Scripps Mercy
PHYSICIAN
PARTNERS

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Agenda

Review of Meaningful Use

Changes from Stage 1 to Stage 2

ICD-10 overview

Roadmap to 2015

What is Meaningful Use?

"Meaningful Use" of certified EHR technology.

- Submit data to CMS for entire length of the program (not just the initial year)

$24,000 if the participant begins in 2014 through the Medicare EHR Incentive program

- Over 3 years of demonstrating meaningful use

$63,750 through the Medicaid EHR incentive program as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology

- Over 6 years of demonstrating meaningful use

The Medicare and Medicaid EHR incentive programs are staged in th steps with increasing requirements for participation

Eligibility Review

Medicare	Medicaid
MD, DO, Dental med/surgeon, DPM, Optometry & Chiropractors	Additional providers eligible include NP, CNM, Dentist, & PA's who practice in a FQHC/RHC led by a PA
None -Incentive based on 75% of allowable charges	30% patient volume, 20% for Peds
$24,000 over 3 years beginning in 2014	$63,750 over six years
Last payment year is 2016	Last payment year is 2021
Attestation	AIU year one, Attestation after that

The Clock is Ticking…

The last year to begin participation in the Medicare EHR incentive program is:

2014

- If you do not adopt and successfully demonstrate meaningful use of a certified EHR technology by 2015, your Medicare payment amount for covered professional services will be **adjusted down by 1% each year**.

How payment adjustments will impact you

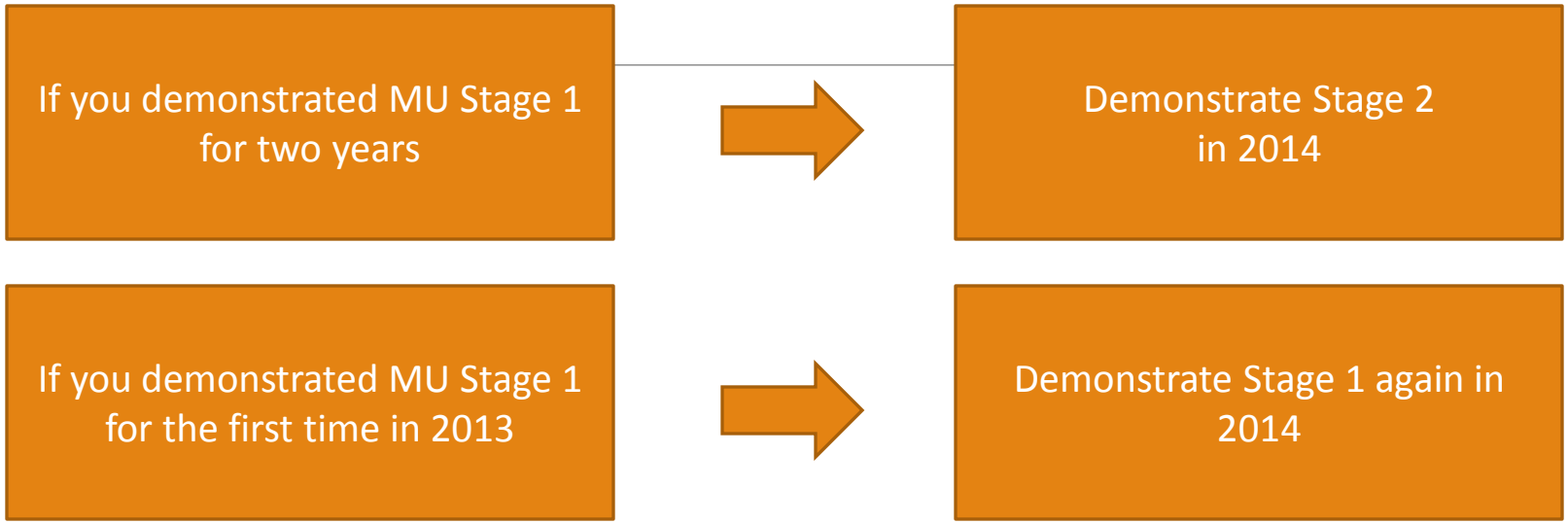
A payment adjustment will be applied to the Medicare physicians fee schedule amount for services furnished during the year

The payment adjustment is 1% per year and is cumulative for every year meaningful use is not met

Payment adjustment percentages are determined by year, not by your participation timeline.

