Dentists and Meaningful Use

PART ONE: OVERVIEW AND STAGE 1

Adele Allison,
National Director of Government Affairs

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Certifications

MediaDent is a division of SuccessEHS, a leading health information technology vendor based in Birmingham, Ala. MediaDent offers electronic dental record (EDR), dental practice management and dental imaging solutions and serves community health centers, dental groups and independent dental practitioners.

MediaDent’s MediaDent IX is 2011/2012 compliant and was certified as a Complete EHR on July 10, 2012 by the Certification Commission for Health Information Technology (CCHIT®), an ONC-ATCB, in accordance with the applicable certification criteria for Eligible Providers adopted by the Secretary of Health and Human Services. The certification ID number is CC-1112-909422-2. The clinical quality measures certified include: NQF 0421, NQF 0013, NQF 0028, NQF 0041, NQF 0024, NQF 0038, NQF 0043, NQF 0031, and NQF 0034. The additional software MediaDent IX relied upon to demonstrate compliance includes: SuccessEHS 6.1. This certification neither represents an endorsement by the U.S. Department of Health and Human Services nor guarantees the receipt of incentive payments.

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Dentists and Meaningful Use

PART ONE: OVERVIEW AND STAGE 1

Adele Allison, National Director of Government Affairs

Contained in the American Recovery and Reinvestment Act of 2009 (ARRA), HITECH provisions for the CMS EHR Incentive Programs also known as Meaningful Use.

- The law is inclusive of the full care continuum, including oral health providers
- Under ARRA, DDS/DMDs are eligible to earn incentives through either the Medicare or Medicaid EHR Incentive Program
- Policymaking has been non-inclusive of the full care continuum, making it hard for dentists to achieve incentives
- There is a disconnect between Electronic Dental Records (EDRs) and Electronic Health Records (EHRs)
- Guidance on how dentists can embrace Meaningful Use has been limited

Contained in this White Paper:

- Glossary of Terms
- Introduction to the EHR Incentive Programs
  - Congressional Intent of HITECH
  - Meaningful Use Rules
  - Medicaid Program Eligibility and Registration
  - Medicaid Program Incentives and Timelines
- Understanding how Certified EHR Technology is Defined
- Achieving Stage 1 Meaningful Use
# Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>American Recovery and Reinvestment Act</td>
<td>ARRA</td>
<td>Legislation also known as the Stimulus Act signed into law on Feb. 17, 2009, by President Obama for the purpose of stimulating the economy through investments in infrastructure, unemployment benefits, transportation and health care.</td>
</tr>
<tr>
<td>Health Information Technology for Economic and Clinical Health Act</td>
<td>HITECH</td>
<td>Title XIII of ARRA that moves the federal government into a leadership role to develop standards, reward and accelerate adoption and use of interoperable, certified electronic health record technology; and, strengthening federal privacy and security laws to protect identifiable health information from misuse.</td>
</tr>
<tr>
<td>Certified EHR Technology</td>
<td>CEHRT</td>
<td>Electronic Health Record (EHR) technology that has the technical capabilities and meets the standards and implementation specifications to be certified for use by an Office of National Coordinator Authorized Certification Body (ONC-ACB) for providers seeking meaningful use incentives.</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>MU</td>
<td>Established under HITECH, meaningful use is a health care entitlement program known as the CMS Medicare and Medicaid EHR Incentive programs designed to create incentives for adopting and using CEHRT and penalties for failure to do so.</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>HIT</td>
<td>A market area that includes the design, development, implementation, use, support and maintenance of computerized information systems for the health care industry.</td>
</tr>
<tr>
<td>Electronic Dental Record</td>
<td>EDR</td>
<td>A real-time electronic patient dental record that provides the oral health professional with the ability to chart information including such details as procedures, diagnoses, notes, x-rays, periodontal charting, soft tissue findings, restorations and active oral health diseases.</td>
</tr>
<tr>
<td>Electronic Health Record</td>
<td>EHR</td>
<td>A real-time patient health record that contains access to evidence-based decision support technology that aids providers in decision-making, automates and streamlines workflow, ensures communication of all clinical information, and supports data collection for other uses including billing, quality management, outcomes reporting, and public health disease surveillance and reporting.</td>
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<tr>
<td>Term</td>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>Eligible Professional</td>
<td>EP</td>
<td>The meaningful use programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade and/or demonstrate stages of federally defined meaningful use. Medicare eligible professionals include those holding a degree of MD, DO, DDS, DMD, DPM, OD or DC. Medicaid eligible professionals include physicians, dentists, certified nurse midwives, nurse practitioners, and physicians assistants in a FQHC or RHC led by a PA.</td>
</tr>
<tr>
<td>Adopt, Implement, Upgrade</td>
<td>AIU</td>
<td>Adopt means to acquire, purchase or secure access to certified EHR technology. Implement means to install or use certified EHR technology capable of meaningful use. Upgrade means to expand the functionality of certified EHR technology at the practice, including staffing, maintenance, training or upgrading from an existing EHR to a certified EHR technology.</td>
</tr>
<tr>
<td>Authorized Testing and Certification Body</td>
<td>ATCB</td>
<td>An organization authorized by the Office of the National Coordinator (ONC) for HIT to test and certify that certain types of EHR technologies are compliant with the standards, implementation specifications and certification criteria adopted by HHS and meet the federal definition of certified EHR technology.</td>
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</table>
Introduction to the EHR Incentive Programs

