



March 15, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-0033-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program

Dear Acting Administrator Frizzera:

The American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE), representing virtually all of the more than 17,000 gastroenterologists in the United States, appreciate the opportunity to submit written comments on HHS' proposed rule entitled, *Medicare and Medicaid Programs; Electronic Health Record Incentive Program* [CMS-0033-P] that was posted in the *Federal Register* on Jan.13, 2010. The gastroenterology (GI) societies have also provided separate comments on the companion interim final rule (IFR) published by the Office of the National Coordinator on Health Information Technology (ONCHIT) on meaningful use entitled, *Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology*. Our societies have enlisted extensive input from our members and relevant clinical and quality committees whose expertise deems them capable of commenting on this proposed rule.

This proposed rule provides many areas for potential comment; therefore, we are focusing on the top issues of concern to our specialty. In presenting our top issues, we strongly support moving forward on the development of a Nationwide Health Information Network that includes the maximum participation by all clinician categories and health care delivery settings. The challenge will be to ensure all providers will be able to achieve the meaningful use requirements. Our societies support the adoption of electronic health records (EHRs) by practicing physicians/clinicians. Improvements in quality of care for all patients can only occur if as many providers as possible utilize

EHRs that effectively support clinical practice and if they participate in related incentive programs.

Definition of Reporting Period

The proposed rule defines the reporting period for the first payment year for eligible professionals as any continuous 90-day period within the payment year in which the eligible professional demonstrates meaningful use. We believe that this proposed reporting period is reasonable given the complexity of the proposed meaningful use requirements and because it will likely be difficult for physicians to be compliant with the meaningful use requirements if the reporting period was to begin on Jan. 1, 2011.

Recommendation: The GI societies believe that flexibility with the reporting period also may be necessary throughout Stage 1 and for the first reporting year following updates to the meaningful use criteria. At a minimum, we agree with the recommendation conveyed to CMS by the HIT Policy Committee on Feb. 17, 2010. The committee recommendation stated that CMS should advance its timetable for the release of future notices of proposed rule-making on meaningful use in order to allow adequate ramp-up time for EHR vendors and eligible professionals.

Determining Eligible Professional Eligibility

In the proposed rule, CMS states that it believes that an eligible professional (EP) has control over the EHR technology available in the setting in which they see the greatest proportion of their patients. Therefore, CMS is proposing that to be a meaningful EHR user an EP must have 50 percent or more of his/her patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. An EP who does not conduct 50 percent of his/her patient encounters in any one practice/location would have to meet the 50 percent threshold through a combination of practices/locations.

Unlike primary care physicians, gastroenterologists provide care and services in a variety of settings. It is not uncommon for a gastroenterologist to spend four hours in an ambulatory surgical center (ASC) performing diagnostic, screening and interventional endoscopic procedures and then to go to his/her office to conduct several visits. That same provider may then go to the hospital the next morning to perform procedures and examine patients. **Because ASCs are not included in the proposed rule as an entity eligible for the EHR incentive payment, it leaves open the question of what the meaningful use obligations will be for gastroenterologists who are treating patients in the ASC setting.** We believe it will be extremely difficult for the majority of gastroenterologists to meet the requirements of meaningful use, as proposed, even if they implement a certified EHR in their office practices, since only approximately 30 percent of the total services provided by gastroenterologists are provided in the office setting.

Gastroenterologists tend to have a high percentage of Medicare patients in their practices. Commonly performed procedures are listed below with the percent of procedures performed in the ASC setting for Medicare beneficiaries.

43235 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*) 18 percent;
43239 (*Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple*) 29 percent;
45378 (*Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)*) 30 percent;
45380 (*Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple*) 36 percent;
45385 (*Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*) 37 percent;
G0105 (*Colorectal cancer screening; colonoscopy on individual at high risk*) 42 percent;
G0121 (*Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*) 37 percent.

Recommendation: Because an ASC is not an eligible entity under the proposed rule and therefore not expected to maintain a comprehensive certified EHR, the GI societies recommend that procedures performed in the ASC site of service be exempt when determining whether an eligible professional has met the 50 percent or more threshold of his/her patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology.

