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A Supplement to *EyeNet* October 2011

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EYENET EXTRA

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For more about *EyeNet Magazine*, go to www.eyenetmagazine.org.

REPORTING GUIDANCE FOR EYE M.D.s

This supplement is intended to augment the Attestation User Guide, which can be downloaded from the CMS website: Go to www.cms.gov/EHRIncentivePrograms, select "Attestation" and then "Attestation User Guide for Medicare Eligible Professionals."

Ophthalmology experts. The guidance in this supplement was provided by the AAOE's EHR subcommittee—**Gregory S. Brinton, MD, MBA; Albert Castillo; David A. Durfee, MD; Paulette Hottle; Mildred M. G. Oliver, MD; Paula Vaughn, OCS; Robert E. Wiggins, MD, MHA** (cochairman); and **E. Joy Woodke, COE, OCS** (co-chairman)—with **Kelsey Kurth,** Academy health policy manager, and **Flora Lum, MD,** Academy policy director for Quality and Knowledge Base Development and deputy director of the Hoskins Center for Quality Eye Care.

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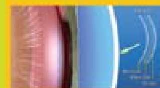

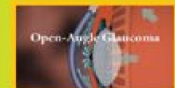

Qualifying: 10 Questions to Consider

What does it take to qualify for the Medicare EHR incentive program? In your first year of participation, you will use the CMS web-based system to attest that you have used a certified EHR system to meet the stage 1 requirements of "meaningful use." This involves reporting on 20 objectives—all 15 from a core set (see pages 5 and 6) and five from a menu set of 10 (see page 8)—and six to nine Clinical Quality Measures (see page 10).

1. What are the stages of meaningful use? The criteria for meaningful use will become more demanding as you progress through stages 1, 2 and 3. Eligible professionals (EPs) who join the program in 2011, 2012 and 2013 will need to demonstrate stage 1 of meaningful use in their first two years of participation. It is expected that they will have to meet a more stringent stage of meaningful use in their third year.

Although the schedule for this phased approach has not yet been finalized, EPs who enter the program later may face a steeper learning curve.

2. How long is the EHR reporting period? The first year that you participate in the program, you must attest to meeting the meaningful use objectives for any consecutive 90-day reporting period. After your first year of participation, you will be required to attest to meeting the meaningful use objectives for a full year.

3. What is an "exclusion"? The regulations recognize that certain objectives might not be relevant to all physicians. In those cases, the regulations specify certain circumstances in which you can exclude yourself from the obligation to meet those objectives.

4. Which EHR systems are certified? In order to qualify for the bonus, you must use an EHR system that has been certified by an Authorized Testing and Certification body. The Office of the National Coordinator (ONC) maintains a list of certified EHRs at http://onc-chpl.force.com/ehrcert/. (See also the list of EHR vendors on pages 14 and 15.)

5. How much is the bonus? Physicians who successfully attest to the meaningful use objectives beginning in 2011 or 2012 can earn up to $18,000 for their first year of participation. (It is important to note that you cannot receive both a Medicare e-prescribing incentive and a Medicare EHR incentive in the same year, so many ophthalmologists may choose to wait until 2012 to attest to meaningful use to maximize their incentive payments.)

6. Are payments based on Medicare charges? Yes. Incentive payments will be paid on a yearly basis with the amount—subject to an annual limit (see chart)—being 75 percent of the EP's Medicare physician fee schedule allowed charges. That calculation will be based on claims for all the EP's services performed during the calendar year, provided that the claims for those services are submitted no later than two months after the end of the calendar year.

7. Do fiscal deductions start in 2015? Yes. EHR implementation will eventually be necessary to avoid incurring penalties. In 2015, the initial penalty will be 1 percent of the Medicare fee schedule, increasing to 2 percent in 2016 and 3 percent in 2017. After that, regulators have the option of increasing it by 1 percent per year, up to a maximum of 5 percent.

8. Can a multiphysician practice earn multiple payments? Yes. The incentive payments will be paid on a participating-physician basis.