- Example: If you successfully participate in 2014, but do not participate in 2015, you would incur a 3% payment adjustment in 2017

Stage of Meaningful Use in 2014



Reporting period in 2014

All providers regardless of their stage of MU are only required to demonstrate MU for a three-month EHR reporting period in 2014:

- Medicare providers – 3-month reporting period is fixed to one of the four quarters of the calendar year for EP's (Q1,Q2,Q3,Q4)
- Medicaid providers – 3-month reporting period is not fixed

Beginning in 2014???

If you plan to begin in 2014...

- If you first demonstrate Meaningful Use in 2014, you must demonstrate Meaningful Use, Stage 1 for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015.
- This reporting period must occur in the first 9 months of calendar year 2014
- EPs must attest to Meaningful Use no later than October 1, 2014, to avoid the payment adjustment.

Where are you in the MU process?

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html

Do I Need to Upgrade My EHR?

Most likely – Check with your EHR vendor to ensure you have the version certified for Stage 2

- Includes those attesting for stage 1 for the first time

Work with your EHR vendor to ensure you understand where to document in the EHR to successfully capture and report on the measures

Ensure EHR is properly "mapped" for capturing the reporting measures

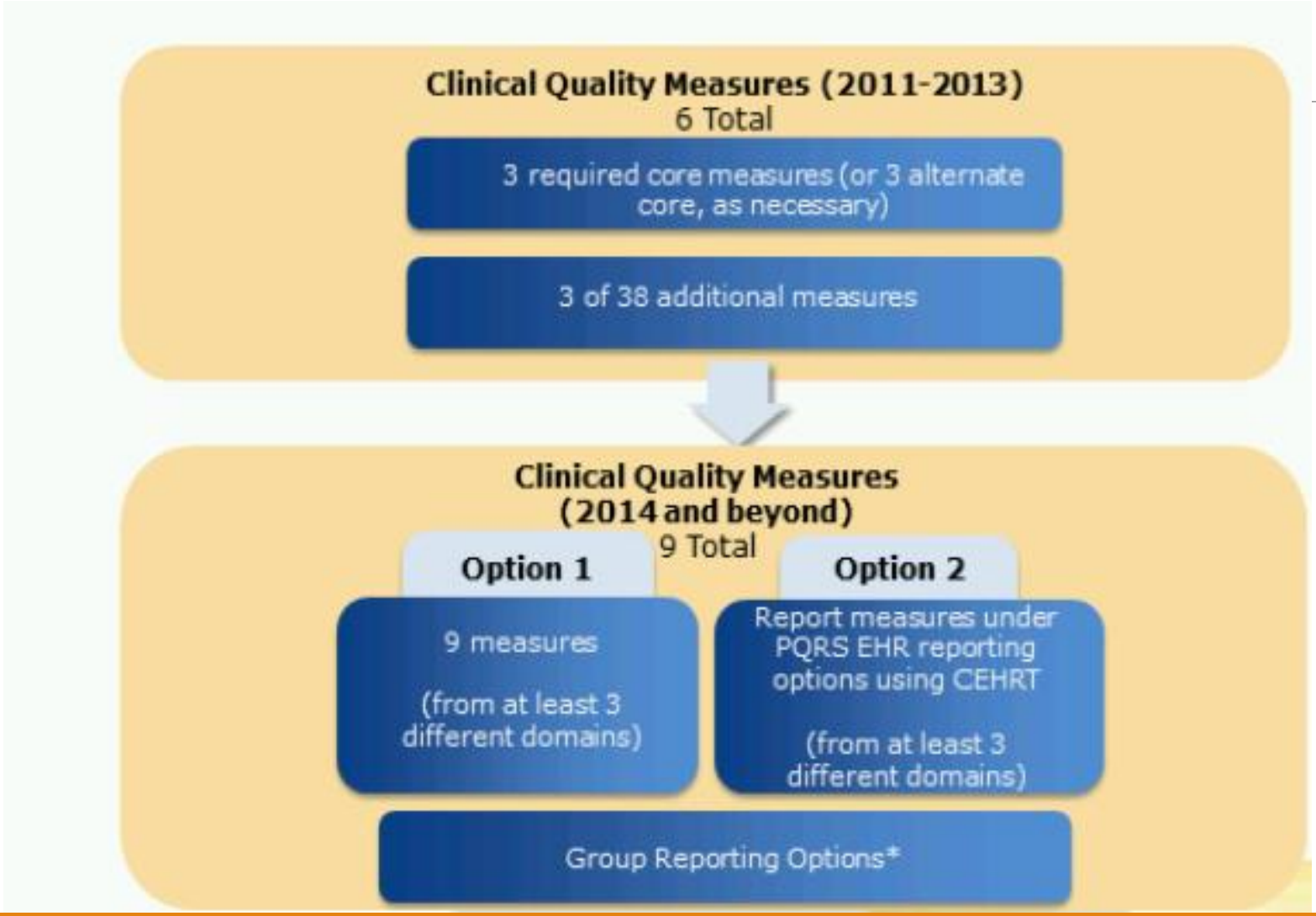
Monitor your "dashboards" or MU reports monthly – don't wait till you are ready to begin your attestation!

