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The Future Of The EMR

The EMR that physicians' need right now, today, is different from the EMR they will need three, four, or five years out. Many physicians will purchase an EMR application today and then realize two to three years from today that they have purchased the wrong EMR application based on new things that will occur in the future.

It is a difficult problem facing a doctor who wants to switch from one EMR application to another. With practice management software, there are ways of switching, but with EMR, we have not had very good standards in the past, which makes it very hard to switch from one EMR vendor to another, since the data does not transfer over as well as would practice management demographics and monetary balances.
Among the requirements needed by doctors who use EMR applications today are: Formularies – Formularies need to be health care plans pay from them and it also reduces phone calls going back and forth regarding drug-to-drug interactions and other types of drug comparisons.

Pay-for-performance (P4P) standards that will track types of services such as Health Maintenance – Pre ventive CareDetermines whether tests and procedures for detection or prevention of specific diseases are Being performed regularly according to recommended schedules based on age, gender, one or more CPT's and the frequency that the test should be performed.

Example – Welcome to Medicare Initial Physical Examination – One Time Only - Patient must have the physical examination within the first built in because six months that the patient has

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2007 OIG Work Plan

Billing Service Companies

We will identify and review the relationships between billing companies and the physicians and other Medicare providers who use their services. We will identify the types of arrangements that physicians and other Medicare providers have with billing services and determine the impact of these arrangements on physicians' billings.

Physician Pathology Services

We will determine whether the billings for pathology laboratory services comply with Medicare Part B requirements. We will focus on pathology services performed in physicians' offices. Medicare pays more than $1 billion annually to physicians for pathology services. We will also identify and review the relationships between physicians who furnish pathology services in their offices and outside pathology companies.

Cardiography and Echocardiography Services

We will review Medicare payments for cardiography and echocardiography services to determine whether physicians billed appropriately for the professional and the technical components of the services. Like many physician services, cardiography and echocardiography include both technical and professional components. When a physician performs the interpretation separately, the modifier 26 should be used to bill Medicare.

Physical and Occupational Therapy Services

We will review Medicare claims for therapy services provided by physical and occupational therapists to determine whether the services were reasonable and medically necessary, adequately documented, and certified by physician certification statements. Physical and occupational therapies are medically prescribed treatments concerned with improving or restoring functions, preventing further disability, and relieving symptoms.

Payment to Providers of Care for Initial Preventive Physical Examination

We will evaluate the impact of the initial preventive physical examination (IPPE) on Medicare payments and physician billing practices. Section 611 of the MMA provides for coverage under Part B of an

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IPPE, including a screening electrocardiogram (EKG) for new Medicare beneficiaries, effective January 1, 2005. In addition to the screening EKG, the IPPE must include a measurement of height, weight, and blood pressure; a review of medical and social history; assessment of the potential for depression; and evaluation of functioning ability. For new Medicare beneficiaries with established relationships, the physician is presented with the opportunity to claim a higher payment for the IPPE under a new Healthcare Common Procedure Coding System (HCPCS) code, G0344, for services that may already have been performed in a past evaluation and management visit.

Wound Care Services

We will determine whether claims for wound care services were medically necessary and billed in accordance with Medicare requirements. Medicare-allowed amounts for certain wound care services billed by physicians increased from approximately $98 million in 1998 to $147 million in 2002. We will also examine the adequacy of controls to prevent inappropriate payments for wound care services.

Evaluation of "Incident to" Services

The purpose of this study is to evaluate the appropriateness of Medicare services performed "incident to" the professional services of physicians. We will identify services performed "incident to" physicians' professional services and will determine the extent to which the services met Medicare standards for medical necessity, documentation, and quality of care.

Potential Duplicate Physical Therapy Claims

We will assess whether CMS's systems are able to identify and prevent payment for potential duplicate claims for physical therapy submitted by providers. In May 2004, CMS issued a fraud alert regarding physical therapy suppliers switching their submission of claims between Part A and Part B.

We will review the current Common Working File operations to determine whether edits are adequately identifying potential duplicate physical therapy claims submitted to Part A and Part B contractors.

