

FormSmith Systems, Inc.
770-478-2191

EHR GUIDE

What every Doctor Needs to Know before buying EHR ...

Fact #1: EHR is NOT mandatory. You DO NOT have to adopt EHR

Currently there is a lot of hype and pressure tactics being applied to Doctors of Chiropractic in an effort to SCARE them into buying Electronic Health Records (EHR).

YOU DO NOT HAVE TO Adopt EHR. Some insurance companies MAY require you to adopt EHR in the future in order to participate with their plan but NONE have to date.

Fact #2: The government has taken a “Carrot & Stick” Approach to EHR

“Carrot” = Adopt EHR and you may qualify for up to \$44,000 Incentive over 5 years.

Program must be EHR Certified by CMS approved company
Doctor must demonstrate Meaningful Use each year to qualify
Doctor must transmit “required data” to CMS and Attest to Meaningful Use yearly
Doctor must maintain documentation for possible EHR audit

“Stick”=Non EHR starting 2015 may receive 1%-5% reduction in Medicare payments.

Any doctor who treats Medicare and/or Medicaid patients and does not adopt EHR by 2015 will have their Medicare and/or Medicaid payments cut by 1% starting with 2015 and continuing each year thereafter until a 5% reduction in payments. Not such a big deal since Medicare has cut the physician’s fee schedule for 2012 by 27.4% (if not rolled back).

Fact #3: EHR must be Certified (25 Criteria)-To be eligible for Incentive Payments

Programs must be certified by a CMS approved agency. There are a total of 25 “meaningful use” objectives. When selecting an EHR system, doctors must be sure that it can report the CQM’s (clinical quality measures) for Meaningful Use reporting.

Requirements are in three phases: 1). 2011-2012 2). 2013-2014 3). 2015

Phase 1: To qualify for incentive, 20 of 25 meaningful use objectives must be met.

Phase 2: requirements not yet published

Phase 3: requirements not yet published

For a list of Certified EHR programs visit : <http://onc-chpl.force.com/ehrcert>

Fact #4: EHR Module can be added to Existing Billing/Practice Management Programs such as FormSmith and Qualify for Incentive Payments. FormSmith Expert System + EHR Module saves you \$3,500 to \$10,000 over many “EHR Total Systems.”

Most EHR vendors offer an “EHR Module” that adds onto existing Billing/Practice Management software as well as an “EHR Total System.” Vendors will try to sell you their “EHR Total System” simply because they make a lot more money over just the EHR Module. FormSmith + EHR Module is much cheaper than many total systems. For a new installation:

FormSmith Expert System	\$2,850.00 (multi doctors)	\$2,850.00 (multi doctors)
ChiroQuick Charts EHR Module	<u>\$3,594.00</u> (one doctor)	<u>\$4,389.00</u> (two doctors)
	\$6,444.00	\$7,239.00

Existing FormSmith Clients would only need to purchase the EHR Module

“EHR Total Systems” range from \$10,000 (one doctor) to \$20,000. Many of these systems are very medical orientated and the billing/management portion is unsuited for chiropractors.

Fact #5: \$44,000 Incentive to adopt EHR was designed for Hospitals, Large Group Practices and Doctors who see a lot of Medicare and Medicaid patients.

The whole incentive program is based on paying 75% of your Medicare Allowed Charges up to a limit per year. The spinal adjustment is the only “covered service” for Chiropractors under the current Medicare coverage and its “allowed charge” will be the only basis for meeting the “qualifying thresholds”. In most states this is \$23 to \$41 per adjustment.

Fact #6: \$44,000 incentive is NOT an Automatic Payment when you buy EHR

The incentive is based on a 5 year payout with a decreasing amount per year based on 75% of “YOUR MEDICARE ALLOWED CHARGES” billed to Medicare each calendar year.

Maximum Incentive Payments Based on the First Calendar Yr In which the Eligible Provider (EP) Participates in the Program				
Calendar Yr	2011	2012	2013	2014
2011	\$18,000	-----	-----	-----
2012	\$12,000	\$18,000	-----	-----
2013	\$ 8,000	\$12,000	\$15,000	-----
2014	\$ 4,000	\$ 8,000	\$12,000	\$12,000
2015	\$ 2,000	\$ 4,000	\$ 8,000	\$ 8,000
<u>2016</u>	<u>-----</u>	<u>\$ 2,000</u>	<u>\$ 4,000</u>	<u>\$ 4,000</u>
Total	\$44,000	\$44,000	\$39,000	\$24,000

In the first year of qualification, the doctor must meet “meaningful use” for 90 consecutive days; each year thereafter it must be met for the full year. In order to receive the maximum incentive a DC would have to average about 67 Medicare adjustments per month in 2011 and about 86 adjustments per month in 2012 due to a 27.4% fee reduction (if not rolled back).

