

# *THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO (AMCNO)*

## *PRACTICE MANAGEMENT MATTERS*

SUMMER EDITION 2010

## Medicare

### Federal Officials Release the Final Rule on Meaningful Use

Federal officials have released the final rule on meaningful use, which will allow physicians and hospitals to qualify for thousands of dollars in stimulus funding incentives for the adoption of electronic health records. The 864-page final rule outlines the specific qualifications providers must meet to achieve the meaningful use of electronic health records.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. One of the regulations defines the “meaningful use” objectives that providers must meet to qualify for the bonus payments, and the other regulation identifies the technical capabilities required for certified EHR technology. According to David Blumenthal, MD, national coordinator for health information technology, the final rule differs from the proposed rule issued last January in that it allows providers more flexibility in choosing which measures to use for qualifications. According to Blumenthal, the proposed rule required doctors to comply with 23 measures, and hospitals 25 measures. The government received more than 2,000 comments on the rule, many of them asking for more flexibility in allowing clinicians to qualify.

Blumenthal said the final rule took those comments into account. The final rule requires doctors to comply with a set of 15 core objectives during the first year - or Stage 1- of adoption. Hospitals are required to comply with 14 core objectives. In addition to the core objectives, both hospitals and doctors will have to choose five more objectives from a "menu" of 10, he said. The remaining objectives will be deferred to Stage 2 of adoption.

Dr. Blumenthal authored an article in the New England Journal of Medicine on the MU rules – to view this article go to <http://content.nejm.org/cgi/reprint/NEJMp1006114.pdf>

### Key changes in the final CMS rule include:

- Greater flexibility with respect to eligible professionals and hospitals in meeting and reporting certain objectives for demonstrating meaningful use. The final rule divides the objectives into a “core” group of required objectives and a “menu set” of procedures from which providers may choose any five to defer in 2011-2012. This gives providers latitude to pick their own path toward full EHR implementation and meaningful use.
- An objective of providing condition-specific patient education resources for both EPs (eligible providers) and eligible hospitals and the objective of recording advance directives for eligible hospitals, in line with recommendations from the Health Information Technology Policy Committee.
- A definition of a hospital-based EP as one who performs substantially all of his or her services in an inpatient hospital setting or emergency room only, which conforms to the Continuing Extension Act of 2010.
- CAHs (critical access hospitals) within the definition of acute care hospital for the purpose of incentive program eligibility under Medicaid.

### In this issue –

In this issue – Don't forget to register for the AMCNO Solving the Third Party Payor Seminar in November – details inside

**The AMCNO sent comments on the meaningful use rules. An article outlining how our comments impacted changes to the rule along with an overview of the final rule can be found “News You Can Use” in this publication.**

Two companion final rules were also announced. One regulation, issued by the Centers for Medicare & Medicaid Services (CMS), defines the minimum requirements that providers must meet through their use of certified EHR technology in order to qualify for the payments. The other rule, issued by the Office of the National Coordinator for Health Information Technology (ONC), identifies the standards and certification criteria for the certification of EHR technology, so eligible professionals and hospitals may be assured that the systems they adopt are capable of performing the required functions.

As much as \$27 billion may be expended in incentive payments over ten years. Eligible professionals may receive as much as \$44,000 under Medicare and \$63,750 under Medicaid, and hospitals may receive millions of dollars for implementation and meaningful use of certified EHRs under both Medicare and Medicaid.

A CMS/ONC fact sheet on the rules is available at <http://www.cms.gov/EHRIncentivePrograms/>

**As part of this process, the Department of Health and Human Services (HHS) is establishing a nationwide network of Regional Extension Centers to assist providers in adopting and using in a meaningful way certified EHR technology. In Ohio the Ohio Health Information Partnership (OHIP) will be working with regional partners. The regional partner for the Northern Ohio region is CWRU and the AMCNO and our physician leadership are working with CWRU on this project. OHIP and their regional partners will provide services to physicians that will help practices identify and address practice-specific technical and functional requirements that may serve as barriers to EHR adoption; assist practices in the selection and acquisition of a certified EHR; help practices maximize the benefits associated with the use of an EHR, and serve as a liaison between the practices and EHR vendors regarding the technical assistance they need to “go live.” (More on OHIP can be found under “News You Can Use” later in this publication).**