Definition of Eligible Professional

In the proposed rule, CMS states that hospital-based professionals are not eligible for the Medicare incentive payments, nor would the majority of hospital-based professionals be eligible for Medicaid incentive payments except for those practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

CMS proposes to define hospital-based EPs as those who furnish at least 90 percent of Medicare-covered professional services in a hospital setting, regardless of whether they are inpatient, outpatient or emergency department services. CMS would determine non-eligibility based upon place of service (POS) codes. We are concerned that the proposed rule will have a limiting effect on eligible providers working in a hospital outpatient clinic setting from participating in the EHR incentive payment programs and believe that CMS may have inadvertently narrowed the scope of the legislation by using POS codes to determine incentive eligibility.

The GI societies are concerned about this proposed definition and its impact on physicians who provide services in a hospital-based setting but who have paid for or are maintaining their own EHR systems. It is essential that a physician who practices in a group that is owned by a hospital, but is not a hospitalist, anesthesiologist, emergency room, pathologist or other hospital-based physician, is an eligible professional for purposes of the incentive payments if the hospital is not providing the EHR system.

We are concerned that CMS did not follow congressional intent under this proposed rule. Congress' intention was to not provide EHR bonus payments to "hospital-based eligible professionals" or physicians who furnish substantially all of their services in a hospital setting since the hospital would be providing, paying for and maintaining the EHR system. It is our understanding that Section 4101(a)(C)(ii) of the American Recovery and Reinvestment Act (ARRA, P.L. 11-5), as well as the ARRA Conference Report, provide the intent of this law and clearly excludes provider-based entity physicians who are providing ambulatory care services from the term "hospital-based eligible professionals." Section 4101(a)(C)(ii) states that "the determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider." In addition, the conference agreement language does not disqualify otherwise eligible professionals from receiving bonus payments merely on the basis of some association or business relationship with a hospital.

Recommendation: The GI societies request that CMS revisit the congressional intent of the definition of an eligible professional and not disqualify from receiving an incentive payment those EPs who have invested in an EHR, specifically those providing services in an ambulatory or outpatient setting.

Stage 1 Criteria

We believe that the CMS timeline for EHR meaningful use is overly aggressive given that CMS has proposed 25 measures that would need to be met for Stage 1 meaningful use. We believe that the proposed timeline coupled with the complexity of the Stage 1 meaningful use requirements will actually serve as a deterrent to EHR adoption by eligible professionals, particularly those in small- and medium-sized practices. We are particularly troubled that compliance with some of the meaningful use criteria fall outside the direct control of physicians. Our societies urge CMS to ensure that those EPs attempting to satisfy "meaningful use" requirements not be excluded from the incentive program because electronic interface is not possible with other parties or entities with whom they must exchange data. Many objectives presume that another entity has the technological functionality to submit patient data to an EP or has the capability to receive data from the EP. For example, an EP must generate and transmit 75 percent of all permissible prescriptions electronically. However, unless a fax satisfies this requirement (note: in the e-prescribing rule, FAXs are not considered electronic

transactions), CMS presumes that any pharmacy has the ability to accept the prescriptions electronically. Also, what should an EP do when a patient refuses to complete forms or otherwise convey information regarding ethnicity or some other required-demographic? CMS must ensure that an EP trying to satisfy each criterion is not excluded from the incentive program due to the behavior of others.

While we agree with CMS' staged approach to achieving meaningful use EHRs, we do not support proceeding with the all-or-nothing approach proposed for earning an incentive payment. We believe that Stage 1 needs to better account for differences in practice size, specialty, and practice locations, especially during the early transition years.

Recommendation: When deeming an EP as a "meaningful user," CMS should focus on health IT capability of both parties to an electronic transaction for those criteria in which an EP is dependent upon the actions or health IT functionality of others.

Although CMS' objective is to increase and incentivize the meaningful use of health information technology (IT), the current state of EHRs in the United States and certification standards for EHRs clearly remain in the developmental stages. Concurrent with this proposed rule, the ONCHIT's IFR sets forth the health IT functionality required in order for a complete EHR or EHR module to become a "certified" product. Our societies are concerned about the timelines of CMS' proposed rule when there is a lack of maturity of the standards and processes for which HHS will certify health IT products. For example, the IFR released by ONCHIT is still open for public comment and the ONCHIT has been able to identify few implementation specifications in use today for various EHR standards. This means that CMS is developing an incentive program and provider reporting measures while its agency counterpart, ONCHIT, is still in the process of developing health IT standards and certifying bodies. While the societies agree that the standards and certification process are established pursuant to the IFR, it is far from being operational or finalized. This is putting the cart before the horse.

