

**September 15, 2010**

**Submitted to the Centers for Medicare and Medicaid Services  
And the Office of the National Coordinator/HHS**

**Questions Regarding Meaningful Use under the EHR Incentive Program**

1. Are there any requirements or limitations on physicians' assigning their stimulus payment to hospitals or health systems that may have provided them 85% or less of the required funding for an EMR through the Stark relaxation provisions?
2. In an ambulatory group practice, a patient encounter can span a period of several days. The patient may often be seen by several physicians during that time. Will one summary at the end of that entire patient encounter satisfy the rule, or do we need to have a summary for each physician, produced each day?
3. For "Exchange Clinical Information," would an HL7 lab result interfaced from the hospital lab system to a physician EMR qualify if it was distinct EHR technology and a different legal entity? If not, what are the required data types and elements that must be a part of the clinical information exchange? Must both systems be certified to meet the requirements?
4. Would providers who have deployed an integrated set of applications (i.e., Epic) among all components of their delivery system (physicians and hospitals) be eligible to qualify for the health exchange measure? For instance, if one is running a vendor's Inpatient EHR and Ambulatory EMR both of which have their own licensing fees but share a common technology platform, would the data exchange between the two qualify as a health exchange?
5. If two legally separate physicians have each deployed the same vendor's ambulatory EMR hosted by the same outsourced firm, could they meet the requirement for a Core Health Information Exchange if the outsourcer/host used the EMR vendor's common enterprise exchange platform to do so?
6. The Meaningful Use measures apply to unique inpatient hospital admissions or emergency department visits where EHR technology is used. Does the "or" represent the option to choose, for example, to do 30 % CPOE for inpatient admissions only or do 30 % for ED visits only or does it mean you must do 30% CPOE for the combined population of inpatients and ED patients?
7. Would prescriptions written by physicians at the time of hospital discharge be considered a medication order under the CPOE requirement if done through e-prescribing?

8. There is still lack of clarity as to the process for providers to ensure certification for all required systems and modules. It is assumed that there will be a list published by CMS of all modules needed for certification and the vendors and products that have been certified to deliver each, including specificity about whether the module is part of a bundled or complete EHR system.

9. There is lack of clarity as to what constitutes a module or function that needs to be certified. For example, if a laboratory system receives orders and returns structured results through an interface to and from a certified EHR product, does the laboratory system need to be certified? What about the interfaces and interface engine?

10. In regard to certification and the ED metrics, there are questions from providers who have different EHR products for ED and inpatient care. This is a fairly common scenario. Since measures and quality metrics require numerators and denominators, adding inpatient and ED unique visits together will be difficult, if not impossible for either product alone to produce the metrics. As a practical matter to overcome this deficiency, metrics may have to be calculated via data extract and compilation routines. How would such a site achieve certification?

11. We assume when a patient asks for an electronic copy of their records or discharge summary that the time clock for compliance begins when the record is complete. It is impractical to assume that the entire record will be complete at the moment the patient is discharged. Many reports are dictated post-discharge, and many lab test results are not available upon discharge. Does the clock actually start when the EH or EP has completed the chart by assembling all missing elements or at discharge?

12. Regarding CMS Answer ID: 10071. Please elaborate as there is still confusion. Specifically, if a pharmacist or nurse is electronically entering orders that are written down on an order sheet or made verbally by physician, would that count as provider order entry?

13. In regard to the Stage 1 measure of CPOE use, if physicians are not using certified EHR technology to enter data or document the emergency department's (ED) visits, can one exclude ED visits from the denominator? What if clerical and nursing staff are using certified EHR technology to place orders to ancillary services and physicians look up the results on the system, can we still exclude ED visits?

14. Many providers use quality gathering and reporting systems that extract data from EHRs, allow manual entry of data abstracted from physician notes and other dictated reports to compile and report quality metrics. Many of these metrics are the same quality measures required for meaningful use. Can quality data gathering and reporting systems of this nature get certified for quality reporting? Can data abstractors enter data directly into these systems?