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August 19, 2010

Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1504-P**
PO Box 8013
Baltimore, Maryland 21244-1850

Re: File Code CMS-1504-P

Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2011 Payment Rates; Proposed Rule (75 *Federal Register* 46170)

Dear Dr. Berwick:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Hospital Outpatient Prospective Payment System (OPPS) and calendar year 2011 Rates, as published in the August 3, 2010 *Federal Register*. Our comments focus on those areas of particular interest to our members.

AHIMA is a not-for-profit professional association representing more than 59,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most.

Consistency in medical coding and the use of medical coding standards in the US is a key issue for AHIMA. As part of this effort, AHIMA is one of the Cooperating Parties, along with

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CMS, the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

AHIMA participates in a variety of coding usage and standardization activities in the US and internationally, including the American Medical Association's (AMA's) Current Procedural Terminology® (CPT®) Editorial Panel and the Editorial Advisory Boards for the AHA's *Coding Clinic for ICD-9-CM* and *Coding Clinic for HCPCS*.

AHIMA and its members also participate in a variety of projects with other industry groups and agencies of the Health and Human Services Department related to the use of secondary data for a variety of purposes including quality monitoring, reimbursement, public health, patient safety, biosurveillance, and research.

Our detailed comments and rationale on the NPRM for OPPTS are below.

III: Proposed OPPTS Ambulatory Payment Classification (APC) Group Policies (75FR46240)

III-A-1: Proposed Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes (75FR46241)

CMS indicates that they do not recognize the four new H1N1 category I CPT vaccine codes that became effective on July 1 because they already recognize existing HCPCS G-code G9142. **AHIMA recommends that CMS recognize the four new H1N1 CPT vaccine codes in place of the G-code, so there is a single, standard mechanism for reporting these services.**

III-D: Proposed OPPTS APC-Specific Policy: Skin Repair (APCs 0134 and 0135) (75FR46250)

CMS is proposing to create two new Level II HCPCS G-codes to report the application of Apligraf or Dermagraft specific to the lower extremities. While the G-codes may be needed initially to meet CMS' reporting needs, **we recommend that CMS seek appropriate revisions to the corresponding CPT codes to meet their needs for accurately reporting these services so that CPT codes can ultimately be used instead of these G-codes.** Not only is it confusing to have multiple ways to report the same services, it will create additional confusion to use G-codes for application of Apligraf or Dermagraft to the lower extremities

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and CPT codes for other anatomical sites. The 2011 proposed rule for the Medicare Physician Fee Schedule indicates the use of these G-codes is expected to be temporary, and we urge CMS to work with the American Medical Association to ensure that is true.

IX: Proposed OPPS Payment for Hospital Outpatient Visits (75FR46294)

IX-B-1: Clinic Visits: New and Established Patient Visits (75FR46296)

For 2011, CMS proposes to retain the current definitions of “new” and “established” patient. **AHIMA continues to believe that the distinction between new and established patients under the OPPS should be eliminated. We recommend that CMS select a single set of CPT codes (for either new or established patients) for reporting purposes under the OPPS**, as long as the CPT evaluation and management (E/M) codes continue to be used for reporting hospital clinic visits.

While distinctions between “new” and “established” patients are relevant for physician services, they are not relevant for facility services. Under the facility definition, an “established” patient may have been registered for any number of services, including a single diagnostic test. The mere fact that a patient has been registered in the previous 3 years does not appreciably affect the level of facility resources utilized for the current visit. Any cost differences among hospital clinic visit patients should be captured by the facility’s guidelines for determining the appropriate visit code level.

IX-B-3: Visit Reporting Guidelines (75FR46297)

AHIMA continues to urge CMS to promulgate national visit guidelines for clinic and emergency department visits. **The use of hospital-specific internal coding guidelines is contrary to government and industry goals of data uniformity, consistency, and comparability.** In an era of healthcare initiatives aimed at data standardization and interoperability, and the use of electronic health records (EHRs), the continued lack of national facility visit guidelines is increasingly unacceptable. The use of hospital-specific internal guidelines defeats the purpose of using a standard coding system because it is not possible to compare codes and resource usage across hospitals.

