

## FAQs for Web

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### Need information on how to implement e-prescribing.

We have information to help you get started in implementing an electronic prescribing program and reporting to CMS on our website at:

<http://www.rheumatology.org/practice/office/hit/erx.asp?tab=0>.

If you aren't currently e-prescribing, you need to act fast to get a qualified system in place. If you are considering investing in a full EHR system in the near future or if you would like to take more time to evaluate e-prescribing systems that might be the best long-term fit for your practice, then consider:

- Subscribing to an online solution, which does not call for a long term contract
- The free [NEPSI](#) system

These temporary alternatives may help you gain compliance, qualify for incentives, and avoid penalties. You can find out more about available systems at [www.getrxconnected.com](http://www.getrxconnected.com).

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### Are refills of controlled substances through e-Rx allowed now?

The answer is yes, as well as no.

E-Rx of controlled substances is allowed, legally, according to the federal government. Note that the current infrastructure facilitating the prescribing process, and many state laws, do not yet permit electronic prescribing of controlled substances according to the DEA rule, though.

In June of 2010 the Drug Enforcement Administration's (DEA) rule "Electronic Prescriptions for Controlled Substances" went into effect, giving physicians the option to write electronic prescriptions for controlled substances. The regulations will also permit pharmacies to receive, dispense and archive these electronic prescriptions. It is a very complex process to ramp up the system and it could be another year or two before we see widespread electronic prescribing of controlled substances.

The rule creates new technical demands that must be addressed in order to make the process feasible. Software developers may need a year or more to get up to speed with the programming needed to manage the hard tokens and biometrics in addition to making updates to computer systems that will allow prescribers to transmit scheduled medication orders, intermediary networks need to build out their systems in order to process the prescriptions according to DEA guidelines, and pharmacies need to reprogram and have their systems certified by an entity approved by the DEA in order to receive the electronic prescriptions.

Additional legal and policy barriers will need to be tackled in order for these prescriptions to move electronically. State Boards of Pharmacy and other state agencies will need to modify any outdated state regulations that are barriers to e-prescribing of controlled substances. Keep in mind that although the federal government has deemed it legal to e prescribe controlled substances according to the DEA rule, the stricter state law applies and in some states it is not legal to e-Rx controlled substances according to governing state law. You might want to contact your state's Board of Pharmacy to identify any local policy barriers that are stalling progress in the e-Rx of controlled substances.

The ACR will work to keep the membership current as the e-health environment matures to facilitate electronic prescribing of controlled substances. I will send e-mails out, as well as will post updates to our website when I see any federally-/industry-issued updates and guidance on working with your system vendor, DEA, and local pharmacies on e-prescribing of controlled substances.

If you would like more detail on the requirements of the rule, check out [http://www.uspharmacist.com/content/d/pharmacy\\_law/c/21533/](http://www.uspharmacist.com/content/d/pharmacy_law/c/21533/) for an article on electronic prescribing of controlled substances published July of 2010 in *US Pharmacist*. The DEA has also published instructions to physicians for [getting started](#).

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#### Do you need to register for e-prescribing as well?

No, you do not need to register to report e-Rx to CMS. In order to report to avoid the 2012/2013 payment adjustments and take advantage of the 1% bonus payment in 2011, you simply need to begin submitting the e-Rx G-code (G5583) to CMS via claims.

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#### I have E-clinical Works, Version 9, that I know qualifies. Would you recommend continuing to submit for an e-prescription bonus, as we have done, and wait until 10/12 to submit for meaningful use?

The ACR does not prescribe a date for practices to begin reporting on attestation of meaningful use, but encourages members to keep in mind that for those who want to attest for meaningful use in pursuit of the maximum incentive amount (up to \$44,000 for Medicare), the timeline for reporting requires that you begin attestation for a period of 90 consecutive days prior to the beginning of the 2013 calendar year. This means that an eligible provider must attest to meaningful use for **any** consecutive 90-day period by prior to or ending on December 31, 2012 in order to be eligible for the maximum amount.

If an eligible provider wants to take advantage of the 2011 e-Rx incentive payment and begin reporting for his first payment year under the CMS EHR Incentive program in 2012, according to the program timeline, the EP will remain eligible to receive the maximum incentive amount (up to \$44,000) as long as he successfully attests to meaningful use for **ANY** 90 consecutive days in 2012.

The point made during the presentation is not that providers should wait until October of 2012 to begin reporting, but that the **last** 90 consecutive day reporting period for the FULL incentive amount begins October 2012. Eligible providers should be aware of this timeline and plan accordingly.