**Medicare Administrative Contractor (MAC)**

The issue of the MAC for Ohio has yet to be resolved. In July 2010 J15 region (which includes Ohio) was awarded to CIGNA. Several protests have been filed since the award went to CIGNA. Palmetto did not file a protest since they were not the primary bidder for J15. The protests are still pending so PalmettoGBA remains the MAC for Ohio until further notice. However, it is important that physicians and their office staff review the instructions for a MAC transition, since inevitably this will occur in Ohio once the protests have been exhausted. The Centers for Medicare and Medicaid Services (CMS) has published a Transition packet for providers – MLN SES1017 – this is an excellent tool for your staff to use in preparation for the transition when it does occur. The publication provides step-by-step instructions on the MAC transitions. <http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf>

**Medicare Temporary Payment Fix is Not Enough – Tell Your Medicare Patients Their Choice of Physician Could be At Risk**

On June 25, 2010, President Obama signed into law the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010.” This law establishes a 2.2 percent update to the Medicare Physician Fee Schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010. Physicians may now expect to see a 2.2% update in their Medicare payments through November 30, 2010.

**This temporary fix is not enough.** The AMCNO has been lobbying Congress for many years asking for a permanent fix to this problem once and for all. Physicians across the region have contacted their Congressional representatives asking for a permanent fix. Yet every year our members are forced to face this same issue. At the June AMCNO board meeting it was determined that one way to keep the pressure on Congress to **permanently fix** this problem is to engage Medicare patients in the discussion. We must get Congress to fix this problem once and for all. The AMCNO encourages our members to:

- Tell your Medicare patients to contact Congress and ask them to repeal the Medicare cuts formula – tell your patients how this has impacted you and your practice and tell them if this problem continues that their choice

of physician could be at risk. Tell your Medicare patients that by repealing the SGR formula, Congress can avert these cuts. On average, legislation to repeal the SGR would prevent cuts of \$18,000 per year to each Ohio physician.

- Tell your Medicare patients that Ohio, at 15 percent, has an above-average proportion of Medicare patients and, at 18 practicing physicians per 1,000 beneficiaries, Ohio has a below-average ratio of physicians to Medicare beneficiaries, even before the cuts take effect.
- Tell your Medicare patients that 39 percent of Ohio's practicing physicians are over 50, an age at which surveys have shown many physicians consider reducing their patient care activities. Today, about one out of four Medicare patients looking for a new primary care physician are having trouble finding one. Continued cuts in the program will only make matters worse.
- Tell your Medicare patients that Congress needs to fix this problem once and for all so seniors can be assured of continued access to care and choice of physician.

### **Have questions about the Version 5010 and ICD-10 transition? The Centers for Medicare and Medicaid Services (CMS) Has Resources Available**

CMS has resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

- [The ICD-10 Transition: An Introduction](#)
- [ICD-10 Basics for Medical Practices](#)
- [Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices](#)
- [Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors](#)

Compliance timelines, materials from CMS-sponsored calls and conferences, and links to resources are available at [www.cms.gov/icd10](http://www.cms.gov/icd10). Check back often for the latest information and updates. **Keep Up to Date on Version 5010 and ICD-10.** Please visit [www.cms.gov/icd10](http://www.cms.gov/icd10) for the latest news and sign up for Version 5010 and ICD-10 e-mail updates!

### **Benefits of HIPAA version 5010**

HIPAA Version 5010 introduces clarity and standards that promote automation, payer consistency and many other benefits including:

- Enhanced automation of reimbursement and remittance transactions, expediting payments and improving claims turnaround.
- Clarification on the use of 10-digit National Provider Identifier (NPI) numbers.
- Better instructions for handling reversals, corrections, interest payments and prompt pay discounts.
- Clearer eligibility transactions that include comprehensive benefit and coverage information.
- More timely and appropriate decisions for authorizations and referrals to specialty care professionals.

### **HIPAA version 5010 – compliance changes**

The compliance date for covered entities is January 1, 2012. The 5010 structural changes that impact utilization and submission of the EDI format include:

- File formatting
- Situational and required data elements
- Loops, segments and qualifiers

### **The international classification of diseases ICD-10 and IDC-10-PCS**

Bringing further clarification of diagnosis and procedure codes, IDC-10 codes offer more detail and depth for use for diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases in virtually every aspect of a provider's operations – both clinical and administrative.

ICD-10 benefits:

- Increases the specificity of the diagnosis codes and standardized definitions.

