



March 12, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: CMS-0033-P; RIN 0938-AP78; Comments of the American College of Radiology, Radiological Society of North America, and Society for Imaging Informatics in Medicine

On behalf of the American College of Radiology (ACR)¹, American Board of Radiology (ABR)², Radiological Society of North America (RSNA)³, and the Society for Imaging Informatics in Medicine (SIIM)⁴, we appreciate the opportunity to comment on the proposed Medicare and Medicaid electronic health record (EHR) incentives program as it applies to radiology. The following comments focus primarily on the Medicare version of the “meaningful use” incentives program for eligible professionals (EPs), as we believe that particular version of the program will directly impact our members.

We estimate that approximately 74 percent (or over 22,200) of 30,000 post-training professionally active radiologists perform some of their services outside of the hospital setting. Furthermore, most radiologists participate extensively in the Medicare program because of the general age demographic of patients in need of diagnostic imaging. As diagnostic radiologists will be among the most impacted by Medicare incentives and penalties, it is imperative that “meaningful use of certified EHR technology” be defined in such a way that makes clinical sense and is reasonably achievable for all radiologist EPs.

General Comments

Historically, radiology has been the forerunner in the physician community in terms of adoption and innovation of health information technology (HIT) and health information exchange (HIE) because of the specialty’s natural reliance on technology and data sharing. The radiology community created what became DICOM—a standard for communication of digital image information which is currently implemented by almost all imaging device manufacturers—throughout the 1980s and culminating in 1993; as well as Integrating the Healthcare Enterprise (IHE) initiative in 1997, which later branched out to other areas in medicine. Radiology boasts the most widespread HIT adoption of any specialty, with

¹ The **American College of Radiology (ACR)** is a professional organization representing more than 36,000 radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists. ACR works collaboratively to maximize the value of radiology, radiation oncology, interventional radiology, nuclear medicine, and medical physics while making imaging safe, effective, and accessible to those who need it.

² A Member Board of the American Board of Medical Specialties, the **American Board of Radiology (ABR)** examines and certifies the nation’s practicing diagnostic radiologists, radiation oncologists, and radiologic physicists. In its 76-year history, the ABR has certified more than 66,000 individuals. More recently, under guidelines adopted by the ABMS, ABR’s Maintenance of Certification (MOC) program has been developed to assure the public of the high quality of care and continuous professional development of ABR diplomates. Indeed the mission of the ABR is to serve patients, the public, and the medical profession by certifying that its diplomates have acquired, demonstrated, and maintained a requisite standard of knowledge, skill, and understanding essential to practice.

³ The **Radiological Society of North America (RSNA)** is a professional membership society committed to excellence in patient care through education and research. More than 40,000 medical imaging professionals are members of RSNA, including radiologists, radiation oncologists, medical physicists and allied scientists.

⁴ The **Society for Imaging Informatics in Medicine (SIIM)** is devoted to advance computer applications and information technology in medical imaging through education and research. SIIM membership exceeds 2,200 individual, 90 institutional, and 35 corporate members.

Radiology Information Systems (RIS) and/or Picture Archiving and Communication Systems (PACS) already implemented in the vast majority of hospitals and practices. Radiologists understand firsthand how technology can contribute to improved patient care outcomes, and encourage HIT adoption by colleagues in all sectors of the medical community.

However, CMS' proposed implementation of the "meaningful use of certified EHR technology" incentives program mandated by the American Recovery and Reinvestment Act of 2009 (ARRA) does not appreciate the leadership of radiology in HIT/HIE, nor the unique role radiologists and other specialists play in patient care. In fact, contrary to Congressional intent, most radiologists in ambulatory settings would be disenfranchised by the proposed incentives program unless it is modified in CMS' Final Rule to be cognizant of the various scopes of practice and HIT functionality needs of radiology specialists. We are disappointed CMS did not directly engage in transparent collaboration with specialty societies prior to writing the proposed rule, despite efforts by groups like ACR to provide specialty-specific meaningful use recommendations to ONC's federal advisory committees. HHS did not consider medical specialties until the October 2009 meeting of the ONC's HIT Policy Committee—by then, too late in the rulemaking process to have a substantive impact on CMS' proposed rule. Moving into the Stage 2 and Stage 3 rulemakings, it imperative that CMS develop direct communication with those immersed in the nuance of delivering specialty care to help to craft measures that represent the reality of daily practice.