During the Q&A portion of the webinar, I suggested that those who plan to submit attestation for meaningful use plan their meaningful use implementation timeline so that it allows for at least one 'dry run' or 'test period.' What I mean is that you should not wait until the last 90 days of the calendar year to implement a workflow and plan to track progress in meeting the meaningful use measures if you plan to submit attestation for that year.

Remember, the CMS EHR Incentive Program is about 'meaningful use' of the EHR system. This requires not only installing the certified system, but using it according to the meaningful use criteria. It is likely that many of the stage 1 meaningful use objectives are already a routine part of your practice (e.g., e-prescribing or structured entry of vital signs), but there may be some objectives that

require a new workflow. It may be helpful to work with your vendor to implement reminders or alerts that prompt actions required for objectives that call for a new action or extra step outside of your routine. These tasks may require that you and your staff alter workflow and form new habits. This takes time.

My recommendation would be to identify **at least** one consecutive 90-day period prior to the planned reporting period for attestation, to have your team engage in meaningful EHR use, inputting data, running required reports and executing plans for monitoring progress toward successfully meeting the meaningful use metrics.

At the end of the 90-day ‘test’ period, run final reports and if you successfully meet all measure thresholds for each of the 15 Core objectives and the 5 Menu objectives of your choosing, then you can submit attestation to CMS for the 90 days that you established as your ‘test period.’ However, if this ‘dry run’ reveals that you are unable to meet all of the measures of meaningful use, you still have time to make adjustments to your workflow or to your EHR system and then attempt to successfully meet the measures for a 90-day period prior to the end of the calendar year.

Note that you will not need to notify CMS when you begin, or intend to begin, the 90 consecutive days for attestation of meaningful use. You will only need to attest to meaningful use after you successfully achieve meaningful use for a period of 90 consecutive days.

	Amount of payment each year if EP continues to meet requirements						Total payment received
	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	
EP begins reporting for Meaningful Use: <b>CY 2011</b>	\$18,000 <u>Reporting period:</u> Any 90 consecutive day period during calendar year	\$12,000 <u>Reporting period:</u> 1 calendar year	\$8,000 <u>Reporting period:</u> 1 calendar year	\$4,000 <u>Reporting period:</u> 1 calendar year	\$2,000 <u>Reporting period:</u> 1 calendar year	\$0 <u>Reporting period:</u> 1 calendar year	\$44,000
EP begins reporting for Meaningful Use: <b>CY 2012</b>		\$18,000 <u>Reporting period:</u> Any 90 consecutive day period during calendar year	\$12,000 <u>Reporting period:</u> 1 calendar year	\$8,000 <u>Reporting period:</u> 1 calendar year	\$4,000 <u>Reporting period:</u> 1 calendar year	\$2,000 <u>Reporting period:</u> 1 calendar year	\$44,000
EP begins reporting for Meaningful Use: <b>CY 2013</b>			\$15,000 <u>Reporting period:</u> Any 90 consecutive day period during calendar year	\$12,000 <u>Reporting period:</u> 1 calendar year	\$8,000 <u>Reporting period:</u> 1 calendar year	\$4,000 <u>Reporting period:</u> 1 calendar year	\$39,000
EP begins reporting for Meaningful Use: <b>CY 2014</b>				\$12,000 <u>Reporting period:</u> Any 90 consecutive day period during calendar year	\$8,000 <u>Reporting period:</u> 1 calendar year	\$4,000 <u>Reporting period:</u> 1 calendar year	\$24,000
EP begins reporting for Meaningful Use: <b>CY 2015</b>					\$0	\$0	\$0

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### If e-prescribing is not started by 6/11, then will we be penalized in 2012?

Yes, you must report on 10 e-Rx events for Medicare Part B patients by June 30, 2011 in order to avoid the 2012 payment adjustment. If you aren't currently e-prescribing, you need to act fast to get a qualified system in place. If you are considering an investment in a full EHR system in the near future or if you would like to take more time to evaluate e-prescribing systems that might be the best long-term fit for your practice, then consider:

- Subscribing to an online solution, which does not call for a long term contract
- The free [NEPSI](#) system

These temporary alternatives may help you gain compliance, qualify for incentives, and avoid penalties. You can find out more about available systems at [www.getrxconnected.com](http://www.getrxconnected.com).

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### How does one run 'tests' before the 90-day reporting period?

The final rule for the CMS EHR Incentive program states that the reporting period for your first year attesting to Meaningful Use (whether that is in calendar year 2011, 2012, 2013 or 2014) is 90 consecutive days during the calendar year.

During the Q&A portion of the webinar, I suggested that those who plan to submit attestation for meaningful use plan their meaningful use implementation timeline to that timing allows for at least one 'dry run' or 'test period.' What I mean is that you should not wait until the last 90 days of the calendar year to implement a workflow and plan to track progress in meeting the meaningful use measures.

