Changes to Stage 1 Meaningful Use in 2014: Impact on Radiologists

Adeel Siddiqui · Paul G. Nagy · David Bonekamp · Keith J. Dreyer

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Abstract The goal of this work is to provide radiologists an update regarding changes to stage 1 of meaningful use in 2014. These changes were promulgated in the final rulemaking released by the Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology in September 2012. Under the new rules, radiologists are exempt from meaningful use penalties provided that they are listed as radiologists under the Provider Enrollment, Chain and Ownership System (PECOS). A major caveat is that this exemption can be removed at any time. Additional concerns are discussed in the main text. Additional changes discussed include software editions independent of meaningful use stage (i.e., 2011 edition versus 2014 edition), changes to the definition of certified electronic health record technology (CEHRT), and changes to specific measures and exemptions to those measures. The new changes regarding stage 1 add complexity to an already complex program, but overall make achieving meaningful use a win-win situation for radiologists. There are no penalties for failure and incentive payments for success. The cost of upgrading to CEHRT may be much less than the incentive payments, adding a potential new source of revenue. Additional benefits may be realized if the radiology department can build upon a modern electronic health record to improve their practice and billing patterns. Meaningful use and electronic health records

represent an important evolutionary step in US healthcare, and it is imperative that radiologists are active participants in the process.

Keywords Meaningful Use · Stage 2 · 2014 Base EHR · Certified electronic health record · Complete EHR · Electronic health records · Meaningful Use in radiology

Background

Meaningful Use (MU) is a government program to accelerate the adoption of electronic health records (EHR) in the USA. Up until 2012, physicians could have received incentive payments totaling \$44,000 per radiologist paid over 3 years. For those who start participating in 2014, the maximum incentive payment is \$24,000 paid over 3 years. In order to receive incentive payments in 2014, a practice must have successfully deployed certified EHR technology (CEHRT) by October 1st, 2014.

MU is divided into stages, with stage 1 dealing with data capture, stage 2 dealing with clinical decision support, and stage 3 dealing with measuring clinical outcomes. Additional stages beyond stage 3 are also possible. Almost everyone is currently in stage 1, and early adopters can move into stage 2 in 2014. Newcomers to MU in 2014 can still start with stage 1 and are required to stay in each stage for 2 years. The Center for Medicare and Medicaid Services (CMS) manages the eligible professional and eligible hospital participation requirements of the program. They work closely with the Office of the National Coordinator for Health Information Technology (ONC), who administers EHR product certification requirements and the certification program.

Once a physician has access to CEHRT, they would have to show “MU” of the software by meeting certain measures (i.e., recording smoking status). This is done via attestation on the

A. Siddiqui (✉)
University of Tennessee Health Science Center, Neuroradiology,
Memphis, TN, USA
e-mail: adeelsiddiquimd@yahoo.com

P. G. Nagy · D. Bonekamp · K. J. Dreyer
Russell H. Morgan Department of Radiology, Johns Hopkins
University, Ellicott City, MD, USA

K. J. Dreyer
Massachusetts General Hospital, Radiology, Boston, MA, USA

CMS website. These measures are broken down into a core set, meaning required items, and a menu set, meaning a physician can choose which measures to follow. For both core and menu set measures, physicians are allowed to “exclude” recording and reporting on certain MU measures based on predefined exclusion criteria, i.e., a physician that writes fewer than 100 prescriptions per year would not be required to report on the number of prescriptions submitted through a CEHRT.

MU regulations are released by CMS and ONC. The final rule for stage 1 was released in 2010. The final rule for stage 2 was released in September of 2012. In addition to outlining stage 2 measures, the 2012 rulemaking made significant changes to existing MU requirements and stage 1 objectives as well. This article is in regard to changes applicable to stage 1 MU in the 2012 rulemaking. Specifics regarding stage 2 measures are beyond the scope of this article.

