Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP

[16] Objective: Submit claims electronically to public and private payers.
Measure: At least 80 percent of all claims filed electronically by the EP.

[17] Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request
Measure: At least 80 percent of all patients who request an
electronic copy of their health information are provided it within 48 hours.

[18] Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)
Measure: At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information

[19] Objective: Provide clinical summaries to patients for each office visit.
Measure: Clinical summaries provided to patients for at least 80 percent of all office visits.

[20] Objective: Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure: Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

[21] Objective: Perform medication reconciliation at relevant encounters and each transition of care.
Measure: Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.

[22] Objective: Provide summary care record for each transition of care and referral.
Measure: Provide summary of care record for at least 80 percent of transitions of care and referrals.

[23] Objective: Capability to submit electronic data to immunization registries and actual submission where required and accepted.
Measure: Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries.
[24] Objective: Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice. Measure: Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically).

[25] Objective: Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities. Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.

**Have the Details of MU been finalized?**

The comment period for the NPRM (Notice of Proposed Rule Making) for Meaningful Use is currently open but will close on March 15, 2010. You can read the NPRM [here](#). Many individuals and organizations have expressed concern that the timeline for implementing EHR and meeting MU criteria is too short for the majority of providers. The American Academy of Family Physicians (AAFP) recently sent a 7-page letter to acting CMS Administrator Charlene Frizzerathat included the following concerns:

1. The administrative burden of reporting computerized physician order entry measures “is excessive to the point of being unachievable for most eligible providers.”
2. The rule could require manually entering results from laboratories that don’t have an interoperable interface with the physician’s electronic health record.
3. The term “health information” is used throughout the proposed rule, but is never defined.
4. A requirement that a patient’s health information be shared with that patient within 48 hours doesn’t take in account that physicians or their staff may not be able to process the information if that 48-hour period includes weekend days.

5. There is no incentive for physicians who meet less than 100% of the proposed requirements, so it is an all-or-nothing approach.

The Medical Group Management Association recently surveyed (see Modern Healthcare story here) 445 physician practice administrators in February 2010 with the following feedback:

1. Nearly all are aware of the upcoming incentive programs for meaningful use of electronic health records, but fear the programs will reduce physician productivity.

2. 68% of respondents expect physician productivity will decrease if all 25 proposed meaningful use criteria are implemented.

3. Nearly one-third believe the decrease in productivity will be greater than 10 percent.

4. Almost 25% of practices without an EHR doubt some of their providers will ever attempt to qualify for incentives.

5. Among practices with an EHR, nearly 84 percent believe some of their physicians will attempt to qualify for Medicare or Medicaid incentives by the end of 2011.

How Do I Comment on the MU Standard?

You can submit your comments on the NPRM on MU here.

You can read comments already submitted here.

How Do I Know if My EHR is Certified?

No EHRs have been certified for the CMS Incentive Program and the certifying bodies have not yet been announced. It seems reasonable that CCHIT will be one certifying body, but there
are expected to be others. If your vendor tells you that his EHR is certified before the rule has been finalized and the certifying bodies have been announced, ask him “For what?”

**What Does it Mean to Be Eligible? (description courtesy of Everything HITECH)**

This term encompasses three general types of payers to establish eligibility: 1) Medicare Fee For Services (FFS), 2) Medicare Advantage (MA) and 3) Medicaid.

For hospitals to be eligible, they can be acute care (excluding long term care facilities), critical access hospitals, children’s hospitals.

For providers, these include non-hospital-based physicians who receive reimbursement through Medicare FFS program or a contractual relationship with a qualifying MA organization. The Act defines the term “hospital based” eligible professional to mean an EP such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her Medicare covered professional services during the relevant EHR reporting period in a hospital setting (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital’s qualified EHR’s (Fed Reg p. 1905). The determining factor is the site of service as to whether the service is hospital based or not. If the EP provides at least 90 % of their services in a hospital inpatient, hospital outpatient or hospital emergency room setting (Point of Service codes 21, 22, 23), then they are considered a hospital based EP and not eligible for EHR incentive payments (i.e. providing substantially all of his or her Medicare covered professional services).