My recommendation would be to identify **at least** one consecutive 90-day period prior to the planned reporting period for attestation, to have your team engage in meaningful EHR use, inputting data, running required reports and executing plans for monitoring progress toward successfully meeting the meaningful use metrics.

At the end of the 90-day 'test' period, run final reports and if you successfully meet all measure thresholds for each of the 15 Core objectives and the 5 Menu objectives of your choosing, then you can submit attestation to CMS for the 90 days that you established as your 'test period.' However, if this 'dry run' reveals that you are unable to meet all of the measures of meaningful use, you still have time to make adjustments to your workflow or to your EHR system and then attempt to successfully meet the measures for a 90-day period prior to the end of the calendar year.

Note that you will not need to notify CMS when you begin, or intend to begin, the 90 consecutive days for attestation of meaningful use. You will only need to attest to meaningful use after you successfully achieve meaningful use for a period of 90 consecutive days.

Remember, the CMS EHR Incentive Program is about 'meaningful use' of the EHR system. This requires not only installing the certified system, but using it to collect information in a structured way, use the information, using the EHR system to engage patient, and to exchange information.

It is likely that many of the stage 1 meaningful use objectives are already a routine part of your practice (e.g., e-prescribing or structured entry of vital signs), but there may be some objectives that require a new workflow. It may be helpful to work with your vendor to implement reminders or

alerts that prompt actions required for objectives that call for a new action or extra step outside of your routine. These tasks may require that you and your staff alter workflow and form new habits. This takes time.

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#### **If you register in 2012, would you still be required to report on 90 consecutive days or for the full year?**

It is important to note that registration in the EHR Incentive program does not mean that you have to attest to meaningful use at that time. Registration for the program simply indicates your intent to participate. You might register in 2011, but not attest to meaningful use until 2012 and that is acceptable.

Your first payment year, as in the first year you attest for meaningful use, will require a reporting period of 90 consecutive days, without regard to the year you register or begin reporting. This means that the reporting period of 90 consecutive days is required for the first year that you actually attest to meaningful use, whether that is 2011, 2012, or 2013. A reporting period of a full calendar year is required after your first year of participation/attestation in the program.

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#### **If I have registered as an EP for MU but have not attested, is it too late to hold off on MU until 2012 to be able to do e-Rx in 2011?**

No, you can register now and can begin attestation for Meaningful Use when you are ready to attest for your first incentive payment year, a reporting period of 90 consecutive days.

CMS recommends that eligible providers register as soon as possible. Registration for the incentive program (Medicare or Medicaid) simply acknowledges your intent to participate and does not suggest a certain date that you will begin reporting for attestation of meaningful use. You can register now, and then begin reporting whenever you are ready.

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#### **How does one hold the EHR incentive to get the E-Rx incentive for 2011?**

In order to collect the 2011 e-Rx incentive payment, as well as the full EHR incentive payment of up to \$44,000, you will need to report 25 unique e-Rx events for Medicare Part B patients during CY 2011 using the e-Rx G-code and then report/submit attestation of Meaningful EHR Use to CMS during any continuous 90-day period during CY 2012.

This will allow you to fully collect on both incentive programs since the CMS EHR Incentive program timeline allows for EPs to begin reporting on Meaningful Use in 2012 and still collect the maximal incentive payment of up to \$44,000.

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EP begins reporting for Meaningful Use: <b>CY 2011</b>	\$18,000 <u>Reporting period:</u> Any 90 consecutive day period during calendar year	\$12,000 <u>Reporting period:</u> 1 calendar year	\$8,000 <u>Reporting period:</u> 1 calendar year	\$4,000 <u>Reporting period:</u> 1 calendar year	\$2,000 <u>Reporting period:</u> 1 calendar year	\$0 <u>Reporting period:</u> 1 calendar year	\$44,000
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EP begins reporting for Meaningful Use: <b>CY 2015</b>					\$0	\$0	\$0

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### Explain again: why October 2012 for EHR, rather than April 2012?

The ACR does not prescribe a date for practices to begin reporting on attestation of meaningful use, but encourages members to keep in mind that for those who want to attest for meaningful use in pursuit of the maximum incentive amount (up to \$44,000 for Medicare), the timeline for reporting requires that you begin attestation prior to the beginning of calendar year 2013. This means that an eligible provider must attest to meaningful use for **any** consecutive 90-day period by prior to or ending on December 31, 2012.

The point made during the presentation is that eligible providers should be aware of the timeline and plan accordingly. This means that, in order to submit for meaningful use and be eligible for the full incentive amount of up to \$44,000, the provider must begin reporting and submit attestation of meaningful use based on 90 consecutive days during calendar years 2011 or 2012 (with the **last** 90-day reporting period for the FULL incentive amount beginning October 2012).