It is important to note that, today, less than seven months before eligible hospitals or EPs may begin receiving incentive payments, we are still waiting to determine which products meet meaningful use criteria under the IFR. There are also many physicians who have already invested a substantial amount of money in health IT systems. Providers who have embraced health IT to improve patient quality may indirectly be punished if they were not lucky enough to have chosen the correct EHR. In order to be deemed an EP, these providers must purchase modules or upgrades, requiring even more money. There must be a clear understanding of the products, costs, functionality, and certification process before providers commit more financial resources to buy or upgrade and EHR system. The fact that CMS does not have the means to receive the clinical quality reporting requirements for the Medicare incentive program in 2011, and

instead will require EP's to self-attest only adds to our memberships' concern that CMS is moving forward with health IT requirements before the certification and processing foundation for the program is intact. What's more, their practices will be faced with a payment adjustment in 2015 if they do not invest in this soon-to-be certified technology. There should be some financial recognition or "meaningful use" leeway for those providers who were early investors in health IT for the good of their patients and practices.

Recommendation: The GI societies strongly encourage CMS to provide physicians with more flexibility for achieving meaningful use. A possible solution could be to scale back the number of meaningful use objectives for Stage 1 to those that are most attainable and would impose a minimal administrative burden on eligible professionals, but would begin to advance the goal of widespread meaningful use of EHRs.

Once the certification process is intact and EP's adopt, implement, and upgrade to certified EHRs, we believe these core measures could include the following:

- Implement drug-drug, drug-allergy, and drug formulary checks.
- Maintain active medication list.
- Maintain active allergy list.
- Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT.
- Send specialty-specific reminders to patients requiring preventive/follow-up care.
- Generate and transmit permissible prescriptions electronically.
- Record patient demographics when available.
- Record and chart changes in vital signs and mass body index.
- Record smoking status.
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.
- Protect electronic health information created or maintained using certified EHR technology through the implementation of appropriate technical capabilities.

EP Objective 1: Use computerized provider order entry to directly enter medical orders from a computer or mobile device

CMS seeks comment on its EP objective requiring the use of computerized provider order entry (CPOE) for at least 80 percent of all patient orders and its percentage-based formula used measure this objective. As stated in the proposed rule, success will be based on a percentage, where the numerator is "orders issued by the EP using CPOE functionality of certified EHR technology" during the reporting period. The denominator is "all orders issued by the EP" during the reporting period.

For CPOE to occur, EHR interface is needed between systems, such as hospital and freestanding clinical and anatomic pathology laboratories, ASCs and independent diagnostic testing facilities (IDTFs). While electronic exchange is not required for Stage 1, with the exception of electronic prescribing, entering the order electronically through CPOE would then need to be followed up with a manual process involving a paper form. Because the expected administrative burden, we are concerned that it is unreasonable to expect EPs to achieve 80 percent compliance, whereas hospitals only have to be compliant with 10 percent.

Recommendation: Rather than suggesting that the 80 percent threshold be lowered to some lower percentage for Stage 1, we recommend that EPs can meet this measure by attesting they have performed at least one test of certified EHR technology's capacity to conduct CPOE.

The societies also appreciate the opportunity to comment on how CMS will define successful completion of this objective. **We contend that CMS allow for the reporting of hard numbers and not have to meet specific percentages.** However, should CMS decide to use a percentage, **we request that CMS revamp the numerator and denominator to the percentage of patients for which CPOE was used compared to all other patients and not by the percentage of orders CPOE was used versus all other orders.** Our societies are unclear as to how CMS is defining "all other orders." Secondly, since the goals of the proposed rule are to incentivize providers to invest in and use health IT, CMS must make every effort to ensure that providers can actually extrapolate and report the desired data back to CMS. If the denominator is the total numbers of patients seen (all patient groups) and the numerator is the number of times CPOE was used, then CMS would still achieve its goal of having providers use CPOE and providers would have a clear understanding of what they need to report to CMS.