Example: PAR DC in 2011 in rural Georgia; if 25 of total adjustments are 98940 (1-2 region) and about 42 are 98941 (3-4 regions) the total “allowed charges” billed for one month would be [25 x \$24.38=\$609.50] + [42 x \$33.82=\$1420.44] = \$2029.94 x12 months=\$24,359.28 annual billing to Medicare. Total Allowed Charges, \$24,359.28 X 75% = \$18,269.46. Based on the incentive limit this DC would be eligible for \$18,000 incentive provided he/she has met the MEANINGFUL USE requirements. See section on MEANINGFUL USE.

Fact #7: Must Demonstrate “Meaningful Use” every year. 20 of 25 Criteria Must be met. Fifteen Core Objectives and Five of Ten Menu Objectives must be met. This is the catch to getting the Money!

Eligible Professional (EP) Core Objectives - All 15 Must Be Met

- (1) Use CPOE (Computerized Provider Order Entry) for medications orders.
Exclusion provided for any doctor who writes fewer than 100 prescriptions.
DC can meet by “attesting to exclusion” from this requirement.
- (2) Implement drug-drug and drug-allergy interaction check.
No Exclusion. This may require the use of an “on-line service” to do drug to drug and drug to allergy matching. Cost of such a service ranges from X to Y/mo.
- (3) Maintain an up-to-date problem list of current and active diagnoses.
No Exclusion. Must have at least one entry or an indication that no problems are known for that patient recorded as structured data on more than 80% of all patients.
- (4) Generate and transmit permissible prescriptions electronically (eRx).
Exclusion provided for any doctor who writes fewer than 100 prescriptions.
DC can meet by “attesting to exclusion” from this requirement.
- (5) Maintain active medication list.
No Exclusion. Must have at least one entry (or an indication that the patient has no prescribed medication) recorded as structured data on more than 80% of all patients.
- (6) Maintain an active allergy list.
No Exclusion. Must have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data on more than 80% of all patients.
- (7) Record all of the following demographics.
(A) Preferred language; (B) Gender; (3) Race; (4) Ethnicity; (5) Date of Birth

Race and ethnicity codes should follow current federal standards published by the office of Management and Budget http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr
No Exclusion. Must have demographics recorded as structured data on more than 50% of all patients.

- (8) Record and chart changes in the following vital signs:
(A) Height; (B) Weight; (C) Blood pressure; (D) Calculate and display body mass index (BMI); (E) Plot and display growth charts for children 2-20 years, including BMI. Must record as structured data on more than 50% of all patients age 2 and over.

Exclusion provided for doctors who see NO patients 2 years or older or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. Note: A chiropractor must take height, weight and blood pressure as part of any musculoskeletal or neurological exam (E/M) according to CPT code definitions.

- (9) Record smoking status for patients 13 years old or older.
Must record smoking status as structured data on more than 50% of all patients 13 yrs old or older. Exclusion for doctor who sees NO patients 13 years or older.

- (10) Report Ambulatory Clinical Quality Measures (CQM) to CMS.
No Exclusion. Must report to CMS ambulatory CQMs selected by CMS in the manner specified by CMS .

What is a Clinical Quality Measure? CQMs can be measures of processes, experiences and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care. CQM results are reported to CMS along with other “meaningful use” objectives to demonstrate that a doctor has used EHR technology in a meaningful way.

For Phase 1, Eligible Professional (doctor) must report a minimum of six and a max of nine total CQMs. Three core CQMs are required(substituting alternate core CQM when necessary) plus three additional measures from a list of 38 CQM’s. Note: a list of clinical quality measures specifications can be found in the EP Measure Specifications file from the CMS website and the Federal Register Vol.75, No. 144 Pages 44397 through 44412 and Core for all EP’s(doctors) are listed in Table 7, Page 44410 of the Federal Register/Vol.75, No.144 Wednesday, July 28, 2010/Rules and Regulations.