9. How do you register for the incentive program? You can register for the incentive program at www.cms.gov/ehrincentiveprograms and click "Registration." Here you also can find a link to the downloadable user guide that will walk you through the registration process. Registration is necessary to access the attestation pages of the website, but it is not necessary to complete attestation at the same time that you register. You can return to the attestation portal at any time.

10. What about Medicaid? There is a parallel program for Medicaid (go to www.aao.org/ehr and select "ARRA Incentive Program," then "Academy Summary," and scroll down to "Medicaid Incentive Requirements").

INCENTIVE SCHEDULE

The year that you enter Medicare's incentive program determines the maximum payments that you could receive, and the stage of meaningful use that you must demonstrate, during the subsequent years. Practices that enter the program in 2015 or later will not qualify for the bonus. In addition, beginning in 2015, CMS will apply penalties to EPs who are not meaningful users of EHRs. The penalties start at 1 percent of allowed charges, increase to 3 percent by 2017 and may increase incrementally each year, to a maximum of 5 percent in 2019.

	2011	2012	2013	2014	2015	2016	TOTAL
Start in 2011	$18,000 Stage 1	$12,000 Stage 1	$8,000 Stage 2	$4,000 Stage 2	$2,000 Stage TBD		$44,000
Start in 2012		$18,000 Stage 1	$12,000 Stage 1	$8,000 Stage 2	$4,000 Stage TBD	$2,000 Stage TBD	$44,000
Start in 2013			$15,000 Stage 1	$12,000 Stage 1	$8,000 Stage TBD	$4,000 Stage TBD	$39,000
Start in 2014				$12,000 Stage 1	$8,000 Stage TBD	$4,000 Stage TBD	$24,000
Start in 2015					$0 Stage TBD	$0 Stage TBD	$0

Reporting: 15 Core Measures

All participating physicians are required to report on all 15 objectives in the core set, but exclusion options are available for six of them. Please note that many of the objectives require that the measure be met for a minimum percentage of patients. In these cases, the percentage stated in the measure must be exceeded (e.g., in the first measure, for CPOE, any percentage greater than 30 percent will qualify).

1. Computerized physician order entry (CPOE): More than 30 percent of all unique patients with at least one medication in their medication list seen by the eligible professional (EP) have at least one medication order entered using CPOE.

Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Reporting guidance: Most ophthalmologists will be able to either meet the objective or qualify for the exclusion. You must answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

In some cases, EHRs may include medication lists that are maintained by multiple physicians. In these circumstances, it may be difficult for the ophthalmologist to meet the reporting threshold due to the volume of entries for medications that he or she does not manage. CMS allows physicians who do not qualify for the exclusion (i.e., those who write 100 or more prescriptions) and who maintain medication lists that include medications ordered by other providers to limit their CPOE measure calculation to only those patients for whom they have previously ordered a medication. Ophthalmologists who are facing this scenario should work with their EHR vendor to determine how to limit the measure calculation.

2. Drug-drug and drug-allergy interaction checks: The EP has enabled this functionality for the entire EHR reporting period.

Reporting guidance: All ophthalmologists should answer "yes." This feature is expected to be built into every certified EHR.

3. Maintain an up-to-date problem list of current and active diagnoses: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.

4. E-prescribing: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.

Reporting guidance: You must answer either "yes" or "no" to the exclusion. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

5. Maintain active medication list: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

6. Maintain active medication allergy list: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

7. Record demographics: More than 50 percent of all unique patients seen by the EP have demographics (preferred language, gender, race, ethnicity and date of birth) recorded as structured data.

Reporting guidance: If a patient declines to provide all or part of the demographic information, or if capturing a patient's ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. If patients do not know their ethnicity, EPs should treat them as patients who decline to provide race or ethnicity (i.e., identify in the patient record that the patient declined to provide this information).

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or White.

Ethnicity: "Hispanic or Latino," or "Not Hispanic or Latino."

8. Record vital signs: For more than 50 percent of all unique patients age 2 years and older seen by the EP, height, weight and blood pressure are recorded as structured data.

Exclusion 1: Any EP who sees no patients 2 years or older.

Exclusion 2: Any EP who believes that all three vital signs of height, weight and blood pressure of their patients have no relevance to their scope of practice.