Change is afoot for health care delivery in the U.S. The onset was triggered by legislation signed by President Obama known as the American Recovery and Reinvestment Act (ARRA). The U.S. had just experienced a bursting of the $8 trillion housing bubble, plunging the financial market into crisis and launching what has become termed as the “Great Recession.”

The 44th presidential term thus began with President Obama being sworn into office on Jan. 20, 2009. At that time, our federal lawmaking system had taken a strong shift to the left with a Democratic-led House, Senate and White House. This swing of pendulum resulted in ARRA being signed into law on Feb. 17, 2009, less than 30 days after the president’s inauguration. Also known as the Stimulus Act and offering “cash for clunkers,” the 1,400-page legislation contained around 60 pages known as the Health Information Technology for Economic and Clinical Health (HITECH) Act. It is these 60 pages that provision and govern what is known among health care providers as Meaningful Use.

Congressional Intent of HITECH

HITECH has four principal goals:

1. Place the federal government in a role of leadership to develop standards-based, nationwide electronic exchange and use of health information to improve the quality of care.
2. Invest in health information technology (HIT) through our two federal socialized health care programs, Medicare and Medicaid, to accelerate and reward providers and hospitals to use HIT to electronically exchange patient health information.
3. Promote savings for the federal government and throughout the health care industry through operational efficiencies, improved care quality and coordination, reduction in errors and decreases in duplicative care.
4. Strengthen federal privacy and security laws that protect personal health information from misuse as the health care industry embraces and uses HIT.

Under HITECH, the CMS Medicare and Medicaid EHR Incentive Programs were born. Termed the Meaningful Use (MU) programs, incentives are not funded by congressional appropriations. MU is a provider entitlement program, meaning eligible professionals (EPs) are entitled to the incentives as a matter of law if they qualify. Section 495.100 of the Act defines the following professionals as being eligible to participate in the MU programs:

- **Medicare EHR Incentive Program EPs** – Health care professionals holding a degree of MD, DO, DDS, DMD, DPM, OD, or DC.
- **Medicaid EHR Incentive Program EPs** – Health care professionals who are physicians, dentists, certified midwives, nurse practitioners or physician assistants. Physician assistants are only eligible if serving in a FQHC or rural health center clinic site led by a physician assistant.
For EPs, the incentive programs are mutually exclusive, meaning each EP must select from which program he/she will pursue incentives. Officially, dentists can participate in either the Medicaid or Medicare MU incentive programs. However, the Medicare MU incentives are calculated using a percent of the EP’s Medicare Physician Fee Schedule allowable charges for the calendar year. Due to a statutory limitation in the Social Security Act (§ 1862(a)(12)), Medicare does not cover general dental care or most dental procedures such as cleanings, fillings, tooth extractions or dentures. Only in rare instances would a dental provider file a medical Medicare claim, typically for oral surgery related encounters (e.g., reconstruction of the jaw following accidental injury or extractions in preparation for radiation treatment for neoplastic diseases of the jaw). Because the Medicare MU is a non-viable program option for dentists, they must look to the Medicaid EHR Incentive Program for participation.

**Meaningful Use Rules**

It is the policymaking under CMS that outlines the tasks and thresholds to which each EP must attest to earn an incentive. Herein lays the complexity. The law is merely a framework. HITECH contemplates a comprehensive, holistic provider continuum that includes oral health. Generally speaking, law is fairly static inasmuch as a change in law requires, quite literally, an act of Congress. Policymaking, on the other hand, expresses the granular details of how a law will be administered and regulated. Policymaking is quite variable and changes constantly with politics, public opinion, agency leadership, cabinet positions, etc. And, the devil is always in the details.