Recommendation: The societies also request that if CMS moves forward with a percentage-base criteria for the CPOE measure, it revise the numerator and denominator in determining whether an EP has successfully completed the objective by using the percentage of patients for whom CPOE is used rather than the percent of orders for which CPOE is used.

EP Objective 10: Incorporate Clinical Lab-Test Results into the EHRs as Structured Data

Stage 1 meaningful use requires the incorporation of clinical laboratory test results into an EHR as structured data. The functionality measure for this requirement is that at least 50 percent of clinical laboratory test results are incorporated in certified EHR technology as structured data.

In the proposed rule, CMS acknowledges that this objective is reliant on the electronic exchange of information and that the infrastructure necessary to support such exchange

is still being developed. In instances where the laboratory cannot interface with an EHR, we do not believe that those physicians should be disqualified from earning the incentive payment, nor should they be required to enter laboratory test results manually into their patients' EHRs to meet the objective. In the proposed rule, CMS notes that it believes that 80 percent compliance is too high a threshold for the Stage 1 criteria of meaningful use and solicited comment on whether the 50 percent threshold is feasible.

Recommendation: We do not believe it is a matter of the threshold being set too low or too high. We simply believe that physicians should not be required to meet objectives for which they lack control and for which the current infrastructure does not support. Therefore, this measure as proposed should not be included in Stage 1.

We believe CMS also fails to acknowledge the cost of purchasing a laboratory interface and the fact that easily implemented standards do not exist for electronic test ordering and transmittal of results. Furthermore, a laboratory may choose to not support an interface with a low-volume customer. **Physicians should choose to enter into contractual relationships with laboratories because they are reliable and deliver high quality services.** As proposed, this measure could force physicians to choose laboratories based on cost and capability of EHR interface.

EP Objective 12: Reporting Clinical Quality Measures and Proposed Clinical Quality Measures

Stage 1 Criteria

For 2011, CMS states in the proposed rule that it is unlikely to have the capacity to receive information electronically on clinical quality measures from EHRs. CMS therefore proposes that eligible professionals use attestation to submit summary information to CMS on clinical quality measures as a condition of demonstrating meaningful use of certified EHR technology. CMS expects it will be able to receive clinical quality measures electronically beginning in 2012, and proposes that eligible professionals submit information on clinical quality measures electronically at that time. CMS invites comment on whether it may be appropriate to defer some or all clinical quality reporting until the 2012 payment year. CMS further asks that if reporting on some but not all measures in 2011 is feasible, then which key measures should be chosen for 2011 and which should be deferred until 2012 and why.

We believe that the capturing and submission of clinical quality data through EHRs are laudable goals; however, we believe that the timeline proposed by CMS may be too aggressive for some specialties. What CMS is proposing is the creation of an entirely new quality reporting program for which the technical infrastructure does not currently exist across the physician community. First and foremost, as CMS acknowledges, electronic specifications currently exist for only nine of the 90 proposed clinical measures and the timeline for when electronic specifications will be available for the full complement of measures remains uncertain. Secondly, we believe that until CMS is

prepared to receive clinical quality data electronically, the interim attestation requirement as proposed would be administratively burdensome. Many of the Physician Quality Reporting Initiative (PQRI) measures on which physicians are currently reporting are not proposed for the EHR incentive program and, therefore, may not be in the queue for the development of electronic specifications. It is possible that at least for Stage 1 as proposed, physicians will be reporting on different measures through two different incentive programs, which we believe is unnecessarily burdensome.

We appreciate the acknowledgement by CMS in the proposed rule that in 2012 the reporting of clinical quality measures by eligible professionals could occur by submission through registries “dependent upon the development of the necessary capacity and infrastructure to do so using certified EHRs.” We believe that sufficient time will be necessary to develop and test specialty-specific measures for electronic submission.

We encourage CMS to consider allowing eligible professionals for 2011 to satisfy the clinical quality data reporting measure by attesting participation in a data registry or an established quality reporting program such as the PQRI. We believe because physicians are still having difficulty meeting the PQRI reporting thresholds, it would be incumbent upon CMS to infuse some flexibility in the PQRI reporting requirements before establishing *successful* PQRI reporting as a way to satisfactorily meet the EHR meaningful use clinical quality reporting measure.