Changes from Stage 1 to Stage 2

Stage 1	Stage 2
Eligible Professionals 15 core objectives 5 of 10 menu objectives 20 total objectives	**Eligible Professionals** 17 core objectives 3 of 6 menu objectives 20 total objectives

- **Most of the Stage 1 objectives are now "core objectives" and the thresholds have been increased**

CQM changes for Stage 2



Changes for Stage 2

New Requirements

- Secure Messaging
- Family Health History
- Imaging Results
- Registry Reporting
- Progress Notes

Updated Requirements

- Lab Results
- Patient Lists
- Patient Education
- Summary of Care Records
- Medication Reconciliation
- Immunizations
- Patient Reminders
- Online Patient Information

Secure Electronic Messaging - Patient Engagement

Stage 2 has a greater emphasis on patient engagemen objectives such as:

- Patient Electronic Access (5%)
- Patient Reminder
- Patient Education
- Secure Electronic Messaging (5%)

Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP

Action - enable your EHR's patient portal

Interoperability

Interoperability is the cornerstone of Meaningful Use Stage 2
The objectives include:

- Transition of care/referrals,
- State cancer registry and identify and report specific cases to a specialized registry (other than a cancer registry)
- Submit immunization data
- Imaging results

» Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.

» The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.

» At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.

Audit Basics

5 – 10% of providers subject to audits

Random audits and risk profile of suspicious/anomalous data

If a provider continues to exhibit suspicious/anomalous data, could be subject to successive audits

In order to ensure robust oversight, CMS will not be making the risk profile public

Audit Basics

Any provider that receives an EHR incentive payment for either EHR incentive program may be subject to an audit

Post payment audits began in July 2012 and will take place during the course of the incentive program

CMS began pre-payment audits in 2013

Providers selected for an audit will be required to submit supporting documentation to validate their submitted attestation data

Audit Basics

It is the providers responsibility to maintain documentation

Documentation to support attestation data for meaningful use objections and clinical quality measures should be retained for six years post attestation

Save any electronic or paper documentation that supports attestation, including documentation that supports values you entered in the Attestation Module for clinical quality measures

Audit Basics

Primary Source Document - the information generated by the certified EHR

This information should contain the following elements

- **Numerators and denominators for the measures**
- **Time period the report covers**
- **Evidence to support that it was generated for that provider (NPI, CMS certification number, provider name, practice name, ect)**

Other documentation

Additional Documentation

Example:

Meaningful Use Objective	• Drug-Drug/Drug-Allergy Interaction Checks
Audit Validation	• Functionality is available, enabled, and active in the system for the durations of the EHR reporting period
Suggested Documentation	• One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation

Attestation “Challenges”

Printing visit summary

California state immunization data submission

- Complete two forms, plus the test submissions

Security rule (Stage 1 Core Measure 15)

- Implement policies and procedures to prevent, detect, contain and correct security violations