Ultimately, federal health care policymaking answers to the White House under the cabinet position known as the Secretary of Health and Human Services (HHS). Under HHS, there are 12 agencies (e.g., FDA, ONC, HRSA, CMS, etc.). Provider policymaking, known as rules or regulations, will always come from their governmental payer—the Centers for Medicare and Medicaid Services (CMS)—for the MU programs.

MU also challenges providers to use standards-based, certified EHR technology (CEHRT). This means vendors of CEHRT must become regulated, as well. The agency that writes policy on that which the EHR vendor community must develop, test and certify to be recognized as CEHRT is the Office of National Coordinator for Health Information Technology (ONCHIT) or simply the ONC. Therefore, the MU programs will always be dually-regulated through companion rules coordinated and issued by CMS for providers and the ONC for vendors.

That is a lot of details—hundreds of pages of regulations, in fact! The rules governing “meaningful use” of CEHRT are being rolled out in stages. Stage 1 rules were released to the public on July 13, 2010. Stage 1 regulations for providers and vendors totaled 1,092 pages. The final rule regulating Stage 2 was subsequently released on August 23, 2012, totaling 1,146 pages and including changes to Stage 1 participation requirements.
Medicaid Meaningful Use Program Eligibility

We previously established that dentists are administratively restricted to participation in the Medicaid MU program. Because Medicaid receives funding from both the federal and state government, Medicaid MU is offered and administered by each individual state and territory. A listing of the Medicaid MU milestones by state, including launch dates, program URL links and contact emails can be found on the CMS website.²

For a provider to be eligible for the Medicaid EHR Incentives, he/she must meet the individual state’s requirements for calculating the Medicaid volume threshold. The Stage 1 final rule established guidelines for this calculation, which were expanded under the Stage 2 final rule to include Title XXI-funded Medicaid expansion encounters, but not separate Children’s Health Insurance Programs (CHIPs).

The general threshold for Medicaid patient volume per provider is 30 percent. Dentists performing more than 50 percent of their services to a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) are afforded special considerations in the calculation. These safety net providers may perform their calculation using “needy patient” encounters. Under section 495.302 of the Act, a needy encounter is defined as one in which the patient receives Medicaid or CHIP assistance, uncompensated care by the provider or services provided at no cost or a reduced cost based upon a sliding scale and the patient’s ability to pay.

Originally, under Stage 1 the EP would use a 90-day date range from the previous calendar year to conduct the patient volume calculation. Under the Stage 2 final rule, the look back period to make this calculation has been changed to a rolling 12 months preceding the provider’s attestation and is no longer tied to a calendar year.

The final rule allows for calculation of the Medicaid volume threshold in the following fashions:

1. **Encounter.** An encounter is any single day when services are rendered and paid by Medicaid, or where Medicaid pays premiums, copayments and/or cost-sharing.
2. **Panel.** Panels are represented by the total Medicaid patients assigned to a provider through a managed care panel, medical home, or similar capitation or case assignment structure.
3. **Group Practice or Clinic.** Group calculations would require that all providers in the practice use the same method of calculation with no limitations on the patient volume in any way.
4. **Other.** States can define an alternative method to calculate. It just has to be approved by the Secretary of HHS.
Each individual state has the ability to determine a number of variables, including the method for calculating the Medicaid volume. Generally, most states allow the calculation of Medicaid patient volume using the following formula:

- **Numerator:** Total Medicaid patients (Needy encounters for FQHCs and RHCs) for a 90-day period during the previous 12 months, and
- **Denominator:** Divide by the total number of encounters for all patient encounters during the same 90 days, and
- **Multiply by 100 = Patient Volume Threshold Percent**

Dentists should consult their state Medicaid Agency websites to fully understand their state’s policy for volume calculation.

