M-CEITA Call with NPO Practices 10/16/14

Question: The practice has been doing the reporting for the 30% encounters using group level reporting. Is that sufficient or should she do provider level reporting?

Answer: It's certainly sufficient to use Group Proxy reporting for the eligibility portion of the Medicaid EHR Incentive Program. If fact, in many instances, it's the most advantageous way to prove eligibility as it allows you to normalize Medicaid visits across all providers (so if someone is at 29% and someone else is at 31%, both EPs qualify because it's an average). Group Proxy calculating also allows you to count nearly ALL visits on Medicaid patients, including PA visits, RN visits, etc. This can help to boost the Medicaid numbers over that 30% target. If calculating eligibility by EP, you're relegated to ONLY that provider's Medicaid visits. I also clarified that the 90 day window for eligibility is different than the 90 days for MU reporting. Eligibility is a 90 day window in the past calendar year or previous 365 days. Which one you choose is up to you and allows you to cast a wide net for finding a suitable 90 day window where all of your EPs qualify (and avoid months where Medicaid visits traditionally plummet). Your eligibility period CAN be the same as your MU reporting period, but doesn't need to be, and in most cases is not. Finally, Vickie had an additional question regarding the how to secure the "site level ID for public reporting" that an IT person was asking her for. This is something called the OID which is a unique number that is used only in public reporting which identifies for the State where the data is coming from. MDCH has set up their own method for issuing OIDs for MI practices which can be found here: https://mimu.michiganhealthit.org/OID/

Question: The Practice has a new provider, just out of residency. Where does she fit for reporting?

Answer: While her new provider just out of residency CAN attest to MU this year, she does not need to be a Meaningful User. New providers get an automatic 2 year pass on the Medicare Payment penalty so no hardship exception can (or should) be filed for this provider. The clock begins to tick when a new provider bills his/her first Medicare claim under their own NPI. Again, her attaining meaningful use is optional at this point. She can choose to opt in to the program already if desired, which means starting to receive the incentives.

Question: Does she have to have providers attest every year at the federal level?

Answer: Regarding "attesting" at the Federal level each year, Medicaid program participants register at the Federal level but attest to MU in CHAMPS. Federal registration is not required each year, however, it's in your best interests to go back into the Federal Registration site each year to ensure what's listed there is still valid for the current program year. https://ehrincentives.cms.gov/hitech/login.action

Question: First, the MAQ dashboard reporting looks OK for 4 of the 5 physicians. The last physician had a name change but she doesn't think that is the problem. Can she hand count for this physician or does she need to put in a ticket?

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Question: In general, can hand-counting work at all or do all measures need to be through MAQ? The example is Chlamydia reporting. They do chlamydia along with GC so it is not part of the EMR MAQ stats. Can she hand-count?

Answer: M-CEITA Response: Hand counting is allowed for the Meaningful Use measures but NOT for CQMs. CQMs must be calculated by your EHR. It's certainly safest to use your Certified EHR technology to figure your numerators and denominators for the Meaningful Use measures, but if those reports are broken, you do have the option to use your own manual reporting instead. If you do your own reporting, make sure you're keeping VERY accurate records of your calculations as well as the justification for not using your CEHRT reports in case you're audited. Also, it's best to have record of having reported the reporting issue to your vendor as well, so you can show effort at resolving whatever the issue is that prevents you from using your embedded reporting. And all that being said, you are not at fault for the incorrect reports generated by your CEHRT. If you attest with faulty reports, you will not be held to the bad reporting in the event of an audit (CMS FAQ #6097).

From 10/01/14 M-CEITA call:

Question: Can ecw submit one message for all practices for syndromic surveillance?

Answer: I refer you to CMS FAQ 3819 in answer. One Syndromic Surveillance test CAN be used for all EPs in one organization across multiple locations as long as they all use the same EHR and that CEHRT is on a single shared network. Let me know if you need any additional information regarding this question.