Meaningful Use: An Update for Physiatry Practices

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INTRODUCTION

The American Recovery and Reinvestment Act of 2009 incorporates the Health Information Technology for Economic and Clinical Health Act, which includes provisions that define the process of "meaningful use" (MU) that relates to electronic health records (EHR). The Health Information Technology for Economic and Clinical Health Act uses incentives and penalties for hospitals and professionals to encourage adoption of EHRs [1]. Although the MU incentive program has brought about increased adoption of EHRs by physicians [2], there have been many challenges that practitioners have faced as they have implemented MU [3]. Some physiatric practices have already begun to adopt MU as a means of receiving incentive funds to help offset the costs of implementing EHRs. However, because impending penalties are looming, other physiatrists, especially those in smaller practices, are now beginning to consider whether or not to adopt MU. This article will help address common questions with regard to MU implementation and whether or not it should be considered for your practice.

WHAT IS MU?

MU has been defined as the use of certified EHRs in a meaningful manner, such as for electronic prescribing, electronic exchange of health information, and electronic submission of quality measures. There are 3 progressively more comprehensive stages of MU, each with a specific set of compliance measures. There currently are 2 ways to attest for MU, through either the Medicare program or the Medicaid program, depending on the population of patients seen by the provider (Table 1). The Medicare program is more relevant for most adult-care providers, whereas Medicaid may be more relevant for pediatric-care providers who see a higher volume of patients with Medicaid.

WHO IS ELIGIBLE?

Eligibility depends on which program you wish to attest. Typically, physicians are eligible for both the Medicare and Medicaid programs regardless of specialty. Mid-level providers, such as nurse practitioners and physician assistants, qualify for the Medicaid program only under certain conditions. Attestation is done at the individual provider level; one cannot attest as a group. MU enrollment for rehabilitation hospitals does not exist as all; postacute care facilities have been excluded from the incentive program.

WHAT ARE THE INCENTIVES?

The incentives depend on which program you wish to participate with and in which year you begin your attestation (Table 2). Those who had not enrolled in MU by 2013 have already missed the larger maximum incentive payments of $44,000. The last year to attest for MU and receive incentive payments for Medicare is 2014, and the maximum total incentive has been reduced to $24,000. The amount of incentive received is equal to 75% of allowable Part B Medicare charges for covered professional services up to the maximum amount listed in Table 2 (ie, to achieve the full $12,000 incentive for 2014, the provider would need to have $16,000 of allowable Medicare charges for that calendar year). You have until 2016 to enroll in the Medicaid program to receive incentive payments.

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Table 1. *Comparison of Medicare and Medicaid Incentive Programs*

	Medicare	Medicaid
Provider types	MD, DO, and chiropractors	MD, DO; nurse practitioners; physician assistants if practicing Federally Qualified Health Center of Rural Health Clinic
Eligibility	Must have 10% or more Medicare charges performed in an outpatient setting	Patient volume of 30% or more Medicaid patients (20% if a pediatrician)
Incentives	2014 is the last year to enroll; maximum incentive is $24,000; payments are over 5 consecutive years	2016 is the last year to enroll; maximum incentive is $63,750; payments are over 6 years, does not have to be consecutive years
Penalties	Beginning 2015, 1% reduction in reimbursement to maximum of 5% by 2019	None for Medicaid charges
Requirements	For stage 1, must meet all core measures and 5 of 10 menu items; also need to report on quality measures	
Compliance	Providers must demonstrate meaningful use every year to receive incentive payments	In the first year, providers can receive an incentive payment for adopting, implementing, or upgrading electronic health record technology; providers must demonstrate meaningful use in the remaining years to receive incentive payments; does not have to be consecutive years

WHAT ARE THE MEASURES?

The specific measures for MU are summarized on the Centers for Medicare and Medicaid Services (CMS) Web site (Table 3 provides a list of CMS links) [4,5]. Measures are based on the stage of MU being implemented. For the first 2 years of attestation, clinicians need to meet stage I requirements. In brief, there are 15 core items and 10 menu items from which the provider must choose 5 menu items to implement. The critical point to understand is that to meet MU, each individual provider must meet all the measures. The biggest concern among providers who implement MU is the amount of extra tasks or duties placed on providers and their clinical staff to meet the specific measures of MU. Key element stage 1 measures that have impact on physiatric practices include core measure items and menu measure items.

Core Measure Items

1. Electronic Prescribing, Drug-Drug, and Drug-Allergy Checking
   These measures have been found to be quite useful by many clinicians. The ability to electronically prescribe medications as well as to perform automatic allergy checking is helpful. In addition, many EHRs allow for importation of external medication histories electronically so that a provider can view and import medications that a patient has filled at outside pharmacies. There are still some limitations to electronic prescribing for controlled substances for many states and EHRs; therefore, controlled substance prescriptions are excluded from MU and require a paper-generated prescription. Many EHRs can generate paper-based prescriptions. However, maintenance of electronic lists of medications can be time consuming. Obtaining the initial list of medications and entering them into the EHR or importing them from the external pharmacy, updating any changes at each office visit, and collecting the pharmacy information are needed to leverage effective electronic prescribing and drug-interaction checking.
2. Maintain Problem List
   This is new to the workflow of many clinicians because problem lists typically were used by primary care physicians. Creating and updating the problems list will be an extra task for clinicians to remember to perform. Some EHRs will have problems and

Table 2. *Meaningful use incentive payments (U.S. dollars)*

	2014		2015		2016	
Calendar Year	**Medicare**	**Medicaid**	**Medicare**	**Medicaid**	**Medicare**	**Medicaid**
2014	12,000	21,250				
2015	8000	8500		21,250		
2016	4000	8500		8500		21,250
2017		8500		8500		8500
2018		8500		8500		8500
2019		8500		8500		8500
2020				8500		8500
2021						8500
	24,000	63,750	0	63,750	0	63,750