

CMS Issues Final Rules on EHR Stage 2 Criteria and ICD-10 Codes; ONC Issues Final Rule on EHR Certification Process

On August 23, 2012, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) issued final rules setting forth respectively the requirements for providers in Stage 2 of the Medicare and Medicaid Electronic Health Records (EHR) Incentive program and modifications to the EHR certification process. CMS also issued a final rule on August 24, 2012, delaying the compliance date for the use of International Classification of Diseases, 10th Edition medical data code sets (ICD-10 codes) and implementing unique health plan identifiers (HPIDs) for all insurers.

The most significant changes include postponing implementation of Stage 2 criteria for meaningful use of EHR, adding objectives and modifying measures to determine meaningful use, and delaying the use of ICD-10 codes.

Please see Ropes & Gray's [February 2012](#) alert for a summary of CMS's notice of proposed rulemaking regarding Stage 2. CMS's final rules regarding Stage 2 and the use of ICD-10 codes can be found [here](#) and [here](#). ONC's final rule regarding modifications to the EHR certification process can be found [here](#).

Stage 2 of EHR Incentive Program

Background

Under the American Recovery and Reinvestment Act of 2009 (Recovery Act) certain eligible professionals, hospitals, and critical access hospitals (CAHs) can qualify for Medicare and Medicaid incentive payments when they adopt and meaningfully use certified EHR technology. Stage 2 of implementation is intended to increase the health information exchange between providers and promote patient engagement by giving patients secure online access. Stage 3 will be developed in further rulemaking.

Timing

Originally, Medicare and Medicaid providers were required to meet Stage 2 criteria for meaningful use in 2013 in order to continue receiving EHR payments and avoid payment adjustment beginning in 2015. The final rule, however, allows providers to continue to meet Stage 1 criteria for meaningful use (instead of Stage 2) until 2014. Additionally, in 2014 providers will only have to demonstrate meaningful use for a 3-month EHR reporting period, in order to give providers who must upgrade to 2014 certified EHR technology adequate time to implement their new systems.

Meaningful Use Objectives and Measures

In both Stages 1 and 2, CMS based its criteria for meaningful use on a series of specific objectives, divided into core and menu objectives. For providers to be meaningful users of EHR technology, they must meet all of the core objectives and an applicable set of the menu objectives. The final rule modifies the meaningful use objectives, adding two new objectives:

- Providers must use secure electronic messaging to communicate with at least 5% of patients on relevant health information.
- Hospitals must automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

These new core objectives were designed to encourage patient engagement. The final rule also requires “outpatient lab reporting” as a meaningful use objective for hospitals and “recording clinical notes” as a menu objective for hospitals and physicians.

In the final rule CMS also scaled back on two measures for electronic exchange of summary care documents between providers. The final rule requires that each provider send a summary of care record for 50% of transitions of care and referrals, reduced from 65% in the proposed rule. CMS also eliminated the organizational and vendor limitations for its requirement that providers electronically transmit a summary of care for more than 10% of transitions of care and referrals. Instead, CMS will require at least one instance of exchange with a provider using EHR technology designed by a different EHR vendor or with a CMS-designated test EHR system.

CMS also modified certain of the processes for meeting objectives. For example, CMS finalized the ability to use a batch reporting process for meaningful use, allowing groups to submit attestation information for all of their individual electronic providers. This change should simplify the submission process for providers. Additionally, the threshold for two meaningful use objectives—providing patients online access to health information and secure messaging between patients and providers—was reduced from 10% to 5% in response to providers’ concerns.

Other Changes Affecting Eligible Providers

Lastly, CMS changed the definition of “hospital-based” physicians to allow physicians to demonstrate that they are non-hospital based and, therefore, eligible to receive meaningful use incentives. Hospital-based eligible professionals were originally defined under the Recovery Act as those professionals furnishing substantially all of their professional services in a hospital setting (whether inpatient, outpatient, or emergency room). The modification of this definition is important in that it allows physicians to self-fund their EHR systems and, therefore, be eligible to receive incentive payments directly. In order to receive incentive payments directly, physicians must demonstrate that they fund the acquisitions, implementation, and maintenance of EHR, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital and use their EHR system instead of the hospital’s system. CMS will determine who qualifies for direct incentive payments through an application process.

ONC’s Final Rule

ONC released a complimentary final rule modifying the EHR certification program, designed to streamline the certification process. ONC’s final rule revises the definition of certified EHR technology to allow health care providers to adopt only the EHR technology they need to meet the meaningful use stage they are seeking to achieve. The rule also requires that EHR software be designed to automatically encrypt electronic health information stored locally on end-user devices.

Use of ICD-10 codes and HPIDs

CMS also announced on August 24, 2012 a delay to the implementation of ICD-10 codes, specifically from October 1, 2013 to October 1, 2014 and the establishment of National Health Plan Identifiers. By way of background, in 2009, CMS released a proposed rule that would make ICD-10 the standard code set for identifying diseases and procedures on health care transactions. Currently, the standard code used is ICD-9. The switch is significant because it expands the current set of 14,000 codes to over 69,000 codes. Several industry and provider groups have expressed significant concerns that the cost burden of implementing an

expanded code set outweighs the benefits of using ICD-10. CMS already delayed the switch once from its originally proposed transition date of October 1, 2011.

The August 24, 2010 rule also deals with National Health Plan Identifiers, commonly referred to as HIPIDs. The Patient Protection and Affordable Care Act (ACA) called for the Secretary of HHS to promulgate a Final Rule to establish HIPIDs. The final rule requires that each unique HPID be a standard length and format to facilitate routine use in computer systems and to unify the range of identifiers that health plans use.

We continue to monitor developments with respect to the Medicare and Medicaid EHR Incentive Programs, especially those changes that may affect the hospital, physician, and information technology communities, as well as other HIPAA administrative simplification requirements. If you have questions on the incentive programs, please contact any of the attorneys listed below or the Ropes & Gray attorneys with whom you regularly work.

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