When the stage 1 final rule was released in 2010, noncompliant radiologists were subject to penalties for not being meaningful users when the penalty phase of MU begins in 2015. The penalty would start off at 1 % of the physician’s Medicare Physician Fee Schedule-based compensation for professional services in 2015 and increase to 2 % in 2016 and 3 % in 2017. What makes this complicated is that the penalties are applied to the MU status 2 years prior. In 2015, the MU status of the physician will be assessed for 2013. So even if a physician is a meaningful user in 2015, the 2013 status will be counted, not the 2015 status. CMS has given a little leeway; in that, if a group attests to MU by October 1st, 2014, they will not be penalized in 2015 for not achieving MU in 2013.

The 2012 rulemaking temporarily eliminates these penalties for radiologists, pathologists, and anesthesiologists. However, certain caveats to this policy change are discussed below under the “[Significant Hardship Exemptions](#)” section.

Another change in the 2012 rulemaking was in the definition of CEHRT. CEHRT is defined as a product or combination of products that meets the Base EHR definition, is certified for additional criteria corresponding with CMS MU objectives/measures, and is able to report on the clinical quality measures (CQMs). EHR products can be certified as a Complete EHR and meet all of the required certification criteria, or an EHR Module and meet only a few specific certification criteria. Under the prior iteration of MU, a physician had to possess either a certified Complete EHR or an assortment of certified EHR Modules that would add up to a Complete EHR in order to have “CEHRT”. This was regardless of whether or not a physician would need to meet the CMS measures that correspond with certain certification criteria. For example, radiologists had to “possess” e-prescribing software even though they did not have to comply with the e-prescribing measure. The reason for this was to have a basic software framework that would make upgrading to stage 2 and beyond easier. However, as more and more

radiologists found they would have to purchase software that they would never actually use, this clause turned out to be one of the most limiting factors in meeting MU for specialists. The 2012 rulemaking has made significant changes to this requirement, which is discussed in detail in the “[EHR Editions](#)” section.

Additional updates in the final rulemaking regarding changes to specific measures and changes to CQMs are also viewed from a radiologist’s perspective.

Evaluation

Below we discuss changes in the 2012 rulemaking and how that may affect radiologists who wish to participate in the program. Changes to the significant hardship exemption and EHR editions are discussed in more detail because of their impact on radiologists.

Significant Hardship Exemptions

Radiologists can claim significant hardship exemptions based on specialty to avoid penalties. To do so, diagnostic radiology, nuclear medicine, or interventional radiology must be listed as the primary specialty of the physician in the Provider Enrollment, Chain, and Ownership System (PECOS). The “deemed” language in the final rulemaking suggests that this exemption will be automatically granted, and no special paperwork will have to be filled out by the radiologist. However, this has yet to be officially confirmed by CMS.

However, continuation of this significant hardship exemption is not guaranteed. By statute, significant hardship exemptions cannot last more than 5 years. In order to extend the significant hardship exemption beyond 5 years, new legislation may be required. Moreover, it is unknown if other insurers and accountable care organizations (ACOs) will honor significant hardship exemptions for radiologists. Below is an excerpt from the stage 2 final rules, released in September 2012, which explains the logic and caveats behind the significant hardship exemption best.

“As discussed previously, this exemption is subject to annual renewal. In future rulemaking we will consider whether the proliferation of health information exchange or any other developments are sufficient to remove lack of face-to-face interaction as a barrier, and whether the proliferation of CEHRT is sufficient to remove lack of control over the availability of CEHRT as a barrier. We will consider these issues in relation both to the exception itself and its application to the specialties of anesthesiology, radiology, and pathology. As such, physicians in these three specialties should not expect

Table 1 2014 Base EHR certification criteria

Adopted from the ONC final rule published in the Federal Register and gives a broad overview of what exactly is included in the 2014 Base EHR definition	EHR technology	Certification criteria
	Includes patient demographic and clinical health information, such as medical history and problem lists	Demographic § 170.314(a)(3) Problem list § 170.314(a)(5) Medical list § 170.314(a)(6) Medication allergy list § 170.317(a)(7)
	Has the capacity to provide clinical decision support	Clinical decision support § 170.314(a)(8)
	Has the capacity to support physician order entry	Computerized provider order entry §170.314(a)(1)
	Has the capacity to exchange electronic health information with and integrate such information from other sources	Transition of care § 170.314(b)(1) and (2) Data portability § 170.314(b)(7)
	Has the capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged	Privacy and security § 170.314(d)(1) through (8)
	Has the capacity to capture and query information relevant to health care quality	Clinical quality measures § 170.314(c)(1) through (3)

