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Digital Dilemma: Physicians oppose EHR requirements

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by Geri Aston

The federal government's proposed rule establishing incentive payments for physicians who "meaningfully use" electronic health records (EHRs) is too onerous and would discourage physicians from participating, some otolaryngologists say.

"The idea of having physician's offices and medicine brought into the electronic age is very noble and worthy," said Howard Kotler, MD, clinical assistant professor of otolaryngology/head and neck surgery at the University of Illinois College of Medicine in Chicago. He added, however, that the proposed rule would "make it impossible to get the payments. It will further alienate physicians from the government and vice versa. And it will do nothing to improve quality of care, and that's the key thing."

"Meaningful Use" Defined

The rule includes 25 meaningful use criteria for physicians to report in order to qualify for incentive payments, which are available starting in 2011. Beginning in 2015, physicians who do not meet the meaningful use criteria will not receive full payment for their Medicare professional services.

The number of criteria is too high, the thresholds established to meet them are often too tough and the timeframe to get payment in the first year is too short, otolaryngologists interviewed by *ENT Today* said. The American Medical Association (AMA) agreed with this assessment in its March 15 letter to the Centers for Medicare & Medicaid Services (CMS). The proposed meaningful use criteria are "too aggressive" and, if adopted, would deter many physicians from participating in the incentive program, the letter states.

The proposed regulation, which would implement part of the American Recovery and Reinvestment Act of 2009, would require physicians to provide patients with clinical summaries of their office visits. To meet the measure, doctors would have to provide these summaries for at least 80 percent of all office visits.

"That sounds fantastic, but how about operationalizing it?" said Rahul Shah, MD, FACS, FAAP, assistant professor of otolaryngology and pediatrics at the George Washington University School of Medicine and Health Sciences and attending physician in the department of otolaryngology at Children's National Medical Center in Washington, D.C. The 80 percent threshold and other targets seem pulled out of thin air, he said: "It feels like we're being set up to fail on something that sounds attractive to the average consumer."

The AMA letter notes that it might not be practical or necessary for physicians to give every patient a summary at the end of each visit. According to the association, doctors and patients are in the best position to decide what records are needed and when.

How Much Will You Get?

The size of your incentive payment will vary depending on whether you participate in the Medicare or Medicaid arm of the program, whether you are in a health professional shortage area (HPSA) and what year you begin participation. Here is the maximum possible amount over the entire course of the incentive program, listed by the first year of incentive payment.

	2011	2012	2013	2014	2015	2016
Medicare physician, general	\$44,000	\$44,000	\$39,000	\$24,000	\$0	\$0
Medicare physician, HPSA	\$48,400	\$48,400	\$42,900	\$26,400	\$0	\$0
Medicaid physician	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

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Another problem is that many of the meaningful use criteria don't apply to what specialists do on a day-to-day basis, said Dr. Kotler, past chairman of the Medical Informatics Committee of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS). For example, the proposal would require physicians to record changes in blood pressure and body mass index (BMI) for 80 percent of patients, as well as plot growth charts for children aged two to 20.

In addition, physicians would have to report both core clinical measures and measures in a defined specialty group. Otolaryngology is not among the 15 specialty groups, which include primary care and proceduralist/surgeon. The specialty measures don't mesh with what otolaryngologists do in their practices, Dr. Kotler said.

The AMA recommends that the core measures be dissolved and moved to the primary care specialty measures group and that the rule then be changed to allow doctors to attest that they are using at least three clinically relevant quality measures. According to the organization, if three clinically relevant measures cannot be identified among the specialty groups, physicians should be able to attest that zero, one or two measures are applicable.

The proposed regulation also requires physicians to be able to communicate electronically with others. At least 75 percent of all permissible prescriptions written by a physician would have to be transmitted electronically using certified EHR technology. But not all pharmacies have electronic systems to receive e-prescriptions, noted Dr. Kotler and the AMA.

The burden of meeting the meaningful use criteria is another concern. One major problem is that the interim final regulation for federal certification of EHRs doesn't require that the software be designed in a way that allows physicians to meet the meaningful use criteria, Dr. Kotler said. If a physician's EHR doesn't have a function to automatically pull out patients' BMI data, for example, the doctor or a staff member would have to go through EHRs and manually extract that data to meet the meaningful use criteria, Dr. Kotler explained. "It would be so much better and more efficient if you could literally click a button on your EHR, and it would extract that information out in the format that CMS wants, and then just send it to them electronically," he said. "But no vendors have that functionality yet."

Incentive Payments

The rule sets out two incentive programs for meaningful EHR users, one for physicians participating in Medicare and the other for physicians who meet a Medicaid patient threshold, generally 30 percent of patient volume. On the surface, the payments appear reasonable, Dr. Kotler said. But considering that implementing an EHR is more than just buying and installing software, the payment size falls short, he said, explaining that after installation, physician practices can't handle their normal patient load for up to six months while the staff gets up to speed.

Physicians in the Medicare incentive program who meet the criteria in the first or second year could receive a maximum of \$44,000 over the course of the project. The figure is higher for those in health professional shortage areas and for those participating in the Medicaid incentive program. The regulation estimates the average cost of adopting, implementing or upgrading an EHR at \$54,000 per full-time physician, with an additional \$10,000 per doctor in annual maintenance costs.

The payment incentive "is better than nothing, but it still doesn't really address the true dollar amount that comes with implementing health information technology," Dr. Kotler said.

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