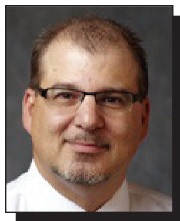
Joseph Borreggine, DPM

Michael Brody, DPM

James Christina, DPM

Tony Poggio, DPM

J. Kevin West

EHR and Meaningful Use in Podiatry

Our experts discuss how practitioners will be affected.

BY MARC HASPEL, DPM

With little exception, no single development has swept through the profession of podiatric medicine—as well as all the rest of healthcare, for that matter—than the emergence of electronic health records and the concept of meaningful use. Fueled by the American Recovery and Reinvestment Act, which has provided substantial sums of incentive money for using electronic health records in a meaningful way, many physicians have transitioned to this contemporary form of record-keeping. Naturally, this program has also been fraught with pitfalls. First, there are looming future penalties in store for those physicians who choose not to engage in electronic health records. More immediately, while the program involves a relatively uncomplicated attestation process in order to claim incentive funds, truly fulfilling every requirement—particularly that involving HIPAA security—has proven to be somewhat uncertain, and has opened doors for audits, leading to potential demands for refunding of incentive monies.

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As the profession remains inexorably involved in EHR and meaningful use, *Podiatry Management* magazine has assembled a panel of DPM participants in these programs (along with a healthcare attorney highly experienced in these matters) to offer insight into this productive yet problematic initiative.

Joining this round table:

Joseph Borreggine, DPM has been in practice for over twenty-five years and has been avidly involved in Illinois' podiatric leadership for much of that time. He served as Illinois' president in 2009 and now participates as their Healthcare Advisory Committee Chair along with serving on the newly formed APMA carrier advisory committee for DME issues.

Michael Brody, DPM has presented webinars for the e-Health initiative, (www.ehealthinitiative.org/) and is active in the EMR workgroup of the New York E Health Collaborative (www.nyehealth.org/). He has provided consulting services to physicians for the implementation of EHR software and to EHR vendors to assist in making their products more compatible with CCHIT and HIPAA guidelines. Dr. Brody is Chief Compliance Officer for Sammy EHR.

James Christina, DPM is board certified by the American Board of Podiatric Surgery. After 20 years in private practice in Rockville, MD, he accepted the position as director of Scientific Affairs for the American Podiatric Medical Association in 2005 and remains in that position today.

Tony Poggio, DPM is in private practice in Almeda, CA. He is board certified by both the American Board of Podiatric Surgery and the American

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Board of Podiatric Medicine. He is a podiatric reviewer for several national insurance carriers and serves as his state's Carrier Advisory Committee representative.

J. Kevin West is a shareholder in the law firm Parsons Behle & Latimer in Boise, ID. Mr. West has been a healthcare attorney for over 25 years, representing providers, and in particular podiatrists, in malpractice, Medicare audits and investigations, HIPAA compliance, meaningful use audits and other regulatory matters. He acts as national counsel for Medicare and regulatory matters for PICA, and is the author of the APMA Privacy and Security Manuals.

Q *PM: Have you had experience with Meaningful Use audits, and what can you tell us about them?*

Brody: I have had the opportunity to work with nearly fifty doctors and their practices in responding to meaningful use audits. Many of these audits are straightforward, and we are able to gather the documentation necessary to respond and successfully navigate them. This process usually involves an initial response to the auditor, and one or more additional requests for information.

There have been incidents, however, where the doctors were not able to pass the audits. This has been because they cannot produce the necessary documentation to support their attestation for meaningful use. The most common cause I have encountered is that they have not properly completed a risk analysis. Doctors who have submitted check-off sheets, or have printed boilerplate materials downloaded from the Web have failed meaningful use audits for that very reason. The second most common cause has been the result of poor education/communication between the software vendors and the doctors. In these cases, the doctors did not understand their responsibilities in meeting meaningful use and attested improperly based upon this communication breakdown.

I have also been involved in situations where doctors attempted to respond to the audits on their own, and did not pass the audits. Here, the best advice I can provide to doctors who receive an audit letter is to immediately contact their malpractice carriers and see if they have a program that can assist them in responding to the audits.

West: Yes, I have defended, or am currently defending, over three dozen meaningful use audits on behalf of PICA and its insured doctors. These audits relate to both first year and second year attestations. The audits are being conducted by a single contractor, the accounting firm of Figliozzi & Company, based in New York City. The audits begin with a letter from Figliozzi requesting documentation. After the documentation is reviewed, there are often requests for additional information and documentation, after which a final decision is made to either allow or deny payment (and require repayment) of the meaningful use monies. Many of our cases have had successful outcomes. A few of the cases, however, have had a negative audit result, and we are currently appealing them through the process set up by CMS.

