

# Pressure's on to Adopt Electronic Health Records

*Many of the biggest players are gathering this month in Washington for National Health IT Week.*

BY MARY ELLEN SCHNEIDER  
Senior Writer

More than 2 years after President Bush issued his call to action on the adoption of electronic health records, experts say there is growing pressure on physicians to heed that call.

Although physician adoption of EHRs remains low—especially in small practices—the movement toward pay for performance could start to drive adoption, said Dr. Mureen Allen, senior associate for informatics and practice improvement at the American College of Physicians. And the certification of electronic health records by an independent body, which is slated to begin this summer, should help too. “The paradigm to some extent is changing.”

This month, many of the biggest players in health information technology will gather in Washington for National Health IT Week.

More than 40 groups are slated to participate in this first-ever event, including medical professional societies such as the American Academy of Family Physicians, government agencies, a regional health information organization, and other public and private organizations.

The series of events follows on the heels of more than 2 years' major actions in the health IT landscape starting with President Bush's State of the Union address in January 2004 in which he called for the widespread adoption of interoperable EHRs within the decade.

A few months later, the Health and Human Services secretary appointed Dr.

David J. Brailer as the first National Health Information Technology Coordinator. Dr. Brailer resigned from the post last month, saying that he only planned to stay in the job for 2 years.

Dr. Brailer said there is still much work to be done in closing the adoption gap between large and small physician practices. His office has been focused on three strategies to close the gap—lowering costs, raising the benefits, and lowering the risks involved in purchasing an EHR system, he said during a teleconference announcing his resignation.

Last fall, HHS Secretary Mike Leavitt established the American Health Information Community, a federally chartered commission to advise the secretary on interoperability issues. HHS proposed allowing hospitals and other entities to give physicians health IT hardware, software, and training.

HHS also awarded three contracts to public and private groups to create processes for harmonizing information standards, certifying health IT products, and addressing variations in state laws on privacy and security practices.

And starting in January, prescription drug plans participating in the Medicare Part D program were required to begin supporting electronic prescribing. The regulation is optional for physicians and pharmacies.

Most recently, the Food and Drug Administration adopted the Systematized Nomenclature of Medicine (SNOMED) standard as the format for the highlights section of prescription drug labeling. The format will be required starting on June 30

for all new drugs and drugs approved within the last 5 years.

The use of the SNOMED standards will make it easier for electronic systems to exchange FDA-approved labeling information, according to the agency.

One of the most significant developments has been the establishment of the Certification Commission on Health Information Technology (CCHIT). This group was formed in 2004 by the American Health Information Management Association, the Healthcare Information and Management Systems Society (HIMSS), and the National Alliance for Health Information Technology to develop criteria for the certification of EHRs.

CCHIT received a 3-year grant from HHS last fall to certify products in the ambulatory and inpatient settings, and to certify the systems' networks. The announcement of the first certified products in the ambulatory setting is expected in late June or early July.

The means for objectively comparing EHR systems is “about to become a reality,” said CCHIT Chair Dr. Mark Leavitt.

Current estimates put physician adoption of EHRs at around 14%. Dr. Leavitt said he hopes that taking some of the risk out of buying an EHR product will boost those adoption figures.

“I think we are on track,” said Dave Roberts, vice president of government relations at HIMSS.

Although physicians still need to be educated about the value of EHRs, there are some other encouraging signs. For exam-

ple, many states are becoming more interested in health IT and are helping to form regional health information organizations, he said.

These groups, called RHIOs, help to standardize the various regulations and business policies surrounding health information exchange. The federal government has funded more than 100 of these regional projects, and more efforts, supported by private industry or state governments, are underway, according to HHS.

“The states are really buying into this whole initiative,” Mr. Roberts said.

For the majority of physicians, it just hasn't made financial sense to purchase an EHR system, Dr. Allen said. However, some physicians are beginning to see a strategic advantage in the adoption of technology. One advantage stems from regulations that encourage electronic prescribing.

EHR adoption is inevitable, Dr. Allen said, if only because so many younger physicians were trained on EHRs and it is not acceptable to them to go back to a paper system once they enter practice. And older physicians recognize that the change is coming, she said.

But Dr. Allen advised physicians that they don't need to jump into a full-blown EHR system.

Electronic prescribing systems and electronic patient registries may be easier to adopt than a full EHR system. Physicians can also purchase EHRs in a modular fashion so that they can ramp up over time, she said. ■



**The means for objectively comparing EHR systems is 'about to become a reality.'**

DR. LEAVITT

## Expert Recommends Using This Year's Cutting-Edge Billing Codes

BY KERRI WACHTER  
Senior Writer

WASHINGTON — There are some new billing codes available this year to think about incorporating into your practice, Dr. Joel F. Bradley Jr. said at a meeting sponsored by the American Academy of Pediatrics.

Dr. Bradley of Vanderbilt University in Nashville, Tenn., and a member of the American Medical Association's CPT Editorial Panel, offered a few thoughts on these cutting-edge codes:

► **Pay-for-performance.** Pay-for-performance may be closer than you think. Although it is presently voluntary for physicians participating in Medicare, “most physicians now will be using CPT codes initially to participate in pay-for-performance programs,” said Dr. Bradley.

To this end, CPT has created a category of codes (category II codes) that are a

set of supplemental tracking codes, which can be used for performance measurement. “The American Academy of Pediatrics is participating in the process by which these codes come to fruition in CPT,” said Dr. Bradley.

**For example, Code 99058 is an add-on charge for services provided on an emergency basis in the office that disrupt other scheduled office services.**

“What's the Medicare plan—which private payers are likely to follow?” he asked. “In 2006, physicians now enroll in a voluntary pay-for-reporting program ... in 2007 or 2008, they'll be paid for reporting quality measures, and then beyond 2008, they should be paid for performance.”

► **Moderate sedation.** “Most of you who work in children's hospitals know that physicians there have not been paid often for doing procedural sedation unless you're an anesthesiologist,” said Dr. Bradley. Physicians who are hospitalists or who specialize in emergency or critical care are doing a lot of sedation as part of sedation teams. “To support that service,

new codes were created this year for moderate sedation that allow physicians who are either providing sedation for their own procedure or supporting another physician to get paid,” said Dr. Bradley. These codes are 99143-99145 and 99148-99150.

► **Special services.** “These are a little bit different in that they're not Evaluation and Management] codes but codes that are added on with existing E/M codes when you provide those E/M services under special circumstances,” said Dr. Bradley.

The most commonly used of these codes are 99050, 99051, and 99058.

Code 99050 is used for services provided in the office at times other than regularly scheduled office hours.

Code 99051 “allows you to bill separately on top of an E/M code for services provided during regularly scheduled evening, holiday, and weekend office hours,” said Dr. Bradley.

Code 99058 is an add-on charge for services provided on an emergency basis in the office that disrupt other scheduled office services.

► **Obesity interventions.** Also this year, there are new ICD-9 codes for obesity in-

terventions. “These are V codes that are pediatric codes for [body mass index] percentiles by age,” said Dr. Bradley. “So that at least now, you'll be able to stratify a population in your practice by BMI.” These V codes provide a way of tracking patients through a medical record system. If payers begin to cover obesity interventions based on levels of BMI, “you've got a way to prove to your payers the medical necessity of providing an intervention.” ■

### VERBATIM

*“It's important to make the distinction between burnout and depression. Burnout is more of a reference to your work setting, whereas depression ... would extend to every aspect of your life.”*

Dr. Darrell A. Campbell Jr., p. 46