Meaningful Use Stage 2
Frequently Asked Questions

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General

Merge Healthcare sponsored several webinars to outline the final Meaningful Use (MU) Stage 2 rules. The following are frequently asked questions from the events.

For more information:
- Visit the Meaningful Use Resource center on the Merge website
- Listen to a recording of the “MU2 Stage Rules are Final. Now What?” webinar

Where can I get a copy of the Stage 2 rules?
Visit for information and helpful links or visit the CMS website.

Dates and Timing

When exactly does Stage 2 start?
The proposed Stage 2 rules were finalized on August 23, 2012. Stage 2 rules are scheduled to go into effect in 2014, with the option to adapt to changed rules on stage 1 in 2013.

How long will the attestation period be for Stage 2?
For Eligible Professionals (EPs), the following table outlines the reporting and submission periods for Stage 1 and Stage 2. A special quarterly reporting has been introduced for year 2014 only, where EP will be able to pick a single quarter to report for.

<table>
<thead>
<tr>
<th>Reporting Period for 1st year of MU (Stage 1)</th>
<th>Submission Period for 1st year of MU (Stage 1)</th>
<th>Reporting Period for Subsequent years of MU (2nd year and beyond)</th>
<th>Submission Period for Subsequent years of MU (2nd year and beyond)</th>
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<tbody>
<tr>
<td>90 consecutive days within the calendar year</td>
<td>Anytime immediately following the end of the 90-day reporting period, but no later than February 28th of the following calendar year.</td>
<td>1 calendar year (January 1st – December 31st)</td>
<td>2 months following the end of the HER reporting period (January 1st – February 28th)</td>
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We are starting MU in 2012. Should we jump ahead to the Stage 2 rules?
Irrespective to when you start, you must start with Stage 1. Note that MU implementation calls for progressive implementation and must begin with Stage 1 irrespective of what year you begin.
If a rule changes in Stage 2, does that mean it also changes for Stage 1?
If you will be attesting to Stage 1 rules in or beyond 2014, there are specific objectives where the measurement calculations have changed. Any technology that is certified for Stage 2 will be able to address these changes. Following measure calculations are affected for Stage 1 as proposed with Stage 2 MU:

- **CPOE** – changes to denominator calculation
- **Vital Signs** – BP now applicable for ages 3 years and up; Exclusion now differentiated between BP only and WT+ BMI only
- **Clinical Quality Measures** – Reporting is aligned with PQRI, so may have alternate reporting methods
- **Electronic Copy of health Information** – has been replaced with View online, download and transmit health information

The Stage 1 rules have not changed and you will need to meet Stage 1 requirements per Stage 1 thresholds to attest to Stage 1.

If we attested for Stage 1 on the last quarter of 2011, do we need to attest for the whole year for 2012 or just a quarter?
You’ll need to attest for the entire year.

**Rules**

*Our ambulatory practice doesn’t request enough labs to warrant investing in a lab system. Can we be exempt from this rule?*
The requirement is to incorporate lab results as structured data either via electronic exchange of data (HL7 interface) or via manual data entry. It is not necessary to have a Lab System in house to meet this requirement.

It should be noted that under the Stage 1 rules, clinical lab results are a Menu item. If you are attestng for Meaningful Use Stage 1, you can opt out of this Menu item.

*What about collecting patient weight at ophthalmology practices? Will that requirement be dropped for Stage 2?*
Stage 2 will now allow EPs to either report BP only or report WT with BMI only.

*As an Orthopedic office, we are not able to send RX electronically. Are we going to be able to electronically prescribe narcotic medication?*
You will be able to prescribe narcotics but there will need to be specific provisions enabled in your EHR software to validate that the person prescribing electronically is a valid physician. This could, for example, take the form of double passwords or challenge questions in the application.

Vendor Certification

Does the vendor certification process change in Stage 2? If my EHR vendor has validated for Stage 1, are they still validated for Stage 2?
To meet Stage 2 MU requirements, the certified technology must be certified to report for Stage 2, i.e., they must obtain 2014 Edition of certification.

Our RIS vendor is obtaining modular certification. It meets all of needs as we will be filing several exceptions. Do we have to purchase a product that we will never use, just to show complete certification?
If you select an EHR that has obtained “complete EHR” certification, you are good-to-go. You know that it’s been certified for ARRA incentives by the ONC.

It's fine to choose several modular certification solutions that each meets a subset of the requirements but together meet all your MU requirements. If you do choose this route, it is your responsibility to assemble the solution. If you can validate that your chosen solution meets all the requirements that your practice needs to address, you should qualify to receive ARRA incentives.

Radiology Specific Questions

Can hospital-based radiologists piggyback on the hospital information system?
Absolutely! If your hospital has certified ambulatory EHR technology, you can use that technology to qualify for MU.

The rule specifically states:

“EPs can demonstrate that they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH — in lieu of using the hospital’s CEHRT — can be determined non-hospital-based and potentially receive an incentive payment.”