It is also important to point out that some of the audits are post-payment and some are pre-payment audits. Obviously, as the terms suggest, in a post-payment audit, the government is operating on a "pay and chase" model in which they are determining after the fact as to whether money was properly paid for meaningful use measures. Under the pre-payment model, the government is obtaining information and making a decision before any funds are paid to the doctor.

Christina: I have had many communications with association members who have had audits. The auditors have a basic checklist that they follow, and it is important to keep documentation of everything that is attested to—this can be screenshots, reports from EHR, etc. If there are discrepancies between an EHR report and attestation report, there better be documentation to explain any major differences. The security risk analysis, core measure 15 has been a stumbling block for many podiatrists in their audits. Podiatric physicians must have a security risk audit performed and document the findings and corrective actions taken. This includes having an up-to-date HIPAA manual and having their staff-training up-to-date.

Poggio: The vast majority of the information required is generated by the EHR program. It is simply a matter of meeting the numerical criteria. Where audits have failed has been in the security analysis measure. This is something that many of us were unaware of as to the standard that the auditors are requiring. Many of the software companies were also unaware. There is nothing inherent in the EHR software to meet this measure. So this must be done by the provider or an outside company. It is unfortunate because all measures have to be met to achieve meaningful use and simply missing this one measure can jeopardize the entire payment.

Q *PM: How do you think meaningful use relates to future payment paradigms?*

Borreggine: Meaningful use is, and will be, the mainstream of data-mining along with its eventual partner of ICD-10. With these two in tandem, CMS now, and eventually all carriers, will identify the cost-effectiveness of medical providers delivering healthcare. Instead of the fee-for-service model being dictated by providers without constraint, meaningful use, along with ICD-10, will eventually shape a diagnosis-driven payment model similar to what hospitals experienced back in the late 1980's, which dramatically controlled healthcare costs.

Christina: If one looks at some of the current legislation, particularly the SGR fix, they include meeting meaningful use standards as part of the payment paradigms that are being suggested. Some proposals have significantly more penalties in terms of payment than what is currently

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scheduled by CMS for meaningful use. There is no question that meaningful use will play into the future reimbursement models for CMS.

Poggio: Meaningful use will probably morph into some type of PQRI program where, if one meets criteria, there may be an incentive payment. Currently, it seems that the incentive process is one of fining the doctors and imposing penalties if they do not meet certain criteria. Fee schedules are already ratcheted down. Evaluation management services were also reduced in value this year. Primary care physicians can gain more money if they meet certain criteria and this may, in fact, be the wave of the future coupled with documentation gathered through an EHR program.

Brody: I believe the more appropriate question would be how meaningful use relates to current payment paradigms. There are already many pay-for-performance programs that are based upon quality reporting from doctors. Stage 2 of meaningful use has many quality metrics built into it as well as requirements for clinical decision support tools that are based upon evidence-based medicine and must relate to the clinical quality measures of meaningful use.

Reports that are generated from existing electronic health record programs are already being utilized by insurance carriers to provide performance bonus payments to doctors and to contract with physicians. A well-known pilot of this type of paradigm is Bridges to Excellence, and it has demonstrated that these programs can result in cost savings and improved outcomes.

Q ***PM:*** *How has implementing EHR software impacted how you practice?*

Borreggine: It has been an excellent improvement to medical record-keeping and storage. We have followed all the necessary steps to attest for meaningful use since 2011 for stage 1 and look forward to stage 2 as well. EHR has streamlined our medical office staff dramatically and thereby reduced expenses, but the initial outlay was dramatic, to say the least.

Poggio: Well, at this stage, I would like to think that it is helping improve patient care, but with all the burdensome regulations, coupled with the constant fear of audits (including having to pay back incentive money that was spent to purchase the EHR programs, hardware, etc.), difficulty in getting DME covered, and the impending ICD-10 changes, the meaningful use program is putting added strain on practice, which ultimately negatively impacts patient care. At this stage, I have not yet seen the supposed cost-savings or higher efficiency as our staff is being required to do more and more busy work. The vast majority of patients in my practice decline the clinical summaries, for example, yet the requirement is getting even more stringent in 2014.

Brody: I must say that implementing EHR software has had a major positive impact on my practice. Any change can be difficult, and the process of moving from paper records to electronic records can be upsetting to the workflow of an office. Of course, when implementing any new tool, there is a learning curve. By approaching the project of implementation with enthusiasm and optimism in practice, I found the pain of implementation of the software was minimized. I now find that I am more efficient in my office by utilizing the tools available in my EHR program.