**Example specific to spinal treatment is CQM #0052 Title “Low Back Pain: Use of Imaging Studies”
The doctor would report: The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.**

DC’s should think about this one!

Note: In the full description of CQM #0052 the Clinical Recommendation Statement goes on to say: Agency for Healthcare Policy and Research (AHCPR): Plain x-rays are not recommended for routine evaluation of patient with acute low back problems within the first month of symptoms unless a “red flag” [indicator of potentially serious spinal pathology or other nonspinal pathology] is noted on clinical

examination. (Strength of evidence: B) Plain x-rays of the lumbar spine are recommended for ruling out fractures in patients with acute low back problems when any of the following red flags are present: recent significant trauma (any age), recent mild trauma (patient over age 50), history of prolonged steroid use, osteoporosis, patient over age 70. (Strength of evidence: C) Plain x-ray in combination with CBC and ESR may be useful for ruling out tumor or infection in patients with acute low back problems when any of the following red flags are present: prior cancer or recent infection, fever over 100 degrees F, IV drug abuse, prolonged steroid use, low back pain worse with rest, unexplained weight loss (Strength of evidence: C).

- (11) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

No exclusions. Doctor must implement one “clinical decision support rule” in addition to drug-drug and drug-allergy interaction checks.

What is a “Clinical Decision Support Rule”? It is general and person-specific information organized and displayed by an EHR system at appropriate times to health care workers to enhance health and health care of that patient. For a chiropractor this could be a list of contraindications to manual adjusting such as non-segmentation of a vertebral body, severe osteoporosis, level of fused vertebrae, bleeding disorders (anticoagulants), myelopathy (cauda equina syndrome), benign tumors of spine, etc.

Contraindication or cautions for electrical therapy in a chiropractic office would be such patient information as pace makers, implanted metal objects, skin desensitized due to diabetes, etc.

- (12) Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

Doctor must provide it within 3 business days on more than 50% of all patients who request an electronic copy of their health information.

Exclusion only if there are no requests from patients or their agents.

Note: The definition for Diagnostic Test Results is All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Providing patient records must be in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524, Access of individuals to protected health information. The minimum information that must be provided would include the elements listed in the ONC final rule at 45 CFR170.304(f) for EP’s (doctors). The form and format of information should be human readable and comply with HIPAA Privacy Rule at 45 CFR164.524(c). Charging of fees for this information is governed by the HIPAA Privacy Rule at 45 CFR164.524(c)(4).

- (13) Provide clinical summaries for patients for each office visit.

Must provide clinical summaries for more than 50% of all office visits within 3 business days. Exclusion only if NO office visits during the reporting period.

Key Definitions: Office Visit- separate billable encounters that result from evaluation and management services provided to the patient.

Clinical Summary-an after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider’s office contact information, date and location of visit, and 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 minimum EHR data provided must include: Problem List, Diagnostic Test Results, Medication List and Medication Allergy List. Providers should not charge patients a fee to provide this information.

- (14) Capability to exchange key clinical information among providers of care and patient authorized entities electronically.
No exclusion. Doctor must perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information. Every payment year requires its own, unique test.
- (15) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
No Exclusions. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.

Eligible Professional (EP) Menu Objectives - 5 of 10 Must Be Met

- (1) Implement drug formulary checks.
Exclusion provided for any doctor who writes fewer than 100 prescriptions.
DC may "attest to exclusion" from this requirement.
- (2) Incorporate clinical lab test results into EHR as structured data.
More than 40% of all clinical lab test results ordered by the EP (doctor) during the EHR reporting period whose result are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion for doctor who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
- (3) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.
Generate at least one report listing patients with a specific condition.
No exclusion.
- (4) Send patient reminders per patient preference for preventive/follow-up care.

Doctor must send an appropriate reminder to more than 20% of all patients 65 yrs or older or 5 yrs or younger.

Exclusion for doctor who has no patients 65 yrs old or older or 5yrs old or younger with records maintained using certified EHR technology.

- (5) Provide patients with timely electronic access to their health information (including lab results, problem list, medication list, and allergies) within 4 business days of the information being available to the EP (doctor).

Must insure that at least 10% of all patients seen by the EP (doctor) could electronically access their health information within 4 business days if they so desired. The doctor at his/her discretion may withhold certain information from electronic access.