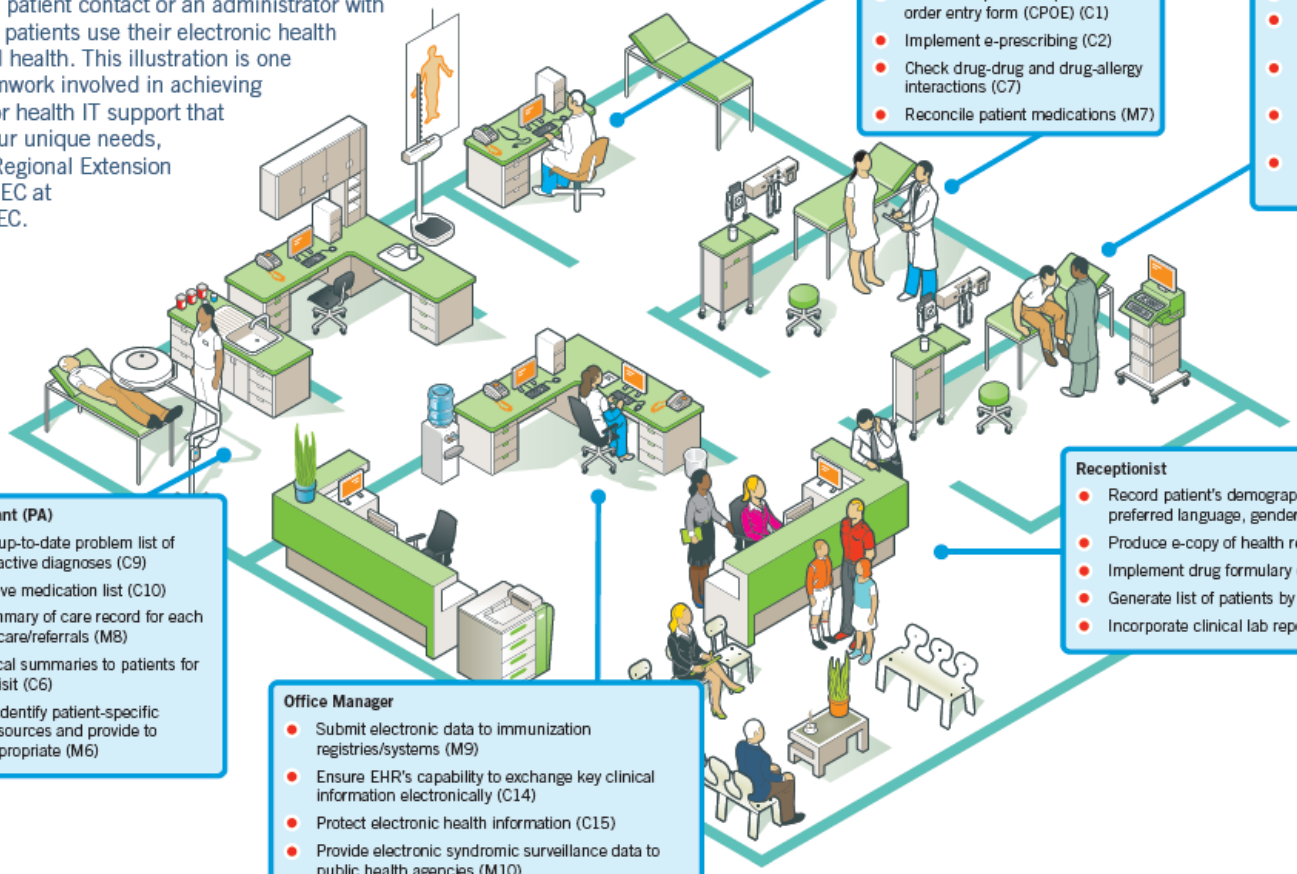
Electronic data exchange of key clinical Information

Patient engagement

Document, document, document and document.

Meaningful Use is a team sport!

Everyone plays an important role in meeting both the core and menu criteria of Meaningful Use. Whether you're a clinician with direct patient contact or an administrator with none, you can help patients use their electronic health record for improved health. This illustration is one example of the teamwork involved in achieving Meaningful Use. For health IT support that is customized to your unique needs, contact your local Regional Extension Center. Find your REC at www.healthit.gov/REC.