For clinical quality reporting in Stage 2 and beyond, the GI societies are supportive of CMS’ proposal that clinical quality measures be reported on all applicable patients, both Medicare and non-Medicare. We believe that infusing quality reporting into physician practice patterns is important for all patients, regardless of payer. As an example, the Bridges to Excellence Physician Office Link (POL) program is focused on promoting the office practice’s use of information systems to enhance the quality of patient care. Office practice sites that implement specific processes to reduce errors and increase quality can earn an incentive for each patient covered by a participating health plan and/or employer. In addition, the National Committee for Quality Assurance Physician Practice Connections® (PPC®) recognizes practices that use systematic processes and information technology to enhance the quality of patient care. A practice that meets PPC® standards is one that has established connections to information, patients and other providers.

Clinical Quality Measures

We agree with CMS’ preference to include clinical quality measures that have been adopted by the National Quality Forum (NQF) for use in the PQRI program but, at the same time, allow measures to be included that are not currently NQF endorsed but may be appropriate for the EHR incentive program. This flexibility is important since it will broaden the pool of measures available for specialists. Given that specialties are at

different stages of measure development and the timeframe required for measures to be considered for endorsement by NQF, we support this measure inclusion criteria.

We further agree with CMS' statement that it is the role of the clinical quality measure owner, developer, or maintainer to make basic changes to a clinical quality measure in terms of the numerator, denominator, and exclusions.

We recommend that the quality data specifications need to be consistent and harmonized across all programs, governmental and commercial, in order to minimize the reporting burden on eligible providers and EHR vendors. We also recommend that changes in technical requirements over time, such as adoption of ICD-10, will need to be integrated into certification criteria and EHR products without creating heavy financial and administrative burden on practices.

In the proposed rule, CMS is soliciting comments on the inclusion of clinical quality measures for 2013 and beyond for the Medicare and Medicaid incentive program, based on Stage 2 and Stage 3 meaningful use criteria. In addition to specific measures, CMS welcomes comment on clinical quality measure topics. CMS proposes that each EP will need to submit information on two measure groups – a set of core measures as applicable for their patients and a set of specialty group measures specified in the rule.

With regard to the core measures chosen by CMS, we note that inquiries regarding tobacco use and drugs to be avoided in the elderly, may not be applicable to practices that see pediatric populations. Given the increasing incidence and the health consequences of obesity, we suggest that NQF 0024, Body Mass Index (BMI) 2 through 18 years of age, be considered as a core measure, and that the core measure group should be relaxed to allow the EP to be required to report on a minimum of two core measures in Stage 2.

As gastroenterology encompasses subspecialties, including nutrition and hepatology, we are concerned that the gastroenterology specialty measure set, as proposed, would not be applicable for many gastroenterologists who do not routinely see patients with hepatitis C.

Recommendation: We recommend that CMS not implement its proposal of narrowing down the measures specified on the proposed rule to 3-5 measures. Rather, we recommend for 2013 that CMS allow PQRI 128/NQF 0421, Preventive Care and Screening, Body Mass Index to count as a GI specialty measure. We also recommend that CMS retain all of the measures included in the proposed rule (Tables 5-19, pages 1891-1895) and require two measures to be reported, allowing the physician to choose which two measures to report.

EP Objective 13: Send reminders to patients per patient preference for preventive care or follow-up care

To be deemed a successful “meaningful user” of health IT pursuant to this proposed rule, an EP must send a reminder to at least 50 percent of all unique patients seen by the EP that are 50 years or older. CMS proposes that successful completion of this objective is based on a percentage, comparing the number of unique patients age 50 or older who were provided reminders versus the number of unique patients seen by the EP during a reporting period.

Recommendation: The GI societies believe that this objective needs to be specialty specific. Many unique patients that see our physicians do not require a follow-up. As such, our societies recommend that CMS revise this objective to have an EP demonstrate that 50 percent of unique patients requiring follow-up for a condition in that specialty receive a reminder. Also, we urge CMS to clarify what would constitute a “reminder” and how EPs would satisfy HIPPA requirements when sending these reminders to patients.