During the Q&A portion of the webinar, I suggested that those who plan to submit attestation for meaningful use plan their meaningful use implementation timeline so that it allows for at least one 'dry run' or 'test period'. What I mean is that you should not wait until the last 90 days of the calendar year to implement a workflow and plan to track progress in meeting the meaningful use measures if you plan to submit attestation for that year.

Remember, the CMS EHR Incentive Program is about 'meaningful use' of the EHR system. This requires not only installing the certified system, but using it according to the meaningful use criteria. It is likely that many of the stage 1 meaningful use objectives are already a routine part of your practice (e.g., e-prescribing or structured entry of vital signs), but there may be some objectives that

require a new workflow. It may be helpful to work with your vendor to implement reminders or alerts that prompt actions required for objectives that call for a new action or extra step outside of your routine. These tasks may require that you and your staff alter workflow and form new habits. This takes time.

My recommendation would be to identify **at least** one consecutive 90-day period prior to the planned reporting period for attestation, to have your team engage in meaningful EHR use, inputting data, running required reports and executing plans for monitoring progress toward successfully meeting the meaningful use metrics.

At the end of the 90-day ‘test’ period, run final reports and if you successfully meet all measure thresholds for each of the 15 Core objectives and the 5 Menu objectives of your choosing, then you can submit attestation to CMS for the 90 days that you established as your ‘test period.’ However, if this ‘dry run’ reveals that you are unable to meet all of the measures of meaningful use, you still have time to make adjustments to your workflow or to your EHR system and then attempt to successfully meet the measures for a 90-day period prior to the end of the calendar year.

Note that you will not need to notify CMS when you begin, or intend to begin, the 90 consecutive days for attestation of meaningful use. You will only need to attest to meaningful use after you successfully achieve meaningful use for a period of 90 consecutive days.

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EP begins reporting for Meaningful Use: <b>CY 2015</b>					\$0	\$0	\$0

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### **If none of the 38 Clinical Quality Measures apply to rheumatology, can we report exempt?**

Yes, if none of the 38 clinical quality measures from the menu set are within your scope of practice, you can attest to that fact. If this is done, the EP is exempt from reporting any of the additional clinical quality measures. We expect to receive further clarification on how this will be done as soon as CMS opens the Attestation Portal (around April 1<sup>st</sup>).

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### **Please clarify which questions to ask for smoking status and meaningful use!**

In order to successfully meet the core objective addressing the recording of smoking status for patients greater than 13 years of age, more than 50% of all unique patients (those patients seen by the EP more than once during the reporting period) 13 years old or older must have “smoking status” recorded.

In order to successfully record smoking status in the EHR system, the EP must use the capabilities of the Certified EHR technology to electronically record the smoking status of a patient as structured data. Smoking status types must include:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked

Note that if this information is already in the medical record as structured data and available through certified EHR technology, the EP does not need to make an inquiry every time the patient is seen. The frequency of updating this information is left to the provider.

Smoking status can be collected and entered into the certified EHR system by any member of the medical staff.

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### **Are demographics required at each visit?**

No, for the purpose of meeting the objective, you do not have to collect/update the patient’s demographics at *each visit*. You only need to ensure that *each patient* that you see has each of the following demographic elements recorded in the certified EHR system:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of Birth

The demographic data must be in the record as structured data, but not necessarily updated at every visit.

In some cases, a patient might decline to give you some of the required demographic data. This is perfectly acceptable as long as you make a (structured data) notation that the patient declines to give you this information rather than leaving the field blank. The point is to distinguish between fields that are left blank because you did not ask the patient versus a field that is blank because the patient declined to give the information.

According to the Meaningful Use criteria, in order to successfully meet the threshold for this measure, more than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

$$\frac{\text{Numerator: } \begin{array}{l} \text{the number of patients in the} \\ \text{denominator who have all of the} \\ \text{elements of the demographics} \\ \text{(as specified above) recorded as} \\ \text{structured data} \end{array}}{\text{Denominator: } \begin{array}{l} \text{number of unique patients} \\ \text{seen by the EP or during the} \\ \text{EHR reporting period} \end{array}} = > 50\%$$

This means that when you run the report at the end of your 90-day reporting period, more than 50% of *those patients that you saw more than once during that 90-day period (unique patients)* must have something entered as structured data for each of the following demographic elements: preferred language, gender, race, ethnicity, and date of birth.

