MCEITA Call With NPO Practices – 7/7/14 (Dan Belknap from M-CEITA responses in red)

Question 1: The practice has a new provider joining in August who has been in army last 4 years, and not had any Meaningful Use participation. The practice is attesting to stage 2. This new provider has not attested to any stage. Since the practice is attesting to stage 2, will this new provider be attesting to stage 2 also?

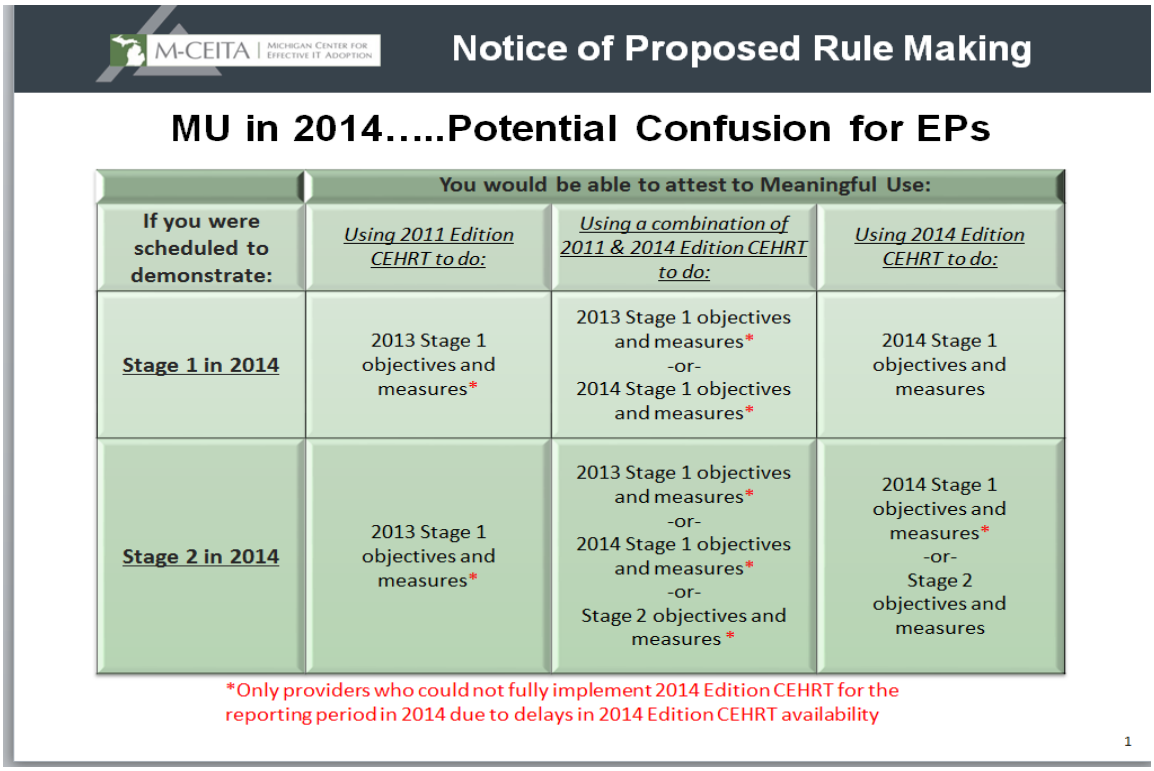
- Incentives are on an individual basis, not a practice basis. If a provider attested and received an incentive at a prior practice, then the provider would continue with the next stage. If the provider has never attested for an incentive, the provider needs to start at stage 1.

Question 2: If the provider worked in 2012 for a health system that had attested for year 1, and then came to new practice mid-year 2013, does the provider still need to attest to a full years' worth of activities?

- If the practice is able to obtain the MU report for the provider individually from the prior practice, and aggregate it with the provider's patient visits in the new practice, then the provider is able to perform meaningful use for 2013.
- M-CEITA recommends that a practice fill out a hardship exclusion form for 2014 if the practice does not yet have the software to attest for 2014. If the software cannot successfully perform when needed, then the practice will be able to fall back on the hardship.

Question 3: What are the alternate methods of attestation if you are eligible for Stage 2?

- Slide below provided after call.



Question 4: For the Syndromic Surveillance measure, we are hoping to attest to Stage 2. We are getting conflicting information from our vendor and the state. We have registered with the public health depts., filled out the paperwork, and submitted support tickets to the vendor (eCW) for the interface, and have been told that the interface is not ready for ambulatory practices yet, and that you just need to be registered with the state, but the state is telling us that we need to run a test message through their validator system. Please clarify.

