



September 10, 2007

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P
PO Box 8011
Baltimore, Maryland 21244-1850

Re: File Code CMS-1392-P

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2008 Payment Rates; Proposed Rule (72 *Federal Register* 42628)

Dear Mr. Weems:

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 2008 Rates, as published in the August 2, 2007 *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 51,000 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 CMS, the Department of Health and Human Services' (HHS) 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).

1730 M Street, NW, Suite 502, Washington, DC 20036
phone (202) 659-9440 · *fax* (202) 659-9422 · www.ahima.org

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.

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.

Because of AHIMA's history of seeking uniformity and integrity in the collection, storage, use, and distribution of health information and data, we have noted through out these comments proposals by CMS that violate the principles of uniformity, consistency, and integrity. AHIMA and its member applaud the current work of the Department of Health and Human Services (HHS), the Agency for Healthcare Research and Quality (AHRQ), various committees, as well as CMS is seeking accurate, consistent, and uniform secondary data, and we urge CMS to maintain these same principles when it comes to the requirements for data under the Medicare program.

II-A-4: OPPTS – Packaged Services (72FR42648)

While AHIMA supports CMS' goal to encourage hospitals to provide care as efficiently as possible, we have concerns regarding the implications of a fully-developed encounter-based payment methodology for OPPTS services. The proposed rule states (page 42652): "Ideally, we would consider a complete HOPD [hospital outpatient department] service to be the totality of care furnished in a hospital outpatient encounter or in an episode of care." In this context, what would be the definition of "encounter" and "episode of care?" Would an encounter encompass all outpatient services provided in the hospital on a single day? It seems reasonable to package CPT add-on codes with the primary procedure with which they are reported. However, hospital outpatients may be seen in multiple departments or clinics (especially in tertiary care centers and university teaching hospitals), for unrelated services, on a given day. So, for example, it might not be appropriate to package all diagnostic tests performed on the day of a scheduled procedure because these tests might have been performed in a different department or clinic and may not be related to the scheduled procedure.

As CMS expands the packaging concept, AHIMA recommends that CMS strongly encourage and work with the HIM profession and hospitals to report the appropriate HCPCS codes for any packaged services that were performed, consistent with CPT instructions. To ensure complete and accurate data collection, it is important that all services provided be accurately reported, regardless of whether they are paid separately.

III-D-7: Implantation of Cardioverter-Defibrillators (72FR42714)

AHIMA fully support CMS' proposal to delete the Level II HCPCS codes for ICD insertion procedures and require the appropriate CPT codes instead. As noted in the proposed rule, the use

of CPT codes is less administratively burdensome because it ensures that the same code set is used across all payers.

III-8-7: Implantation of Spinal Neurostimulators (72FR42715)

For the reason noted above, AHIMA appreciates CMS' decision to continue to use the CPT codes for neurostimulator implantation rather than create Level II HCPCS codes. If new codes that distinguish between chargeable and nonchargeable neurostimulators are ultimately felt to be necessary, we recommend that CMS pursue the creation of new CPT codes with the AMA rather than create Level II HCPCS codes.

III-D-9: SRS Treatment Delivery Services (72FR42716)

AHIMA recommends that CPT codes for linear accelerator-based SRS treatment delivery services be used under the OP-PPS instead of HCPCS Level II codes. If the existing CPT codes for linear accelerator-based SRS treatment delivery services do not adequately differentiate facility resource use for these procedures, AHIMA recommends that CMS pursue modification of these CPT codes or creation of new CPT codes rather than continuing to use Level II HCPCS codes.

Use of different code sets for the same service, for different payers, is not consistent with government and industry goals of data uniformity and consistency and is administratively burdensome for hospitals. The regulations for electronic transactions and code sets promulgated under the Health Insurance Portability and Accountability Act (HIPAA) indicate that maintainers of the various code set standards should work together in order to attain and maintain coding consistency and avoid duplicate codes.

IX: Proposed Hospital Coding and Payment for Visits (72FR42751)

Need for national guidelines: AHIMA urges CMS to adopt national guidelines for coding emergency department and clinic visits. **The use of hospital-specific internal coding guidelines is contrary to government and industry goals of data uniformity and consistency.** Also, national guidelines are needed in order to provide a standard benchmark for auditing facility visit code levels. CMS is working within the American Health Information Community (the Community) framework and with other uniform efforts for clinical data and other secondary data. National coding guidelines are a key part of the efforts to achieve the goals of the Community and the industry. These goals will not be achieved until uniformity and consistency are maintained in all government and industry processes including those outlined in this CMS proposal.

Regardless of whether the national distribution of levels appears to be normal, data across hospitals are not consistent or comparable as long as visit codes are not assigned in accordance with a set of national guidelines. 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. The expert panel convened by AHIMA and the American Hospital Association coded a sample of medical records

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using several different hospitals' internal guidelines and major discrepancies were identified. The same service was often assigned to very different levels, depending on which set of internal guidelines was used. Final visit codes often varied considerably for the same medical record, again depending on which set of internal guidelines was used.