**Medicaid Meaningful Use Program Registration**

All Medicaid EPs must register at the national level with CMS at [www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/), and meet any state registration requirements. Data required for national level registration includes:

- EP’s name, NPI, business address, and business phone
- Taxpayer Identification Number (TIN) to which the EP wants the incentive payment made. Payment can be assigned to an employer or entity with whom the EP has a valid contractual arrangement allowing the employer or entity to bill for the EP’s services.
- Elected program of participation – Medicare or Medicaid
- Such other information as specified by CMS

Once national level registration is complete, the dentist will need to register with their state Medicaid Agency. Obviously, the dentist must participate with Medicaid to be eligible. The state Medicaid agency will need to collect and verify additional eligibility information, such as patient volume and adoption, implementation, or upgraded certified EHR technology. Each state will have an “eligibility verification tool” to manage the registration and attestation process online. Be aware that although the provider will only register one time with CMS and their state, the dentist’s eligibility must be assessed, including patient volume threshold, each year of participation. To access your state Medicaid EHR Incentive Program website link, visit the CMS website at [https://www.cms.gov/apps/files/statecontacts.pdf](https://www.cms.gov/apps/files/statecontacts.pdf).

**Medicaid Meaningful Use Incentives and Timelines**

Medicaid MU incentives are paid out over a six-year period. The participation years need not be consecutive. The latest year a dentist can start the Medicaid program is 2016 with the program continuing to pay incentives through 2021. In the first year of program participation under Medicaid, dentists are eligible for $21,250 for merely adopting, implementing or upgrading CEHRT. Each subsequent year of program participation the dentist can receive $8,500 but must successfully demonstrate meaningful use. Successful participation in the entire six years will yield a total incentive payout of $63,750 per dental provider.
Year 1 participation to adopt, implement or upgrade (AIU) is specifically defined under section 495.302 of the Act, as the dentist doing one of the following:

- **Adopt** means to acquire, purchase or secure access to certified EHR technology.
- **Implement** means to install or use certified EHR technology capable of meaningful use.
- **Upgrade** means to expand functionality of certified EHR technology at the practice site, including staffing, maintenance, training or upgrading from an existing EHR to a certified version.

All EPs will essentially perform two years of MU within each stage. After the first year of AIU, dentists must meet meaningful use to participate. What objectives and measures must be performed for each stage is set forth in the final rules for each stage of the program. Meaningful use will require the dentist to measure data points and reach a defined threshold during a set amount of time, known as the EHR reporting period, for each year of participation.

The first year a dentist performs MU, he/she must measure and report data for a 90-day period (EHR Reporting Period) during the calendar year. Each subsequent year, EPs will generally have a full year EHR Reporting Period with the exception of CY2014. CY2014 is a pivotal year for the MU program because it is the first year any provider can perform Stage 2 MU. As such, CMS has given special consideration to CY2014 to assist with transition from Stage 1 to Stage 2. Therefore, dentists performing their first year of Stage 2 or their second year of Stage 1 in CY2014 will have an EHR reporting period of only three months, defined by quarter (Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec), unless otherwise defined by the EP’s state Medicaid Agency. (See Table 1)

Latecomers of CEHRT initiating meaningful use after 2015 will be subject to a full year EHR reporting period. The reason for the full year of reporting is for consideration of data integrity between the clinical quality submissions and efforts towards alignment with other federal programs initiated or strengthened under the Affordable Care Act, including the Physician Quality Reporting System (PQRS), Accountable Care Organizations (ACOs) and others.

*Table 1 – Revised Meaningful Use Timetable (Red line of demarcation indicates the point of Medicare Payment Adjustments for non-compliance.)*

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<td>TBD</td>
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<td>2013</td>
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<td>2014</td>
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<td>1</td>
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<td>2015</td>
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<td>3</td>
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<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*3-month quarter EHR reporting period for Medicare; continuous 90-day EHR reporting period (or 3-months at state option) for Medicaid. All first year EPs in 2014 use any continuous 90-days.*
How Certified EHR Technology is Defined

EPs must use certified EHR technology (CEHRT) to qualify for incentive payments under MU. As discussed in the previous section, EHR technology is becoming regulated under HITECH. In so regulating, the federal government is taking a leadership role to ensure standards-based health IT that is consistent, safe and secure. The ONC is the regulating agency for EHR vendors and will test and certify that such technologies meet the minimum federal standards through approved Authorized Testing and Certification Bodies (ATCBs). Currently, there are four organizations approved by the ONC to perform testing and certification as an ATCB: Certification Commission for Health Information Technology (CCHIT), Drummond Group, ICSA Laboratories, and InfoGard Laboratories. Only technologies that have been certified by an ATCB will be listed on the ONC website as approved products.

Because this technology and regulatory process is relatively new, it is evolving much like MU through a robust rulemaking process orchestrated by the ONC. Think of CEHRT as building blocks.

