**AHIMA**
American Health Information
Management Association®

September 26, 2012

The Honorable Kathleen Sebelius          The Honorable Eric H. Holder, Jr.
Secretary                                Attorney General
Department of Health and Human Services  U.S. Department of Justice
200 Independence Ave., S.W.              950 Pennsylvania Ave., N.W.
Room 445-G                               Washington, DC 20530
Washington, DC 20201

Dear Secretary Sebelius and Attorney General Holder:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the letter that was sent to national hospital associations regarding alleged "upcoding" of hospital emergency department (ED) visits.  AHIMA is committed to promoting health informatics and information management (HIM) practices that produce clear, consistent, and complete health record documentation and diagnostic and procedural codes selected based on compliance policies and procedures that accurately represent a patient's healthcare encounter.  Your letter raises three issues of concern to AHIMA and its members and I would like to comment on all three and offer the expertise of AHIMA and its Health Information Management member professionals as you pursue resolution to your issues.

E/M Coding for Hospitals

For more than 10 years, AHIMA has urged the Centers for Medicare and Medicaid Services (CMS) to adopt a national set of coding guidelines for hospital reporting of emergency department and clinic visits in place of the current system of internal guidelines developed by each hospital for its own use.  In 2003, AHIMA collaborated with the American Hospital Association (AHA) to develop a standardized set of coding guidelines for reporting emergency department and clinic visits and recommended its adoption to CMS.  However, CMS has not yet implemented this or any standardized system for hospital reporting ED and clinic visits.

Hospitals use the American Medical Association's (AMA) Current Procedural Terminology (CPT®) evaluation and management (E/M) codes to report clinic and ED visits. Recognizing that the E/M descriptors were designed to describe physician rather than hospital services, CMS instructed hospitals to develop internal hospital guidelines to determine the level of clinic or ED services provided.

The use of hospital-specific internal coding guidelines is contrary to government and industry goals of data uniformity, consistency, and comparability.  Certainly, other code set reporting requirements for reimbursement purposes already mandate adherence to national coding guidelines as required under HIPAA to promote accuracy and consistency and provide a standard against which to assess coding accuracy (e.g., *ICD-9-CM Official Guidelines for Coding and Reporting*).

AHIMA continues to believe that nationally adopted official coding guidelines are necessary in order to ensure accurate, consistent, and comparable reporting of ED and clinic visits across hospitals as well as

proper and equitable reimbursement for the services provided to patients. **AHIMA stands ready to work with CMS and other groups to develop national guidelines for the coding and reporting of hospital ED and clinic visits and assist in a nationwide implementation of these guidelines as a replacement for individual hospital guidelines.**

Fraud and Abuse with the Electronic Health Records

In AHIMA's championing for the development, adoption, and use of electronic health record systems (EHRs), AHIMA and its members have been cognizant of the potential for coding errors as a result of variations in an EHR system. For this reason, AHIMA has been very active in developing standard clinical transactions and works with a number of global standards groups including the Health Level Seven (HL7), the International Health Terminology Standards Development Organization (IHTSDO), the International Organization for Standards (ISO) Technical Committee 215 for Health Informatics (215), the Joint Commission, and the World Health Organization (WHO). AHIMA is also the designated Secretariat for the ISO 215 and the US 215 Technical Advisory Group.

Several years ago AHIMA through its Foundation also worked with the HHS Office of Inspector General to investigate the issues of fraud and abuse with electronic health records because we believe there are ways to ensure that EHR systems are built and used properly so that potential for fraud and abuse can greatly be reduced. Much has changed since this work in the last decade and we are quite willing to work with you further on this issue. AHIMA has also worked with the Federal Bureau of Investigation (FBI) on other fraud and abuse projects so I believe you are aware of our expertise and desire to ensure that the EHRs and the systems that produce secondary data from EHRs, including claims, generate accurate information.

**Impact of better documentation and coding on reimbursement**

Improved documentation and coding that result in higher reimbursement does not equate to fraud or abuse. Since coding accuracy and specificity depend on the quality of the medical record documentation, any efforts to improve the quality of the documentation will (or should) result in improved coding accuracy and specificity. More accurate and detailed coding leads to more accurate reimbursement, not inappropriate payment.

Since one of the touted benefits of EHRs is improved documentation, it follows that documentation will improve as the result of EHR adoption, and coding quality and the accuracy of the reimbursement amount based on the reported codes will also improve. Providers should be encouraged to improve the quality of their documentation and coding, not be criticized for doing so. As CMS and other government agencies have acknowledged in various regulations, there is a growing demand for more accurate and detailed data due to new and expanding healthcare initiatives such as value-based purchasing, quality reporting, and patient safety monitoring. With better and more accurate data, patient care can only be improved. Therefore, any analysis of the causes of increases in reimbursement should clearly differentiate between real improvements in the accuracy and specificity of documentation and coding versus inaccurate documentation and coding resulting from EHR misuse or other improper practices.

AHIMA

AHIMA is a nonprofit, professional association representing more than 64,000 health information management (HIM) professionals who work throughout the healthcare industry. HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing,

protecting, validating the integrity of, reporting, releasing, and utilizing data vital for patient care, while making it accessible to patients, healthcare providers, authorized requestors, and appropriate researchers when it is needed most. AHIMA members are deeply involved in the development, planning, implementation and management of electronic health records, in addition to the analysis and reporting of healthcare data for secondary use. AHIMA has a history of working with the Department of Justice, the Department of Health and Human Services, CMS, and the Office of the Inspector General to combat fraud and abuse in current and future health record systems and the process of coding.

AHIMA is a leader in assuring that the health information used in care, research, health management, and all other purposes is valid, accurate, complete, trustworthy, and timely. A *Code of Ethics* and *Standards of Ethical Coding* have been developed by AHIMA, which set ethical expectations for HIM and coding professionals. For example, the *Standards of Ethical Coding* state that coding professionals should "assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules, and guidelines." These *Standards* also state that coding professionals should "refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines."

Conclusion

Again, AHIMA urges you to move CMS to develop and implement an official E/M set of national coding and reporting guidelines such as we, and the AHA, have proposed to eliminate many of the concerns you address in your recent letter. AHIMA also urges you to recognize that as EHRs produce more data for primary and secondary use, the better defined coding reflects this change and not a desire to defraud or abuse the system. AHIMA stands ready to work with your departments to resolve the issues of concern for not only coding and coding standards and guidance, but also to ensure that the US adoption and use of EHRs results in correct data and accurate trusted information.

If you would like to follow up on this offer, or have any further questions or concerns, please feel free to contact Sue Bowman, AHIMA's senior director for coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org or Dan Rode, AHIMA's vice president for advocacy and policy at (202) 659-9440 or dan.rode@ahima.org. Thank you for your time and consideration of this request.


Sincerely,

Lynne Thomas Gordon, MBA, RHIA, CAE
Chief Executive Officer


cc: Patty Terry Sheridan, MBA, RHIA, FAHIMA, President AHIMA
    Dan Rode, MBA, CHPS, FHFMA
    Sue Bowman, MJ, RHIA, CCS, FAHIMA