Crash Course in Meaningful Use: What Orthopaedic Surgeons Need to Know
Sponsored by: Pennsylvania Orthopaedic Society
November 9, 2011
Q&A

Q: RE Medicaid 30% threshold - Most of our Medicaid pats are not straight medicaid - they are some other insurance UPMC for you - for instance - similar to the MCR advantage insurances- do those count?

A: Each state sets the guidance on the 30% threshold. I would check with the Pennsylvania Department of Public Welfare on their definition.

Q: Pg 9 - says ONE public health must be reported

A: One public health objective must be selected in Stage 1, the other deferred to Stage 2. An exclusion counts as meeting the objective.

Q: Recently registered & noted that the deadline for this year is NOV 30

A: November 30, 2011 is the last day for eligible hospitals and critical access hospitals to register and attest to receive an Incentive Payment for Federal fiscal year (FY) 2011. February 29, 2012 is the last day for eligible professionals (e.g. physicians) to register and attest to receive an Incentive Payment for calendar year (CY) 2011.

Q: Can you explain #7 on page 9 a little more? Care settings? Dr. to Dr.?

A: Yes, doctor to doctor is considered "between care settings" as well as "transition of care." For meaningful use, a physician who *receives* a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. ''Medication reconciliation'' is defined as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider. ''Transition of care'' is defined as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Q: Can we report height and weight and BP from what the patient provides, in writing as opposed to actually performing?

A: CMS has stated that self-reported or estimated *height* can be used. We would extrapolate that applies to weight as well (although no known authority exists). However, we would caution against self reported BP as the Federal Register has stated, "while this objective could be met by receiving this information from other providers or non-provider data sources, we recognize that the only guaranteed way for a provider to obtain this information is through direct patient interaction"

Q: Can you expand on the Clinical Decision Support Rule?

A: Clinical decision support is HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care. Work with EHR vendor to develop one rule that is applicable to your clinical practice. Reminders to x-ray total joint patients after xx months after surgery is one example. There are no limits as to what the rule that you create is as long as it is relevant to your specialty and the ability to track compliance with the rule.

Q: Is the 30%/40% related only to Medicare patients?

A: No, meaningful use objectives are reported on all patients, not just Medicare patients.

Q. Should I register for the EHR incentive even though I'm not ready to attest meaningful use?

A. Yes, go ahead and register now.

Q. How do you file for an exclusion?

A. During the attestation process, you will be asked if you qualify for an exclusion. An attestation worksheet can be viewed at https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_Worksheet.pdf