- Increases coding consistency and accuracy.
- Reduces miscoded, rejected and improperly reimbursed claims.
- Reduces the need for supporting documentation.

The ICD-10 final rule from the U.S. Department of Health and Human Services (HHS) – Centers for Medicare & Medicaid Services (CMS) overhauls the diagnosis code scheme for health care claims and will require:

- Field size expansion
- Increases number of diagnosis codes supported on a claim
- Changes in alphanumeric code composition, values, definition and interpretation.

The compliance date for covered entities for ICD-10 is October 1, 2013. To plan for compliance and increase your EDI utilization:

- Educate office staff on the HIPAA Version 5010 and ICD-10 compliance requirements. The HHS website offers information at [http://www.cms.hhs.gov/Versions5010andD0/01\\_overview.asp#TopOfPage](http://www.cms.hhs.gov/Versions5010andD0/01_overview.asp#TopOfPage)
- Review your current systems and work processes – electronic or manual.
- Investigate the potential changes to existing practice work flow and business processes.
- Contact your current practice management system vendor, clearinghouse or billing service to identify submission upgrade expectations.
- Compare options and benefits of full system upgrades vs. minimal compliance to take advantage of new automated features.
- Determine installation, testing and implementation timeframes
- Evaluate and plan for staff training needs.

**Systems Changes Necessary to Implement Patient Protection and Affordable Care Act (PPACA) Section 6404: Maximum Period for Submission of Medicare Claims Reduced to Not More Than 23 Months**

Section 6404 of PPACA amended and timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010

**What You Need to Know**

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service January 1, 2010 and later received more than 1 calendar year beyond the date of service will be denied as being past the timely filing deadline.

NOTE: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement’s “From” date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify expectations to one (1) calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for “error or misrepresentation” of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

**Additional Information**

The official instruction (CR6960) issued to your Medicare FI, Carrier, DME MAC, A/B MAC and/or RHH1 is available at <http://www.cms.gov/Transmittals/downloads/R6970TN.pdf> on the CMS website.

### **State of Ohio Selects Medical Mutual of Ohio to Operate Temporary High Risk Pool Program**

The Ohio Department of Insurance Director has announced that the State of Ohio plans to designate Medical Mutual of Ohio as the non-profit entity that will operate the temporary high risk pool program for Ohioans, as created through the federal Patient Protection and Affordable Care Act, in order to provide uninsured people with pre-existing conditions the opportunity to purchase more affordable health insurance.

The Department of Insurance recently has submitted a letter to the U.S. Department of Health and Human Services (HHS) indicating that Medical Mutual will operate the Ohio temporary high risk pool. The agency will collaborate with Medical Mutual and HHS to detail the logistics of the program and to obtain final approval from HHS as to Ohio's plan for implementing the program.

The Temporary High Risk Pool is a federally subsidized health plan, authorized under the Affordable Care Act, which makes coverage for individuals with pre-existing conditions more affordable for people who cannot purchase health insurance in the private market because of their health status. In their proposal, Medical Mutual estimated that with the available funding they could cover more than 5,000 Ohioans through the duration of the program, with individuals paying a standard rate premium for their coverage. No state funds will be used to provide this coverage.

### **Bureau of Workers' Compensation (BWC) Policy Communication Notice**

BWC implemented bill payment processing changes on Aug. 1, 2010. These changes impact services having an effective date on or after Aug. 1, 2010 and include the following:

Modifier #54 (surgical care only) appended to all emergency department procedures for professional services; 90-day global period for major surgeries reduced to 60 days.

The change with Modifier #54 addresses the misapplication of global surgical billing, which has resulted in unnecessary administrative costs by BWC to correct payments made to the wrong provider. It also addresses delayed reimbursement to the correct provider who provided the follow-up care.

The 60-day global period for major surgeries change refines the current global surgery follow-up period. This improvement recognizes the role primary care providers, or physicians of record play in facilitating a prompt, safe recovery and return to work for an injured worker who has experienced major surgery. Shortening the follow-up period will facilitate earlier engagement by the primary care providers or physician of record. The next *Billing and Reimbursement Manual* and *MCO Policy Reference Guide* will reflect these policy changes or revisions.