Physician

- Utilize computerized provider order entry form (CPOE) (C1)
- Implement e-prescribing (C2)
- Check drug-drug and drug-allergy interactions (C7)
- Reconcile patient medications (M7)

Registered Nurse (RN)

- Maintain active medication allergy list (C11)
- Send reminders to patients per patient preference for preventive/follow-up care (M4)
- Provide patients with timely electronic access to their health information (M5)
- Record and chart vital signs, including height, weight and blood pressure (C12)
- Record smoking status for patients 13 years or older (C13)

Physician Assistant (PA)

- Maintain an up-to-date problem list of current and active diagnoses (C9)
- Maintain active medication list (C10)
- Produce summary of care record for each transition of care/referrals (M8)
- Provide clinical summaries to patients for each office visit (C6)
- Use EHR to identify patient-specific education resources and provide to patient, if appropriate (M6)

Receptionist

- Record patient's demographic information, including preferred language, gender and race (C8)
- Produce e-copy of health records (C5)
- Implement drug formulary check (M1)
- Generate list of patients by specific condition (M3)
- Incorporate clinical lab report as structured data (M2)

Office Manager

- Submit electronic data to immunization registries/systems (M9)
- Ensure EHR's capability to exchange key clinical information electronically (C14)
- Protect electronic health information (C15)
- Provide electronic syndromic surveillance data to public health agencies (M10)
- Report clinical quality measures to CMS/states (C3)
- Implement one clinical decision support rule with the ability to track compliance (C4)

Legend:

C1-C15: Stage 1 Core Set Objectives

M1-M10: Stage 1 Menu Set Objectives

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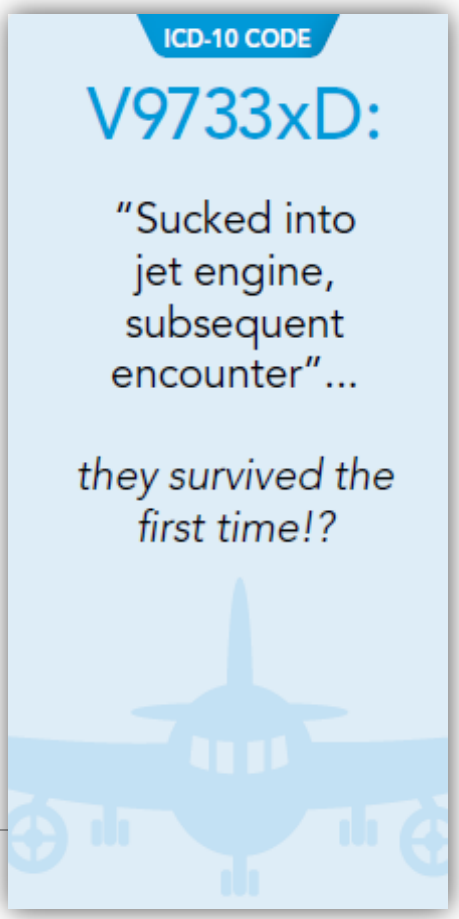
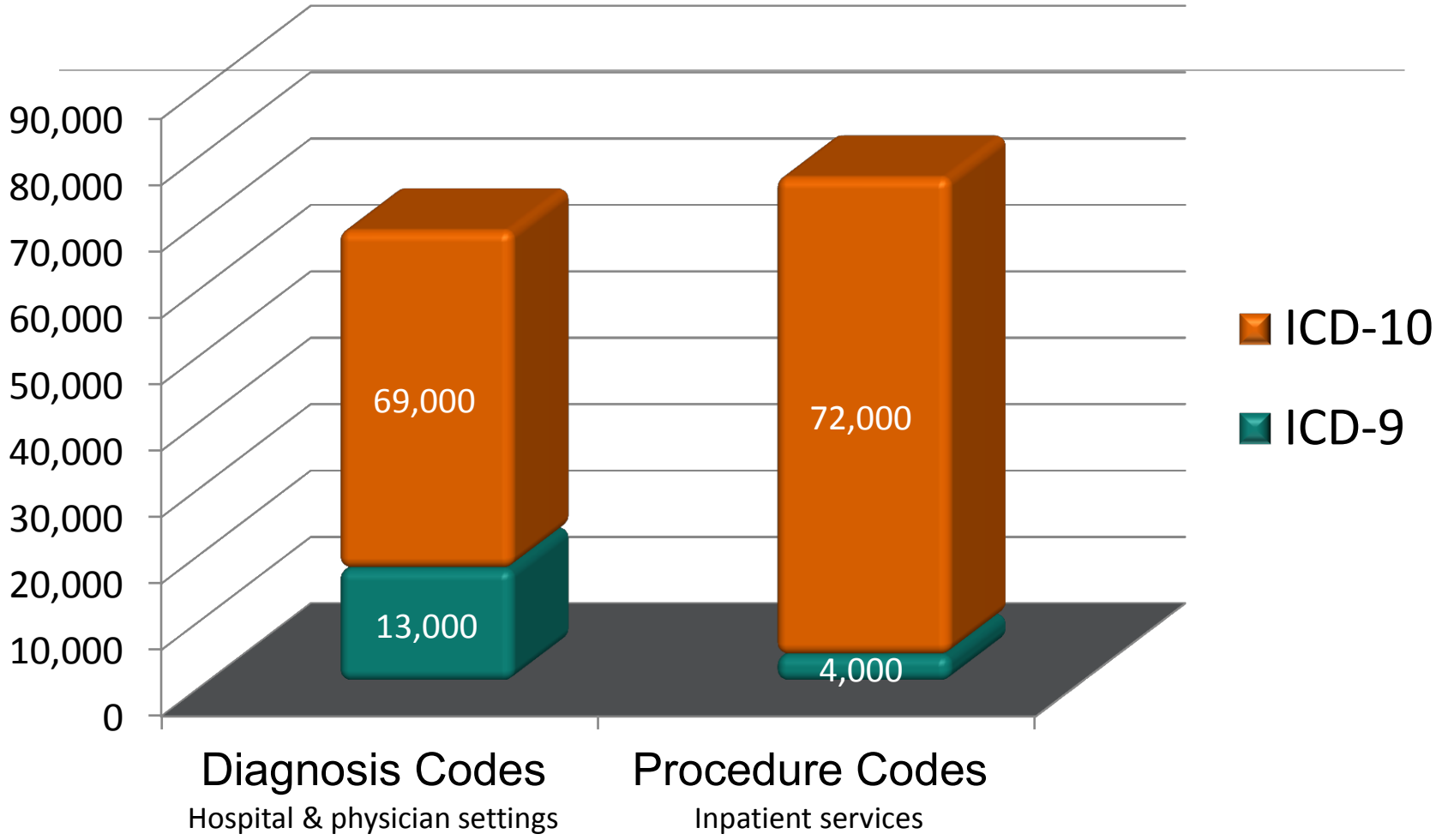
What is ICD-10?