I am a hospital-based radiologist. I understand we qualified for MU via outpatient services. We also operate a small vein clinic. If we obtain a certified electronic EHR for this clinic will it satisfy our requirements for the entire hospital-based group?
An EP is currently required to use certified technology for 50% of patient encounters. If more than 50% of your patient encounters are at your vein clinic, you’ll be able to attest.

For Stage 1, the CMS has noted that if an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient’s information into a certified EHR technology at another practice location, those patients can be counted in the numerators and denominators of MU measures. In this case though, the CMS also notes that it is unlikely that they will be able to include such patients in the numerator for the measure of the "use CPOE" objective or the e-prescribing measure. In Stage 2, EPs with only those patient visits that occur at the location with CEHRT can be considered. EPs may aggregate the data, if they are using multiple technologies in multiple locations.

*What is the easiest way for hospital-based radiologist to completely avoid getting involved in any meaningful use process without getting fined in the future?*

Until 2015, MU is an optional program. You can avoid being fined until then. EPs that do not have face to face encounters with patients and can demonstrate no need of follow-up with the patients can file for exemption.

EPs must demonstrate that they meet the following criteria:

- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients

*Any update on a hardship exception for hospital-located radiologists?*

EPs whose primary specialties are anesthesiology, radiology or pathology can now claim hardship exemption based on:

- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients

EP’s can also claim hardship exemption under following circumstances:

- Infrastructure: EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband)
- New EPs: Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments
- Unforeseen Circumstances: Examples may include a natural disaster or other unforeseeable barriers
- EPs who practice at multiple locations must demonstrate that they: Lack control over availability of CEHRT for more than 50% of patient encounters
The CMS notes that hardship applications need to be submitted no later than July 1 of the year before the payment adjustment year and they encourage earlier submission.

The CMS states that they do not believe any one of these barriers taken independently constitutes a significant hardship.

**We have a separate program to view images and that program is on the same computer as our EHR system. Does this qualify for the measure that requires images to be viewed from the EHR system?**
The Final rule clearly states that the images should be accessible from the EHR.

**Our X-rays are done in office. Does this allow us to meet the imaging requirement for MU?**
The Stage 2 final rule states that >10% of all scans / tests and associated reports, whose result is one or more images, are accessible through the EHR. If the X-rays done in the office are accessible through your EHR, you will meet the proposed rule.

**Our imaging centers are IDTFs (Independent Diagnostic Testing Facilities) so we bill globally and not by NPI. Does that impact our radiology MU qualification criteria?**
No, it does not impact your qualification criteria.

**How does MU apply to a teleradiology practice?**
In teleradiology, patient images such as x-rays, CTs, and MRIs are shared electronically between locations, enabling radiologists to provide services without actually having to be with the patient. CMS provided guidance on how MU applies to teleradiology in a Q&A on June 2011 - [https://questions.cms.hhs.gov/app/answers/detail/a_id/10664](https://questions.cms.hhs.gov/app/answers/detail/a_id/10664). Their guidance states:

In cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures. For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all meaningful use measures that include patients "seen by the EP." EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies as least some of the services they render for patients as "seen by the EP" and this policy must be consistent for the entire EHR reporting period and across meaningful use measures that involve patients "seen by the EP" -- otherwise, these EPs would not be able to satisfy meaningful use, as they would have denominators of zero for some measures.
Policy

**How will the election affect MU? Does it matter who gets elected?**

MU arises from the ARRA, which has never undergone any threat of repeal. Therefore, we believe this legislation will continue independent of political changes.

**My hospital is a remote rural area with no Internet access. How can we meet Meaningful Use?**

There is a significant effort to increase broadband connectivity nationally. The Broadband USA website at [http://www2.ntia.doc.gov/SBDD](http://www2.ntia.doc.gov/SBDD) is a good resource to learn about progress being made in each state to support connectivity.

You should look for assistance from your state to get Internet access. Each state can provide assistance, though the department for hospitals to work with will vary by state. For example, in Illinois, the Office of Health Information Technology (OHIT) has a very good relationship with the Illinois Critical Access Hospital Network (ICAHN) as they have been very early and active stakeholders in the Illinois Health Information Exchange.

In your state, look for a Critical Access Hospital (CAH) membership organization that addresses the needs of and issues related to rural and remote hospitals or a Regional Extension Center (REC). The RECs have received two rounds of funding to assist Critical Access Hospitals with adopting EHRs and can be a good resource to help rural hospitals. For more information on REC funding, see the article at [http://www.regionalextensioncenters.com/2011/02/20/onc-to-provide-additional-funding-to-critical-access-and-rural-hospitals-for-switch-to-electronic-health-records/](http://www.regionalextensioncenters.com/2011/02/20/onc-to-provide-additional-funding-to-critical-access-and-rural-hospitals-for-switch-to-electronic-health-records/).