The law (HITECH) sets forth a statutory definition of a qualifying EHR, which includes: the ability to capture demographics and clinical information; perform decision support, order entry, and quality measurements; and, is interoperable with other systems for electronic exchange of identifiable patient information in accordance with federally required standards. (Figure 1)

The MU programs were launched in January 2011, meaning the market had to deliver CEHRT that met the Stage 1 standards on the same timeline. Thus, a companion rule issued by the ONC was released for EHR vendors in tandem with the provider Stage 1 rule released by CMS for MU on July 13, 2010. These ONC requirements have been designated as the 2011 Edition Standards and Certification Criteria (S&CC), setting the bar for minimum technology requirements. (Figure 2)

The 2011 Edition S&CC added additional requirements beyond those set forth under the HITECH statutory definition to parallel the specific objectives and measures required by CMS for Stage 1 MU. But here is the rub—the 2011 Edition CEHRT definition is static. This means the requirements of the technology purchased by the EP are the same regardless of specialty. So, a dentist would be required to purchase the same EHR technology as a pediatrician or cardiologist that captured vitals, managed immunizations, plotted growth charts, and incorporated lab results.

Since the launch of ONC regulated certification of EHR technology, there have been more than 500 certified Complete EHRs and EHR Modules tested, certified and listed on the Certified Health IT Product List (CHPL, pronounced “Chapel”) under the 2011 Edition.5
Simply explained, a Complete EHR meets all of the criteria required under a given stage of MU. This means providers that purchase 2011 Edition Complete EHRs should have all the technologies needed to perform any of the 25 measures required for Stage 1 MU. Be aware that the Complete EHR solution may consist of a variety of products, such as a drug database for ePrescribing or a third-party product for patient education. However, an advantage is that the solution was brought to the testing and certification table as a whole solution, not disparate pieces. On the other hand, an EHR Module has been tested and certified to meet some of the MU criteria. This means providers that purchase 2011 Edition EHR Modules will need to assemble parts and pieces to meet all 25 measures; and, these products are completely disparate, which means they may or may not integrate well. (Figure 3)

2014 Edition CEHRT and Base EHR Definition

Much has been learned in the first two years of MU, resulting in some welcomed policy changes, including the certification rules. On Aug. 23, 2012, CMS and the ONC released a rules set to govern MU Stage 2, available to EPs beginning in CY2014. The ONC rule creates the 2014 Edition S&CC.

Stage 2 MU builds upon Stage 1 by adding new requirements, changing old requirements, consolidating multiple Stage 1 measures into a single measure, and expanding Stage 1 measures’ scope and thresholds. To accommodate the new Stage 2 requirements, CEHRT will become more dynamic. The ONC has changed the definition of CEHRT to address provider-specific variability, recognizing, to quote a cliché, that every job is not a nail and every tool a hammer. As a result, CEHRT will vary by which core and menu MU objectives and measures a provider is seeking to achieve. All CEHRT will have to contain the “base” HITECH statutory EHR requirements (“Base EHR”). However, under the 2014 Edition, providers would only have to have additional technology for the Stage 1 or Stage 2 core and menu set objectives required by the EP. (Figure 4)
All providers will be required to adopt or purchase, not necessarily use, CEHRT that meets the federal definition of “Base EHR” regardless of type and/or specialty. Pulling directly from the HITECH statutory definition, for EPs a Base EHR is defined in the final rule for meeting 2014 Edition CEHRT as required under MU as an EHR on an individual that:

1. Includes patient demographic and clinical health information, such as medical history and problem lists;

2. Has the capacity to: provide clinical decision support; physician order entry; capture and query information relevant to health care quality; exchange health information with and integrate such information from other sources; and, protects the confidentiality, integrity and availability of health information stored and exchanged;

3. Has been certified to the certification criteria adopted by the Secretary of HHS (defined in rulemaking under the ONC); and,

4. Has been certified for no fewer than nine clinical quality measures (CQMs) covering at least three domains selected by CMS for EPs, including six CQMs from the recommended core set identified by CMS.

