# EHR 2014: Highlights of the Proposed Stage 2 Certification Rule



By Kevin Heubusch

In March, the Office of the National Coordinator for Health IT published a proposed rule on EHR certification, a companion to the proposed rule on stage 2 of the meaningful use EHR incentive program that was published on the same day by the Centers for Medicare and Medicaid Services.

ONC's rule defines the technology standards and implementation specifications that will support the new and revised objectives and measures for stages 1 and 2 of the meaningful use program. Effective 2014, EHR technology must be certified against these criteria to be used in the program. The rule also proposes a change to the definition of a "qualified" EHR, which will allow providers more flexibility in the scope of the systems they implement.

Comments on the rule are due May 7. ONC will then prepare a final rule, again in tandem with a final rule on stage 2 from CMS. Final rules are possible this summer.

## Classifications and Terminologies

ONC proposes the use of SNOMED CT in support of several meaningful use objectives, including problems lists. The International Release January 2012 version would be required.

SNOMED would also support other objectives related to patient access to information, cancer registry and public health reporting, and transition of care.

ICD-10-CM/PCS would be used for encounter diagnoses and procedures.

Just two weeks before ONC released its rule, however, the Department of Health and Human Services announced its intention to delay ICD-10 implementation past October 1, 2013. In response, ONC requests industry comment on whether it should be "more flexible" with the proposed requirement based on "any potential extension of the ICD-10 compliance deadline or possible delayed enforcement approach."

Further, ONC asks whether it would be more appropriate to require EHR technology to be certified to a subset of ICD-10, to either ICD-9 or ICD-10, or to both ICD-9 and ICD-10 for encounter diagnoses and procedures.

For procedures, ONC would continue to permit a choice for EHR technology certification-either ICD-10-PCS or the combination of HCPCS and CPT-4. Preliminary cause of death would be reported using ICD-10-CM in order to take advantage of the increased specificity the code set provides.

LOINC 2.38 would be required laboratory tests, and RxNorm would be used for medications.

The Consolidated Clinical Document Architecture (CDA) standard is the only recommended standard for summary transactions.

## Stepping Up Security

The new security criteria in the rule reflect the increased security requirements of CMS's rule, including a requirement that systems encrypt data at rest.

New requirements also reflect updated patient engagement objectives, including a "patient accessible log" to track use of the view, download, and transmit capabilities. Beginning in 2014, systems would be required to record a user's identification and actions in addition to the health information viewed, downloaded, or transmitted. This information would then be made available to the patient.

## Support for Patient Access

In response to new patient engagement objectives, EHR technology would be required to support a patient's ability to view, download, and transmit his or her information to a third party. Transport standards include two specifications that were developed under ONC's Direct Project, which enables direct, provider-to-provider exchange of information.

Systems must be capable of generating patient summaries, and in ambulatory settings, systems must enable secure messaging with providers.

## A Shift to "Base EHRs" in 2014

ONC also proposes changes to its definition of a "qualified" EHR, intended to give providers more flexibility.

In response to feedback, ONC would allow professionals and hospitals the ability to implement only the EHR technology that they need to demonstrate meaningful use.

Under the current definition, program participants must have EHR technology that has been tested and certified to all applicable certification criteria adopted for the setting for which it was designed. Thus, for example, an eligible professional who qualifies for an exclusion of an objective and associated measure still must have EHR technology that supports the capability.

Effective 2014, ONC's rule would require professionals and hospitals to possess a "base EHR" to support universal fundamental capabilities. They would then require any additional technology necessary to meet the program objectives and measures for the applicable stage of meaningful use, and the technology needed to capture and report clinical quality measures.

The revised definition reads: "All EPs, EHs, and CAHs must have EHR technology (including a Base EHR) that has been certified to the 2014 Edition EHR certification criteria that would support the objectives and measures, and their ability to successfully report the CQMs, for the MU stage that they seek to achieve."

## Infobutton, Please

Underpinning the objectives related to clinical decision support and patient-specific education resources, ONC proposes the use of the HL7 Context-Aware Knowledge Retrieval Standard, International Normative Edition 2010-or "Infobutton."

The Infobutton standard has been in active use for several years, ONC notes, and many reference content vendors provide their products using the standard. Providers are increasingly using Infobutton to identify and provide patient-specific education resources.

## Accounting of Disclosures

Among a set of "additional" comments that ONC requests are questions related to an EHR's ability to support accounting of disclosures.

ONC's 2011 certification criteria include an optional accounting of disclosure certification criteria, requiring EHR technology be capable of electronically recording disclosures made for treatment, payment, and healthcare operations. Systems must record date, time, patient identification, user identification, and a description of the disclosure.

ONC proposes adopting the same criterion as optional in the 2014 edition, but it requests comments on whether the criteria should be made mandatory and if they should be revised to better reflect the proposed modifications to accounting of

disclosure made by the Office for Civil Rights, which were published after ONC's stage 1 certification rule.

As with ICD-10, ONC is challenged in the timing of its rule: comments are due May 7, and at press time the final rule on accounting of disclosure modifications was filed for review by the Office of Management and Budget- the final step before publication.

## Reference

Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. "Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology." March 7, 2012. www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4430.pdf.

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