that this exception will continue indefinitely, nor should they expect that we will grant the exception for the full 5-year period permitted by statute. We will consider the extent to which these specialties continue to face these barriers in the Stage 3 rule and in other future rulemaking. We will also work to develop strategies to assist physicians who lack face-to-face interactions and the need to follow up with patients in demonstrating MU. We may develop such strategies in the context of future rulemaking (for example, the Stage 3 rule) or in the form of additional guidance to physicians in these specialties. We also encourage all anesthesiologists, radiologists, and pathologists to continue to build out their ability to participate in health information exchange, adopt CEHRT and apply for the Medicare or Medicaid EHR incentives. Those seeking the Medicare EHR incentives can start through 2014, while those seeking the Medicaid EHR incentives can start through 2016.”

Source: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2; Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health

Information Technology; Final Rules. <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>. Accessed May 31st, 2013.

EHR Editions

The previous set of EHR certification requirements is now known as the “2011 edition EHR certification criteria”. New 2014 edition EHR certification criteria have been defined. In order for software to be certified as a Complete EHR, 2014 Edition, the software must meet ALL of the nonoptional criteria. However, a new definition of “Base EHR” has been described which details a basic list of criteria that have to be met by one product or a group of products to count as CEHRT, listed in Table 1 (see also Tables 2, 3, 4, and 5).

It is important to note that both the 2011 and 2014 EHR versions are independent of stage, and physicians in either stage 1 or stage 2 will need 2014 edition certified products in 2014 and beyond. The reason for this is to allow updates in software regardless of what stage a practice is in.

The new 2014 Base EHR definition does not take into account an individual physician's required measures and criteria. While a physician can deploy software certified for the criteria included in the “Base EHR” definition, no specific “Base EHR” certification status exists.

Table 2 Potential benefits and pitfalls of a 2014 Base EHR

Benefits	Pitfalls
Base EHR that only has the basic components needed	Will still have a physician order entry system
Meant to minimize having to “possess” technology someone is excluded from	Will still have transfer of care
Will not have vital signs, drug–drug interactions, and drug allergies	May not have all the features specific to your needs (i.e., may not have a specific CQM you need.)

Table 3 Meaningful use timeline

	1st year	Stage of Meaningful Use										
		2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD	
2012			1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013				1	1	2	2	3	3	TBD	TBD	TBD
2014					1	1	2	2	3	3	TBD	TBD
2015						1	1	2	2	3	3	TBD
2016							1	1	2	2	3	3
2017								1	1	2	2	3

Other Changes

Other changes regarding stage 1 include reducing the number of core measures from 15 to 13. The “health information exchange” objective is no longer required. CQMs are now considered inherent to MU and are no longer counted as a separate objective (although still required). Additional changes are outlined below.

One particular change that will be felt in 2014 is to the menu set items. The menu set items are a group of ten measures (such as immunization registries) of which a radiologist must choose five (stage 1). If they meet an exclusion (ie give no immunizations), they can still pick the menu set item and claim the exclusion for that item. A physician can theoretically pick five menu set items that they also meet the exclusions for. This way, a physician can comply with the menu set portion of MU, without having to actually achieve the stated objectives. Beginning in 2014, a physician will not

be able to claim an exclusion on a menu set item if they can meet other menu set items on the list. In other words, a physician will have to pick five items from the menu list that their setup can perform. In this new paradigm, an exclusion can only be claimed after all “possible” menu set items have been exhausted. What menu set items are “possible” for radiologists before they would be able to pick menu set items with exclusions is not exactly clear at the time of this writing. Hopefully, CMS will provide more guidance on this issue in the near future.

Another change in the 2012 final rulemaking is regarding CQMs, which are an integral part of MU. They are essentially a small checklist of “mini-measures”, of which physicians have broad latitude to choose among. CQMs have a numerator and denominator and are calculated by their CEHRT using available data elements. For radiologists, CQMs can be reported using zero denominators as calculated by their CEHRT, and they will still comply with MU. ONC requires that at least 9 CQMs, including six CQMs from the core set of CQMs, are certified for the Base EHR definition.