In sum, all EPs meeting MU until CY2014 will have to adopt and use 2011 Edition CEHRT; purchase CERHT that meets all Stage 1 Objectives and Measures regardless of whether the EP may exercise an exclusion clause and not use a specific component of the 2011 Edition CEHRT. As of CY2014, all EPs whether satisfying Stage 1 or Stage 2 MU will be required to adopt and use 2014 Edition CEHRT; purchase CEHRT that contains a Base EHR meeting all the statutory HITECH requirements, plus such additional core and menu Objectives required by and applicable to the EP’s given specialty area for his/her stage of MU.
Electronic Dental Record vs. CEHRT

Now that we understand the requirement of CEHRT for MU and its definition, let us explore how electronic dental record (EDR) technology fits into the equation. An EDR provides real-time data to the oral health professional and includes the ability to chart information including such details as procedures, diagnoses, notes, x-rays, periodontal charting, soft tissue findings, restorations and active oral health diseases. Essentially, oral health is an element of a patient’s longitudinal health record, particularly in efforts to provide holistic patient care.

A recent study published in the Journal of the American Dental Association shows a growing trend among U.S. dentists to incorporate EDR technology into their practices, as follows:7

![Figure 5. U.S. Electronic Dental Record Adoption Rates](image)

From 2004 to 2012, the number of dentists using chairside computing tripled from just 25 percent to 75 percent. Additionally, the small number of dentists deemed paperless in 2004, just 1.8 percent, has increased to 15 percent. With U.S. group practices slightly leading solo practitioners, the study also assessed the types of data being captured and stored with the following results:7

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Percent Stored in EDR</th>
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</thead>
<tbody>
<tr>
<td>Patient Appointment Information</td>
<td>85%</td>
</tr>
<tr>
<td>Treatment Plans</td>
<td>73%</td>
</tr>
<tr>
<td>Imaging Modalities</td>
<td>60%</td>
</tr>
<tr>
<td>Dental Status</td>
<td>57%</td>
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<tr>
<td>Medical History</td>
<td>40%</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>40%</td>
</tr>
<tr>
<td>Chief Complaint</td>
<td>37%</td>
</tr>
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</table>
Most dentists integrate practice management functionality such as billing with other practice needs including scheduling, insurance claim management, and financial reporting. Integrating the clinical-dental workflows into the CEHRT creates an extension of dental automation to include such solutions as case management support, patient communication and reminders, current medications and allergies, and patient care coordination with dental specialists, physicians and other ancillary providers. To facilitate integration, dental office systems must be compatible with medical office systems. However, the common information technology infrastructure that exists between physicians and hospitals is virtually non-existent in dentistry today. The problem is compounded with a lack of EHR to EDR interoperability standards in the industry.

If a CEHRT is a comprehensive, electronic record of the patient health information in any given care delivery setting, logic dictates that an EDR is a component part. Yet, it is by far the exception not the rule that an EDR is included in best-practices of patient health record automation. Understand that there are no ONC-certified EDR systems, only EDR systems that have integration models with commercial EHR systems approved by the ONC for the 2011 Edition certification. Why are there no truly certified EDRs? The policymaking for Stage 1 MU contained no dental-specific measures, only medical-specific measures. Therefore, an EDR must be included with a full EHR in order to be an ONC-recognized 2011 Edition CEHRT.

There are currently 2,933 ONC 2011 Edition Complete EHR products and EHR modules on the ONC website of Certified Health IT Product List (CHPL, pronounced “Chapel”). EHR vendors will begin testing and certifying against the 2014 Edition certification criteria this year in preparation for Stage 2 MU, which is available to EPs starting Jan. 1, 2014. As a result, the market will begin seeing 2014 Edition certified products in CY2013. Beginning this year, EPs will have the ability to use CEHRT that is certified to the 2011 Edition criteria, the 2014 Edition criteria, or a combination of 2011 and 2014 Edition criteria (E.g. EHR Modules) to generate a CMS EHR Certification ID, which is required to attest for MU.

Select certified EHR systems have partnered to be used in conjunction with an EDR to satisfy the definition of CEHRT 2011 Edition for Stage 1. For instance, MediaDent includes the SuccessEHS 6.1 EHR as an integrated solution and has been ONC 2011 Edition certified as a Complete EHR for dentists. However, dentists will need to evaluate how well an EDR integrates with its EHR solutions to accomplish a broader goal of seamless workflows and other necessary solutions.