While a hospital’s internal data may be consistent, data across hospitals are not consistent or comparable as long as there is no national reporting standard. And reimbursement at the individual hospital level is not necessarily accurate, since there is no national standard for the facility definition of each visit code and hospitals are free to define each visit level however they wish.

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Also, national guidelines are needed in order to provide a standard benchmark for auditing facility visit code levels. Without a nationally-accepted standard set of guidelines, hospitals are at increased risk during an audit or fraud investigation. CMS' principles for development of facility-specific internal guidelines are not sufficient for ensuring compliance because judging compliance with these principles is subject to varying interpretation.

AHIMA recommends that CMS take a fresh look at approaches for adopting national visit guidelines by carefully re-evaluating proposals that have been submitted in the past as well as evaluating different sets of hospital-developed internal guidelines that appear to be working well.

We also believe that more than 6-18 months notice prior to implementation of national guidelines is needed. **We recommend 12-18 months lead time, in order to allow facilities sufficient time for education and the process of converting their existing system to the national standard.**

XI: OPPS Proposed Procedures That Will Be Paid Only As Inpatient Procedures (75FR46301)

XI-B: Proposed Changes to the Inpatient List (75FR46301)

AHIMA supports the proposed removal of CPT codes 21193, 21395, and 25909 from the inpatient list.

XII: Proposed OPPS Nonrecurring Technical and Policy Issues (75FR46302)

XII-B-3: Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic (75FR46317)

We support the proposed creation of a HCPCS modifier that would be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service.

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XVI: Reporting Quality Data for Annual Payment Rate Updates (75FR46360)

XVI-A-2: Hospital Outpatient Quality Data Reporting Under Section 109(a) of Public Law 109-432 (75FR46360)

Although Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures that reflect consensus among affected parties, we are pleased to observe CMS' movement toward a consistent goal in using measures that have reached consensus whether by the National Quality Forum (NQF) or other entity.

AHIMA supports CMS' assertion that measures from the RHQDAPU should not automatically be adopted for the HOP QDRP without further analysis. If measures from the RHQDAPU apply to the HOP QDRP program we do agree in order to keep data collection and reporting burdens to a minimum, they should be selected.

XVI-A-6: HOP QDRP Quality Measures, Technical Specification Updates, and Data Publication for the CY 2011 Payment Determination (75FR46361)

We appreciate CMS' sensitivity to the burden upon HOPDs associated with chart abstraction and the desire to minimize the collection burden associated with quality measurement. We encourage CMS to seek out ways and methods that can leverage existing programs or through electronic means to collect data once and report for a variety of purposes, such as quality measurement.

XVI-B-1: Considerations in Expanding and Updating Quality Measures Under the HOP QDRP Program (75FR46362)

AHIMA commends CMS for aligning efforts to identify alternatives to chart abstracting for hospitals such as registries and EHRs to collect data once and repurpose it for multiple quality reporting initiatives. We also appreciate the goals to consider the burden placed upon the hospitals in gathering the data and trying to align measures used in the HOP QDRP with other CMS incentive programs. We believe that by working toward such goals will enable CMS to continue to develop thoughtful and comprehensive programs whereby efficiencies will increase and data integrity will improve.

AHIMA supports CMS' intention to develop an awareness of proposed measures in the out years as described in the proposed regulation and support the ability to provide as much information as possible to enable entities to prepare for the impending reporting requirements. In light of the variety of regulatory changes and compliance dates, we encourage CMS to

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reconsider identifying proposed measures so far in advance. With the meaningful use program being implemented, new and improved health information technology and with the changes that ICD-10-CM/PCS will bring there are many opportunities and challenges to meeting all of the requirements during this fast paced environment. We encourage CMS to provide proposed measures only for CY 2012 and possibly 2013 as we believe the industry is going through unprecedented changes in electronic health records and other HIT initiatives which may change a variety of factors in this reporting program over time.