Overview: What is ICD-10?

Question	Answer
When does it start?	**October 1st, 2014**
Why the change?	To bring global alignment with other developed countries
What does it affect	ICD-CM/PCS health care transactions • Outpatient claims with dates of service on/after October 1st, 2014 • Inpatient claims with dates of discharge on/after October 1st, 2014
Who does it affect	Covered entities • All payers, providers, and clearinghouses
Says **who**?	Dept. of Health & Human Services (DHHS)

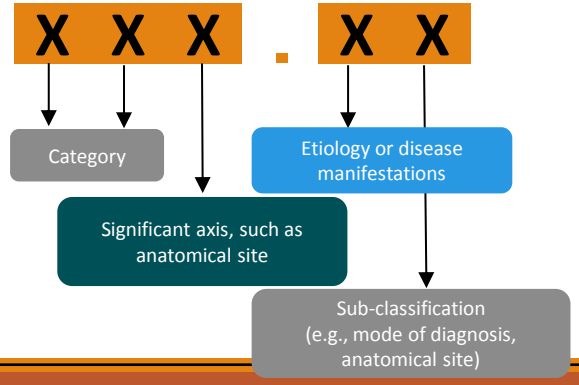
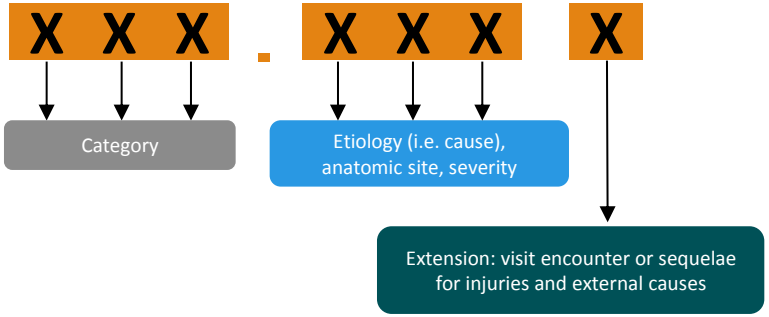
Impact: significantly more complex than ICD-9



