Robert Anthony from CMS Takes Questions on Stage One Meaningful Use in PhysiciansPractice Webinar

Today, **PhysiciansPractice** sponsored a webinar with CMS's Robert Anthony on the topic of "Meaningful Use Stage 1." Robert Anthony is a Health Insurance Specialist in the Office of E-Health Standards and Services (OESS) at the Centers for Medicare & Medicaid Services (CMS), where he focuses on the EHR Incentive Programs. Robert had a very pleasant voice to listen to, and he gets my vote for the best CMS Employee Speaker that I've heard!

I was not familiar with the OESS before, so I looked it up and found out what they do: **Provide the overall leadership for and coordinate the implementation of Title IV of the HITECH Act. (Title IV = Medicare and Medicaid Health Information Technology)**

Robert briefly reviewed what has happened to date with the EHR Incentive Program and the terms of the Medicare and Medicaid programs. The three main differences in the two programs are:

1. The **types of provider**s that are eligible for each program – information **here.**
2. The **volume of each type of patient** needed to participate: no volume needed to participate in the Medicare program and 30% Medicaid patients for all eligible practitioners except pediatricians who only need 20% Medicaid patients.
3. The **tasks in year one** in which the certified EHR is adopted. For Medicaid the practice only needs to attest that they have adopted, implemented or upgraded an EHR.

In year one for Medicare the practice needs to attest to meaningful use for 90 days, which means data is collected and input into the attestation system.

The majority of the webinar was devoted to FAQs (my favorite part of any CMS-related education session!)

FAQs

Q: Can entities participate in the Medicare EHR Demonstration Project, and the Medicare or Medicaid EHR Incentive programs too?

A: Yes. The demonstration projects are about to be sunsetted (completed.)

Q: What information must be provided to patients to meet the requirement for a clinical summary at the end of each visit?

A: If system is certified, it will automatically provide the appropriate information for the clinical summary, which includes the patient's problem list, medication list, medication allergy list, and diagnostic test results.

Robert suggested looking at the answer online at the CMS FAQ which I posted below:

In our final rule, we defined "*clinical summary*" as: an after-visit *summary* that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on *clinical* discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, *summary* of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other

appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

The EP must include all of the above that can be populated into the *clinical summary* by certified EHR technology. If the EP's certified EHR technology cannot populate all of the above fields, then at a minimum the EP must provide in a *clinical summary* the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

Q: How and when are incentive payments made?

A: After the online attestation is made (attestation thresholds must be attained), provider information is verified, then in 6 to 8 weeks a payment is generated. Payments are made in whatever way the entity typically gets CMS payments.

***Q: What if patients do not routinely receive prescriptions during an office visit? How can the threshold be met*? (Referring to computerized provider order entry (CPOE) for medication orders.)**

A: For attestation, practices need to do this for 30% or more of all unique patients with at least one medication in their medication list. Note that patients with no medications in their medication list are excluded, so CMS believes this core initiative is realistic.

Q: For the Medicaid program, do you count the patient visit or

the number of services (e.g. patient visit plus two tests equals three patient ticks) during the visit?

A: This question needs follow-up and if you send an email to editor@physicianspractice.com, they will be sent to CMS for the answer. Here is additional information from the CMS FAQ:

> ***When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are eligible professionals (EPs) required to use visits, or unique patients?***
>
> *There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.*

Q: We are a new practice and plan on getting an EMR in the next 3 months. Can you walk me through the time lines?

A: If you haven't chosen an EMR yet, your first year in either program will probably be 2012. In the first year of Medicare participation, you will need to use the EMR meaningfully for 90 days during calendar year 2012, and you have up to 60 days after the close of the calendar year to attest to your use. In the first year of Medicaid participation, you will need to adopt (acquire, install), implement (commence utilization of EHR such as train, data entry), or upgrade (expand) a certified EHR and attest to your activity at any time during the calendar year.

Q: What validation or oversight will CMS provide for the

attestation process?

A: Before any payment is made, checks of provider eligibility and information will be done. Keep in mind that attestation is a legal process. Random audits will be put in place in the near future.

Q: ***Should a practice register if we don't know which program we are going to use?***

A: You can register at any time, and you can change from one program to the other prior to attesting, so you can register for one program and change before you begin the attestation.

Q: If your first year of attestation is in 2012, can you get the full 44K over the course of the program?

A: Yes.

Q: Can you verify if Physician Assistants are eligible for one of the programs?

A: Physician Assistants (PAs) are only eligible under the Medicaid program and must be the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to qualify.

Q: Does a radiology practice have to provide a clinical summary for patients?

A: No practice type is excluded from clinical summary mandate. CMS has not heard of any practice type having a problem with this so far. Remember, to achieve meaningful use, you must provide clinical summaries to patients for more than 50 percent of office visits within three business days. **Exclusion: Any EP who has no office visits during the period of EHR reporting.**

Q: Is the problem list supposed to be related to the chief compliant of the office visit?

A: Not necessarily. Practices are required to maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) codes. To comply, at least 80 percent of all unique patients seen by eligible providers must have at least one entry (**or an indication of none**) recorded as structured data.

Q: What if questions were not able to be answered during the webinar?

A: Please **e-mail** Physicians Practice and we'll get your answers from CMS. This could take several days, so please be patient. We will post your answers and all post-webinar questions at **http://www.physicianspractice.com** and notify you via e-mail as well.

Resources

A great list of additional resources were provided by Robert Anthony and Physicians Practice:

Resources from CMS

- **EHR Incentive Programs website**
- **ONC website**
- **FAQs**
- **Listserv**
- **Meaningful Use Specification Sheets**
- **EHR Information Center**
- **Registration & Attestation User Guides**
- **EHR Hotline:** 888-734-6433 / -6563 (TTY)

Resources from PhysiciansPractice.com

- Topic Resource Centers
  - **EHR**
  - **Meaningful Use**
- Tools

- **Are You Ready? Quiz**
- **Pricing Worksheet**
- **Preparation Checklist**
- **Meaningful Use Stage 1 Crib Sheet**

- ***You can also listen to an archived video of today's webinar here.***

Other Posts I have written on this topic:

Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last Week's CMS Call

CMS Holds National Provider Calls for the Medicare EHR Incentive Program and EHR Attestation Q & A

Digging Into the Details of "Certified EMR" & Tips For Buying an EMR

How Do You Get That Stimulus Money for Using an Electronic Medical Record? (You Register!)

How My Practice Knew We Were Ready for EMR

10 Ways to Get More Out of Your PM, EMR or Any Medical Software