It is unconscionable that CMS has failed to replace the hospital-specific coding guidelines with a set of national guidelines, when the movement throughout the healthcare industry is toward data standardization, as demonstrated by ongoing efforts to standardize quality measures, data elements, and data sets. CMS stated in the proposed rule that their goal is to ensure that OPSS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits. However, it is impossible to achieve consistent and accurate reporting of hospital outpatient visits as long as there is no national standard for the definitions of the visit levels. The need for consistent and comparable coding of visits should be particularly important to CMS as it strives to achieve greater bundling of OPSS payments.

The proposed rule indicates that CMS has been actively engaged in evaluating and comparing various guideline models. The AHA/AHIMA expert panel has also recently reviewed nationally-available guideline models. Based on this review, AHIMA believes that there are existing guideline models that could be successfully implemented under the OPSS, after a reasonable amount of expansion or modification. **AHIMA recommends that CMS work with the expert panel on selection and implementation of one of these models.**

Need for different visit codes: Regardless of whether national or hospital-specific guidelines are used, either new CPT codes or Level II HCPCS codes must be created to replace the use of the CPT evaluation and management (E/M) codes. Use of the E/M codes for facility reporting violates the regulations for electronic transactions and code sets promulgated under HIPAA because they are not being used in accordance with CPT definitions. As CMS has acknowledged in this and previous proposed OPSS rules, CPT E/M codes were defined to reflect the activities of physicians and do not necessarily describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters.

Distinction between new and established patients: AHIMA recommends that the distinction between new and established patients for clinic visits be eliminated. Due to confusion regarding the definition of "new" and "established," we do not believe these codes are being reported accurately (for example, a patient may be "new" to a particular hospital clinic but have an existing hospital medical record number because the patient has previously been seen in another hospital department). We agree with the APC Panel recommendation that hospitals bill the appropriate level clinic visit code according to the resources expended while treating the beneficiary. In other words, the coding guidelines should reflect any resource cost differences between new and established patients rather than reporting different codes for new and established patients.

Consultation Codes: AHIMA supports CMS' proposal to change the status of the consultation codes so that they are no longer recognized for payment under the OPSS. We agree with the APC Panel's recommendation that consultation services be built into the coding guidelines for

reporting outpatient clinic levels based on the complexity and resources used for these outpatient visits.

Principles for visit coding guidelines: Some of the principles CMS believes should be applied to hospital-specific guidelines are too vague and subject to interpretation. This is the true of both the original set of principles and the new ones being proposed. For example, one principle states: “The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.” Whether or not a set of hospital-specific guidelines meets this principle, is subject to interpretation. This is one example of the benefits of national guidelines. CMS could ensure that any set of national guidelines they implement under the OP-PPS meets their interpretation of this principle. Also, it is impossible to judge whether or not a visit code level is “accurate” when there is no national standard as to the services that should comprise a given level.

One of the current principles indicates that the coding guidelines should meet the HIPAA requirements. However, it is not possible for any set of hospital-specific guidelines to comply with this principle because hospitals are required to use the CPT E/M codes in a way that is contrary to the CPT definitions, which is a violation of HIPAA.

One of the proposed new principles states that “the coding guidelines should not change with great frequency.” What does CMS consider to be “great frequency?” We recommend that this principle be revised to define great frequency – perhaps the guidelines shouldn’t change more often than annually.

Critical Care: AHIMA recommends that payment for critical care services be provided for less than 30 minutes of critical care. There are times when patients expire without being admitted and a lot of resources are utilized in a very short period of time.

XIII-E: Cardiac Rehabilitation Services (72FR42773)

AHIMA opposes the proposal to discontinue recognizing the CPT codes for cardiac rehabilitation services under the OP-PPS and to establish two new Level II HCPCS codes for facility reporting instead. As stated elsewhere in this comment letter, it is administratively burdensome to have two different code sets for reporting the same services. Also, the proposed Level II HCPCS codes describe a “per hour” service, which seems contrary to CMS’ goals of increased packaging and bundling. The CPT codes describe cardiac rehabilitation services “per session,” which is more consistent with an increased packaging strategy. Also, we have heard anecdotally from hospitals that a session is typically an hour.

XVII: Quality Data (72FR42799)

XVII-B: Proposed Hospital Outpatient Measures (72FR42800)

According to the proposed rule, the quality measures CMS is proposing address care provided in a large number of adult patients in hospital outpatient settings, across a diverse set of conditions,

and were selected for the initial set of Hospital Outpatient Quality Data Reporting Program (HOP QDRP) measures based on their relevance as a set to all hospitals. However, CMS does not indicate in the proposed rule whether or not they have assessed these measures for data collection and reporting feasibility, especially in a future electronic environment.

The measures that CMS is proposing had not received National Quality Forum (NQF) endorsement at the time the proposed rule was written. AHIMA understands CMS' appreciation and support for NQF endorsement of measures not only for inpatient measures but outpatient measures as well. We would caution CMS about finalizing the 10 measures prior to NQF endorsement. It is unclear if CMS expects to receive endorsement by NQF for these measures or what the process will be if these measures are not endorsed by NQF. AHIMA recommends that CMS provide further detail on the process of these measures and their expected endorsement by NQF.