Review of Evaluation and Management Services During Global Surgery Periods

We will determine whether (1) physicians received separate payments for evaluation and management (E&M) services provided during the global surgery period and (2) industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was initially developed in 1992. Under the global surgery fee concept, physicians bill a single fee for all their services usually associated with a surgical procedure and related E&M services provided during the global surgery period. E&M services related to the surgery provided during the global period should not be billed for and paid separately by Medicare. The global surgery fee includes payment for a certain number of E&M services provided during the global surgery period.

Violations of Assignment Rules by Medicare Providers

We will examine the extent to which providers are billing beneficiaries in excess of amounts allowed by Medicare requirements. Providers must accept Medicare's payment and beneficiary co-payment, known as the Medicare allowed amount, as payment in full for all covered services. Providers cannot bill beneficiaries for amounts in excess of the Medicare allowed amount. We will also assess beneficiary awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines.

Part B Mental Health Services

We will determine whether Medicare Part B mental health services provided in physicians' offices were medically necessary and billed in accordance with Medicare requirements. Payments for mental health services provided in the physician's office setting accounted for approximately 55 percent of the $1.3 billion in Medicare payments for Part B mental health services in 2002. In a prior report, we found that Medicare allowed $185 million in 1998 for inappropriate mental health services in the outpatient setting. We will also determine the financial impact of claims that do not meet Medicare requirements.

Eye Surgeries

We will determine whether Medicare payments for ophthalmology services related to cataract and lasik eye surgery were billed in accordance with Medicare requirements. We will also examine the adequacy of carrier claims processing controls to prevent inappropriate payments for these services.

Place of Service Errors

This review will determine whether physicians properly coded the place of service on claims for services provided in ambulatory surgical centers and hospital outpatient departments. Medicare regulations provide for different levels of payments to physicians depending on where the service is performed. Medicare makes higher payments for physician office services.

Psychiatric Services Provided in an Inpatient Setting

We will determine whether psychiatric services provided in an inpatient setting are being properly billed to Medicare. Medicare makes payments to physicians and certain non-physician practitioners for therapy sessions provided to beneficiaries, including individual and group therapy sessions, based on a fee schedule. Because a group therapy session is reimbursed at a lower rate than an individual session, physicians may have an incentive to bill Medicare for an individual session when a group therapy session was

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Medical Part B.

Immunization

Schedule determines the number of immunizations of a specific type and when they should be given according to the recommended schedules based on age, frequency and one or more CPT's.

Example – Age 2 months
PEDARIXI, HIB1, PREV1 should be given.

Disease Management

Chronic Conditions Determines whether tests or procedures are being performed regularly on a patient with a certain diagnosis, one or more CPT's, one or more ICD-9's, age, gender and frequency that the tests needs to be ordered.

Example – Patient with hypercholesterolemia should have a Hepatic Panel 80058 done 3 times per year for drug monitoring.

Medication Management

Determines whether tests or procedures are being performed in adherence to a recommended schedule based on age, gender, medication or one or more CPT's, and the frequency with which the test or procedure should be performed.

Example – A patient on Methotrexate has a liver and renal function test ordered at least every three months.

CCHIT Standards

What are the requirements of the future? Many EMR vendors will pass CCHIT this year, but who's going to pass CCHIT in 2008? That is the big question, since each year each EMR vendor has to renew their product's CCHIT stamp of approval. Right now there seems to be a big push from the government, healthcare plans, and malpractice insurance companies who want doctors using some kind of certified EMR, government-certified if possible.

When a physician decides to purchase an EMR they have to first determine their requirements. Every medical specialty and size of practice obviously has different requirements. You must consider the combined future demands of healthcare organizations, plus the ongoing needs of Medicare and other government agencies, and create a baseline requirement. The most difficult part is comparing that baseline requirement to what the vendors actually have. Believe it or not, the vendors sometimes say all kinds of things that aren't actually true. Once you have created your general requirements take a survey of vendors and match each of them in 20+ categories with good vendors that you know about. Then match the needs of your medical group with the information in your vendor survey database and then create a report that contains EMR's that best match the medical group's requirements. Specialty EMR programs are always recommended to matching specialty medical groups.

