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Todd Lawson
Acting Director
Office of E-Health Standards and Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Suite 400
20 F Street, NW
Washington, DC 20001-6701

Tel: 202.737.6662
Fax: 202.737.7061
www.aao.org

Dear Mr. Lawson,

On behalf of the American Academy of Ophthalmology, we are writing to request clarification about the use of scribes to satisfy the Computerized Provider Order Entry (CPOE) requirements of the Medicare Electronic Health Records Incentive Program. The Academy is supportive of the goals of the Meaningful Use program, and based on our analysis of CMS data, we know that close to 50 percent of eligible ophthalmologists have participated in the Meaningful Use program. The Academy aims to help its members improve healthcare quality, safety and efficiency through the use of health IT by providing education, resources and information to our members on the requirements of the Meaningful Use program. The Academy also seeks to ensure that Academy members always have the necessary information available to them needed to be successful under the Meaningful Use program.

Unfortunately, there is a great deal of confusion and disagreement among various medical associations, providers and other entities about whether the use of certified medical scribes is permitted to satisfy the CPOE requirements of the Meaningful Use program. Written materials from CMS provide conflicting information, and we are aware of individuals who have received different answers from CMS staff on the issue. **We would greatly appreciate guidance or clarification on whether certified medical scribes are permitted by CMS for purposes of satisfying the CPOE requirements under Meaningful Use.**

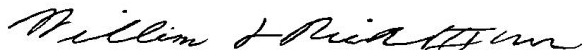
In the final Meaningful Use Stage 2 rule released in September 2012, CMS expanded the CPOE requirements from “licensed healthcare professionals” to also allow “credentialed medical assistants” to use CPOE for medication, laboratory and radiology orders to satisfy the CPOE measures. In FAQ 9058, CMS further explains that as long as a medical professional is appropriately credentialed and performs similar duties to a medical assistant, he or she can enter orders for purposes of satisfying the CPOE requirements of Meaningful Use, even if the job title is not Certified Medical Assistant. However, conflicting with this is CMS’ FAQ 10134, which states that only licensed healthcare professionals can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective. **We request that CMS remove FAQ 10134 because it is outdated and causes confusion among providers and other key stakeholders.**

Also in the final Stage 2 rule, CMS explains that medical scribes are not permitted to use CPOE to satisfy the Meaningful Use requirements because there is no licensing or credentialing of scribes guaranteeing they are qualified to correctly enter the order, evaluate CDS and then either make a change to the order based on the CDS intervention or bypass the intervention. However, just prior to the 2012 rule, at least one organization, the American College of Medical Scribe Specialists, has developed an accredited program to certify medical scribes. **We request prompt clarification from CMS as to whether certified medical scribes are permitted to enter orders for the purposes of satisfying the Meaningful Use CPOE measure.** It is important that we receive this clarification soon so that our members and other providers are not misinformed, have the correct information needed to comply with the Meaningful Use requirements and succeed in the program and are not inappropriately required to refund incentive monies.

While the Academy is requesting clarification in this letter on whether certified medical scribes are permitted by CMS for purposes of satisfying the Meaningful Use CPOE measure, we also would like to stress our position that **CMS should not require formal certification of staff that enters electronic medication, laboratory or radiology orders into the EHR.** The medical staff entering orders for purposes of satisfying the CPOE measure act under the supervision and direction of the ordering physician, and ultimately it is the physician that signs off of the final order entry. Many ophthalmology offices do not have formally certified medical assistants, technicians or scribes, and requiring certification of staff presents workflow and financial burdens. It is the responsibility of the physician to finalize all entries and other information placed in the EHR and as long as the physician is overseeing the completion of the record it is unnecessary to require additional staff certification.

For questions or comments on this letter, please contact Rebecca Hancock, Manager of Quality & Health IT Policy at rhancock@aaodc.org.

Sincerely,



William L. Rich III, M.D.
Medical Director of Health Policy
American Academy of Ophthalmology