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#### **I am registering for the doctors in my clinic. Can I do this under my name as administrator?**

According to the CMS EHR Incentive Program website, [https://www.cms.gov/EHRIncentivePrograms/20\\_RegistrationandAttestation.asp#TopOfPage](https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#TopOfPage):

**UPDATE regarding third-party registration:** At this time there is no method available for a third party to register multiple eligible professionals for the Medicare and Medicaid EHR Incentive Programs. Beginning in May 2011, CMS plans to implement functionality that will allow an eligible professional to designate a third party to register and attest on his or her behalf. We will release detailed information about that process when it is available. States will not necessarily offer the same functionality. Eligible professionals should contact their state to see if there is additional information they will need to provide.

Please be aware that eligible professionals are not currently permitted to allow a practice manager or any other person to register in their place. Sharing your National Plan and Provider Enumeration System (NPPES) user ID and password with third parties can place your information at risk. Until CMS implements new functionality in May 2011, each EP should register himself or herself separately for the Medicare and Medicaid EHR Incentive Programs.

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### **I need more information on registering the five rheumatologists in our practice.**

Registration for the Medicare and Medicaid EHR Incentive Programs is now open and CMS is encouraging providers to register for the Medicare and/or Medicaid EHR Incentive Program(s) as soon as possible. You can register before you have a certified EHR. To register, visit <https://ehrincentives.cms.gov/hitech/login.action> and be sure to have the following information available during the process:

- National Provider Identifier (NPI)
- National Plan and Provider Enumeration System (NPPES) User ID and Password
- Payee Tax Identification Number, if you are reassigning your benefits
- Payee National Provider Identifier (NPI), if you are reassigning your benefits

Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register. Before 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

For more information on registration for the CMS EHR Incentive Program, visit [https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicareEP\\_RegistrationUserGuide.pdf](https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf) to access the CMS EHR Incentive Program Registration User Guide.

**NOTE regarding third-party registration:** At this time there is no method available for a third party to register multiple eligible professionals for the Medicare and Medicaid EHR Incentive Programs. Beginning in May 2011, CMS plans to implement functionality that will allow an eligible professional to designate a third party to register and attest on his or her behalf. We will release detailed information about that process when it is available. States will not necessarily offer the same functionality. Eligible professionals should contact their state to see if there is additional information they will need to provide.

Please be aware that eligible professionals currently are not permitted to allow a practice manager or any other person to register in their place. Sharing your National Plan and Provider Enumeration System (NPPES) user ID and password with third parties can place your information at risk. Until CMS implements new functionality in May 2011, each EP should register himself or herself separately for the Medicare and Medicaid EHR Incentive Programs.

([https://www.cms.gov/EHRIncentivePrograms/20\\_RegistrationandAttestation.asp#TopOfPage](https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#TopOfPage))

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### **I have a Nurse practitioner in my practice. Can I enroll in the Medicare program while she enrolls in the Medicaid program or do we both have to enroll in the same program?**

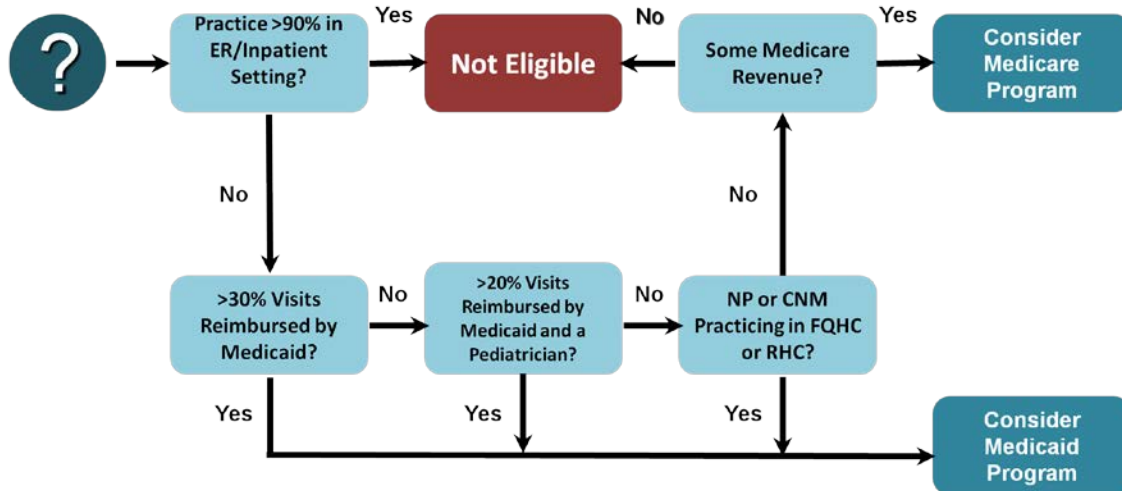
Yes. The CMS EHR Incentive program for Eligible Providers is administered at the level of the individual provider. If your Nurse Practitioner meets the eligibility requirements for the Medicaid program (those NPs with **>30% of their visits reimbursed by Medicaid** ), then s/he can register and participate in the Medicaid EHR Incentive program and collect incentive payments up to \$63,750 program while you participate in the Medicare program.

