A Guide to Healthcare Buzzwords and What They Mean: Part Two (M through Z)

Meaningful Use (MU)

Meaningful Use is the phrase used in the 2009 HITECH Act to describe the standard providers must achieve to receive incentive payments for purchasing and implementing an EHR system. The term meaningful use combines clinical use of the EHR (i.e. ePrescribing), health information exchange, and reporting of clinical quality measures. Achieving meaningful use also requires the use of an EHR that has been certified by a body such as CCHIT, Drummond Group, ICSA Laboratories, Inc. or InfoGuard Laboratories, Inc. The term can also apply informally to the process of achieving the standard, for example “How is our practice doing with meaningful use?”

mHealth

An abbreviation for Mobile Health, mHealth is a blanket label for transmitting health services, and indeed practicing medicine, using mobile devices such as cell phones and tablets. mHealth has large implications not only for newer devices like smartphones and high-end tablets, but also for feature phones and low-cost tablets in developing nations. Many different software and hardware applications fit under the umbrella of mHealth so the term is used conceptually to talk about future innovations and delivery systems.

NLP

An acronym for Natural Language Processing, NLP is a field of study and technology that seeks to develop software that can "understand" human speech – not just what words are being said, but what is meant by those words. By "processing" text input into an NLP program, large strings of text can be parsed into more traditionally meaningful data. For example, narrative from a doctor in a medical record could be transferred into data for research and statistical analysis. If we had every medical record and narrative in history, we could search it and look for trends – and possible new cures and symptoms. IBM's famous Watson machine that could "listen" to Jeopardy! clues and answer is an advanced example of NLP.

ONCHIT

An acronym for "Office of the National Coordinator for Healthcare Information Technology," the ONCHIT is a division of the Federal Government's Department of Health and Human Services. The Office oversees the nation's efforts to advance health information technology and build a secure, private, nationwide health network to exchange information. Although the National Coordinator position was created by executive order in 2004, the Office and its mission were officially mandated in the 2009 HITECH Act as a part of the stimulus package.

Patient Engagement

Patient Engagement is a broad term that describes the process of changing patient behaviors to promote wellness and a focus on preventative care. "Engagement" can roughly be read to describe the patient's willingness to be an active participant in their own care and to take responsibility for their lifestyle choices. Patient Engagement efforts can be as simple as marketing campaigns for public heath and appointment reminders, and as advanced as wearable monitors that can transmit activity and exercise information so patients can

track their fitness. Improving the health system's ability to engage patients is considered key to lowering healthcare spending and attacking epidemics like obesity and heart disease.

Patient Portal

A patient portal is software that allows patients to interact, generally through an internet application, with their healthcare providers. Portals enable communication between providers and patients in a secure environment with no fear of inappropriate disclosure of the patient's private healthcare information. Patients can get lab results, request appointments and review their own records without calling the provider. Patient portals can be sold as a standalone software module or as part of a comprehensive Practice Management/EHR package.

Patient-centered Care

Patient-centered care is a healthcare delivery concept that seeks to use the values and choices of the patient to drive all the care the patient receives. As elementary as it sounds, developing a culture that places the needs and concerns of the patient – the whole patient – at the center of the decision-making process is a new development in the healthcare system. Patient engagement is at the core of patient-centered care, because the patient is the central driver of the decisions – as is only right!

PCMH

An acronym for Patient Centered Medical Home, a PCMH is a model for healthcare delivery where most or all of a patient's services for preventative, acute and chronic primary care are delivered in a single place by a single team to improve

patient outcomes and satisfaction as well as lower costs. PCMHs may also operate under a different reimbursement structure, as they can be paid on an outcome basis or on a capitation model as opposed to fee-for-service.

PHR

An acronym for a “Personal Health Record,” a PHR is a collection of health data that is personally maintained by the patient for access by caregivers, relatives, and other stakeholders. As opposed to the EHR model, in which a single hospital or system collects all the health information generated in the facility for storage and exchange with other providers, the PHR is maintained, actively or passively with mobile data capture or sensor devices, by the patient. The PHR can supplement or supplant other health records depending on the way it is used.

