

Definition of ‘Meaningful Use’ Elusive for EHRs

BY JOYCE FRIEDEN

WASHINGTON — Just what exactly does “meaningful use” mean?

It sounds like a simple question, but there’s a lot of money riding on the answer. The Recovery Act, formally known as the American Recovery and Reinvestment Act, stipulates that for a physician to receive up to \$44,000 in financial incentives for purchasing an electronic health record, the record must be put to “meaningful use.” Now the government has to come up with a definition of the term.

At a subcommittee meeting of the National Committee on Vital and Health Statistics, which was convened to discuss meaningful use, several speakers explained why having more physicians adopt an electronic health record (EHR) was so valuable.

“The financial meltdown ... has shown us how we as a nation need to totally transform the U.S. health care system,” said Helen Darling, president of the National Business Group on Health. “We have a fiscal crisis, not just a health crisis; we have to act urgently.”

Dr. Elliott Fisher, professor of medicine at Dartmouth University, Hanover, N.H., started explaining the benefits of

EHRs by noting that more health care is not always better care. “Gray area” discretionary decisions about when to refer to a specialist explain most of the regional differences in health care spending and are responsible for most of the health care overuse, he said.

The only way to reduce that overuse is to feed the information—gathered through EHRs—back to the physician



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DR. RAPP

“and start to have a conversation” about when certain tests or referrals are necessary, Dr. Fisher said.

Although everyone agreed that EHRs were valuable, speakers’ definitions of their “meaningful use” differed. “Meaningful use might vary by site of care as well as by type of care,” said Dr. David Classen of Computer Sciences Corp., whereas Dr. John Halamka of the Health Information Technology Standards Pan-

el, a government-funded group that helps ensure EHR interoperability, said his definition of meaningful use was “processes and work flows that facilitate improved quality and increased efficiency.”

Several panelists agreed that EHRs had to allow for three things in order to be used meaningfully: electronic prescribing, interoperability with other computers, and reporting on health care quality measures. EHRs are particularly useful for reporting quality measures because they are a direct source of information and provide very timely data, said Dr. Michael Rapp of the Centers for Medicare and Medicaid Services.

Experts at the meeting also agreed in general that EHR systems need to be certified by a government-approved organization such as the Certification Commission for Healthcare Information Technology to meet the Recovery Act’s requirements. However, certification alone is not sufficient, because many parts of a certified EHR are not necessarily implemented, said Dr. Floyd Eisenberg, senior vice-president for health information technology at the National Quality Forum, which sets goals for performance improvement.

The day after the subcommittee’s 2-

day meeting concluded, the Markle Foundation held a press conference to release a consensus document on the definition of meaningful use. The document was endorsed by a number of provider and advocacy groups, including the AARP, the American Academy of Family Physicians, the Joint Commission, Surescripts, America’s Health Insurance Plans, and the National Committee for Quality Assurance.

The consensus document provides a “simple” definition of patient-centered meaningful use: “The provider makes use of, and the patient has access to, clinically relevant electronic information about the patient to improve patient outcomes and health status, improve the delivery of care, and control the growth of costs.” The document lists slightly different meaningful use requirements for the first 2 years, however; during that time period, meaningful use would be when “the provider makes use of, and the patient has access to, clinically relevant electronic information about the patient to improve medication management and coordination of care.” ■

The consensus document is available at http://www.markle.org/downloadable_assets/20090430_meaningful_use.pdf.

ICD-10 More Complicated Than ICD-9—but More Useful

BY JOYCE FRIEDEN

WASHINGTON — The upcoming ICD-10 diagnosis and procedure coding system is more complicated than was its predecessor, ICD-9, but it will allow for a greater level of clinical detail and will be better able to keep up with advances in technology, according to several speakers at a meeting sponsored by the American Health Information Management Association.

“ICD-9 badly needs to be replaced,” said Nelly Leon-Chisen, director of coding and classification at the American Hospital Association. “It’s 30 years old, and the terminology and classification of some conditions are obsolete.”

There are two parts to ICD-10, formally known as the International Classification of Diseases, 10th revision, which goes into effect in the United States on Oct. 1, 2013: ICD-10-CM, which is the clinical modification of the World Health Organization’s ICD-10 diagnostic coding system; and ICD-10-PCS, an inpatient procedural coding system developed under contract to the Centers for Medicare and Medicaid Services.

ICD-10 “will have better data for evaluating and improving quality of care. It will provide codes for a more complete picture,” she added, noting that the new code set will allow health officials to be “better able to track and respond to global health threats.”

Because ICD-10 can more precisely document diagnoses and procedures, it will bring better justification of medical necessity for billing purposes, “but not from day 1,” said Ms. Leon-Chisen. “It will take a little while” for people to adjust to the new codes. The new system also may reduce opportunities for fraud, she added.

Ms. Leon-Chisen outlined a few basic differences between ICD-9 and ICD-10 diagnosis codes:

► ICD-9 codes contain three to five characters, whereas ICD-10 contains three to seven characters.

► In ICD-9 codes, the first character can be alphabetic or numeric, but in ICD-10, the first character is always alphabetic.

► ICD-10 codes can include the use of a placeholder “x,” whereas ICD-9 codes cannot.

Ms. Leon-Chisen gave an example to illustrate the differences between the two revisions. Under the ICD-9 coding system, a patient with a pressure ulcer on the right buttock might receive a diagnosis code of 707.05, “pressure ulcer, buttock.” Under ICD-10, the same patient would get L89.111, “decubitus ulcer of right buttock limited to breakdown of the skin.” A pressure ulcer on the left buttock or a more severe one including necrosis of the bone would get a different ICD-10 code.

MS. LEON-CHISEN

American Health Information Management Association, noted that ICD-10-PCS can have even more complexities. For example, under ICD-9, there is only one code for artery repair; under ICD-10-PCS, there are 276 codes.

However, “once you work with it, you’re struck by the logic of the system,” she said. “It’s really not that difficult.” Under the ICD-10 code structure, each character has a specific meaning. (See box.)

Ms. Bowman pointed out some of the differences between procedure codes under the two revisions. For example, ICD-9 procedure codes have three to four characters, whereas ICD-10-PCS codes always have seven characters. Also, all ICD-9 procedure code characters are numeric, whereas ICD-10-PCS code characters can each be alphabetic or numeric; alphabetic characters are not case sensitive.

As an example of the difference in procedure codes, she cited the ICD-9 code 17.43 for “percutaneous robotic assisted procedure” vs. 8E093CZ, the ICD-10-PCS code for “robotic assisted procedure of head and neck region, percutaneous approach.”

One issue with which Medicare officials and others dealing with ICD-10 are wrangling, according to Ms. Bowman, is when—or even whether—both ICD-9 and ICD-10 should be “frozen” (that is, when no more new entries should be added to either code set so that they will be stable while people are making the changeover from ICD-9 to ICD-10).

Both code sets are currently updated annually, according to Ms. Bowman. ■



With ICD-10 in hand, health officials will be better able to track and respond to global health threats.

ICD-10 Resources

Sue Bowman recommended the following resources for more information on ICD-10 coding:

National Center for Health Statistics/Centers for Disease Control and Prevention
www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm

Centers for Medicare and Medicaid Services
www.cms.hhs.gov/ICD10

The American Hospital Association’s ICD-10 Resource Center
www.ahacentraloffice.com/ahacentraloffice_app/ICD-10/ICD-10.jsp

American Health Information Management Association
www.ahima.org/icd10