If you have a nurse practitioner who meets this criterion and would like more information on the Medicaid EHR incentive program, please e-mail [hit@rheumatology.org](mailto:hit@rheumatology.org).

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### Can you please repeat your strategy on Medicare and Medicaid reimbursement one more time?

Eligibility for the CMS EHR Incentive programs, both Medicare and Medicaid, is assessed at the level of the individual provider, so a practice might have some providers participating in the Medicare program while others participate in the Medicaid program. Providers should review the eligibility requirements for each program to determine if they meet the criteria for participation.



Providers who are eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register. Before 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

Keep in mind that while Nurse Practitioners are not eligible to participate in the Medicare EHR Incentive program, those **NPs with >30% of their visits reimbursed by Medicaid ARE eligible to participate in the Medicaid EHR Incentive program and collect incentive payments up to \$63,750.** If you have a nurse practitioner who meets this criterion and would like more information on the Medicaid EHR incentive program, please e-mail [hit@rheumatology.org](mailto:hit@rheumatology.org).

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### If you are hospital-employed do they sign you up for the program?

I would recommend that you first confirm that you are a hospital-based provider according to the definition provided in the Final rule on Meaningful use. The rule defines 'hospital-based' as indicated by the Place of Service codes billed to Medicare via claims, without any regard to employment or billing arrangement between the provider and any other provider or hospital system.

For the purposes of determining an eligible provider (EP) for the EHR incentive program, CMS will use claims data from the prior fiscal year (October through September) in order to provide information regarding hospital based status of each EP at the beginning of the payment year. If **more than 90% of the provider services** are provided in place of service codes 21 (in-patient

hospital) or 23 (emergency room), then CMS will deem the EP hospital based and not eligible for incentive payments.

If you are hospital-based, then you will need to check with your organization to find out whether they plan to submit for Meaningful Use incentives and their anticipated timeline. Your organization should instruct you on any next steps as they register and plan to attest for hospital based incentives.

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#### **Should docs register on the EHR incentive site, even if they don't plan to report until 2012?**

Yes, you can register now and can begin attestation for Meaningful Use when you are ready to attest for your first incentive payment year, a reporting period of 90 consecutive days.

CMS recommends that eligible providers register as soon as possible. Registration for the incentive program (Medicare or Medicaid) simply acknowledges your intent to participate and does not suggest a certain date that you will begin reporting for attestation of meaningful use. You can register now, and then begin reporting whenever you are ready.

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#### **Are there any colleagues currently using EHR system(s) fulfilling the required criteria and satisfied with the outcomes?**

As this is a new program, launching just this past January, we do not have any record of success yet. However, as part of the ACRs programs on Meaningful Use, we have identified and are tracking three rheumatology practices--at various levels of EHR adoption/implementation—and will be reporting on their experiences throughout the next year. Their accounts will be made available in several issues of *The Rheumatologist*, as well as on our website at [www.rheumatology.org/hit](http://www.rheumatology.org/hit). We are also looking to provide new forums for all ACR members and practice staff to share their experience, best practices, and lessons learned as we move forward with the CMS EHR Incentive Program.

If you have any suggestions for educational programs or communication platforms that will aid in your journey to meaningful EHR use, please e-mail me at [hit@rheumatology.org](mailto:hit@rheumatology.org).

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#### **Allscripts has just been released. Will be very interested to see how the incentive program works.**

Please keep us posted as you implement this system and work toward 'meaningful use.' We are collecting narratives detailing user experience, best practices, and lessons learned to share with the ACR member community.

The CMS EHR Incentive program is a new and evolving program. Your experience will not only help others working toward meaningful EHR use, but also help to guide the development and rule making process for objectives and measures in stages 2 and 3.

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**What will the penalty be, if any, for physicians who will not purchase and/or use the electronic medical record? Who is enforcing/requesting that physicians purchase an EMR? The government? What implications are they threatening us with?**

As specified under the HITECH Act, CMS is required to pay EPs less than 100 percent of the fee schedule if they are not meaningful users of certified EHR beginning in calendar year 2015.

Beginning in 2015, if an EP is not a meaningful EHR user for any EHR reporting period for the year, then the Medicare physician fee schedule amount for covered professional services furnished by the EP during the year (including the fee schedule amount for purposes of determining a payment based on the fee schedule amount) is adjusted to:

- 99% for **2015**(or, in the case of an EP who is not a successful electronic prescriber under the CMS e-Rx program, 98%)
- 98% for **2016**
- 97% for **2017** and each subsequent year

In addition, if for 2018 and subsequent years, the Secretary finds that the proportion of EPs who are meaningful EHR users is less than 75%, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95%.