Structural and volume changes

Key Differences: Diagnosis Codes

ICD-9-CM vs. ICD-10-CM

Feature	ICD-9-CM	ICD-10
Code Set	ICD-9-CM Volume I and II	ICD-10-CM (Clinical Modification)
Volume	13,000 Diagnosis Codes	68,000 Diagnosis Codes
Structure	• Minimum of 3 digits, maximum of 5 digits, decimal point after the third digit • Numeric, except for supplementary codes — V codes and E codes • Structure of injuries designated by wound type • No laterality (left v. right)	• Minimum of 3 digits, maximum of 7 digits, decimal point after the third digit • Alphanumeric, with all codes using alphabetic lead character — V and E codes have been eliminated and incorporated into the main code set • Structure of injuries designated by body part (location) • Laterality (left v. right)
Sample Codes	733.01, Senile osteoporosis	M80.011a, Postmenopausal osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture
Format		

Are you an ICD-10 expert?

ICD-10	Definition
V9542XA	Forced landing of a spacecraft injuring occupant, initial encounter
W5922XA	Struck by a turtle
V9107xD	Burn due to water-skies on fire, subsequent encounter
T7501XD	Shock due to being struck by lightning, subsequent encounter

How do I prepare for about 69,000 codes

1. Identify your current systems and work processes that use ICD-9 codes
2. Talk with your EHR vendor about accommodations for ICD-10 codes
3. Discuss implementation plans with all clearinghouses, billing services, and payers to facilitate a smooth transition
4. Identify potential changes to workflow and business processes
5. Assess staff training needs
6. Conduct test transactions using ICD-10 codes with payers and clearinghouses
7. Budget for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials, and training
8. Find your top 25-50 ICD-9 codes and create cheat sheets with the equivalent ICD-10 codes

eCW view of ICD-9 to ICD-10

Assessments (Smith, John - 01/14/2014 12:00 PM, NV) *

Pt. Info Encounter Physical Hub

Assessment

Assessments

Auto map to ICD10

Default

Previous Assessments
Problem List
Assessments
ICD10byGEMSImport
Ingenix ICD9 Codes

ICD-9 To ICD-10 Mapping

ICD-9 to ICD-10 Conversion

select approriate choice for the target ICD10

Viewing Scenario# 1 / 1 Scenario(s)

ICD-9 : 493.90 (Asthma, unspecified, unspecified status)

TO

- J45.909 (Unspecified asthma, uncomplicated)
- J45.998 (Other asthma)

Prev Scenario | Next Scenario | Preview | Apply | Cancel

Risk | Clear

Find In (Assessments)

Starts With | Go

asthma

Active

Vitals | New | Assessments

Assessments (Smith, John - 01/14/2014 12:00 PM, NV) *

Pt. Info Encounter Physical Hub

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select approriate choice for the target ICD10

Viewing Scenario# 1 / 1 Scenario(s)

ICD-9 : 845.00 (Unspecified site of ankle sprain and strain)

TO

- S93.401A (Sprain of unspecified ligament of right ankle, initial encounter)
- S93.402A (Sprain of unspecified ligament of left ankle, initial encounter)
- S93.409A (Sprain of unspecified ligament of unspecified ankle, initial encounter)
- S96.919A (Strain of unspecified muscle and tendon at ankle and foot level, unspecified foot, initial encounter)

Prev Scenario | Next Scenario | Preview | Apply | Cancel

Risk | Clear

Remove | Problem List

Find In (Assessments)

