Medicare This Week: June 22nd, 2012, Only 8 days Left For 2013 eRx Exemption, National Provider Call on Certified EHR Programs, New CME Modules

- **Only 8 Days Left to Apply for a 2013 ePrescribing Exemption: Will You Face a 1.5% Adjustment? (jump to story)**
- **Register Now: CMS National Provider Call on Certified EHR Technology (jump to story)**
- **Two New CME Modules on Medscape: Fraud and Abuse (jump to story)**

If You Are Not Currently ePrescribing, and Have Not Applied for a Hardship Exemption, You Have Until July 1st, 2012 to Do So

Reminder from CMS. All Emphasis Mine.

The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the following criteria:

- The eligible professional is a successful electronic prescriber during the 2011 eRx 12- month reporting period (January 1, 2011 through December 31, 2011).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

Avoiding the 2013 eRx Payment Adjustment

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between **January 1 and June 30, 2012.**

6-month Reporting Requirements to Avoid the 2013 Payment Adjustment:

- Individual Eligible Professionals – **10 eRx events** via claims

- Small eRx GPRO – **625 eRx events** via claims
- Large eRx GPRO – **2,500 eRx events** via claims

For more information on individual and eRx GPRO reporting requirements, please see the MLN Article SE1206 – 2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments.

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that **compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship**.

Significant Hardships

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

Submitting a Significant Hardship Code or Request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communication Support Page) **on or between March 1 and June 30, 2012**. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship

exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page **or on at least one claim** during the 2013 eRx payment adjustment reporting period (**January 1 through June 30, 2012**). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

For more information on how to navigate the Communication Support Page, please reference the following documents:

- Quality Reporting Communication Support Page User Guide
- Tips for Using the Quality Reporting Communication Support Page

For additional information and resources, please visit the E-Prescribing Incentive Program web page.

If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST.

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Registration Open for National Provider Call on Certified EHR Technology

If you are feeling “a little lost” about switching from a paper record, Meaningful Use, and choosing an EHR to get you started, this is the national provider call for you!

Wednesday, June 27; 2-3:30pm ET

Join CMS and the Office of the National Coordinator for Health Information Technology (ONC) for a National Provider Call providing an overview of the use of certified EHR technology to meet meaningful use. Learn about the different types of certification and what certification actually tests. As of April 30, over $5 billion has been paid in EHR incentives under both programs. This is the last year Medicare eligible professionals can begin to participate to earn the full Medicare Electronic Health Record (EHR) incentive payments.

Target Audience: Eligible Professionals and Eligible Hospitals as defined by the Medicare and Medicaid EHR Incentive Programs.

Agenda:

- **Overview of Meaningful Use**
- **How and Why of Certification**
- **Which EHR Products are Certified**
- **Resources**
- **Q&A with CMS and ONC experts**

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls web page. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

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Two New CME Modules Now Available on Medscape on Fraud and Abuse

In early June, Medscape posted two new CME modules entitled, “Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients” and “How CMS Is Fighting Fraud: Major Program Integrity Initiatives.” These modules highlight efforts by CMS to fight fraud and abuse and how health care professionals can be part of those efforts.

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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 of care 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

[2] Objective: Implement drug-drug, drug-allergy, drug-formulary checks
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.

[5] Objective: Maintain active medication list.
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.

[6] Objective: Maintain active medication allergy list.
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.

[7] Objective: Record demographics.
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.

[12] Objective: Report ambulatory quality measures to CMS or the States.
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 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
”¢ CCN ”“CMS Certification Number
”¢ CDS ”“Clinical Decision Support
”¢ CMS ”“Centers for Medicare & Medicaid Services
”¢ CY ”“Calendar Year
”¢ EHR ”“Electronic Health Record
”¢ EP ”“Eligible Professional
”¢ eRx ”“E-Prescribing
”¢ FFS ”“Fee-for-service
”¢ FY ”“Federal Fiscal Year
”¢ HHS ”“U.S. Department of Health and Human Services
”¢ HIT ”“Health Information Technology
”¢ HITECH Act ”“Health Information Technology for Electronic and Clinical Health Act
”¢ HITPC ”“Health Information Technology Policy Committee
”¢ HIPAA ”“Health Insurance Portability and Accountability Act of 1996
”¢ HPSA ”“Health Professional Shortage Area
”¢ IFR ”“Interim Final Rule
”¢ MA ”“Medicare Advantage
”¢ MCMP ”“Medicare Care Management Performance Demonstration
”¢ MITA-Medicaid Information Technology Architecture
”¢ MU ”“Meaningful Use
”¢ NPI ”“National Provider Identifier
”¢ NPRM ”“Notice of Proposed Rulemaking
”¢ OMB ”“Office of Management and Budget
”¢ ONC ”“Office of the National Coordinator of Health Information Technology
”¢ PQRI ”“Medicare Physician Quality Reporting Initiative
”¢ Recovery Act ”“American Reinvestment & Recovery Act of 2009

”¢ TIN ”“Taxpayer Identification Number

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?**”