### **BWC Board Updates Professional Providers and Medical Services Fee Schedule**

During its July 29, 2010 meeting, the BWC Board of Directors approved an update to BWC's professional providers and medical services fee schedule, which sets reimbursement rates for the more than 64,000 certified medical providers. The updated fee schedule will become effective Oct. 25. The updated schedule is projected to increase reimbursement to providers serving Ohio's injured workers by nearly 3 percent. New codes used to identify medical services and procedures will make certain injured workers receive appropriate

care; ease the reimbursement process; and bring more clarity to the benefits covered under BWC's plan. BWC fee schedules are available for viewing at [www.ohiobwc.com](http://www.ohiobwc.com)



NEWS YOU CAN USE

### **Ohio Health Information Partnership (OHIP) Offers Assistance to Physicians to Advance Adoption and Meaningful Use of Health Information Technology**

**Do you have an electronic health record (EHR) system? If you do, will you be able to collect \$44,000 or \$63,750 from Medicare or Medicaid with your system? If you aren't sure or need help setting up an EHR system, the Ohio Health Information Partnership (OHIP) is here to help.**

OHIP, a non-profit entity supported by the AMCNO, is designated by the state to advance the adoption, implementation and "meaningful use" of Health Information Technology (HIT) among health care providers in Ohio. OHIP is partnering with seven regional centers, called REC Regional Partners to provide technical assistance helping Priority Primary Care Physicians (PPCPs) convert to electronic health records and e-prescribing.

OHIP also plans to promote greater EHR adoption by:

1. Providing physicians and other providers with access to free or low cost experienced consultants who will work with individual practices to provide assistance throughout the selection, adoption, implementation, and use of an EHR. OHIP will work through seven Regional Partners who have a wide range of EHR expertise to make the EHR adoption process easier and quicker.
2. Vetting EHR vendors to identify those that are best able to meet practice needs and negotiating discounts with those vendors.
3. Helping providers meet "meaningful use" standards. Meeting these standards, which were recently defined by the Office of the National Coordinator, is necessary in order to qualify for financial incentives through Medicare and Medicaid.

In addition, OHIP will be identifying sources of low interest loans for providers who wish to purchase an EHR. The goal of OHIP is to help 6,000 PPCPs convert to EHR and "meaningful use" of health records over the next two years. There is \$26.8 million available for assessment, technical assistance, and helping you qualify for incentive Medicare and Medicaid payments.

REC assistance includes ensuring PPCPs are certified for "meaningful use" of electronic records and therefore qualified to receive up to \$44,000 per provider in Medicare incentive payments or up to \$63,750 per provider in Medicaid incentive payments over a period of 6 years.

Are you eligible? How do you qualify? What are the timelines and deadlines? How do you register? For answers to these questions and the specifics about the program go to [www.ohiponline.org](http://www.ohiponline.org) or email [info@ohiponline.org](mailto:info@ohiponline.org) or contact one of the regional extension centers in the Northern Ohio region listed below:

#### **OHIP REGIONAL CONTACTS IN NORTHERN OHIO:**

**Case Western Reserve University**, Joseph Peter, [joseph.peter@case.edu](mailto:joseph.peter@case.edu)  
216-368-5756 (For counties: Ashtabula, Cuyahoga, Geauga, Lake, and Lorain)

**Akron Regional Health Foundation**, Marianne Lorini, [mlorini@arha.org](mailto:mlorini@arha.org)  
330-873-1500 (For counties: Ashland, Carroll, Harrison, Holmes, Medina, Portage, Richland, Stark, Summit, Tuscarawas, and Wayne.)

## **The Road to “Meaningful Use” EHR Stimulus Payments**

*By Amy S. Leopard, Walter & Haverfield LLP*

On July 28, 2010, the Centers for Medicare and Medicaid Services (CMS) published a final rule regarding what constitutes the “meaningful use” of electronic health records (EHRs) (the “Meaningful Use Rule”) for physicians interested in qualifying for EHR incentive payments from Medicare and Medicaid under the American Recovery and Reinvestment Act of 2009 (ARRA).<sup>1</sup> The Meaningful Use Rule addresses many of the issues and recommendations from providers and associations on the proposed rule, including comments submitted by the Academy of Medicine of Cleveland & Northern Ohio.<sup>2</sup>

At the same time, the HHS Office of the National Coordinator (ONC) for Health Information Technology issued a related final rule on the standards EHR vendors must meet in order to have their EHR technology certified for use by physicians to qualify for the EHR incentive payments (the “Certified EHR Technology Rule”). Now, providers and their vendors have a fairly clear picture of what it will take to earn the EHR ARRA stimulus dollars.

