

Meaningful Use of Certified EHR Technology: FAQ

The following information is provided in response to common inquiries from members regarding the CMS EHR Incentive Program, or “meaningful use.” Readers are encouraged to first read the more detailed [ACR summary of the Stage 1 meaningful use rules](#) (.pdf file).

The following is for general informational purposes only, and is not a legal document or guidance.

What is meaningful use?

Meaningful use of certified EHR technology refers to voluntary Medicare/Medicaid incentive programs for eligible professionals and hospitals created by the American Recovery and Reinvestment Act of 2009. The incentives encourage physicians and hospitals to use certified EHR technology in a certain way to achieve healthcare objectives.

Meaningful use is determined by satisfaction of a variety of *functional measures* using certified EHR technology. There are 15 mandatory *core set* functional measures, and 10 discretionary *menu set* functional measures (eligible professionals choose 5 of the 10, including 1 of the 2 public health measures).

Most of the individual core and menu set functional measures offer exclusions for participants if they meet the specific requirements of the exclusions. Meeting the requirements for an exclusion from a given functional measure is just as acceptable as meeting the measure itself.

Am I eligible for incentive payments?

The vast majority of Medicare participating radiologists will be eligible for the Medicare version of the incentive program for physicians. Only *hospital-based* physicians are ineligible, and CMS defines “[hospital-based](#)” as those providing 90 percent or more of their covered professional services in inpatient (POS Code 21) and emergency room (POS Code 23) settings. Outpatient hospital settings (POS Code 22) are not considered hospital settings for the purposes of this program; many radiologists and other physicians who generally view themselves as hospital-based will find this is technically not the case according to the regulatory definition.

The Medicaid version of the program for physicians features additional compensation, but has a strict eligibility requirement that at least 30 percent of a physician’s patient volume must be attributable to Medicaid. It is unlikely many radiologists will meet the 30 percent threshold for the Medicaid version, so all information in this FAQ is specific to the Medicare version of the program for physicians.

Am I eligible for payment penalties in 2015 and beyond?

Any physician who is eligible for the Medicare version of the program but fails to demonstrate meaningful use in 2015 and every year thereafter will be penalized for noncompliance.

In the future, however, CMS will establish a significant hardship exemption process for eligible physicians to temporarily avoid penalties for noncompliance. Individual EPs may annually apply for the significant hardship exemption for a maximum of 5 years.

Are radiologic technologists, medical physicists, or other technical staff eligible for incentive payments?

The Medicare version of the program for eligible professionals is limited to physicians.

The Medicaid version of the program for eligible professionals is limited to physicians, Certified Nurse Midwives, Nurse Practitioners, and Physician Assistants who furnish services in a Federally Qualified Health Center or Rural Health Clinic that is led by a Physician Assistant.

What about inpatient and emergency room hospital settings?

Hospitals participate in their own version of the meaningful use incentive program. That version of the program has slightly different user and technology requirements. However, hospital-based physicians (those providing 90 percent or more of services in inpatient or ER settings) are not directly incentivized or penalized in that version of the program.

The meaningful use measures appear to be primary care focused – how am I, as a radiologist, going to comply?

By design, most of CMS' Stage 1 meaningful use measures focus on basic patient data traditionally captured and maintained in primary care settings. CMS provides exclusions for many meaningful use measures as well as discretionary "menu set" measures to account for variability in scopes of practice.

Furthermore, many of the measures merely require that certain data elements are accessible in the EHR—in most cases this data could be collected from or processed by others, such as information exchanged with other providers (such as via a health information exchange network) or inputted by administrative or technical staff in your facility. Certain other measures require physicians to verify or test that a given functionality is enabled in the EHR, and a few measures require that patients or referring physicians are provided with certain information after the visit.

The program seems complicated. Where do I start?

You should verify you have access to "certified EHR technology" where you provide your services. The Office of the National Coordinator for HIT's product testing and certification process confirms that the technology is able to facilitate satisfaction of the measures. Certified products are listed on the [Certified HIT Product List website](#).