For example, safety net dentists typically practice with physicians serving the underserved in community health centers. Federally qualified health centers (FQHCs) are under enormous pressure to report data to the federal government known as the Uniform Data Systems (UDS) reports. Dentists working in FQHCs would need to make sure that all UDS encounter information is consolidated into the medical system or EHR to simplify reporting by using a single database for data capture and avoid a manual process to consolidate UDS information. Recommended points of tight integration between an EDR and EHR should include, at a minimum:

- Patient demographics
- Patient health record information
- Scheduling
- Medications
- Medical history
• Encounter data
• Billing information
• UDS encounter information

This means that any change made in the EDR would need to result in a correlating change to automatically occur in the medical record and vice versa. For instance, clinical users would typically utilize the appointment book in the EHR practice management system. A tightly integrated EDR/EHR would automatically update the EDR scheduler with standards-based HL7 data known as a Scheduling Information Unsolicited (SIU) message so that any changes made would automatically update the EDR. Likewise, after treatment is completed, the encounter and transaction information from the EDR would need to automatically push to the medical software through a standards-based HL7 message known as a Detailed Financial Transaction.

Achieving Stage 1 Meaningful Use

The meaningful use programs will roll out in phases to promote and accelerate adoption of interoperable health IT over a number of years. Each phase of MU is called a “Stage.” Under the initial rulemaking process for Stage 1, CMS indicated there would be a total of three stages between the launch of the program in 2011 and 2015. Every EP will perform two years under each stage. There has been some limited indication that there may be a Stage 4, as well.

The law, HITECH, contemplated the full continuum of health care delivery, including oral health. However, the policymaking was quite narrow for Stage 1, being almost entirely focused on the primary care physician. As a result, Stage 1 MU contains no dental-specific measures, making it difficult for a dentist to figure out how to comply.

There are four marks to this transformative process:

1. **Adopt and use** Certified Electronic Health Record Technology (CEHRT)
2. **Capture data** in a structured format
3. **Move data** between disparate systems interoperably
4. **Report data** to the federal and state government

Regardless of the MU stage, each objective/measure can be categorized into one of the four marks. Under the Stage 1 final rule, each EP is asked to perform 15 Core measures and five of the 10 Menu measures for a defined period of time also known as the EHR Reporting Period. The first year of MU performance under the Medicaid MU program, an EP must perform these measures for a continuous 90-day period. The EHR Reporting Period is a full calendar year thereafter, except for CY2014 (see Medicaid Meaningful Use Incentives and Timelines above).
Be reminded that eligibility is determined anew for the dentist each year of participation. The dentist must first be a participating provider with his/her state Medicaid program. Additionally, the dentist must meet a minimum Medicaid patient volume threshold of 30 percent each year to qualify (see Medicaid Meaningful Use Program Eligibility above).

**Stage 1 Core and Menu Objectives and Measures**

The first year a dental EP seeks to perform Stage 1 MU, he/she will need to review the core and menu measures to determine the individual tasks required for a 90-day period. As stated above, there are a total of 25 objectives/measures initially identified for Stage 1 MU. However, in the Stage 2 final rule, CMS made several changes to Stage 1 for EPs beginning in CY2013, including the removal of the core measure requiring a test of exchanging key clinical information with another provider. Dentists need to be aware that effective in CY2014, the industry will be expected to move into production health information exchange. So, this change is not intended to eliminate work on interoperability. Additionally, the submission of Clinical Quality Measures (CQMs) has been eliminated as a formal measure and is now part of the definition of being a Meaningful User.

Included with the Stage 1 measures are 13 potential exclusion clauses. EPs who can exercise an exclusion clause would have a reduction in the number of measures required. The following table sets forth the 13 Core and 10 Menu Stage 1 Measures beginning in CY2013, as modified by CMS, with potential exclusions that may be exercised by a dental EP.