### **Background on the Meaningful Use Rule**

Congress established the ARRA EHR incentive program to incentivize providers to use EHR to improve healthcare delivery, quality, efficiency and patient safety in a transformative way. Under this program, CMS will make EHR incentive payments to eligible professionals and hospitals who qualify for extra Medicare and Medicaid payments by (1) demonstrating use of a certified EHR technology in a meaningful manner, including e-prescribing for physicians; (2) connecting the certified EHR technology to exchange health information electronically to improve quality and care coordination; and (3) submitting clinical quality and other measures selected by HHS.

CMS established a three-stage, graduated approach to Meaningful Use. Each biennial stage will include criteria that become more stringent over time. The stages contemplate an evolution from initially just capturing and using health information in a structured format to tracking clinical conditions and using health IT for order entry, result reporting and improving quality at the point of care, and finally to interoperability among EHR technologies with clinical decision support.

The final rule covers the first two (2) years of the incentive program, which begins as early as 2011 under Medicare. CMS will propose the next two stages of criteria for meaningful use through future rulemaking. For the first payment year only, physicians may demonstrate meaningful use of certified EHR technology over any continuous 90-day period within a calendar year - allowing physicians using certified EHR technology in a meaningful manner as late as October 1, 2011 to qualify for incentive payment for 2011. After the first year, however, physicians must demonstrate meaningful use for the entire calendar year.

### **Medicare EHR Incentive Program**

As originally set forth in ARRA and the proposed rule, Medicare EHR incentive payments for eligible professionals will be 75% of Medicare fee-for-service allowable charges up to an annual cap for up to five years beginning in calendar year 2010. Eligible professionals can receive up to a total of \$44,000 over a five-year consecutive period, including \$18,000 in the first year for early adopters qualifying by calendar year 2012. Eligible professionals must begin by 2014 and the last payment year is 2016. Eligible professionals furnishing more than 50% of their Medicare covered services in a health professional shortage

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<sup>1</sup>This article updates “The Proposed Pathway for Achieving ‘Meaningful Use’ and EHR Stimulus Payments,” *Northern Ohio Physician* (March/April 2010).

<sup>2</sup> The Academy of Medicine of Cleveland & Northern Ohio comments on the January 2010 proposed rule are posted on the website.

area (HPSA) earn an additional 10%. Eligible professionals who do not establish meaningful use by 2015 will face reductions in their Medicare fee schedule.

Medicare carriers will pay physicians demonstrating Meaningful Use in a single lump sum payment during each annual reporting period. The payments will be made to the physician or to a single employer under a valid Medicare reassignment. Physicians cannot allocate payments among multiple entities. Most health systems and group practices will want to review their employment and professional contractor agreements and determine who is entitled to receive the payments. CMS makes clear that the purpose of the Medicare EHR incentive payments is not to be a reimbursement or cost pass through of software costs to encourage purchasing and adopting EHR technology, but to be an incentive to actually use the EHR technology in a manner that supports the HITECH health policy priorities.

### **Medicaid EHR Incentive Program**

Medicaid payments will be made through the states and states must prepare a health information technology plan to receive the CMS match for their EHR incentive programs. The Medicaid incentive program will allow eligible professionals and hospitals to qualify for initial payments before achieving Meaningful Use. Eligible professionals who adopt, implement, or upgrade their certified EHR technology in the first payment year are still eligible for Medicaid payments during the first participation year only and do not have to meet the Meaningful Use objectives and associated measures of the Stage 1 criteria until the second participation year.

CMS defines this as requiring eligible professionals to at least (1) acquire, purchase or secure access to certified EHR technology, (2) install or begin utilization of certified EHR technology capable of meeting meaningful use requirements, or (3) upgrade from existing technology to certified EHR technology or add new functionality to meet the definition of certified EHR technology at the practice site, including staffing, maintenance, and training.

The Medicaid EHR incentive program pays eligible professionals up to \$63,750 over a 6-year period for most physicians. The maximum Medicaid incentive payment is \$21,250 in the first payment year and \$8,500 annually in five subsequent years, with pediatricians in the 20-29% Medicaid patient volume corridor receiving one-third less. There is no HPSA bonus. Physicians must enter the Medicaid EHR incentive program by 2016 to receive full Medicaid incentive payments available through 2021.