There is a difference between Medicare and Medicaid when it comes to defining an eligible professional for EHR incentive payment purposes. Medicare defines an eligible professional as
(Fed Reg p. 1996):

1. doctor of medicine or doctor of osteopathy
2. doctor of dental surgery or dental medicine
3. doctor of podiatric medicine
4. doctor of optometry
5. chiropractor

Medicaid, on the other hand, defines an eligible professional as (Fed Reg p. 2001):

1. physician
2. dentist
3. certified nurse-midwife
4. nurse practitioner
5. physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic, led by a physician assistant.

What are the Guidelines for Providing Patients With Their Medical Records Electronically?

Under HIPAA, patients currently have the ability to access their medical records. Meaningful Use does not change HIPAA in that regard. You may charge patients for the expense related to providing paper or electronic medical records. Each state has its own schedule for charging for medical records ([state-by-state schedule here](#)).

Do Eligible Providers Have to be Participating With Medicare to Receive the Incentive Money?

No, the eligibility requirements only relate to the benchmarks for the percentage of Medicaid patients you have, or amount of allowed Medicare charges you have.

Can Eligible Providers Work at Locations Other Than Hospitals and Private Practices and Receive the Incentive Money?
The location where the provider works is not the issue. The issue is whether or not the provider meets the requirements, either for Medicare or Medicaid, to be considered eligible for the program.

It doesn’t matter where the provider accesses the certified EHR. If they meet the eligibility criteria, and they are using a certified EHR, they can collect on the stimulus money.

**What Are Health Provider Shortage Areas?**

Physicians practicing in determined “health provider shortage” [detailed info here] areas will be eligible for a 10% bonus payment.

**How Does This Incentive Relate to ePrescribing or PQRI?**

If the PQRI Program is extended in its current form, practices can participate in both PQRI and an EHR Incentive Plan.

If the EP chooses to participate in the Medicare EHR Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously. If the EP chooses to participate in the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously.

Also, e-prescribing penalties sunset after 2014, so that no physician will be subject to penalties for failing to both e-prescribe and use an EHR!

**How Do EPs Get Paid For Meaningful Use of a Certified EHR?**

For the first payment year only, all an EP or hospital has to do is to be a “meaningful user” for a continuous 90-day period during the payment year. Hospitals’ payment year is October 1 to September 30 and EPs’ payment year is the calendar year. You must start and complete the 90-day period within the payment year with no overlapping.
Also, if you can qualify as a Medicaid Eligible Provider (or Hospital), are in the process of adopting, implementing or upgrading your EHR and your Medicaid patient volume is at least 30% (Pediatricians only need 20% minimum and Hospitals need 10% minimum), you can collect your incentive money without meeting Meaningful Use criteria.

Attestation forms and forms of other types are most likely the way that EPs will provide information to apply for the incentive funds, although the details have not yet been released.

What Does it Mean to Transition From One Program (Medicaid or Medicare) to Another?

EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs will be able to participate in only one program, and will have to designate which one they would like to participate in. After their initial designation, EPs are allowed to change their program selection only once during payment years 2012 through 2014.

To Recap:

How Do I Get My EHR Stimulus Money?

1. Decide whether you are an eligible provider for any of the programs.
2. If you are, buy a certified EMR (once certification has been defined.)
3. Use your EMR in a way that demonstrates your meaningful use of the product.
4. Pass “GO” and collect your money.

ARRA (Stimulus Bill) Acronyms

¢ A/I/U “Adopt, implement or upgrade
¢ CAH “Critical Access Hospital
For more information who is eligible and for how much, read my post "ARRA Eligible Providers: Who Is Eligible to Receive Stimulus Money and How Much is Available Per Provider?"
NPI Number (National Provider Identifier)

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)). To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers. Legacy provider identifiers include:

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

They do not include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs); or
• Social Security Numbers (SSNs).