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.

My Notes on the March 22, 2011 CMS Open Door Forum on Physician Quality Reporting

System (PQRI) for the Beginner

Today's CMS Open Door Forum was a good one. The slides (**pdf here**), although reviewed quickly during the call, are a comprehensive resource for anyone needing in-depth information on qualifying for incentives through PQRI. The information is complex, but anyone can start the process tomorrow and successfully get their check (next year.)

PQRI has been renamed PQRS.

These are the key points of the information presented:

1. You can tell if you are **eligible** for the incentive program by checking the main PQRS site **here**. Scroll down to Downloads and click on "List of Eligible Professionals."
2. There is **no registration** required to report quality data.
3. PQRS should not be confused with incentives offered for ePrescribing or meaningful use of a certified Electronic Health Record – these are three distinct systems.
4. There are new Physician Quality Reporting Measure Specifications every year – use the correct year.
5. Reporting can be done as **individual eligible providers or as groups,** however groups needed to be self-nominated by January 31, 2011, so that door is closed for this year.
6. Eligible providers can choose to report for 12 months: January 1""December 31, 2011 or for 6 months: July 1-December 31, 2011 (claims and registry-based reporting only.)

7. There are **two reporting methods for submission of measures groups** that involve a patient sample selection: 30-patient sample method and 50% patient sample method. An “intent G-code” must be submitted for either method to initiate intent to report measures groups via claims. If a patient selected for inclusion in the 30-patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to the subsequent claim to indicate that the quality action was performed during the reporting period.
   Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30-patient samples.
8. Eligible professionals who have contracted with Medicare Advantage (MA) health plans should not include their MA patients in claims-based reporting of measures groups using the 30 unique patient sample method. **Only Medicare Part B FFS patients** (primary and secondary coverage including Railroad Medicare) should be included in claims-based reporting of measures groups.
9. **Choose which group measures** OR individual measures (3 minimum) you want to report on based on your method of reporting. Review your choices **here.**
10. If you plan to report using a registry or EHR, make sure the systems are qualified by checking **here.**
11. Here is the **schedule** for PQRS incentives and “payment adjustments” (financial dings.)

- Incentives (based on the eligible professional’s or group’s estimated total Medicare Part B PFS allowed charges)
    - 2007 ”“1.5% subject to a cap
    - 2008 ”“1.5%
    - 2009, 2010 ”“2.0%
    - 2011 ”“1%
    - 2012, 2013, 2014 ”“0.5%

- Payment Adjustments (you lose money)
    - 2015 ”“98.5%
    - 2016 and subsequent years ”“98.0%

What follows are the Questions and Answers from the listeners.

Q: Do PQRS measures need to be reported once per encounter or once per episode?

A: It depends on the measure. Check the list to see what each measure requires.

Q: Is there a code to submit if we cannot qualify due to low numbers of Medicare patients?

A: No, CMS will calculate this and will know you cannot qualify and you will be exempt from the payment adjustment.

Q: Can both admitting physicians and consulting physicians submit the same quality codes?

A: Yes, all eligible providers working with a patient can report the same code if appropriate.

Q: How do we know if we qualified for the eRx incentive for 2010?

A: Payments will come early fall and feedback reports will be available that break down each provider’s incentive.

Q: For the eRx incentive, is it 10 eRxs before June 30, 2011 and 25 before January 31, 2011 for each PROVIDER or each PRACTICE?

A: Each provider.

Q: What is the difference between the numerator and the denominator in PQRS?

A: The numerator is the clinical quality action (for instance, putting a patient on a beta blocker) and the denominator is the group of patients for whom the quality action applies (which patients with appropriate diagnoses are eligible for beta blocker therapy.)

Q: Do all the preventive measures in this group have to be utilized?

A: Not all measures will apply to all patients, for instance mammograms for females only.

Q: Is there a code to be placed on the claim that says a measure is not applicable for this patient?

A: No.

Q: How do you know if a measure code on a claim has been accepted?

A: You will receive a rejection code on your EOB that indicates the code was submitted for information purposes only. Remittance Advice (RA) with denial code N365 is your indication that Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility.

Q: How can a new provider get started with quality reporting?

A: Any provider can start any time by reporting through claims, a registry or an EHR.

Q: Should providers bill for PQRI under their individual number or under their group number?