Consistent with the proposed rule, CMS allows that the Medicaid payment amount for any particular professional to be reduced for EHR technology or support service payments received from outside sources other than state or local governments. This reduction can be up to \$29,000 in the first year or \$10,610 in subsequent years. However, technology provided through an employer-employee relationship, vendor discounts, and in-kind contributions do not need to be backed out.

### **Multiple Programs**

Unlike hospitals that may obtain both Medicare and Medicaid incentives, physicians must choose between the Medicare and Medicaid EHR incentive program. However, a one-time switch between programs can be made before 2015. Choosing between the two programs requires an analysis of the different payment amounts, years and whether the physician has received any cash support payments (e.g., hospital EHR donations).

In the final rule, CMS allows eligible professionals to also participate in the Medicare Physician Quality Reporting Initiative (PQRI) and the Medicare EHR Demonstration while participating in the Medicare EHR Incentive Program. However if an eligible professional participates in the Medicare e-prescribing incentive program, they cannot participate in the Medicare EHR Incentive program in the same year, but could choose



to participate in the Medicaid EHR Incentive Program. HHS is required under the recent health reform legislation to develop a plan to integrate the EHR incentive programs and PQRI by January 1, 2012.

### **Eligibility and the Hospital-based Exclusion**

The strongest recommendation from the Academy of Medicine of Cleveland and Northern Ohio was that CMS should ensure the broadest possible physician participation allowed by statute. Medicare and Medicaid are separate and distinct programs with differing eligibility requirements, but physicians could qualify under either EHR incentive program. Under the Medicare program, the professionals eligible for the incentives are doctors of medicine or osteopathy, dental surgery and medicine, podiatrists, optometrists, and chiropractors participating in Medicare. Physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who practice predominantly in a federally qualified health center (FQHC) or rural health clinic (RHC) if it is led by PAs are all eligible for the Medicaid EHR program by meeting certain patient volume criteria. The Medicaid EHR program volume requirements are 30% of Medicaid patient encounters, with an allowance for pediatricians having at least 20% of Medicaid patient encounters to qualify at a reduced level, and a special formula allowing professionals who practice predominantly in FQHC and RHCs to meet the 30% threshold by serving needy individuals, such as patients covered by CHIP, sliding scale, and free care.

Hospital-based eligible professionals are not eligible for Medicare or Medicaid incentive payments. Unfortunately the ARRA definition was ambiguous and subject to a broad interpretation. CMS originally proposed to exclude all professionals furnishing 90% or more of their professional services in a hospital inpatient, outpatient or emergency department using place of service codes on the professional claim form to calculate eligibility. AMCNO was very concerned about the expansive definition of hospital-based physicians in the proposed rule and argued that CMS should interpret the statute considering the goals of ARRA to promote EHR adoption. The Academy of Medicine of Cleveland & Northern Ohio argued that CMS should interpret the statute considering the goals of ARRA to promote EHR adoption and provided CMS with several alternatives consistent with the statute. In conjunction with area academic medical centers and integrated health systems, AMCNO estimated that this proposal would have a devastating effect on the number of local physicians eligible to participate.

AMCNO recommended that CMS eliminate the hospital outpatient department place of service code 22 from the exclusion criteria. On April 15, 2010, President Obama signed the Continuing Extension Act of 2010 to amend the statutory definition of hospital-based EPs. After reviewing public comments and the amendment, CMS revised the definition accordingly. Under the final Meaningful Use Rule, if more than 90% of an eligible professional's services on claim forms are provided in the Inpatient Hospital place of service code 21 or Emergency Department place of service code 23, the professional will not qualify for incentive payments. CMS estimates that the revised definition would exclude only 14% of Medicare eligible professionals, down from 27% in the proposed rule. This revised definition excludes many hospitalists and traditional hospital-based eligible professionals, but allows many primary care physicians and others practicing in a hospital outpatient department setting.

### **Realistic Objectives and Measures**

AMCNO expressed concern in its comments over the breadth and depth of the objectives and measures required under the proposed rule and suggested that CMS scale back the measures to eliminate the "all or nothing" approach to qualification. In particular, the Academy of Medicine of Cleveland & Northern Ohio expressed concern that requiring physicians to directly enter 80% of their orders for ancillaries, obtaining 50% of all lab results in the EHR, and requiring e-prescribing for 75% of permissible prescriptions were too high.