In the following comments, we will propose specific ways CMS could improve its proposed program in the Final Rule so that radiologist EPs could be engaged in an EHR incentives program that is relevant to radiology's unique contributions to patient care.

HIT Functionality Measures

We do not believe all HIT functionality measures for EPs listed in the proposed rule are applicable to the practice of radiology, and we strongly discourage CMS from requiring EPs to report all 25. In fact, most of the functionality measures are outside of radiology's scope of practice, and some are arduous or impossible to attain in certain patient care scenarios—for example, in teleradiology where patients have the technical component of their imaging procedures done elsewhere and the images are transmitted to remote radiologists for interpretation or consultation. **Instead, CMS should allow individual EPs to choose those HIT functionality measures from the list of 25 that are pertinent to their respective specialties and workflows.**

In its recent comments to CMS on the proposed rule, the ONC's HIT Policy Committee recommended a "3-1-1-1-0" approach for flexibility to permit physicians to "defer" certain HIT functionality measures until a later stage of meaningful use. While we encourage flexibility in general, this suggested approach does not go far enough to align the program requirements with the practice of radiology.

To explain our concerns, the following are specific comments on each of the proposed HIT functionality measures for radiologist EPs. Our comments were informed, in part, by a survey of radiologist EPs and ambulatory radiology CIOs participating in the Imaging e-Ordering Coalition, as well as the expertise of ACR's IT and Informatics Committee leaders.

1. OBJECTIVE: *Use CPOE.*

MEASURE: *CPOE is used for at least 80% of all orders*

RADIOLOGY COMMENTS: Most diagnostic radiologists do not order physician services, such as pathology tests and imaging procedures—rather, they receive orders for interpretations/consultations of imaging studies from referring physicians. As a result, any HIT functionality measure that examines the discrete number or percentage of orders placed would be inapplicable to most radiologist EPs. CMS must address the fact that not all EPs order lab-tests and imaging studies. CMS should instead require that, in Stage 1, specialist EPs who receive orders for their services "enable the functionality to receive electronic orders."

For referring physician EPs who do order imaging studies, the radiology community is strongly supportive of the use of CPOE with integrated evidence-based clinical decision support (CDS), designed to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition, such as ACR's Appropriateness Criteria—evidence-based, guidelines developed and regularly reviewed by expert panels with representation from relevant medical specialties. While we recognize CMS does not require electronic transmission of orders for Stage 1 of meaningful use, we encourage CMS to implement such a requirement with the aforementioned CDS capabilities as soon as possible. Radiology order entry systems with these capabilities currently exist and are shown to reduce inappropriate ordering of diagnostic imaging, thereby improving patient safety (e.g. by reducing radiation exposure to patients), reducing waste and controlling health care costs. These systems also ensure orders are communicated to imaging centers in a clear and efficient manner.

2. OBJECTIVE: *Implement drug-drug, drug-allergy, drug-formulary checks.*

MEASURE: *The EP has enabled this functionality.*

RADIOLOGY COMMENTS: In diagnostic radiology, contrast media is sometimes used and certain agents may have associated contraindications, but it is unclear if CMS' proposed drug-drug, drug-allergy, and drug-formulary checks are also needed for contrast media/imaging agents. This is further complicated by the fact that under the CMS Hospital Outpatient Prospective Payment System (HOPPS), contrast media and radiopharmaceuticals are reimbursed as "supplies" bundled with imaging studies; whereas under the Physician Fee Schedule (PFS), contrast media and radiopharmaceuticals are reimbursed as "drugs" independent of the studies. These complexities noted, CMS should clarify in the Final Rule whether or not contrast media is intended to be covered by this measure.