Reporting guidance: You must answer either "yes" or "no" to both exclusions. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message. Many ophthalmologists will answer "yes" to exclusion 2. You must still input data on the measure as calculated by your EHR, but this will not prevent you from meeting the requirements of meaningful use.

9. Record smoking status: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Exclusion: Any EP who sees no patients 13 years or older.

Reporting guidance: You must answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

10. Clinical Quality Measures (CQMs): Provide aggregate numerator, denominator and exclusions through attestation.

Reporting guidance: All ophthalmolo-

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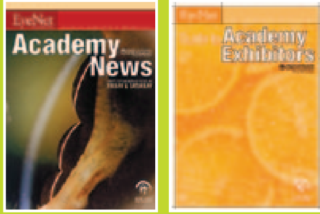

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EyeNet's *Guide to Academy Exhibitors*: comprehensive exhibitor listings, map and contact information.

EyeNet's *Academy Live*: a series of four daily e-newsletters reported on site that provide clinical highlights from the meeting.

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gists should check "yes." See the Clinical Quality Measures section of this document on page 10 for details on reporting measures.

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

Reporting guidance: Consult with your vendor to determine the clinical decision support rule(s) your EHR has the capability to implement. All ophthalmologists should implement the appropriate rule and check "yes."

12. Electronic copy of health information: More than 50 percent of all patients who request an electronic copy of their health information are provided it within three business days.

Exclusion: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

Reporting guidance: You must answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message. Information can be provided in any electronic format, including patient portal, patient health record (PHR), CD, USB flash drive, etc.

13. Clinical summaries: Clinical summaries provided to patients for more than 50 percent of all office visits within three business days.

Exclusion: Any EP who has no office visits during the EHR reporting period.

Reporting guidance: Most ophthalmologists will not be able to check the exclusion for this objective. You must still answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message. The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, CD, USB flash drive or printed copy.

14. Electronic exchange of clinical information: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

Reporting guidance: All ophthalmologists should perform the test and answer "yes." The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy the objective.

The transmission of actual patient information is not required. A fictional patient may be used. The test does not need to be successful to meet the requirement.

15. Protect electronic health information: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

Reporting guidance: All ophthalmologists should review the security of their system, install any necessary updates, and answer "yes."

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Reporting: The Menu Set

All participating physicians must report on a total of five measures from the menu set. There are two public health measures and eight additional measures. You must select one public health measure and four of the additional measures.

Public Health Measures

These measures do not apply to ophthalmologists. To meet the attestation requirements, select one public health measure and attest to the exclusion.

1. Immunization registries data submission: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful.

Exclusion 1: An EP who administers no immunizations during the EHR reporting period.

Exclusion 2: There is no immunization registry that has the capacity to receive the information electronically.

Reporting guidance: Ophthalmologists who select this measure should check "yes" for exclusion 1.

2. Syndromic surveillance data submission: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful.

Exclusion 1: The EP does not collect any reportable information on their patients during the EHR reporting period.

Exclusion 2: There is no public health agency that has the capacity to receive the information electronically.

Reporting guidance: Ophthalmologists who select this measure should check "yes" for exclusion 1.

Additional Measures

All ophthalmologists must report on four of the remaining menu measures.

- **Implemented drug-formulary checks:** The EP has enabled this functionality and has access to at least one internal or external formulary for the EHR reporting period.

Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Reporting guidance: Answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

- **Patient lists:** Generate at least one report listing patients of the EP with a specific condition.

- **Patient reminders:** More than 20 percent of patients 65 years or older or 5 years or younger were sent an appropriate reminder during the EHR reporting period.

Exclusion: An EP with no patients 65 or older or 5 or younger with records maintained using certified EHR technology.

Reporting guidance: Ophthalmologists have the discretion to choose the frequency, means of transmission and form of the patient reminder. Answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

- **Clinical lab test results:** More than 40 percent of all clinical lab test results ordered by the EP whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

Exclusion: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

Reporting guidance: Answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

- **Medication reconciliation:** The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.

Reporting guidance: Answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

- **Transition of care summary:** The EP who transitions or refers a patient to another setting or provider provides a summary of care record for more than 50 percent of transitions of care and referrals.

Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

Reporting guidance: The EP can send an electronic or paper copy of the summary of care record directly to the next provider or can provide it to the patient to deliver to the next provider. Answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

- **Patient electronic access:** At least 10 percent of all unique patients seen by the EP are provided timely (available within four business days of being updated to the certified EHR) electronic access to their health information subject to the EP's discretion to withhold certain information.

Exclusion: Any EP who neither orders nor creates lab tests or information that would be contained in the problem list, medication list or medication allergy list during the EHR reporting period.

Reporting guidance: Answer either "yes" or "no" to the exclusion question. Leaving "no" unchecked and providing acceptable numerator and denominator data will create an error message.

- **Use EHR to identify patient-specific education resources:** More than 10 percent of all unique patients seen by the EP are provided such resources.

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Reporting: Clinical Quality Measures

There are three Core Clinical Quality Measures (CQMs), three Alternate CQMs and 38 Additional CQMs, four of which are specific to ophthalmology. This section of the incentive program's attestation process is based on participation, not on successful reporting. Ophthalmologists will attest at the end of this section that the data presented was generated by their EHR system.

All ophthalmologists should accurately report the measurement data calculated by their EHR system and indicate exclusions where appropriate. There are no thresholds that must be met for the CQMs, and failure to meet the requirements of each measure will not prevent an ophthalmologist from earning the incentive payment as long as all required measures are reported.

Report All Three Core CQMs

All ophthalmologists must report on the three Core CQMs. The Core CQMs are not relevant to most ophthalmology practices; however, it is important to note that reporting zero in the numerator or denominator, as appropriate, will not prevent ophthalmologists from receiving a meaningful use incentive.

NQF 0013: Hypertension: Blood Pressure Measurement. Percentage of patient visits for patients 18 and older with a diagnosis of hypertension who have been seen for at least two office visits, with blood pressure (BP) recorded.

NQF 0028: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment; b. Tobacco Cessation Intervention. a) Percentage of patients 18 and older who have been seen for at least two office visits who were queried about tobacco use one or more times within 24 months. b) Percentage of patients 18 and older who have been identified as tobacco users within the past 24 months and seen for at least two office visits who received cessation intervention.

NQF 0421/PQRS 128: Adult Weight Screening and Follow-Up. Percentage of patients 18 and older with a calculated body mass index (BMI) in the past six months or during the current visit documented in the medical record *and* if the most recent BMI is outside parameters, a follow-up plan is documented.

Report All Three Alternate CQMs

Because some ophthalmologists will report zero in the denominator of the three Core CQMs, they will be prompted to report on the three Alternate CQMs. Most ophthalmologists will also enter zeros in either the numerator or the denominator for each of the Alternate CQMs.

NQF 0024: Weight Assessment and Counseling for Children and Adolescents. The percentage of patients between 2 and 17 years of age who had an outpatient visit with a primary care physician or an obstetrician/gynecologist and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

NQF 0041/PQRS 110: Preventive Care and Screening: Influenza Immunization for Patients 50 and Older. Percentage of patients 50 and older who received an influenza immunization during the flu season (September through February).

NQF 0038: Childhood Immunization Status. Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Choose Three Additional Measures

All ophthalmologists must choose three additional measures from the list of 38. The four ophthalmology-specific measures are listed below. (Specifications for all of the CQMs are available on the CMS website: Go to www.cms.gov/qualitymeasures/03_electronicspecifications.asp, scroll down to the Downloads section, and select the link titled "EP Measure Specifications.")

An ophthalmologist who cannot report on any of the 38 additional measures should exhaust the list of measures that the EHR is capable of reporting on, even if that means reporting zeros in the denominator. This will not prevent the ophthalmologist from earning an incentive payment.

NQF 0055/PQRS 117: Diabetes Mellitus: Eye Exam. Percentage of patients who are 18 to 75 years old with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

NQF 0086/PQRS 12: Primary Open-Angle Glaucoma: Optic Nerve Evaluation. Percentage of patients 18 and older with a diagnosis of POAG who have been seen for at least two office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.