Table 4 Key Meaningful Use terms

Meaningful use (MU)
Physicians must purchase and deploy a certified electronic health record in order to achieve meaningful use
Incentive payments
Physicians will receive incentive payment totaling \$24,000 per physician, paid over 3 years, if they achieve meaningful use by October 1st, 2014.
In order to avoid penalties, meaningful use must be started by July 1st, 2014
Center for Medicare and Medicaid Services (CMS)
Oversee physician and hospital attestation and requirements
Office of the National Coordinator for Health IT (ONC)
Oversees the certification requirements and certification program for EHR technology
Certified electronic health record technology (CEHRT)
A product or combination of products that meets at least the Base EHR definition
Is certified for additional criteria corresponding with CMS MU objectives/measures the EP or EH needs to do

Table 5 Major changes affecting MU in 2014

Significant hardship exemptions
Most radiologists are temporarily exempted from financial penalties for noncompliance for up to 5 years.
May be rescinded in the future
2014 edition electronic health records
2014 and 2011 edition EHRs are independent of stage
There are Complete EHR and EHR Module solutions—Base EHR is just a regulatory definition comprised of a list of the mandatory functionality/criteria
Changes to the menu set
Can no longer choose a menu set item and use the exclusion to that item if there are other items that the physician could have complied with (expect more guidance from CMS regarding this in the near future)
Recording vital signs
A physician can choose height OR weight OR blood pressure if they feel that it is relevant to their scope of practice (previously had to measure all three)

One final noteworthy change made to the program allows for greater flexibility in measuring vital signs (i.e., height or weight or blood pressure as opposed to height and weight and blood pressure).

Discussion

In the following section, we discuss the timeline for adoption of MU, the implication of significant hardship exemptions, and initial thoughts regarding the Base EHR.

It is required that everyone start at stage 1 and move through each stage in a period of 2 years, so many physicians will be dealing with stage 1 2014 edition software. It is important to distinguish between stage and software edition, as this can lead to potential noncompliance in 2014. It is important to make your MU vendor aware of upcoming changes and to be certain that they have a 2014 EHR edition (for both stage 1 and stage 2) in development.

The significant hardship exemption for radiologists temporarily removes the threat of penalties and essentially makes MU a win–win situation (incentives for compliance and no penalty for noncompliance). However, the fact that this can be revoked at any time, and the inevitable role of MU in future accountable care organization metrics means that there could very well be unforeseen penalties in the near future.

This 2014 Base EHR allows many physicians, and particularly radiologists, the ability to purchase software that is more in line with their MU needs. The redefinition of CEHRT is certainly complex and will likely undergo further revision when stage 3 is released. The major benefit that this allows radiologists is the opportunity to exclude vital sign software

from their purchasing decision, if they feel they will be able to exclude these measures.

Certain requirements that radiologists are excluded from are still found in the Base EHR definition. These include computerized physician order entry (CPOE) and transfer of care.

Additional changes to stage 1, such as changes to the vital signs measure, are a welcome change for radiologists.

Conclusion

The redefinition of CEHRT partially addresses some of the concerns of radiologists. A physician is no longer forced to implement certified functionality corresponding with CMS objectives they meet exclusion criteria for; unless the functionality falls within the Base EHR list. While great in theory, the high probability of purchasing software one is excluded from raises concerns. This is still a step forward from the rigid framework that had been in place previously and gives the sense that the ONC and CMS are listening to advocates.

The significant hardship exemption and additional changes made to MU gives radiologists a lot of choices. It is not important to just focus on what MU software can do today, but what can be done with an EHR after it is fully integrated. Electronic billing, electronic order entry, and electronic progress notes are the bricks and mortar towards creating clinical decision support engines, outcome-based research databases, patient health portals, and a nationwide healthcare information exchange. MU and electronic health records represent an important evolutionary step in the US healthcare, and it is imperative that radiologists are active participants in the process.