3. OBJECTIVE: *Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT.*

MEASURE: *At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.*

RADIOLOGY COMMENTS: We support the need to maintain a problem list; however, the proposed definition of "problem list"—a list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient—must be clarified to be inclusive of radiology reports. RadLex—standard terminology which unifies and supplements other lexicons and standards, such as SNOMED-CT and DICOM, and is supported by the National Institutes of Health—should be included in addition to ICD-9-CM and SNOMED CT for describing those conditions for which there is specific radiology terminology.

This measure must also be flexible enough so that the role of specialists in patient care is considered. So, the meaning of the "current and active diagnoses" should be targeted at only those diagnoses that are produced by the respective EP during care of the patient.

4. OBJECTIVE: *Generate and transmit permissible prescriptions electronically (eRx).*

MEASURE: *At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.*

RADIOLOGY COMMENTS: e-Prescribing (eRx), as described in the proposed rule, is typically thought of as inapplicable to diagnostic radiology because radiologists do not commonly have a need for transmission of a patient's prescriptions to another party. With certain exceptions, imaging centers usually order most of their contrast media from medical suppliers in bulk and not in a traditional physician-to-pharmacy eRx model. Radiology personnel could record information on contrast media administered to patients in terms of lot and stock-keeping unit (SKU) identifiers; however, the 75 percent transmission requirement would remain problematic. Some radiologists may also prescribe other medications, such as morphine or Glucagon. CMS

must clarify that the transmission requirement of this measure is not required for EPs who do not have a clinical need to transmit prescriptions via paper, fax, electronic, or otherwise.

5. **OBJECTIVE:** *Maintain active medication list.*
MEASURE: *At least 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.*
RADIOLOGY COMMENTS: This proposed measure could possibly be reported by radiologist EPs, particularly with the option of the “none” indication. As previously mentioned, radiologists do not commonly prescribe medications from the pharmacy. Maintaining a list of contrast media/imaging agents as structured data would make clinical sense for diagnostic radiologists if this proposed measure is intended to capture those data elements. Clarification is needed as to the definition of “medications” and whether or not that definition encompasses contrast media/imaging agents.
6. **OBJECTIVE:** *Maintain active medication allergy list.*
MEASURE: *At least 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data.*
RADIOLOGY COMMENTS: Please see the previous comment. The only allergies of interest to most diagnostic radiologists would be contrast allergies. Many imaging agents do not have significant contraindications, such as radiopharmaceuticals used in nuclear medicine imaging procedures. This measure is more applicable on the interventional side of radiology. CMS should change the denominator to “all applicable episodes of care” and not “all unique patients.”
7. **OBJECTIVE:** *Record demographics: preferred language; insurance type; gender; race; ethnicity; date of birth.*
MEASURE: *At least 80% of all unique patients seen by the EP have demographics recorded as structured data.*
RADIOLOGY COMMENTS: We agree with this objective and measure; however, CMS must clarify in the Final Rule that any technical and administrative personnel can enter this data and/or verify that it has been entered on behalf of the EP. For scenarios in which the EP performs the professional component of patient care remotely—as in teleradiology—CMS must clarify that the data can be captured by personnel at the site where the technical component of the procedure is performed.
8. **OBJECTIVE:** *Record and chart changes in vital signs: height; weight; blood pressure; Calculate and display: BMI; Plot and display growth charts for children 2-20 years, including BMI.*
MEASURE: *For at least 80% of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally plot growth chart for children age 2-20.*
RADIOLOGY COMMENTS: The requirements of this measure are not applicable to radiology medical record keeping, and instead are components of the primary care physician’s scope of practice. We recognize that while blood pressure checks and BMI measurement are sometimes relevant in certain scenarios, it does not always make clinical sense for radiologist EPs to capture this data for 80 percent of unique patients. The denominator of this measure should be “applicable episodes of care,” not “all unique patients.” Additionally, a growth chart would not make clinical sense in radiology—this requirement should be removed.
9. **OBJECTIVE:** *Record smoking status for patients 13 years old or older.*
MEASURE: *At least 80% of all unique patients 13 years old or older seen by the EP have "smoking status" recorded.*
RADIOLOGY COMMENTS: Although not clinically relevant for most non-interventional radiologic procedures, smoking status could potentially be requested during assessment at the site of the technical component of imaging. This measure would become problematic in any patient care

scenario in which the professional component of service is performed in a different location than the technical component. In order to avoid potential problems, CMS should clarify that this measure is only required when the EP is able to capture this data. Additionally, CMS should clarify that smoking status data can be captured by technical and support personnel at the site of the technical component of service.