NQF 0088/PQRS 18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy. Percentage of patients 18 and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed that included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

NQF 0089/PQRS 19: Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care. Percentage of patients 18 and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

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Ambulatory EHR

Do You Need to Hire a Consultant?

By Julia Lee, JD, OCS

Electronic health records implementation is one of those projects with multiple moving parts, high stakes and an even higher learning curve. Depending on the complexity of your implementation, you may be considering whether to outsource some of these activities to a consultant. If chosen wisely, consultants can add great value to your implementation, but they are an expensive resource whose effective use requires thorough consideration and careful management.

What Sort of Consultant?

Be as specific as possible about the scope of work. If you are uncertain about your needs or vague about your objectives, you will have difficulty directing a consultant—and the consultant may have to spend time "assessing" your needs. Thus, begin by determining the gaps in your expertise that you hope to bridge. This will help you identify the consultant who can offer you the most for your money.

The expert on contracts. EHR contracts can be technical and complicated, making a simple legal review insufficient. You will need someone familiar with all aspects of the contract, from industry standards for product installation to implementation, upgrades, licensing restrictions, support and other provisions that will govern your ongoing relationship with the EHR vendor.

The expert on IT infrastructure. Your new EHR system may require you to upgrade your IT infrastructure. Depending on the amount of support your EHR vendor provides, you may have to hire your own IT consultant, especially if you want someone to continue managing your network once the EHR system is up and running.

The expert on EHR templates. You may decide to customize your EHR templates with a consultant who knows your system. Vendors typically charge additional fees for template customization, so it will be up to you to determine whether an outside consultant could offer more value (such as specific knowledge of ophthalmic workflow) at equal or lower cost.

The expert on project management. If you are considering overall project management help, try to find a consultant who has worked with ophthalmic practices before and knows your particular EHR system. If you choose someone without that experience, be prepared to pay extra for the time it takes him or her to get up to speed. As valuable as general knowledge of EHR implementation planning is, your consultant can't go the final mile for you unless he or she can connect that EHR knowledge to the specifics of ophthalmology and your EHR system. The EHR vendor should provide some level of support and project management.

Check references. Be sure to check references. And as you interview potential consultants, don't forget the human factor. You should feel that the consultant you hire is a team player.

What Sort of Contract?

The most straightforward contract covers time and materials, including travel—in other words, you are billed for what you utilize. If the engagement is more comprehensive and long term, you might want to work out a retainer agreement with a flat monthly fee. If you go this route, specify that the contractor provide a detailed hourly accounting so that you can determine whether you are getting the full benefit of the retainer. Build flexibility into your contract so that you can modify the agreement or convert to a time-and-materials approach if you discover that the retainer overestimated the monthly hours expended. You might also consider an arrangement that tapers the amount of dedicated consultant hours as your practice gains proficiency. The scope of work as defined in the contract should be clear to both parties. Make sure you understand which tasks would be billed in addition to the monthly retainer fee. Finally, spend some time reviewing and negotiating the termination provisions so that you can walk away without penalty if you are dissatisfied.

For IT services contracts, pay attention to the terms and conditions for ongoing support. It's also important that the consultant be familiar with the unique needs and security requirements of medical practices. And determine how the contractor defines off- or after-hours support. Medical practices typically open earlier than other businesses: You don't want an 8 a.m. call for support to be considered off-hours. If you are uncertain about committing to a monthly retainer but still want a volume discount, see if the IT consultant or vendor will sell you blocks of time that you can use as needed.

What Sort of Relationship?

Hiring a consultant should not mean relinquishing your sense of project ownership. Consider the consultant an extremely qualified, highly compensated temporary employee. Timely and clear communication should be a given. If your consultant is so overcommitted with other projects that you feel you are not getting his or her best effort, it is time to reevaluate. Better yet, be direct about your expectations during the interview and contracting phase. Are you carving out an area of oversight—network maintenance, for example—and delegating it to the consultant? Are you intending the consultant to train someone within your organization to take on a particular function? Understanding the intended role of the consultant, establishing a clear set of mutual expectations and maintaining regular communication should maximize the value of the consulting relationship.

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