How do I register for the program and report compliance to CMS?

Eligible professionals can register at any time for the program via an [online registration process](#) provided by CMS.

Reporting successful compliance to CMS involves attestation via an [online process](#). Participants attest to the numerators, denominators, and exclusions for all meaningful use measures, as well as provide a variety of other administrative information.

Participants are required to keep documentation supporting their demonstration of meaningful use for six years for CMS' auditing purposes.

What are the incentive amounts and how do I receive payment for satisfying the requirements of participation?

If a physician begins participating in the program in 2011 or 2012, the total incentive payments received can add up to \$44,000 over 5 payment years in the Medicare version of the program. If a physician begins participating in 2013, the payments can add up to \$39,000 over 4 payment years; and if a physician begins in 2014, the payments can add up to \$24,000 over 3 payment years. Physicians in a Health Professional Shortage Area (HPSA) are paid an additional 10 percent. Each year's payment is also capped at 75 percent of the physician's total Medicare fee schedule compensation—so, in order to receive the full \$18,000 in the first payment year for a physician who started in 2011 or 2012, that physician would need to be compensated by the Medicare physician fee schedule for over \$24,000.

The payments are given to eligible professionals in a lump sum after reporting compliance with the meaningful use requirements for an entire reporting period (the first payment year has a 90 consecutive day reporting period, every year thereafter has a full year reporting period). Eligible professionals can choose to reassign the payments back to one practice's Tax Identification Number (TIN) per CMS' existing reassignment policies.

What technology do I need to use?

Participation in the program requires *certified EHR technology*. The technology certification criteria, standards, and implementation specifications fall under the regulatory authority of the HHS Office of the National Coordinator for HIT. According to the regulations, there are two types of "certified EHR technology": (1) *complete*

EHRs that are certified as meeting all mandatory certification criteria; and, (2) combinations of individually certified *EHR modules*, the combination of which meets all mandatory certification criteria.

There are three categories of certification criteria: (1) General, (2), Ambulatory, and (3) Inpatient. Certified EHR technology in the physician version of the program must cover all General and Ambulatory certification criteria (with the exception of one currently optional criterion – see ACR’s [summary](#)).

Are RIS/PACS and other HIT products “certified EHR technology?”

There are a wide variety of EHR certification criteria, so many HIT products that are not considered traditional, complete EHRs/EMRs could still achieve certification via the EHR module pathway. To meet the definition of “certified EHR technology” via the modular pathway, a module would need to be tested and certified, and then would need to be combined with additional certified EHR Modules that cover any missing General and Ambulatory certification criteria.

Additionally, there are advanced RIS solutions that have received, or are in the process of receiving, complete EHR certification. Complete EHR certification means a product can be used by itself to comply with the requirements of the program. See the [Certified HIT Product List website](#).

Who is responsible for submitting the product(s) for testing and certification? And where do they submit the products for testing and certification?

It is generally considered to be the purview of the product developer to submit a given product for testing and certification; however, anyone is able to do this provided they cover the cost of testing and certification. Products must be submitted to ONC Authorized Testing and Certification Bodies (ATCBs). The ATCBs are listed on the [Office of the National Coordinator for HIT’s website](#).

I need consultant help – where do I look?

If someone has digested the ACR, CMS, and ONC materials, and discussed certification issues with their HIT vendors, the next best place for EHR consultation is probably the [Regional Extension Center \(REC\)](#) that services their area. RECs are regional nonprofit organizations that have cooperative agreements with ONC to provide EHR consulting services to eligible providers and hospitals. Thus, REC operations are partially funded by the federal government and they recover the rest of their operational costs through nominal service fees. They are required to prioritize primary care and rural providers, but they also need to service everyone in their area, including specialists.

Do you have a question that was not addressed by the ACR summary or ACR FAQ?

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