XVII-C: Other Proposed Hospital Outpatient Measures (72FR42801)

CMS has identified an additional 30 measures that it anticipates implementing for the hospital outpatient setting. AHIMA applauds CMS' effort to utilize measures that are currently in place and have received endorsement by NQF or expect to receive endorsement shortly. It is unclear what the implementation process will be for the hospital to implement the potential 30 additional measures. There is no discussion regarding a phased approach or whether CMS anticipates implementing the measures all at once. We recommend that CMS identify the expectation for implementation of these measures to allow hospitals enough time for preparation of resources, staff training, and support of this additional requirement.

After a review of the NQF endorsement column of the chart that highlights the potential additional quality measures CMS anticipates implementing, we have identified over 50 percent of those measures that expect to retire their endorsement by the middle of 2009. It is unclear if CMS expects to receive continued endorsement by NQF on these measures, or will retire these measures before they have been implemented for the CY 2010. AHIMA recommends that CMS possibly reconsider these measures or select those measures that will have a longer shelf life by NQF endorsement.

XVII-E-1: Proposed Requirements for HOP Quality Data Reporting for CY 2009 and Subsequent Calendar Years – Administrative Requirements (72FR42803)

CMS anticipates utilizing the same administrative steps necessary for the HOP QDRP program as it currently utilizes for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program for participation in the program. AHIMA applauds CMS for using current processes that have been established and are familiar to hospitals. This is consistent with the desire by the Secretary to use standard processes and not implement new processes and procedures that are unnecessary, inefficient and wasteful. This method will also allow the hospitals to have a shorter learning curve on the methods necessary to submit measures in order to participate in the HOP QDRP program.

Although the administrative steps are consistent with those currently used for IPPS reporting, CMS should consider developing an electronic method for completing and reviewing the current status of required forms (e.g., Notice of Participation Form, Nonparticipation Form, Withdrawal Form, etc.).

XVII-E-2: Proposed Requirements for HOP Quality Data Reporting for CY 2009 and Subsequent Calendar Years – Data Collection and Submission Requirements (72FR42804)

As noted above, AHIMA applauds CMS for using current processes that have been established and are familiar to hospitals, but CMS should clarify if CART-OPD will be a module within the current CART application or a standalone application. Some hospitals may utilize the same staff to collect and report RHQDAPU and HOP QDRP data and these individuals should not be required to install, maintain and operate two separate applications. AHIMA recommends that CMS consider a version of CART-OPD that will operate as a module of the current CART application to reduce administrative burden for hospitals.

XVII-E-3: Proposed Requirements for HOP Quality Data Reporting for CY 2009 and Subsequent Calendar Years – HOP QDRP Validation Requirements (72FR42804)

CMS anticipates utilizing the same validation requirements necessary for the HOP QDRP program as it currently utilizes for the IPPS RHQDAPU program for participation in the program. AHIMA applauds CMS for using current processes that have been established and are familiar with the hospitals. This is consistent with the desire by the Secretary to use standard processes and not implement new processes and procedures that are unnecessary, inefficient and wasteful. This method will also allow the hospitals to have a shorter learning curve on the methods necessary to submit measures in order to participate in the HOP QDRP program.

CMS anticipates implementing a Value Based Purchasing (VBP) program that will replace the RHQDAPU program. AHIMA requests that CMS provide further clarification on what the expectation and impacts will be for the HOP QDRP program with OPDS data validation requirements and other elements of the program that are expected to change with the VBP program.

XVII-F: Publication of HOP QDRP Data Collected (72FR42805)

AHIMA applauds CMS' efforts to allow participating hospitals the opportunity to preview the reported quality measures that CMS receives prior to being posted to the website. AHIMA is concerned that there is no process or procedure identified for hospitals to appeal the information that is being posted should there be a discrepancy.

XVII-H: HOP QDRP Reconsiderations (72FR42805)

CMS anticipates implementing a reconsideration process for the HOP QDRP, which was found to be a successful addition to the IPPS RHQDAPU program. AHIMA applauds CMS for planning to use current processes as described in the proposed rule, which have been established

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and are familiar with the hospitals. This is consistent with the desire by the Secretary to use standard processes and not implement new processes and procedures that are unnecessary, inefficient and wasteful. This method will also allow the hospitals to have a shorter learning curve on the methods necessary to submit measures in order to participate in the HOP QDRP program.

XVII-I: Reporting of ASC Quality Data (72FR42805)

AHIMA applauds CMS' effort to consider not introducing the HOP QDRP program for ASC in the CY 2008. The burden of transitioning to the revised payment system will certainly require a significant amount of resources and some time to adjust to the new system. Hospitals gaining experience under the HOP QDRP will enable them in the future to share best practices and lessons learned with the ASCs which will enable the ASCs to have a reduced learning curve and leverage the experience that hospitals will gain during this program implementation.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Hospital OPSS. 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 Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,



Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc. Sue Bowman, RHIA, CCS