PPACA

An acronym for the “Patient Protection and Affordable Care Act,” the PPACA was a federal law passed in 2010 to reform the United States healthcare system by lowering costs and improving access to heath insurance and healthcare. The PPACA uses a variety of methods – market reforms to outlaw discrimination based on gender or pre-existing condition, subsidies and tax credits for individuals, families and employers, and an individual mandate forcing the uninsured to pay penalties – to increase access to insurance and lower healthcare costs.

PQRS

An acronym for the “Patient Quality Reporting System,” PQRS is a mechanism by which Medicare providers submit clinical quality and safety information in exchange for incentive payments. Physicians who elect not to participate or are found

unsuccessful during the 2013 program year, will receive a 1.5 percent Medicare payment penalty in 2015, and 2 percent Medicare payment penalty every year thereafter.

RAC

An acronym for “Recovery Audit Contractor,” a RAC is a private company that has been contracted by the Centers for Medicare and Medicaid Services to identify and recover fraudulent or mistaken reimbursements to providers. There are four regions of the United States, each with its own RAC which is authorized to recover money on behalf of the Federal Government. A pilot program between 2005 to 2007 netted nearly $700 million dollars in repayments and the program was made permanent nationwide in 2010.

REC

An acronym for “Regional Extension Center,” a REC is a organization or facility funded by a federal grant from the Office of the National Coordinator for Health Information Technology to provide assistance and resources to providers who want to adopt an EHR and achieve meaningful use but need technical or deployment support to get their system up and running. There are currently 62 RECs in the United States who focus primarily on small and individual practices, practices without sufficient resources, or critical access and public hospitals that serve those without coverage.

Registry

A Registry is a database of clinical data about medical conditions and outcomes that is organized to track a specific subset of the population. Registries are important to track the efficacy of drugs and treatment, as well as to analyze and identify possible treatment and policy opportunities to improve care. A registry can also be used to report PQRS.

Telehealth

Telehealth is a broad term that describes delivering healthcare and healthcare services through telecommunication technology. Although the terms telehealth and mhealth can be used somewhat interchangeably, “telehealth” tends to focus more on leveraging existing technologies – phone, fax and video conferencing to deliver services over a long distance, or to facilitate communication between providers. Remote evaluation and management and robotics are both examples of care innovations that would fall under the telehealth umbrella.

Value-based Purchasing

Value-based purchasing is a reimbursement model for health care providers that rewards outcomes for patients as opposed to the volume of services provided. Both through increased payments for positive outcomes, and decreased payments for negative ones, value-based purchasing seeks to lower costs by focusing on increasing quality and patient-focus. Accountable Care Organizations and Patient Centered Medical Homes are both examples of delivery systems that rely on value-based purchasing.

Medicare is Auditing You! What To Do Next?

There are a number of different audits that are carried out by Medicare-contracted auditors. It’s important to know the differences and have a plan for responding.

CERT stands for Comprehensive Error Rate Testing and CERT audits were initiated in 2000. The program is responsible for measuring improperly paid claims. The CERT Program uses the following OIG-approved methodology:

1. A sample of approximately 120,000 submitted claims is randomly selected;
2. medical records from providers who submitted the claims are requested; and
3. the claims and medical records are reviewed for compliance with Medicare coverage, coding and billing rules.

RAC stands for Recovery Audit Contractor and began in early 2009. The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions to stop future improper payments. RAC is currently focusing on inpatient services and physical therapy services. As of the date this post was published RAC was not focusing on physician services.

ZPIC (Zone Program Integrity Contractors) replaces the Medicare Program Safeguard Contractors (PSCs) and Medicare Drug Integrity Contractors (MEDICs) that are currently in use by CMS. ZPICs are be responsible for detection and deterrence of fraud, waste and abuse across all claim types. ZPICs have access to CMS National Claims History data, which can be used to look at the entire history of a patient's treatment no matter where claims were processed. Being able to look at the overall picture will enable them to more readily spot over billing and fraudulent claims. Among other things, ZPICs will look for billing trends or patterns that make a particular provider stand out from the other providers in that community. Once a ZPIC identifies a case of suspected fraud and abuse, the issue is referred to the Office of Inspector General (OIG) for consideration and possible initiation of criminal or civil prosecution. **ZPIC is widely considered to be the greatest threat to physician practices.**