In a welcome relief, CMS lowered the thresholds for most objectives and provided for a core set of objectives and a menu (optional) set of criteria from which to choose. Beginning in Stage 1, eligible

professionals must demonstrate that they meet a core set of 15 objectives, and a menu set allowing the professional to choose 5 out of 10 other measures. In Stage 2, all Stage 1 objectives will be core.

CMS also lowered the thresholds for many of the objectives it retained. For example, using computerized physician order entry (CPOE) for at least 80% of all ambulatory EHR orders was lowered to 30% of patients that have medication orders, with at least one medication ordered through CPOE. Eligible professionals will need to transmit more than 40% of all permissible prescriptions electronically. Professionals must implement at least one clinical decision support rule relevant to their specialty or high clinical priority and be able to track compliance with that rule, down from the 5 decision support rules initially proposed.

While lowering thresholds, CMS held the line on requiring health information to be recorded as structured data. The requirement to maintain an active problem list for at least 80% of unique patients must be recorded as structured data, and eligible professionals must still maintain at least 80% of all active medications and medication allergies as structured data.

### **Quality Measures**

The Academy of Medicine of Cleveland & Northern Ohio commented that the initial list of quality measures should be scaled back to a realistic level with only a few straightforward, achievable measures clearly identified for each specialty. Those measures should be evidence-based measures having full endorsement by the respective medical specialty societies **and** at the level of maturity where implementation specifications have already been developed. In the final rule, CMS limited the Stage 1 measures to those that are already in existence and not under development, but stated that it will seek to align the quality measures for Stage 2 with other quality measures development and reporting related to health care reform and other CMS quality measures programs.

### **Administrative Burdens**

The Academy of Medicine of Cleveland & Northern Ohio commented that CMS should streamline the administrative burden on physicians for easier creation of the compliance documentation, especially considering the technical criteria and the potential for manual calculations. In 2011, eligible professionals must submit aggregate clinical quality measure numerator, denominator, and exclusion data to CMS or the States by attestation, and CMS now estimates about 9 1/2 hours for Eligible Professionals to attest and report objectives and quality measures during the first year. Despite commentator concerns that CMS compliance burden estimates were far too low, CMS says it believes that EHR technology will help reduce the burden as it evolves to calculate the clinical quality measures required for meaningful use incentives. State Medicaid programs will have some flexibility on how they approach provider compliance documentation, although CMS will review the state attestation and provider reporting mechanisms before they are implemented.

### **The EHR Technology Rule**

What is most important is that the EHR technology not only meet the certification criteria, but actually be certified. ARRA requires providers to use EHR technology certified by ONC. The Certified EHR Technology Rule adopted by ONC provides certification standards and a pathway for EHR vendors to have their technology certified, either as a complete EHR or as one or more EHR modules.

Vendors are now gearing up to ensure that their software has the capabilities required or can work with other certified modules to allow providers to meet the minimum standards for an EHR, including the standards for demographics, history and problem list, clinical decision support, physician order entry, quality measures, and exchanging information. Eligible professionals should be working with their vendors to confirm that the vendor can and will pursue certification of the technology under the initial standards and is committed to ramping up over the three stages.

*Amy S. Leopard heads the health care practice group at the law firm of Walter & Haverfield LLP and may be reached at [aleopard@walterhav.com](mailto:aleopard@walterhav.com). This article presents general information and education on legal developments and does not constitute legal advice.*

### **AMCNO Participates in Open Door Forum on Meaningful Use Rules**

On August 10, CMS provided a session on the meaningful use rules. The AMCNO staff participated in the teleconference and listened to the question and answer period that followed the forum. Here are some items that were clarified by CMS on the call:

**Question:** One of the 15 core requirements that must be met for any money to be paid is that eligible providers report ambulatory clinical quality measures to CMS or the states. A total of six such measures must be reported, three of which must come from a core set of six measures, and three of which must come from a larger list of 38 measures. Most, if not all, of these measures (such as hypertension screening via blood pressure measurement, tobacco use assessment, etc.) have no relevance to some specialties, such as dermatology and diagnostic radiology. **Can physicians report a denominator of zero for some or all of these and still earn the full EHR incentive bonus?**

**CMS Response:** “If you met all the other requirements, yes,” CMS says. **NOTE:** The term “denominator” is used here for the purpose of reporting clinical quality measures in order to meet one of the 15 core requirements for meaningful use. To report a clinical quality measure, providers would indicate the total number of patients in their EHR that were screened for hypertension via blood pressure measurement, and the total number of patients in their EHR. The numerator is the number of patients for which the clinical quality measure was met, the denominator is the population of all patients in the EHR. These patient numbers must include all patients, not just Medicare or Medicaid, according to the CMS representatives on the call.