10. **OBJECTIVE:** *Incorporate clinical lab-test results into EHR as structured data.*
MEASURE: *At least 50% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.*
RADIOLOGY COMMENTS: As written in the proposed rule, this measure would be inapplicable to many diagnostic radiologist EPs because most radiologists do not order lab-tests unless they provide interventional radiology or radiation oncology services, or use gadolinium-based contrast agents. Additionally, we strongly disagree with CMS' proposal to delay incorporating diagnostic radiology results as structured data until Stage 2 or Stage 3. The radiology community has a standard terminology, RadLex, which unifies and supplements other lexicons and standards, such as SNOMED-CT and DICOM, and is supported by the National Institutes of Health.
11. **OBJECTIVE:** *Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.*
MEASURE: *Generate at least one report listing patients of the EP with a specific condition.*
RADIOLOGY COMMENTS: We support this objective and measure. CMS should clarify that these lists could also be retrieved through an EP's participation in a data registry.
12. **OBJECTIVE:** *Report ambulatory quality measures to CMS or the States.*
MEASURE: *All EPs are required to report on core measures and one of the subsets of specialty measures.*
RADIOLOGY COMMENTS: Please see the *Ambulatory/Clinical Quality Measures* section of our comments below.
13. **OBJECTIVE:** *Send reminders to patients per patient preference for preventive/ follow up care.*
MEASURE: *Reminder sent to at least 50% of all unique patients seen by the EP that are 50 and over.*
RADIOLOGY COMMENTS: Most advanced diagnostic imaging procedures are not utilized in regularly scheduled intervals. Reminders for preventive/follow-up care would really only be applicable for mammography procedures. Furthermore, not all radiologists read mammography studies, and as a result, this measure is not applicable to all radiologist EPs. The denominator for this measure should be "unique patients for *any applicable follow-up appointments or scheduled procedures,*" not "all unique patients seen by the EP that are 50 and over."
14. **OBJECTIVE:** *Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules.*
MEASURE: *Implement 5 clinical decision support rules relevant to the clinical quality metrics.*
RADIOLOGY COMMENTS: We are proponents of CDS; however, this measure will need further clarification in the Final Rule. Additionally, we would like to see CDS tied not only to the quality metrics, but also to CPOE. Specifically, we are strongly supportive of the use of CPOE with integrated evidence-based CDS, such as ACR Appropriateness Criteria, by referring physician EPs who order imaging studies. An example of "implementing clinical decision support" while ordering diagnostic imaging studies could be deciding not to order a procedure that has a low clinical utility based on existing evidence for the given indications, or electing to order a different diagnostic imaging study that has a higher clinical utility based on existing evidence.