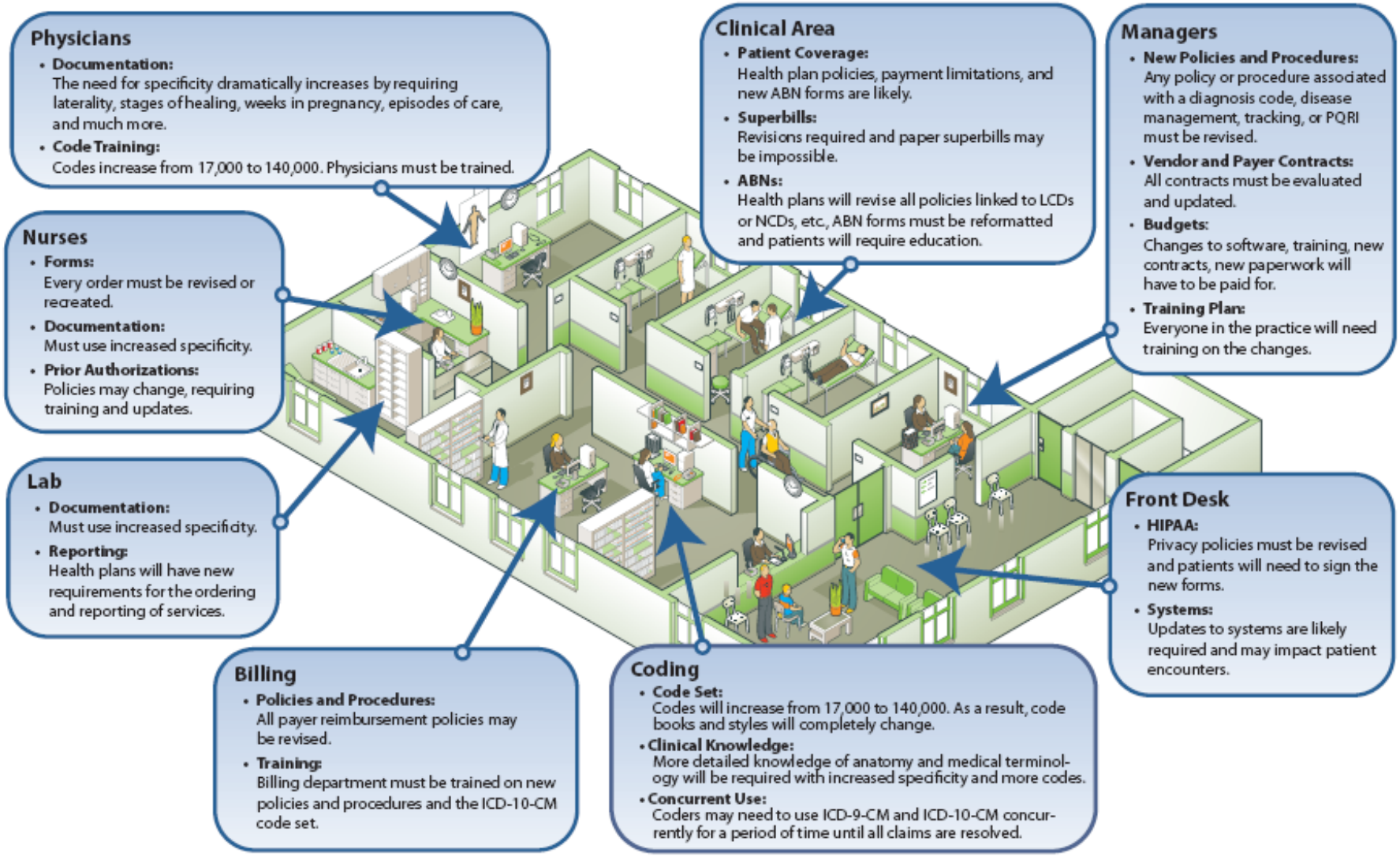
Contains | Go

ankle sp

Active

Vitals | New | Assessments | CDSS

ICD-10 changes everything



Your roadmap to 2015

Jan 2014

- Assign ICD10/MU Champion
- Contact EHR Vendor for upgrade Plan
- Develop upgrade Timeline

Feb 2014

- Start EHR Upgrade Planning
- Contact Clearinghouse about ICD10 readiness
- Educate Staff on MU Stage 2 Milestones
- Develop Patient Engagement Plan

March 2014

- Upgrade EHR/PM
- Customize EHR
- Begin ICD10 Testing & Training
- Set Quality Measures for MU Stage 2 and Train
- Test all Interfaces
- Patient Engagement campaign

Q2 2014

- ICD10 training
- EHR Content Updates
- Confirm Clearinghouse Readiness
- 1st option for MU attestation

Q3 2014

- Continue ICD10 Training
- Insurance file update for vendors not ready for ICD10
- 2nd option for MU attestation

Oct 1st 2014

ICD-10 Mandatory

Q4 2014

- ICD-10 Standard
- Final option for MU attestation
- Continue MU Monitoring

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Thank you

ICD-10 CODE

Z621:

"Parental overprotection"...

aren't all parents 'guilty' of this one every now and then.

ICD-10 CODE

X35.XXXD:

"Volcanic eruption, subsequent encounter"...

that's some really bad luck!

ICD-10 CODE

V9000xA:

"Drowning & submersion due to merchant ship overturning, initial encounter"

...what, no subsequent encounter?

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