**Question: Is the program available to a non-participating Medicare provider?**

**CMS Response:** “You have to have allowed charges, but you don’t have to be a participating physician.”

**Question:** If you meet meaningful use for the first year of participating, and for some reason you do not meet it in the second year, then come back and meet it again in the third year, **can you still get the full payment amount per provider?**

**CMS Response:** In the Medicare EHR incentive program, “you must participate in consecutive years to receive the maximum payment amount,” CMS says. “So you can’t do it in 2011, then come back in 2013 and get the maximum.

**Question: How does the EHR bonus payment work if you see Medicare Advantage (MA) patients?**

**CMS Response:** “The first and most important thing to know is that the MA payments are made only to the MA organization,” CMS says. “Each eligible provider that wants to [participate in the EHR incentive program via MA plans] must furnish at least 80% of his or her professional services to enrollees of the MA organization that’s going to receive the payment.” So if you see MA patients from many MA plans, it’s unlikely you’d be able to meet the 80% requirement with any one of them..

### **The Federal Trade Commission (FTC) Postpones the Red Flags Rule Again**

The Federal Trade Commission has announced that physicians will be granted yet another temporary reprieve from having to comply with the Red Flags Rule, delaying implementation until December 21, 2010. The controversy over the rule, which requires all “creditors,” including physicians, to implement policies to protect consumers from identity fraud, recently led the American Medical Association to sue the FTC for an exemption to the requirement they call “arbitrary and capricious” when applied to doctors. At the end of May 2010, Sens. John Thune (R-S.D.) and Mark Begich (D-Alaska) introduced a bill ([S 3416](#)) that would exempt certain small businesses -- including physician and dentist offices -- from the Federal Trade Commission's so-called “Red Flags Rule,” which aims to minimize identity theft. The FTC rule classifies physicians and other small businesses as “creditors,” thus requiring them to adopt certain measures to prevent identity theft. Thune said FTC's regulations “are too broad and ensnare businesses that pose little risk to consumers.” The bill was referred to the Senate Banking, Housing and Urban Affairs Committee, but a hearing has yet to be scheduled.

## Cuyahoga Community College - Fall 2010

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**For AMCNO member discount information contact: Linda Hale at 216-520-1000**

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Oct 4-Nov 10 M & W	Medical Terminology (36 hours) \$325 UTC	9:00 am-12:00 pm
Oct 6	CPT Coding Fundamentals and More! (6 CEU) \$199 CCE	9:00 am-3:30 pm
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Oct 12-Nov 4 T & TH	Fundamentals of Billing Reimbursement (24 hours) \$325 CCE	6:00 pm-9:00 pm
Oct 20	ICD-10 Preparation Fundamentals of Structure plus Anatomy, Physiology & Terminology Review (4.5 CEU) \$135 CCE	8:00 am-12:30 pm
Oct 27	The Ins and Outs of Surgery Coding (4 CEU) \$169 CCE	8:30 am-12:30 pm
Nov 3	Chart Auditing Workshop and Compliance Update (4 CEU) \$169 CCW	8: 30 am-12:30 pm
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The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

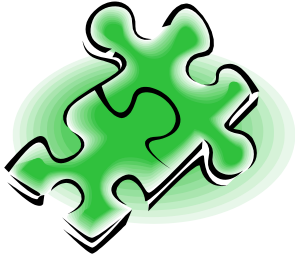
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**Solving the Third Party Payor Puzzle 2010**

**Wednesday, November 17, 2010**

Registration: 7:30 a.m. – 8:00 a.m.

Seminar: 8:00 a.m. – 4:00 p.m.



**WHERE: AMCNO Executive Offices**

**Park Center Plaza I**

6100 Oak Tree Blvd – Lower Level Meeting Room

Independence, Ohio 44131

**PURPOSE:** To educate physicians and office staffs on the many third party payor claims and managed care issues.

**COST:** AMCNO Members and their staff: \$50 per participant

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Questions? Contact Cindy Penton or Linda Hale at:

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