The adjustments are not authorized under Medicaid, but the adjustments will still apply to Medicaid EPs who are also Medicare EPs.

The Secretary of HHS may, on a case-by-case basis, exempt an EP who is not a meaningful EHR user for the year from the application of the payment adjustment if it is determined that compliance with the requirements for being a meaningful EHR user would result in a significant hardship (e.g., an EP who practices in a rural area without sufficient Internet access). The exemption is subject to annual renewal, but in no case may an EP be granted a hardship exemption for more than 5 years.

Keep in mind that the payment penalties are only part of the story and designation as a meaningful EHR user may be tied to other programs that impact your practice, including:

- **Market Impact:** ONC/CMS will publish lists of MC Meaningful Users (providers and hospitals)
- Multiple private insurers have declared that future **contracting** will reflect demonstrated Meaningful Use
- Board **certification**, MOC, state **licensing** may include Meaningful Use status in the future

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**Is the incentive payment disbursed directly to the provider or is it disbursed to the employer/group in the case of a multi-practice group?**

Since the EHR incentive payments for meaningful use are focused on the adoption, implementation, and meaningful use of the technology (rather than the costs associated with the EHR technology), payments will be made directly to the eligible provider who is deemed a meaningful user, or to an employer or other entity to which the EP has reassigned the incentive payment.

The program does allow for reassignment of incentive payments to an employer or entity with which the physician has a valid contractual arrangement allowing the entity to bill for the physician's

services, consistent with all rules governing assignments. In cases where the EP is associated with more than one practice, the EP must select one tax identification number (TIN) to receive any applicable EHR incentive payment.

During the registration process, the EP will identify a Tax Identification Number (TIN) to which the incentive payment should be made. In the case that an EP does not have a TIN, and is enrolled in Medicare or Medicaid through his Social Security Number (SSN), the EP may use his SSN as the TIN to which the incentive payment should be made. If the EP is part of a group with more than one owner or organization that is incorporated, they would have a TIN for the corporation that is not the EP's SSN.

Payments will be disbursed as a single, consolidated, annual incentive payment to EPs and will be made on a rolling basis, as soon as CMS has ascertained that an EP has demonstrated meaningful use for the applicable reporting period (that is, 90 days for the first year or a calendar year for subsequent years), and reached the threshold for maximum payment.

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#### **If you do not reach the "Medicare allowable" threshold in your 1<sup>st</sup> quarter of reporting, does CMS hold it or do you not submit until the threshold is reached?**

Payments will be made on a rolling basis, as soon as the EP has successfully demonstrated meaningful use for the applicable reporting period (that is, 90 days for the first year or a calendar year for subsequent years) **AND** the EP's allowed charges has reached the threshold that qualifies for maximum incentive payment. Once this determination has been made, payment will be issued (within the next 15 to 46 days from the time an EP successfully attests to being a meaningful user).

You should submit attestation for Meaningful Use when you are ready to report and if, at that time, you have not reached the Medicare allowable threshold for maximum payment, CMS will hold your incentive payment until you do reach that threshold or to the end of the year (which ever happens first).

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#### **CCHIT and muEHR – are they different or same?**

The intentions and purpose of **Meaningful Use Certification**, as set forth by the HITECH Act, is very specific and is not comparable to the traditional testing and certification programs carried out by CCHIT (which is a much more robust review of EHR system security, interoperability, and functionality).

Meaningful Use Certification ONLY addresses those objectives set forth in the final rule issued by CMS and ensures that the EHR system is technically able to perform the actions required to meet those objectives and to do so according to common technical standards (working to get systems to 'speak a common language'). Meaningful use certification serves an important purpose in the adoption and utilization of clinical information technology, but it serves a very basic and narrow scope.

Note that [CCHIT](#) has been approved to test and certify EHR systems for meaningful use in addition to their traditional certification programs which offer a more robust review of EHR system functionality, security, and interoperability.

***Rheumatologists seeking to implement a new EHR system or module should not judge the system based solely on 'Meaningful Use Certification' status, but carefully review the system to ensure that it meets all the usability and functionality needs of the individual practice. For more information on EHR evaluation, selection, and implementation, please visit [www.americanehrpartners.com](http://www.americanehrpartners.com).***

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### **I am still awaiting certification of my current EMR. Should I register now or wait until my EMR is certified for meaningful use?**

You can register now, even though your system is not currently certified. **You do not need to have your certified EHR technology in place to register for the EHR incentive programs!** However, you must successfully demonstrate meaningful use of certified EHR technology under the Medicare EHR Incentive Program before you can receive an EHR incentive payment.