15. **OBJECTIVE:** *Check insurance eligibility electronically from public and private payers.*
MEASURE: *Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP.*
RADIOLOGY COMMENTS: We support this objective as a practical part of meaningful use that is relevant to all physicians; however, the 80 percent threshold may be unattainable for many providers in Stage 1. As written in the proposed rule, this measure is largely dependent on private insurance companies. Instead of requiring a minimum percentage, we recommend that CMS change the measure to read “the EP has enabled this functionality.” CMS could then reexamine the issue of requiring minimum percentages in Stage 2 or 3.
16. **OBJECTIVE:** *Submit claims electronically to public and private payers.*
MEASURE: *At least 80% of all claims filed electronically by the EP.*
RADIOLOGY COMMENTS: We support this objective as a practical part of meaningful use that is relevant to all physicians; however, this measure must be modified to exclude those payers that cannot accept electronic medical claims, including certain workman’s compensation and automobile insurance providers. As with the previous comment, we recommend that CMS change the measure to read “the EP has enabled this functionality.”
17. **OBJECTIVE:** *Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request.*
MEASURE: *At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.*
RADIOLOGY COMMENTS: We support this objective and measure for Stage 1; however, we ask for clarification that for radiologists, an “electronic copy of health information” means the patient’s diagnostic images and radiology report delivered using electronic media such as CDs or DVDs for Stage 1, and moving toward true electronic exchange of images in Stage 2 or 3 of the incentives program (please see the *Future Considerations* section of our comments below).
18. **OBJECTIVE:** *Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP.*
MEASURE: *At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information.*
RADIOLOGY COMMENTS: We support this objective and measure; however, CMS should clarify that “health information” is any data resulting from the EP’s professional service. For example, a diagnostic radiologist should not be required to supply the patient with their lab-test results or vitals data. Instead, the radiologist should be responsible for providing the patient with timely access to health information that is specific to the professional service provided by the EP.
19. **OBJECTIVE:** *Provide clinical summaries for patients for each office visit.*
MEASURE: *Clinical summaries provided to patients for at least 80% of all office visits.*
RADIOLOGY COMMENTS: We support this objective and measure; however, “clinical summary” should be defined so that the radiology report would suffice. Additionally, it should be recognized that patients do not always visit the office where the radiologist performs the professional component of the diagnostic imaging procedure, thus the term “office visit” is not applicable in all patient care scenarios.
20. **OBJECTIVE:** *Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically.*
MEASURE: *Performed at least 1 test of certified EHR technology's capacity to electronically exchange key clinical information.*

RADIOLOGY COMMENTS: We support this objective and measure with no further recommendation.

21. **OBJECTIVE:** *Perform medication reconciliation at relevant encounters and each transition of care.*
MEASURE: *Perform medication reconciliation for at least 80% of relevant encounters and transitions of care.*
RADIOLOGY COMMENTS: This measure may be applicable for interventional radiology, radiation oncology, and nuclear medicine. It may not always be directly applicable to diagnostic radiology. Please also see our comments on #2 above, which apply here as well.
22. **OBJECTIVE:** *Provide summary care record for each transition of care and referral.*
MEASURE: *Provide summary of care record for at least 80% of transitions of care and referrals.*
RADIOLOGY COMMENTS: We support this objective and measure as long as the radiology report and/or diagnostic images meet the definition of “summary care record.”
23. **OBJECTIVE:** *Capability to submit electronic data to immunization registries and actual submission where required and accepted.*
MEASURE: *Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.*
RADIOLOGY COMMENTS: While this functionality would be suitable for family physicians and pediatricians, immunization/vaccination is firmly outside the scope of practice of radiology and most other specialties. This measure is very limited in terms of relevance and should not be required of all EPs.
24. **OBJECTIVE:** *Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.*
MEASURE: *Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).*
RADIOLOGY COMMENTS: As written in the proposed rule, this measure does not seem relevant to radiology. We recommend that implementation of this measure be delayed until CMS can determine the specifics on how all EPs will be able to fulfill this requirement.
25. **OBJECTIVE:** *Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.*
MEASURE: *Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.*
RADIOLOGY COMMENTS: We support privacy and security of patients’ health information. We request that CMS clarifies that security updates could be implemented by personnel other than the EP, such as a CIO, HIT consultants, or software vendors, if the EP chooses to pursue that option.

Ambulatory/Clinical Quality Measures

We do not believe the 3 core quality measures are applicable to radiology, aside from certain interventional and radiation oncology procedures. The core quality measures are also arduous or impossible to attain in certain practice scenarios in which the EP does not have direct, physical access to the patient—for example, in teleradiology. Therefore, we strongly recommend that the 3 core quality measures are not required of all EPs, but are instead included with the specialty clinical quality measures for primary care physicians.