Exclusion only if the doctor neither orders nor creates lab tests or information that would be contained in the problem list, medication allergy list [or other information as listed at 45 CFR 170.304(g)] during the EHR reporting period. Most chiropractors would NOT be excluded due to creating information that would be contained in the “problem list”.

- (6) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

Must provide to more than 10% of all unique patients (each patient counts only one time even if the patient is seen multiple times for the each EHR reporting period).

No Exclusions.

- (7) The EP (doctor) who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Doctor must perform medication reconciliation for more than 50% of patients transitioned to him/her.

Exclusion only if the doctor was not the recipient of any transitions of care during the EHR reporting period.

Definition of Medication Reconciliation–The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

- (8) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

EP must provide summary of care record for more than 50% of transitions of care and referrals to another provider. (Electronic or paper copy is acceptable).

Exclusion only if the EP neither transfers nor refers a patient to another provider/setting.

- (9) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

Perform at least one test of certified EHR capacity to submit electronic data to registries.

Exclusion an EP who administers no immunizations during the EHR reporting period.

- (10) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

For more information go to cms.gov and search for EP Meaningful Use Measures.

Fact #8: Must enter “required data” in CMS online Registration and Attestation System. Doctors must enter Statistical Data on all patients for Meaningful Use Objective and Clinical Quality Measures, indicate if they qualify for exclusions from specific objective, and legally attest that they have demonstrated Meaningful Use.

In order to receive the Medicare EHR incentive payment you must register for the EHR program; meet meaningful use criteria; successfully attest, using the CMS Web-based Registration and Attestation system.

The steps to this process are too numerous to list here. For more information on the Attestation process go to : http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp

Fact #9: Incentive Payments are made 4-8 weeks after Program Requirements and Successful Attestation are made and the professional meets \$24,000 threshold in Allowed Charges or 60 days after the end of the calendar year. This may require an average of 67 to 83 Medicare adjustments per month.

Medicare has contracted with another company, a “Payment File Development Contractor” to make the EHR Incentive payments . The payments will be made to the bank account you provided in the “registration” step. Payments may be subject to taxes and other offsets. For more information on taxes call the IRS at 1-800-829-3903. For info on non-tax offsets, call Dept of Treasury, Financial Management Service (FMS) a 1-800-304-3107.

Fact #10: If you think that the EHR \$44,000 Incentive is a “gimme”, Think Again.

Any provider attesting to receive an EHR Incentive payment for either the Medicare EHR Incentive Program or Medicaid EHR Incentive Program potentially may be subject to an audit.

All providers attesting to receive EHR Incentive payment should retain ALL relevant documentation (electronic or paper format used in the Attestation Module responses) for a period of Six Years post attestation (keep in mind that attestation is required annually). Save documentation to support payment calculations in accordance with current document retention processes (In Georgia this is ten years).

Save the documentation to support your Clinical Quality Measures (CQM’s); this will be required during the audit process.

There are numerous pre-payment edit checks built into the EHR Incentive Programs’ systems to detect inaccuracies in eligibility, reporting and payment.

Post-payment audits will also be conducted during the course of the EHR Incentive Program.

If, based on an audit, a provider is found to not be eligible for an EHR Incentive payment, the payment will be recouped.

CMS plans to implement an Appeals Process for EHR in the future.

Questions?

What happens if a doctor uses an EHR system but cannot qualify for Meaningful Use and CQM's?

During the first year of eligibility the doctor has to qualify for 90 consecutive days. If no qualification, he/she can try again for another 90 day period. After year one, you must qualify for the full year. If you cannot qualify, you will be subject to the 1% - 5% reduction in Medicare payments (starting in 2015) just as if you had no EHR at all.

For more EHR frequently ask questions:

https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp

Commentary: If you are looking for fast money, “forget about it”. If you like technology and what it can do for you and your patients forge ahead. GOOD LUCK!

About the Author: Sheila S. Hodges along with Dr. Donald M. Hodges of FormSmith Systems, Inc. have been training chiropractors for more than 22 years in office procedure, business management, documentation, insurance billing and collections via FormSmith Insurance Workshops and their software called the FormSmith Expert System. For more information go to <http://www.FormSmithSystems.com>
Or call 770-479-2191, Mon -Fri 9 AM- 6 PM EST