Meaningful Use for Specialists Tipsheet (Stage 1 2014 Definition)

Last Updated: June 2014

Recognizing that not every meaningful use measure applies to every provider, this fact sheet gives specialty providers tips about how to successfully meet meaningful use measure requirements and navigate the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

Are you facing measures that require data you don't normally collect as a specialist? While eligible professionals (EPs) can choose measures that apply to their practice, in some cases, data that has been collected by another provider—for example, a referring physician— can be used to fulfill required measures.

Meeting Meaningful Use

In the EHR Incentive Programs, there are exclusions that exempt providers from meeting specific objectives for meaningful use. Those who meet the qualifications for an exclusion will not need to report on that objective and can still receive an EHR incentive payment.

Core Measures

All providers have to either meet or qualify for an exclusion for every core measure of the EHR Incentive Programs. Exclusions are not based on specialty, but rather on unique criteria for each exclusion. For instance, if recording vital signs (height, weight, and blood pressure) has no relevance to a specialist's scope of practice, he or she does not need to record them for that measure.

Some exclusion criteria may be universally or nearly universally applicable to a specialty due to the scope of practice of that specialty. However, because there is no blanket exclusion for any type of EP, specialists must individually evaluate whether they meet the exclusion criteria for each applicable objective.

Menu Measures

Providers must select five menu objectives on which to report from the total list of available 9 objectives. However, it is possible that none of the menu objectives are applicable to a particular specialist's scope of practice. If that is the case, you can usually qualify for the exclusions to the objectives. For example, an EP who writes fewer than 100 prescriptions during the reporting period can claim an exclusion to the objective for implementing drug formulary checks. Thus specialists who do not prescribe medications could claim the exclusion for this objective.

If you qualify for all of the exclusions for each of the menu objectives, then select any five menu objectives during attestation and claim the exclusion for each. However, please note that if specialists do not qualify for all of the exclusions to the menu objectives, they should go back and select menu objectives on which they can report.

Clinical Quality Measures

For 2014 Definition Stage 1, providers will be required to report on the 2014 clinical quality measures (CQMs) for eligible professionals. This means eligible professionals will need to report 9 measures of a possible list of 64 approved CQMs. The CQMs reported must cover at least 3 of the 6 available National Quality Strategy domains, which represent the Department of Health and Human Services' NQS priorities for health care quality improvement. A number of the available CQMs are applicable to specialists, and CMS suggests that specialists choose quality measures that are relevant to their practices and clinical workflow.

However, if a CQM is not applicable to your scope of practice, your EHR should generate a zero value since there are no patients in the EHR to whom the quality measure is applicable. Zero is an acceptable value for the CQM denominator, numerator, and exclusion fields and will not prevent you from demonstrating meaningful use or receiving an incentive payment. If needed, you may report a zero for all 9 CQMs.

CQMs do not have thresholds that providers have to meet; you only have to report data on them. Providers do not have to do any calculations for the CQMs, or meet CQM thresholds. They only have to report data. The 2014 CQMs may be reported electronically, or via attestation.

Using Data Entered by Other Providers

CMS encourages specialists to use data supplied by referring and other providers—or accessible through a Health Information Exchange (HIE)—to comply with the meaningful use reporting requirements. CMS understands that some specialists do not interact with patients in the same way as general practitioners. Specialists may not have direct contact with their patients, may not have a need for follow up after an office visit, or may not transition patients to another setting of care themselves, so information exchange, either directly or through an HIE, can be an excellent solution for obtaining reporting data.

Please note that neither the HIE nor the referring provider must have certified EHR technology in order for you to incorporate this information into your EHR for the purposes of meeting the meaningful use objectives. Where the information comes from is unimportant as long as you use your certified EHR technology to record and store it.

Specialists who share an EHR with other providers also can count in the numerator those patients for whom other providers have entered information. While there are many objectives that require the recording of standardized patient information, these objectives do not specify *who* should enter the information. Therefore a shared EHR, documentation accompanying referrals and orders, or receiving information through electronic exchange are excellent strategies for meeting these objectives.

Clinical Summaries: Determining Office Visits

A specialist who does not have office visits with patients is excluded from the meaningful use objective to "provide clinical summaries for patients after each office visit." For the EHR Incentive Programs, an office visit includes separate, billable encounters that result from evaluation and management services provided to the patient.

While CMS does not specify a range of E&M billing codes to which this exclusion applies, we define office visits as:

1. Concurrent care or transfer of care visits
2. Consultant visits*, or
3. Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health).

**A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.*

If you do not have any visits that fit into the three categories above, you may claim the exclusion for this objective.

If a patient is seen by multiple EPs who share an EHR, a single clinical summary at the end of the visit can be used to meet the objective. Therefore a specialist who does not interact with the patient can also count the clinical summary provided by the other EP(s) who saw the patient in order to fulfill this requirement.

Hardship Exceptions

CMS recognizes that even with the available exclusions and the flexibility of obtaining information through electronic exchange, certain specialists may find it difficult to demonstrate meaningful use. These specialists may apply for a hardship exception to avoid the EHR Incentive Program payment adjustments that begin in 2015. Information on applying for a hardship exception is available on the EHR website.

Specialists and other providers who apply for a hardship exception based on limited interaction with patients must demonstrate that they:

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

CMS also recognizes that certain providers who practice at multiple locations are unable to demonstrate meaningful use because of lack of access to Certified EHR Technology at one or more locations. If you are a specialist or other provider who lacks control over the availability of Certified EHR Technology at one or more of your practice locations and therefore cannot use Certified EHR Technology at practice locations for 50 percent or more of your patient encounters, you may also apply for a hardship exception to the payment adjustments.

CMS Resources for Meaningful Use

CMS has created a series of resources to help specialists successfully participate in the EHR Incentive Programs. Some of these resources include:

- An Introduction to the Medicare EHR Incentive Program for Eligible Professionals and An Introduction to the Medicaid EHR Incentive Program for Eligible Professionals— Walks EPs through all of the phases of the Medicare and Medicaid EHR Incentive Programs, focusing on Stage 1 (2014 Definition) meaningful use requirements.

- Stage 1 Specification Sheets (2014 Definition)— Includes the objective, measure, and exclusion for each 2014 Definition Stage 1 core and menu objective, as well as a definition of terms, attestation requirements, additional information, and the corresponding standards and certification criteria.

- Stage 1 Eligible Professional Attestation Worksheet (2014 Definition)— Helps providers to organize their numerator, denominator, and exclusion information in one convenient place so that attestation is an easy process.

- Stage 1 Meaningful Use Calculator— Allows providers to test whether or not they would successfully demonstrate meaningful use for the EHR Incentive Programs.