

Electronic Health Records - Proposed Stage 2 Meaningful Use Requirements Still Not Relevant for Anesthesiologists

Posted on Mar 05, Posted by [Tony Mira](#) Category [Legislative and Compliance](#)

The Centers for Medicare and Medicaid Services (CMS) has just issued a [proposed rule](#) that will make it more difficult than ever for anesthesiologists and pain physicians to qualify for the Medicare or Medicaid electronic health records (EHR) incentive. There will be a 60-day comment period, after which CMS will review the feedback and publish a final rule this summer.

Background

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it in a meaningful way. What is considered “meaningful use” is evolving in three stages:

- Stage 1 (which began in 2011 and remains the starting point for all providers): “meaningful use” consists of transferring data to EHRs and being able to share information, including electronic copies and visit summaries for patients.
- Stage 2 (to be implemented in 2014 under the proposed rule): “meaningful use” includes new standards such as online access for patients to their health information, and electronic health information exchange between providers.
- Stage 3 (expected to be implemented in 2016): “meaningful use” includes demonstrating that the quality of health care has been improved.

The proposed rule extends Stage 1 for an additional year, allowing physicians to attest to stage 2 in 2014, instead of in 2013. CMS decided to delay the onset of Stage 2 by one year to 2014 because the original 2013 timeframe does not give vendors enough time to design, develop and test new functionality and providers to deploy it and track measures over the one-year reporting period.

Furthermore, the payment adjustment (one percent penalty in 2015, two percent in 2016 and three percent thereafter) for failing to demonstrate meaningful use would not apply to any physician who becomes a successful meaningful user as late as three months prior to the end of 2014, and meets the registration and attestation requirements by October 1, 2014. It is not yet clear whether or how the payment adjustment will affect physicians to whose practice the meaningful use requirements do not apply. CMS is soliciting input, however, on a proposed exception “due to a combination of clinical features limiting a provider’s interaction with patients and lack of control over the availability of Certified EHR technology at their practice locations.” We would anticipate that such an exception could benefit anesthesiologists.

In 2011, 57 percent of office-based physicians used EHR systems and 52 percent reported intending to apply for Medicare or Medicaid EHR incentive payments, a 25 percent increase from 2010, according to data from the [National Ambulatory Medical Care Survey \(NAMCS\)](#) . Clearly there are still many primary care and other office-based physicians who are not ready to demonstrate meaningful use of an EHR.

“Meaningful Use” and Anesthesiologists and Pain Physicians

The EHR incentive program is targeted at office-based practices. Indeed, the original version of the program would have excluded anesthesiologists explicitly. The July 28, 2010 final rule establishing Stage 1, however, restricted the definition of “hospital-based” [excluded professionals] so that it only covered physicians who provide 90 percent or more of their services on an inpatient basis or in the emergency department. Most anesthesiologists do more than 10 percent of their cases on an outpatient basis, so they are not disqualified on the grounds that they are hospital-based. Typically they will nevertheless be ineligible for the bonus because fewer than 50 percent of their Medicare allowables will be generated in facilities with certified EHR systems and/or because fewer than 80 percent of their patients will have records in a certified EHR system.

Then there are the meaningful use standards. Stage 1 requires the eligible professional (EP) to

meet—or qualify for an exclusion from—each of 15 core objective functionalities (e.g., drug interaction checks) plus five out of a possible ten “menu set” measures. The EHR must allow the EP to report at least six clinical quality measures, three of which are mandatory and three of which must be selected from a group of 38 measures. The majority of these objectives and clinical quality measures do not apply to anesthesiology or pain medicine practice. For the complete list, see our August 15, 2011 Alert [“Medicare’s eRx and EHR Incentive Programs – Clearing Up the Confusion for Anesthesiologists.”](#)

The proposed Stage 2 meaningful use criteria are no more relevant to anesthesiology or pain medicine. They require that EPs meet, or qualify for exclusion from, 17 core objectives and three of five menu objectives as well as report 12 clinical quality measures. Because they are subject to change before CMS finalizes the Stage 2 regulations this summer, we are reproducing below [CMS’ own summary](#) of some of the changes rather than creating an extensive analysis of the differences:

Some of these changes would be optional for use by providers in Stage 1 but would be required for use in Stage 2. Other changes would not take effect until providers have to meet the Stage 2 criteria. An overview of these proposed changes includes:

- *Changes to the denominator of computerized provider order entry (CPOE) (Stage 1 Optional, Stage 2 Required)*
- *Changes to the age limitations for vital signs (Stage 1 Optional, Stage 2 Required)*
- *Elimination of the “exchange of key clinical information” core objective from Stage 1 in favor of a “transitions of care” core objective that requires electronic exchange of summary of care documents in Stage 2 (Effective Stage 2)*
- *Replacing “provide patients with an electronic copy of their health information” objective with a “view online, download and transmit” core objective. (Effective Stage 2)*

The complete set of Stage 2 core and menu set measures appear in [Table 4](#) in the Federal Register notice of proposed rule-making. Note that this table does not list the exclusions that may make it unnecessary for anesthesiologists’ EHRs to have the particular functionality, e.g., exclusions for EPs who perform no office visits, who do not diagnose or treat cancer.

With respect to clinical quality measures, CMS's goal is to achieve greater alignment and less duplication with the Physician Quality Reporting System (PQRS). For 2012 and 2013, meaningful use will require reporting on three core or alternate core clinical quality measures, plus three additional measures, as in Stage 1. Beginning in 2014, CMS is considering different options, each involving a total of twelve measures to be selected from a set of at least 105 measures. CMS is proposing that "As an alternative to reporting the 12 clinical quality measures as described ..., and in order to streamline quality reporting options for participating providers, Medicare EPs who submit and satisfactorily report [PQRS] clinical quality measures under the [PQRS] EHR reporting option using Certified EHR Technology would satisfy their clinical quality measures reporting requirement under the Medicare EHR Incentive Program."

Complementing CMS' 455-page proposed rule on Stage 2 meaningful use requirements was another proposed rule, this one by the Office of the National Coordinator for Health IT (ONC). The [ONC proposal](#) identifies standards and criteria for the certification of EHR technology, so eligible professionals and hospitals can be sure that the systems they adopt are capable of performing the required functions to demonstrate either stage of meaningful use that would be in effect starting in 2014. According to an article entitled "[Feds Promise Flexibility In Meaningful Use, Stage 2](#)" that appeared in Information Week on February 22,

The program for certifying EHRs would provide more options, too. Notably, providers would not necessarily have to use complete systems certified through one of the ONC-authorized testing bodies. Instead, they could choose what [Steve Posnack, director of ONC's Federal Policy Division] called a "dynamic version of EHR technology." They could pick a single, certified EHR or a combination of modules that do "just enough" to meet the core and menu MU standards.

In this Alert it has been our aim to foreshadow changes to the EHR incentive program that are still in the developmental stage. Like the hospital and physician organizations, we will be analyzing the proposed rules—and particularly their implications for penalties for nonparticipation, which begin in 2015—over the next few months, and we will continue doing our best to keep you informed.

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