CMS recommends that eligible providers register as soon as possible. Registration for the incentive program (Medicare or Medicaid) simply acknowledges your intent to participate and does not suggest a certain date that you will begin reporting for attestation of meaningful use. You can register now, and then begin reporting whenever you are ready.

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### **My vendor is ONC-approved. It is a server based company with no software to maintain, will they implement the meaningful use application for me?**

If your system is certified for meaningful use, then it has been tested against specific criteria developed for each meaningful use objective and has been deemed capable of meeting, calculating and reporting on the objectives and measures using the technical standards specified by ONC.

Certification ensures that the system is fully capable of achieving meaningful use; however, it is still up to the eligible provider to **use** the system appropriately so that objectives are met.

Rheumatologists seeking to apply for the meaningful use incentive should ask their EHR system vendor to demonstrate how their system can achieve meaningful use. Each provider, as well as any clinical or administrative staff member who will be entering data or monitoring reports for the program, should work with the EHR vendor to confirm that the EHR system is being utilized consistent with the measure criteria and to ensure that everyone understands where/how data should be entered and what fields should be filled out in order to appropriately satisfy each objective. For example, you may be entering a problem list, but are you entering this as structured data in the appropriate field? The EHR can't measure this unless it's entered correctly in the right field.

Your vendor should also explain the reporting functionality for monitoring performance and calculating meaningful use measures. The testing criteria for certification includes actions that support the calculation of most measures and your system will most likely be able to run a report to

show your use of the system for each objective that requires a percentage-based response to CMS (e.g., based on unique patients seen for the reporting period, or actions taken on behalf of those patients, when all relevant records are kept in the certified EHR system).

It is likely that many of the stage 1 meaningful use objectives are already a routine part of your practice (e.g., e-prescribing or structured entry of vital signs), but there may be some objectives that require a new workflow. It may be helpful to work with your vendor to implement reminders or alerts that prompt actions required for objectives that call for a new action or extra step outside of your routine.

Keep in mind that this isn't just about data entry and jumping through pointless hoops. The EHR system can only perform advanced operations supporting care delivery and health information exchange if it understands what patient information is available and what the information means. With EHR systems containing patient data, such as a lab results, problem list, allergies, or medications, appropriately entered into the certified EHR technology (actions supporting meaningful use) and stored in agreement with defined specifications (ONC standards and certification criteria), we are working toward a system that will be able to move and use patient information in a way that provides a complete picture of the patient and reduces redundant testing.

**NOTE:** Meeting and reporting on the meaningful use objectives and measures significantly increases the operational requirements for EHR systems. (Operations such as the auto calculation of measures would likely not be a functionality of most EHR systems). For this reason, it is important for **ALL** rheumatology practices with an EHR to review the certification status of their currently implemented version of the system. Most practices will at minimum need to upgrade their system to a version certified to meet the meaningful use requirements.

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### Is it possible to get a 'free' EHR and still receive the \$44,000 incentive program?

Yes, this is possible. The CMS EHR Incentive Program provides incentive payments based on the utilization of the certified EHR system according to the Meaningful Use Objectives and supporting measures. The program does not address which system you use or how you acquire the system, only that it must be a certified EHR technology and used to meet the measures for meaningful use.

To find out which systems are certified for according to the requirements for the CMS EHR Incentive Program and whether your system is on the list, please visit the ONC's Certified HIT Products List (CHPL) at <http://onc-chpl.force.com/ehrcert>. The CHPL provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC).

**Note that only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.**

The CHPL will allow you to review a listing of all products or to filter and review the listing of certified products by practice type (ambulatory or Inpatient), by vendor, or by meaningful use certification criteria. The CHPL lists both EHR products that are certified as complete EHR technology as well as those that are certified as EHR modules.

EHR products classified as a **Complete EHR** have been certified to meet all the mandatory certification criteria as identified in the Standards and Certification Criteria Final Rule (45 CFR Part 170 Part III), all of the General Criteria listed in Section 170.302, plus all of the criteria applicable to a type of practice setting. This means that a system certified as a Complete EHR fulfills all the requirements that you need to attest to using a certified EHR system. If you have a system certified as a Complete EHR, you do not need to purchase any additional EHR modules.

**EHR Modules** are those technologies that are certified for at least one of the certification criteria as defined in the Standards and Certification Criteria Final Rule. Due to the regulatory requirement that EHR Module technologies be certified for the security criteria elaborated in the Final Rule, many EHR Modules will be certified for more than one of the regulatory criteria.

If you are using a modular EHR system, you will need to review each module to ensure that it is certified and then review the collective modular system (including only those modules that are certified) to ensure that the collective system meets the definition of a complete EHR technology. If you are using a modular EHR system, the CHPL will allow you to add EHR modules to your cart in order to determine whether your complete modular system meets 100% of the required criteria.

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