- M-CEITA has staff working with eCW; he will speak with them and get the information to NPO. Provided after the call:

  The issue seems to be that State of MI (SOM) requires a test message for complying with this measure, but eCW is claiming that an interface is needed before they can generate a test message. eCW claims that the SOM wants to test the interface because this is needed for Stage 2 (i.e. on-going transmission). NextGen took a similar stance with MCIR test messages, i.e. claiming that the client had to purchase an interface. In both cases, this is false. The SOM only wants to see an HL7 test message that can be cut and pasted - they intentionally wanted to make this a low hurdle so that practices could easily pass this measure.

  As further verification, other eCW practices in MI have passed this measure using a test message - without purchase of an interface. Bottom line, to be certified, eCW was supposed to have been able to produce a test message.

  NPO is also pursuing this with eCW.

- Another practice stated that Munson is working on this also for the Munson hosted practices.

Question 5 (multi-parts): For the Transition of Care Core measure for Stage 2, we are required to do a transmission to a different system. We were told that practices that enter eCW's P2P portal to retrieve documents do not qualify. These practices have different systems, and we were told by Munson that this does not qualify. Is this correct?

Does pulling from the Portal, not direct to direct, disqualify the measure?

I am wondering about the P2P Open process to use in order for it to comply with the Transition of Care requirement. With P2P Open, if I am using a non-eCW EMR, I have to login to a web portal and retrieve the CCDA from the eClinicalWorks practice. It isn't configured to, in any manner, send the CCDA directly to the non-eClincalWorks EMR. The CCDA XML document has to be downloaded as a webmail attachment and then manually imported into another EMR. If that is the process, can an eClinicalWorks practice still use it to comply with the measure if the recipient is using a different EMR?

M-CEITA's summary of question: Transition of Care - practice has been advised that it is not sufficient for another practice to pull patient data from the eCW portal to meet this measure.

M-CEITA's response: This is correct. While is seems logical, it is insufficient for meeting the measure which is requiring that one EHR push out the information to another.

M-CEITA's summary of question: eCW was vague on whether its P2P product is sufficient to meet the measure.

M-CEITA's response: eCW stated to M-CEITA that P2P was sufficient, but it requires that an "invitation" be sent to the recipient prior to transmission. There is not a cost associated with the recipient accepting the invitation. This can be used to satisfy the TOC requirements. It can also be used for the EHR Randomizer (CMS test message).

M-CEITA's summary of question: Need to clarify eCW's "Direct Trust" product and whether this meets MU. eCW also provides a list of Direct emails for pushing out a TOC - and, which does meet the requirement. Again, how are other eCW practices meeting this measure?

M-CEITA's response: eCW stated that they are just starting up Direct email and they charge non-eCW clients to provide an address.

Quite a gray area, but based on statement #3 below, I believe that it is acceptable to use within the numerator (since the transport is being conduct with an eHealth Exchange participant (i.e. eCW). eCW may not actually be much help on this one because vendors always seem to side with their own developers' intent. It would help to know how this measure is calculated by eCW – do you have knowledge of this?

There are 3 ways to meet the electronic transmission requirement for this measure:

1. Use Direct
2. Use Soap-based optional transport of the EHR
3. Use of CEHRT to create a summary care record in accordance with the required standard (i.e. C-CDA) and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator.

   NOTE a: eCW is an eHealth Exchange participant

   NOTE b: If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient must not be included in the denominator for transitions of care.

   NPO and M-CEITA are still working for more clarification.

Question 6: Does using Certified Medical Assistants/Certified Nurse Aides for POE entry meet meaningful use?

- There was broadening of this measure in the last year, and Certified Medical Assistants have been added to the list. They can be certified by any governing body, other than ones that are owned by the practice itself.
- M-CEITA recommends that you have a specific written guidance, and the source of the guidance saying that here is clarification around a specific issue and if you are audited, that documentation should be sufficient to show the auditor why you did it, it should pass the audit.
- Provided after call:

M-CEITA's summary of question: Physicians are reluctant to allow Nurse Aides or MA's, even if certified to be allowed to enter CPOE data. One caller noted that there is a difference between LPN's and RN's in that LPN's are not certified to address medical alerts or take verbal orders from a physician. I advised that there is specific guidance regarding certification for MA's.

M-CEITA's response: Current MU specifications identify only certified Medical Assistants (i.e. not Nurse Aides) as being eligible to enter medications using CPOE. However, state law states that LPNs can enter medication orders under the direction/supervision of an RN or physician; however CPOE involves contraindications which they are not permitted to act upon. MCEITA is further researching this specific guidance with the Bureau of Healthcare Services, but it seems to most prudent not to allow LPN's to order medications using the CPOE.