XVI-B-3: Proposed HOP QDRP Quality Measures for the CY 2012 Payment Determination (75FR46363)

We are pleased that CMS is proposing a minimum of one chart-abstracted measure for the CY 2012 payment determination. We are concerned however that there are an additional set of four claims-based measures that have not received NQF endorsement, which is a requirement for selection of measures for this program. For purposes of uniformity and consistency, AHIMA recommends that only NQF endorsed measures be used.

XVI-B-4: Proposed HOP QDRP Quality Measures for the CY 2013 Payment Determination (75FR46363)

As we have mentioned previously in our letter, we encourage CMS to potentially reconsider proposing measures for CY 2013 while the industry is undergoing a transformation in the adoption and use of EHRs as well as preparing for the implementation of ICD-10-CM/PCS.

If CMS intends to move forward with the proposed measures for CY 2013 we strongly encourage reducing the number of chart-abstracted measures. CMS has been supporting and promoting a reduction in the use of chart abstracted measures and therefore we were surprised and concerned that in CY 2013 there is a significant increase in the required chart abstracted measures. **AHIMA recommends reevaluating the need for the chart-abstracted measures and consider those measures listed in the Medicare and Medicaid programs Electronic Health Record Incentive Program final rule, Table 6 (75FR44398) or Table 10 (75FR44418) which have electronic measure specifications and enables reporting from EHRs.**

XVI-B-5: Proposed HOP QDRP Quality Measures for the CY 2014 Payment Determination (75FR46370)

As noted previously in our comments, **we recommend CMS refrain from proposing measures for the CY 2014 as the industry is undergoing a transformation toward**

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increased adoption and use of EHRs and transitioning to the ICD-10-CM/PCS code sets.

We believe there will be many changes from now until that time and would prefer CMS to allow for flexibility and align with the reporting capabilities during that time. We are however, encouraged to find that most of the proposed chart-abstracted measures have been listed in the Medicare and Medicaid Electronic Health Record Incentive Program final rule with electronic measure specifications.

We also noted previously our concern for the number of chart-abstracted measures and suggest that CMS move toward reducing these measures and placing focus on other means of reporting such as through EHRs and registries.

XVI-D-2: Proposed Requirements for HOPD Quality Data Reporting for CY 2012 and Subsequent Years – Data Collection and Submission Requirements (75FR46377)

AHIMA supports CMS' consideration in defining data elements in a consistent manner for both inpatient and outpatient settings. True interoperability will not occur until data definitions and coded value sets are standardized and incorporated into technical standards. **AHIMA recommends including additional text describing how common data elements will be aligned with similar data elements in other data sets above and beyond those used in the CMS inpatient and outpatient quality measurement initiatives.** This exercise will support the movement toward collecting data once so it can be repurposed multiple times for quality/patient safety monitoring, population health reporting, research, and administrative uses.

XVI-F: Reporting of ASC Quality Data (75FR46382)

AHIMA commends CMS for choosing to defer quality data reporting for ASCs. As the healthcare industry continues to move toward increased utilization of EHRs to meet the requirements outlined in the EHR incentive program, we encourage CMS to focus on electronic submission of data for quality measurement once it has been determined to move forward with the ASC quality data program.

XVI-G: Electronic Health Records (75FR46383)

AHIMA commends and supports CMS' acknowledgement of the development and adoption of data content and information technology standards that will enable automated data collection and reporting of clinical data from EHR systems. Engaging with HIT standard-setting organizations to promote the adoption of necessary standards regarding data capture is imperative to achieving meaningful use of HIT as well as the overall adoption of technology

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in the healthcare setting. We fully support CMS' efforts to encourage hospitals to take steps forward toward the adoption of EHRs.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Hospital OPPS. If AHIMA can provide any further information, or if there are any questions or concerns with regard to this letter and its recommendations, please contact me at (312) 233-1115 or sue.bowman@ahima.org or in my absence, contact Dan Rode, AHIMA's Vice President of Policy and Government Relations, at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

A handwritten signature in cursive script that reads "Sue Bowman".

Sue Bowman, RHIA, CCS
Director, Coding Policy and Compliance

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations
Allison Viola, MBA, RHIA, Director, Federal Relations