West: My experience has been quite different. Although I do not personally use EHR software, I work with hundreds of physicians whose offices do, and I have both observed the results and heard their numerous comments. I am no doubt influenced by the many negative incidents that I encounter in working with doctors. but, in my opinion, the advent of EHR has been extremely rocky. In my opinion, the quality of medical records is worse now than prior to the advent of EHR. Whether it is bad software or poor practices by doctors and their staff, or a combination of both, the quality of medical records is horrendous in many instances with EHR. In addition, most doctors tell me that the time consumed in preparing medical records is much greater than before and has become extremely burdensome. Doctors have had to reduce the number of patients they see and/or hire additional staff in order to fully utilize EHR. It also appears that many of the software products are inordinately expensive and the service provided by some EHR companies is quite woeful.

I also believe that some EHR companies have intentionally or unintentionally misled doctors by representing that the software satisfied all meaningful use criteria. In fact, this is not possible, because certain meaningful use standards require that the practitioner proactively take certain steps which the software alone cannot accomplish. The chief problem here is Stage 1, Core Measure 15, which is the HIPAA risk analysis. Most of the doctors I work with are completely unaware that this core measure requires a sophisticated set of steps, which include both legal and IT components. These doctors were assured by their EHR vendors that they met the standards, despite the fact that no one ever specifically addressed the HIPAA risk analysis.

Q ***PM:*** *Please share how Meaningful Use has had a positive and/or negative impact on any patient encounters?*

Poggio: The electronic charts are better, if for no other reason than the improved legibility. Also, seeing it on the screen and taking a quick review can provide a sense of the quality of the note. The chart note is more integrated with vitals and prescriptions. Some patients seem to be bothered by taking vitals, especially those with higher blood pressure or weight. This sets up some stress at the initial encounter. If there is a string of new patients, entering vitals doing medication reconciliation and past medical history can be an increased load on the staff/provider. The clinical summaries requirement is yet another burden on the staff especially when the vast majority of

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patients, I find, do not want them on subsequent visits.

While going towards a paperless system, ironically, in my practice, we seem to be going through more and more paper than before. Referrals that used to be faxed over on a single sheet of paper now contain multiple pages of information of past medical history, much of which may not be pertinent to what we are seeing the patient for, but still needs to be incorporated into the patient's file somehow. I think what is lost in this system is that there is some value in simply being able to talk to patients, even for non-medical issues. Asking patients about their grandchildren can bring out a smile. That is difficult to do while entering two pages of medications.

Borreggine: I have seen mostly positive, and very few negative, issues. Patients especially enjoy the improved electronic communication and education that EHR under meaningful use parameters provides.

Q ***PM:*** *If you could change or add one measure to meaningful use what would that be, and why?*

Christina: I would change the measure in Stage 2, core measure # 7 that states "More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information." I do not think it is fair to hold providers responsible for actions of the patients with regard to meeting standards for meaningful use. Many older patients struggle with understanding how to access their medical records electronically. CMS should find other ways to make patients engage that do not potentially penalize providers.

Borreggine: I would make no alterations. In my opinion, there are too many regulations in place to add any others.

Brody: I would extend the CPOE measure to require that all test results be linked to the orders. In this way, all EHR software programs would provide feedback on tests that were ordered that did not have results. This would help prevent patients from falling through the cracks because their physicians did not follow up on ordered tests.

Poggio: Currently faced with the specter of audits, I would change the security analysis. It is unfair that doctors do all of the work in the trenches, meet all the other measures, which, in my opinion, truly impacts patient care and then fail on this one single measure. This seems to be the weakest link where the auditors are focusing, seemingly only as a way to recoup money, since they are incentivized to do so. On one hand, it is difficult for them to challenge statistics that an EHR creates. On the other hand, this measure is the only one up to some potential interpretation. In general, all the meaningful use measures should be pertinent to each practice and there should be variability as to what types of measures we should be required to meet.

More and more of these measures in 2014 are out of our control, relying on the patient's ability to access information via computers, many of whom may not even own computers or have the skills or desire to deal with computers. With all the concerns recently regarding hacking into systems, these requirements put an incredible onus on the small practices to try to prevent these issues. Ironically, large global corporations, with their more abundant resources, are even having trouble with information security.

Q ***PM:*** *Will you continue to meet meaningful use after the incentive money has run out, and why or why not?*

Brody: Yes, I will continue to participate in meaningful use after

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the incentive money runs out. The use of certified technology will provide me with the ability to better communicate with other doctors in the community and my patients. This improved level of communication will enable me to provide quality care, which appeals to me as a medical provider. In addition, the improved communication with both other doctors and patients has already resulted in new referral sources for my office, which appeals to me as a businessman. Finally, the tools built into EHR technology that allow me to tap into the new payment paradigms are extremely important to the future financial health of my practice.