A: Under their individual number.

Q: Can a physician delegate the eRx process to a staff member, just as they might have a nurse write a prescription for them?

A: Yes.

Q: Can you clarify the three incentive programs and which a practice can participate in at the same time?

A: The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are able to also receive the eRx incentive.

If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals can still report the eRx measure but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional.

If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

The transcript and a recording of today's call will be posted on the CMS website within a few weeks.

Image via Wikipedia

E-prescribing: Use it 10 times for Medicare Patients Between Now and June 30, 2011 or Lose Money in 2012

Should I consider ePrescribing in 2011 if I’m not ready to install an EMR?

- In 2012 eligible professionals who are not successful eprescribers, based on claims submitted between January 1, 2011 ”“ June 30, 2011, may be subject to a “payment adjustment” (read payment cut) in their Medicare Part B Physician Fee Schedule (PFS) for covered professional services.
- Those that don’t eprescribe as a part of 10 Medicare patient encounters by June 30, 2011 will only receive 99% of their Medicare payment for all encounters in 2012.
- Those that don’t ePrescribe as a part of 25 encounters by December 31, 2011, will only receive 98.5% of their Medicare payments for all encounters in 2013 and only

98% of their Medicare payments for encounters during 2014 and going forward.
- The payment adjustment does not apply if <10% of an eligible professional's (or group practice's) allowed charges for the January 1, 2011 through June 30, 2011 reporting period are comprised of codes in the denominator of the 2011 eRx measure.

The **DENOMINATOR** is the visit code that is eligible for an eprescribing code (see list below.)

Patient visit during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

The **NUMERATOR** is a prescription generated and transmitted via a qualified eRx system and reported using a quality data code.

G8553: At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system (reported via claims, a registry, or an EHR.)

Please note that earning an eRx incentive for 2011 will **NOT** necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 Payment Adjustment

An eligible professional can avoid losing 1% in 2012 if (s)he:

- Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011

based on primary taxonomy code in NPPES,

- Does not have prescribing privileges. (S)he must report (**G8644**) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator;
- Becomes a successful e-prescriber; and
- Reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

Exemptions from the Medicare Payment Adjustment in 2012

- An (EP) eligible professional or selected group practice may request an exemption from the eRx Incentive Program and from the payment adjustment based upon a significant hardship.
- The qualifying circumstances are based upon two "hardship codes" that need reported on at least one claim prior to June 30, 2011 should one of the following situations apply:

G8642 – The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.

G8643 – The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under
section 1848(a)(5)(A) of the Social Security Act

To Recap:

1. Each Physician or practice that does not currently ePrescribe should consider whether or not ePrescribing is worthwhile. (Note: For group practices participating in eRx GPRO I or GPRO II during 2011, the group practice **MUST** become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure. Check out the Group Practice Reporting Option **here**.)
2. In estimating the value of ePrescribing, the practice manager must consider on one hand the expense (which there is, even for free standalone eRx systems) surrounding the implementation of ePrescribing, and the potential income from the ePrescribing Incentive.
3. The practice must also determine if an EMR is in their future, and if so, if the installation will take place soon enough to report the 10 encounters with Medicare patients.
4. Individual eligible professionals (EPs) may choose to participate in either the PQRI, *eRx*, or both. PQRI and *eRx* are separate incentive programs.
5. If an eligible professional (EP) earns an incentive under the Medicare EHR Incentive Program, he or she cannot receive an incentive payment under the *eRx* Incentive Program in the same program year, and vice versa. However, if an EP earns an incentive under the Medicaid EHR Incentive Program, he or she can receive an incentive payment under the *eRx* Incentive Program in the same program year.
6. Eligible professionals must have adopted a "qualified" *eRx* system. There are two types of systems: a system for *eRx* only (stand-alone) or an electronic health record (EHR system) with *eRx* functionality. Regardless of the type of system used, to be considered "qualified" it

must be based on **ALL** of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PBMs) if available.
- Providing information related to lower cost, therapeutically appropriate alternatives (if any). Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts.
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

For a list of qualified registries and qualified EHR vendors and products, click **here.**

An excellent article, ***Choosing the Right E-prescribing Application: Should you buy a standalone app or an EHR-integrated module?*** was published in January 2011 by Physicians Practice **here.**

Image courtesy of Wikipedia