How should points be scored in favor of a particular vendor's EMR? Listed below are a few suggestions:

Look at functionality –would receive 30% of you evaluation points.

User satisfaction – would receive 30% of your evaluation points

Company viability – would receive 30% of your evaluation points (really a tough one, because most EMR vendors are privately held companies, and won't release financial information).

The remaining 10% of the evaluation points is based on existing customer base, such as how many clinics of the same size, the same specialty, and the same general geographic locality are using that particular EMR.

Another consideration is that some malpractice insurance companies are willing to give premium discounts to doctors who use and EMR that meets certain requirements, to reduce the risk of malpractice claims. Everybody knows that if you document better, you're going to reduce the risk, because a lot of the risk is based on what the doctor did or didn't document. For this reason you want to take look at what a doctor wants as well as what everyone who interfaces with the doctor's might want from them three years from now.

Cost. EMR's can range from $2,000.00 up to $200,000.00. It is important to find out exactly what you are getting for your money. Does the cost include implementation, training and support or is the fee simply for the software itself. Some EMR vendors will bill separately for training and additionally for support a much at $100-$200 per hour plus expenses. For these reasons, when your physician is ready to purchase an EMR get a detailed invoice and make sure exactly what you are paying for.

Listed below are a few questions to ask the EMR vendor:

Does the software work with the 1997 Evaluation and Management Guidelines?

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Does the EMR contain only the Multi-system Guidelines (Internal Medicine, Family Practice, etc.) or does it also contain the Single Organ System Guidelines (Orthopedics, Dermatology, etc.)?

This is important because if it contains only the Multi-systems Guidelines it will need to be trimmed down to fit Orthopedics etc. in the areas that document the physical examination areas.

Does it work with macros that specifically address Orthopedics or do these macros need to be customized for each physician?.

Does it contain a full medical record template (Past, Family Social History, Review of Systems and Physical Examination) that specifically addresses Orthopedics that is ready to use or does the template have to be customized for each physician in the practice?

Do they have a clinical staff that will help customize templates or macros specifically for each physician (by clinical staff I mean an RN or equivalent)?

How many different screens does the physician have to use?

How long does it take for a physician to enter a 99205 (New patient encounter)?

How long does it take for a physician to enter a 99213 (Established patient encounter)?

Time is the most important factor for a doctor.

It is important that you have them demo each type of encounter so you can see exactly what the doctor will be expected to do and how long it will take.

What coding tool do they work with?

Does the physician have to determine medical complexity?

Is the physician able to up code his work (the systems generates a 99213 but he chooses 99215)?

If so then the system does not follow medical necessity guidelines. This means that the diagnosis does not match the level of service he will bill.

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provided to receive a higher reimbursement.

Medicare Reimbursement for Polysomnography

This study will determine the factors contributing to the rise in Medicare reimbursement for polysomnography. Medicare reimbursement for polysomnograpy increased nearly 175 percent in 4 years, rising from $62 million in 2001 to $170 million in 2004. The study will also examine the appropriateness of services billed to Medicare.

Long Distance Physician Claims Associated with Home Health and Skilled Nursing Facility Services

We will determine if Medicare Part B long distance physician services are inappropriately billed for beneficiaries of home health and skilled nursing facility services. Previous inspections identified instances of physicians ordering or billing for services that would normally require face-to-face examination for beneficiaries who live a significant distance from the physician's office.

Advanced Imaging Services in Physician Offices

This review will examine the appropriateness of imaging services provided in physician offices. From 1999 to 2005, utilization of advanced imaging services, such as MRI, PET, and CT scans, has grown on average by 20 percent per year. In 2005 Medicare allowed charges of over $7 billion for these services. This review will examine the nature of the Growth of these services over this period including examination of billing patterns in certain geographic areas and practice settings.

Valuation Services

What is the value of your practice?

If you are thinking about buying or selling a practice - we can help!

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