EP Objective 17: Providing patients with an electronic copy of their records within 48 hours of the information being available to the EP

CMS seeks comment on the timeframe for which an EP must provide the patient with an electronic copy of the patient’s health record, including test results, medication lists, and other problem lists.

We agree that one of the prevailing attributes of health IT is patient access to his/her own records. Some practicing physicians offer web-based “patient portals” that provide a secure location for patients to access and view their records. While this offers an opportunity to easily and securely provide patients with their health records, this practice is far from widespread at this time.

CMS must clarify how successful EPs can provide an electronic record without compromising patient privacy or the security of a patient portal. CMS must also provide guidance on how staff should protect patient privacy if providing an electronic record requires staff to e-mail or fax records to some unsecure location.

Recommendation: Although we support CMS’ proposed objectives to provide patients with an electronic copy of their health information upon request, we strongly oppose CMS’ proposed measure for Stage 1 that requires physicians to provide only electronic copies within 48 hours and to provide patients access to their health information within 96 hours of when it is available to the physician. We strongly recommend that for Stage 1, EPs have the flexibility to provide either an electronic or paper copy generated by the EHR within the time period allowed under HIPAA. It is important to keep in mind that interfaces with EHRs and patient portals (e.g., patient

logs on and can access test results online) are not readily available and will be costly to implement.

Recommendation: CMS should also combine EP Objectives 17 and 18 and measure successful completion by access to a patient's health record to ensure privacy and security.

EP Objective 21: Perform medication reconciliation at relevant encounters and each transition of care

CMS seeks comment on its definitions of "transition of care" and "relevant encounter." According to the Proposed Rule, a successful EP must perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care. CMS defines "relevant encounter" as any encounter that the EP performs medication reconciliation due to new medication or long gaps in between patient encounters or other reasons, as determined by the EP. CMS also defines "transition of care" as a transfer of a patient from one clinical setting or from one EP or eligible hospital to another.

Our societies believe that while CMS defines "transition of care" and "relevant encounters," successfully completing this objective remains unclear because the medication reconciliation and documentation process needs to be further clarified before an EP can successfully achieve this objective. The HIT Policy Committee is recommending that "relevant encounter" be deleted and that "transitions of care" occur when a patient "moves from one setting of care to another." The HIT Policy Committee further states that settings of care should include: hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehab facility.


Our societies also believe greater clarification is needed around the term "medication reconciliation." CMS proposes to describe medication reconciliation as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an externally list of medications obtained from a patient, hospital or other provider.

Recommendation: CMS should delete "relevant encounter" from the medication reconciliation requirements. Furthermore, CMS should modify that medication reconciliation only occur when an office visit/evaluation and management code is generated. We think it is reasonable for medication reconciliation to occur in the office encounter, with the caveat that if the patient does not know his/her medications, or if an active medication list does not come with the referral for the visit, then reconciliation would only entail making the primary care physician aware of any new medications added or medications removed.

The ACG, the AGA, and the ASGE thank you in advance for your consideration of our recommendations on this proposed rule on meaningful use. We also appreciate your

careful consideration of the detailed comments you will be receiving from other medical specialty societies, industry and interested parties. Should you require additional information, please contact Brad Conway, Vice President of Public Policy, ACG, at (301) 263-9000, Anne Marie Bicha, Director of Regulatory Affairs, AGA, at (240) 482-3223, or Camille Bonta, consultant to ASGE, at (202) 320-3658.

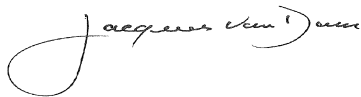
Sincerely:

A handwritten signature in black ink, appearing to read "Philip O. Katz".

Philip O. Katz, M.D., FACG
President, American College of Gastroenterology

A handwritten signature in blue ink, appearing to read "Robert Sandler".

Robert Sandler, MD, MPH, AGAF
Chair, American Gastroenterological Association

A handwritten signature in black ink, appearing to read "Jacques Van Dam".

Jacques Van Dam, MD, PhD, FASGE
President, American Society for Gastrointestinal Endoscopy