<table>
<thead>
<tr>
<th>No.</th>
<th>Objective-Measure</th>
<th>Threshold</th>
<th>Exclusion</th>
<th>Dental EPs Should Perform?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demographics: Record gender, race, ethnicity, DOB and preferred language</td>
<td>50%</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Vitals: Record Height, Weight, BP, BMI, and growth charts for children</td>
<td>50%</td>
<td>EP does not see patients age 3+; or, EP believes 1 or more vitals have no relevance to his/her scope of practice</td>
<td>No (BP may apply)</td>
</tr>
<tr>
<td>3</td>
<td>Problems: Up-to-date list maintained by having at least 1 entry as structured data</td>
<td>80%</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Medications: Up-to-date list maintained by having 1 or more entry as structured data</td>
<td>80%</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Meds. Allergies: Up-to-date list maintained by having 1 or more entry as structured data</td>
<td>80%</td>
<td>None</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Dental EPs must perform five of the 10 available menu objectives and cannot limit the selection of the five to those wherein an exclusion clause can be exercised. In other words, an EP cannot select a menu item simply because he/she can be excluded. Additionally, one of the five measures must be a public health objective. There are two public health measures with associated exclusion clauses: immunization data submission and electronic syndromic surveillance data submission.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Drug Formulary: Implement and access at least one drug formulary.</td>
<td>NA</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Lab Results: Incorporate as structured data – positive/negative or numeric – into the EHR</td>
<td>40%</td>
<td>EP orders no labs with +/- or numeric format during the EHR Reporting Period</td>
<td>Maybe</td>
</tr>
<tr>
<td>3</td>
<td>Lists of Patients: Generate a list of patients by condition for use in quality improvement, reduction of disparities, research or outreach.</td>
<td>1 List</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Patient Education: Provide patient-specific education resources to patients, as appropriate.</td>
<td>10%</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Medication Reconciliation: Perform medication reconciliation during transitions of care (TOC).</td>
<td>50% of TOCs</td>
<td>EP did not receive any transitions of care during the EHR Reporting Period.</td>
<td>Maybe</td>
</tr>
<tr>
<td>6</td>
<td>Summary of Care Record: Provide a summary of the care record for patients referred or transitioned to another provider or setting.</td>
<td>50%</td>
<td>EP neither transfers nor refers a patient during the EHR Reporting Period.</td>
<td>Maybe</td>
</tr>
<tr>
<td>7</td>
<td>Immunization Data Submission: Perform submission and follow-up submission of immunization Data to a Registry or Information Systems.</td>
<td>1 Test and Follow-up Submission</td>
<td>EP administers no immunizations during the EHR reporting period; or, no registry is available.</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>eSyndromic Surveillance Data Submission: Perform submission and follow-up submission of electronic syndromic surveillance data to public health agencies.</td>
<td>1 Test and Follow-up Submission</td>
<td>EP does not collect any reportable data during the EHR reporting period; or, electronic information cannot be received by public health agency.</td>
<td>Maybe</td>
</tr>
<tr>
<td>9</td>
<td>Patient Reminders: Send reminders for preventive and follow-up care for patients aged 65+ or age 5 and under.</td>
<td>20%</td>
<td>EP has no patients age 65+ or age 5 and under.</td>
<td>Maybe</td>
</tr>
<tr>
<td>10</td>
<td>Timely Electronic Access: Provide timely electronic access to health information including lab results, problem lists, medications lists, and medication allergies within 4 days of being updated in the EHR.</td>
<td>10%</td>
<td>EP neither orders nor creates labs, problem lists, Rx lists, and Rx allergy lists during the EHR Reporting Period.</td>
<td>Maybe</td>
</tr>
</tbody>
</table>
In Conclusion

Due to the sheer depth of the Meaningful Use program’s scope, this white paper is part one in a two-part series. Readers are encouraged to continue their study of program participation by accessing the complementary second part of the white paper at http://info.successehs.com/mediadent-white-papers. Part two covers clinical quality measures, Stage 2 Meaningful Use, and the logistics of EDR-EHR integration.

There are undoubtedly challenges faced by a number of providers as they attempt to comply with this and other federal programs. The law contemplates moving the full continuum of care into digital, interoperable automation, but the policymaking for Stage 1 is somewhat myopic leaving many specialists, dentists and other types of health care professions struggling to embrace and succeed with this initiative.

Be aware that there is recognition of the policymaking gap by CMS and future rulemaking will continue to close this gap. We have seen limited steps in this regard between the final rules for Stages 1 and 2. Drafts for Stage 3 rulemaking are already underway, with anticipated launch for availability being January 2015. Let us hope CMS continues towards a holistic view of patient care in their leadership role.
References


8. MediaDent IX, including SuccessEHS 6.1 EHR, was certified as a Complete EHR on July 10, 2012 by the Certification Commission for Health Information Technology (CCHIT®), an ONC-ATCB, in accordance with the applicable certification criteria for Eligible Providers adopted by the Secretary of Health and Human Services. The certification ID number is CC-1112-909422-2. The clinical quality measures certified include: NQF 0421, NQF 0013, NQF 0028, NQF 0041, NQF 0024, NQF 0038, NQF 0043, NQF 0031, and NQF 0034. The additional software MediaDent IX relied upon to demonstrate compliance includes SuccessEHS 6.1. This certification neither represents an endorsement by the U.S. Department of Health and Human Services nor guarantees the receipt of incentive payments.
For more information on how SuccessEHS can help your dental practice achieve Meaningful Use with the certified MediaDent solution, contact us at 888.879.7302 or visit www.mediadentusa.com.