Borreggine: Yes, I will continue since I have invested heavily with time, money, and the physical plant on my meaningful use EHR system.

Poggio: The initial few years of the incentive program had substantial money being paid, but towards the end of the program, the amount of money being paid may not be worth the extra work required to continue to meet meaningful use. There would, therefore, be a possibility that people would quit using their EHR fully. There, however, will probably be a combination of incentives or penalties for not using the EHR programs, and the government will continue to put the onus on all providers to follow through with some form of a meaningful use program.

Christina: Speaking in general, this will be a decision each podiatrist must make individually, taking into account the penalties versus the cost of continuing to meet the requirements. Other factors include how long until one's retirement, whether a functioning EHR that has met meaningful use requirements make a practice more marketable, and if there will eventually be a true exchange of information between providers about patient care through a health information exchange.

Q ***PM:** Now that meaningful use stage 2 is underway, measure #9 states, " Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2) (iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs." Thus, what is the difference between that and measure # 15 in stage 1 of meaningful use, being that they*

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both deal with HIPAA Security?

Brody: I consider the change in wording between the two measures an improvement. HIPAA security is a continuous quality improvement program and the re-write of the measure helps to remind doctors of this fact. I am pleased that, to date, I have helped over five hundred practices implement a HIPAA Security Risk Analysis and Risk Mitigation Plan. The importance of this measure is underscored by recent incidents where podiatrists have had their offices broken into and have had computers with patient information stolen.

West: The primary difference I see is that in measure 15, stage 1 requires, in general terms, the performance of a security risk analysis, while measure 9 in stage 2 makes the same mandate, but is more specific in its mention of encryption of health information maintained in an electronic health record.

Poggio: I agree. In stage 2, the measure specifically addresses encryption/security of data stored in the CEHRT. This is not mentioned specifically in the stage 1 measure. Both require a security risk analysis with documentation of deficiencies and a plan to remedy them.

Borreggine: I believe that the difference is great. The onus truly falls on the medical practice to prove that HIPAA security analysis is assured and implemented by the medical practice. This is no longer an affirmative that security measures are in place, but rather there is an execution plan in place to protect and verify medical data and patient information integrity. The practice must adhere to strict and stringent guidelines to protect patient medical data at all costs.

Q ***PM:*** *What do you think about the recent temporary three-month amendment to the SGR, which will give physicians a 0.5% increase, but ultimately extends sequestration, and how does this relate to meaningful use?*

Poggio: This is a yearly fight, which does nothing but increase stress on practice by not knowing how the 20-30% cuts will impact the viability of any practice. At the last minute, there is always this turnaround with either a breakeven or a slight increase. Meaningful use adds more strain on the practice by taxing employee and provider time, resulting in the making of less and less money. It is difficult to compensate employees and the physician for this added work when the revenue stream is decreasing. Even with the small increase in the conversion factor, oftentimes this

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is offset by a decrease in the RV units, still resulting in a net decrease.

Borreggine: I disagree with this amendment and opine that the SGR should be abolished entirely. The sequestration is nothing more than a political tool divisively used by the government to further divide public opinion on how it needs to save money. I also believe that meaningful use plays into this by creating an ability for the government to finally gather data to show how much money goes to healthcare unnecessarily and, hence, develop plans to reduce fees further in the future.

Christina: The three-month amendment does not specifically relate to meaningful use, but, as noted before, the more permanent SGR fix certainly will. It is important for podiatrists to realize that besides potential penalties from PQRS and meaningful use, there is also the two-percent sequestration reduction, and this applies to incentive payments received as well.

Q ***PM:*** *Has your current EHR achieved Stage 2 certification? Are you currently considering changing EHR programs?*

Borreggine: No, our current EHR has not yet achieved stage 2 certification, and we do not intend to change.

Brody: I, too, am not considering changing EHR programs. I need to point out, however, that there is no such thing as Stage 2 certification; it is known as 2014 certification. All providers, whether they are at stage 1 or stage 2, will need to have 2014 certified software in order to participate in meaningful use in 2014. Achieving stage 2 certification will most certainly involve building in new tools to allow users to easily participate in PQRS in 2014, and building ICD 10 workflows that incorporate clinical decision support.

Poggio: My program has achieved stage II certification. At this point, with so much time and money invested in both the billing and records software, it would be difficult to switch systems. Although some of the data could be transferred electronically, there still is a significant amount of data which need to be manually transferred. Nothing with computers seems as easy as it is made out to be. **PM**

Dr. Haspel is senior editor of this magazine and past-president of the New Jersey Podiatric Medical Society. He is a member of the American Academy of Podiatric Practice Management.