We applaud CMS rulemaking staff for including a radiology subset of specialty ambulatory/clinical quality measures. We ask CMS rulemaking staff to clarify that EPs must only demonstrate those individual quality measures that are applicable to their practice, as opposed to demonstrating all measures within their respective specialty's subset. The clarification is needed because diagnostic radiologists often sub-specialize in specific body parts and modalities. Subspecialists, such as nuclear medicine physicians or breast imagers, may not provide interpretations of all studies mentioned in the radiology subset of quality measures. For example, most nuclear medicine subspecialists do not also read mammograms.

Finally, two of the radiology specialty quality measures could be problematic for individual EPs, *NQF 0052 - Title: Low back pain: use of imaging studies* and *NQF 0513 - Title: use of contrast: thorax CT*. These quality measures were intended to be implemented at the administration/site level using hospital outpatient claims data, and not at the individual practitioner level.

Future Considerations: Radiation Dose, Image Sharing, and CPOE/CDS

There is an immediate need for including radiation dose data in a structured form within the patient's electronic record. Capturing radiation dose data must be a core meaningful use requirement for all EPs who provide radiologic procedures, including non-radiologists. CMS and ONC should leverage the programs and expertise of the ACR, RSNA, and SIIM—which, among their numerous initiatives and programs, includes the ACR Dose Index Registry (DIR)—to best incorporate radiation dose data. All available radiation dose data must be accessible to, and considered by, referring physicians during the ordering process in the form of CDS. Referring physicians have a responsibility to ensure all radiologic procedures they order for their patients are necessary and provide a probable benefit that outweighs the risk.

We recommend that CMS and the Office of the National Coordinator for HIT explore image sharing in the Stage 2 and Stage 3 rulemakings. Currently, the exchange of diagnostic images often requires a physical medium, such as a CD or DVD, to be created and given to patients for sharing with other providers. There is a need within the patient and provider communities for a more transparent paradigm of interoperability via electronic exchange of diagnostic images, which would reduce radiation risk and costs by eliminating duplicative procedures if providers have immediate access to patients' existing images and reports. Any discussion of HIE facilitated by EHR technology should also include radiology considerations, such as the ability to export and import patient image data amongst providers and personal health records using Integrating the Healthcare Enterprise (IHE) profiles. This is an area in which the radiology community continues to make headway, and the associated standards (DICOM and XDS) are already well established. We support leveraging and extending the work of IHE in radiology and across other clinical and infrastructure domains to establish effective interoperability and exchange of health information.

Also in Stage 2 and Stage 3, CPOE for radiology services should inherently include CDS to provide real-time, actionable, evidence-based guidance to ordering physicians about the appropriateness of any requested imaging procedures based on the clinical scenario/indications. This feedback should be drawn from authoritative and transparent sources, such as ACR Appropriateness Criteria, and should consider both standard procedure descriptions and clinical scenario assertions (i.e., signs, symptoms, known diagnoses, demographics, co-morbidities). Optimally, the source and strength of the evidence should be transparent and accessible to the ordering physician at the time of clinical decision making. As already discussed, these radiology order entry systems with integrated clinical decision support capabilities exist now and directly target the imaging overutilization concerns expressed by the ONC's HIT Policy Committee and others in the federal government.

Closing

In summary, the meaningful use measures must align with, and support, radiology's scope of practice to the extent possible. Many of the proposed HIT functionality measures, as well as the core

ambulatory/clinical quality measures, do not make clinical sense for radiology medical record keeping. It is imperative that a solution be implemented in the Final Rule whereby all EPs can participate in the program in a meaningful way. This is particularly important for radiology as most radiologists are not hospital-based, and almost all radiologists participate extensively in the Medicare program due to the general age demographic of patients in need of diagnostic imaging and radiation therapy procedures. We propose that EPs should choose from the HIT functionality measures, rather than requiring all 25 measures of all EPs.

As always, the radiology community welcomes the opportunity for continued dialogue with CMS and the Office of the National Coordinator for HIT on all topics related to HIT and HIE in radiology. Please contact Michael Peters, ACR Assistant Director of Regulatory and Legislative Portfolio, at 202-223-1670 / mpeters@acr.org if our community can be of assistance.

Sincerely,



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