Seven ZPIC zones have been identified. The zones include the following states and/or territories and most have been assigned contractors:

- Zone 1 – CA, NV, American Samoa, Guam, HI and the Mariana Islands **http://www.safeguard-servicesllc.com/zpic.asp**
- Zone 2 – AK, WA, OR, MT, ID, WY, UT, AZ, ND, SD, NE, KS, IA, MO **AdvanceMed was just purchased by NCI** – site not current
- Zone 3 – MN, WI, IL, IN, MI, OH and KY – not awarded
- Zone 4 – CO, NM, OK, TX. **HealthIntegrity**
- Zone 5 – AL, AR, GA, LA, MS, NC, SC, TN, VA and WV **AdvanceMed was just purchased by NCI** – site not current
- Zone 6 – PA, NY, MD, DC, DE and ME, MA, NJ, CT, RI, NH and VT – not awarded
- Zone 7 – FL, PR and VI **http://www.safeguard-servicesllc.com/zpic.asp**

How should you respond to a Medicare audit?

1. Log all requests for records from all payers. Time and date all communications received and all communications sent.
2. Scan all records sent and include a cover letter itemizing contents of response.
3. Send records via certified mail.
4. If you get a request for a large amount of records at one time, consider getting advice from a consultant or attorney who specializes in Medicare audits as a large scale record request may cripple the practice operations.

How can you be proactive before you get an audit letter?

1. Check the audit sites monthly to see if your specialty or any services you provide are being targeted for an audit.
    - **CERT – www.cms.hhs.gov/cert**
    - Check the ZPIC site for your zone above
    - **OIG – www.oig.hhs.gov/reports.html**
    - Check your RAC site in my post **here**
2. Conduct an internal assessment to identify if you are in compliance with Medicare rules or hire a third-party to conduct an audit for you.
3. Identify corrective actions to promote compliance.
4. Appeal when necessary

Excellent resource site **http://www.willyancey.com/sampling-claims.html**

The Cohen Report: Free Webinar on Auditing the RAC Auditors

ï»¿NOTE: If you need the basics on RACs, **click here for my article.**

Image by doug88888 via Flickr

From our friend Frank Cohen:

Over the past year or so, I have been involved in conducting post RAC (and other) audit analyses to determine whether the RAC (or other auditing agency) was using appropriate statistics and calculations to create their overpayment estimates.

As you can probably imagine, in nearly every case, I have found this not to be true. In fact, as it turns out, the errors I find nearly always are in favor of the auditor, not the healthcare provider.

RAC is able to take advantage of the practice in three areas

The first area has to do with pulling samples for review. If these samples are not random or worse yet, if they are intentionally biased, they can create a misrepresentation of overpayment that unfairly penalizes the provider and because RACs are paid a commission, benefits them.

The second area has to do with the way in which the overpayment point estimate is calculated. This is where they come up with something like the average overpayment per audited unit (i.e., claim, claim line, member event, etc.).

The third has to do with the methodology used to extrapolate the point estimate for the sample to the universe of units for the healthcare provider. An error in any one of these areas can result in a gross exaggeration of the final overpayment demand.

Understanding how to defend yourself from the results of an audit

I have developed a series of three short, free webinars to teach you how to catch potential errors in each of three

areas.

Part 1 will be on validating random samples and is scheduled for Monday, December 13 from 1:00 to 2:00 EST.

Part 2 is on how to calculate the overpayment point estimate and is scheduled for Tuesday, December 14 from 1:00 to 2:00 EST.

Part 3 is on verifying extrapolation results and is scheduled for Wednesday, December 15 from 1:00 to 2:00 EST.

Each webinar will probably last around 30 minutes with an additional 30 minutes for questions. I plan to record these and post them later so if you can't make it, don't worry. Each session will be available for review after the last one is completed.

For more info or to register, go to www.frankcohen.com and click on the Webinar tab. Also, feel free to forward this on to co-workers or to post wherever you think folks may benefit.

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