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September 6, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1601-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: File Code: CMS-1601-P

Dear Administrator Tavenner:

On behalf of the American Health Information Management Association (AHIMA), I am pleased to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program, as published in the July 19, 2013 *Federal Register*.

AHIMA is a not-for-profit professional association representing more than 67,000 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, and reporting data vital for patient care, while helping to assure that data are accurate and appropriately available to patients, providers, policymakers and researchers. AHIMA members are directly involved in developing, analyzing, and reporting healthcare data, including value sets associated with quality measurement and in the development, planning, implementation, and management of electronic health records.

In the discussion below we focus on sections of the proposed rules that are of specific relevance and interest to our members.

VII. Proposed OPPS Payment for Hospital Outpatient Visits (78FR43614)

B. Proposed Payment for Hospital Outpatient Clinic and Emergency Department Visits (78FR43615)

Department of Health and Human Services
AHIMA Comments on CY 2014 OPSS Proposed Rule
Page 2

AHIMA applauds CMS' proposed elimination of new and established clinic visits, as we have historically supported this proposed change.

AHIMA is concerned about CMS' proposal to replace the current five levels of hospital outpatient clinic and emergency department (ED) visits with three new alphanumeric Level II HCPCS codes that would distinguish only among clinic visits, Type A ED visits, and Type B ED visits. Given the wide range of clinical complexity and resource utilization covered by hospital clinic and ED visits, a single visit code in each of these three categories is essentially meaningless. CMS stated in the CY 2014 OPSS proposed rule that they had concluded it is not feasible to adopt a set of national guidelines for reporting hospital clinic visits that can accommodate the enormous variety of patient populations and service mix provided by hospitals of all types and sizes throughout the country. AHIMA believes it is even less feasible for a single code to reasonably represent this wide range of populations and services, for either clinic or ED visits.

While we commend CMS' desire to reduce the administrative burden that Medicare payment policies place on hospitals, we believe it is essential for both hospitals and CMS to capture clinic and emergency department visit levels that distinguish significant differences in clinical complexity, patient acuity, and resource utilization. The need for this level of detail seems especially critical in an era when increasingly detailed healthcare data are required by federal and state programs aimed at providing patients the best care at the lowest cost. We are concerned that if private payers may continue to require the reporting of different visit levels, CMS' approach may not fully achieve the goal of reducing the administrative burden of determining the various levels of care.

The basis for CMS' proposal to eliminate the five levels within the categories of clinic, Type A ED, and Type B ED visits is unclear. In past OPSS rules, CMS has stated that they have continued to observe a normal and stable distribution of clinic and ED visit levels in hospital claims. CMS has consistently reiterated their belief that hospitals are generally billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. Even in the CY 2013 OPSS final rule, where CMS mentioned recent reports in the public media of billing inaccuracies for hospital outpatient visits, there was no indication that CMS' own data analysis supported these reports. In that rule, CMS reminded hospitals that they are committed to vigorously enforcing their payment policies and would pursue appropriate action against any potentially fraudulent activities they identify – clearly affirming that there are ways of addressing potentially fraudulent billing practices other than eliminating visit level distinctions entirely.

Rather than eliminating visit level distinctions altogether, **AHIMA recommends that CMS consider establishing three levels within each visit category rather than five.** The use of three levels would potentially allow for adequate distinctions in clinical complexity and resource utilization, while facilitating consistency in visit code reporting and auditing.

AHIMA further recommends, that CMS promulgate national guidelines for reporting these clinic and ED visit levels. CMS has indicated previously that the system of hospital-

developed internal guidelines for reporting the appropriate visit level appeared to be working well (i.e., according to CMS' data analysis, hospitals were billing in an appropriate and consistent manner), so it was not necessary to implement national guidelines. However, apparently CMS no longer believes this system is working well (and that hospitals are billing appropriately for clinic and ED visits), since the CY 2014 proposed rule indicates that one of the reasons for the proposed elimination of distinctions among visit levels is the removal of any incentive for hospitals to "upcode." Implementation of national guidelines for reporting visit levels would standardize the reporting of hospital outpatient visits, allowing for consistent and standardized auditing of hospitals' billing practices for clinic and ED visits and easier identification of inappropriate practices requiring further action. **AHIMA specifically recommends that CMS work with the American Hospital Association (AHA), AHIMA, and other stakeholders to update the set of guidelines for clinic and ED visit coding previously developed by an independent expert panel convened by these organizations and then adopt them as the set of national guidelines for visit code reporting under the OPPTS.**

XIII-Hospital Outpatient Quality Reporting Program Updates (78FR43643)

XIII-A-3-a-Process for Updating Quality Measures (78FR43644)

AHIMA considers conversion of a measure to use ICD-10-CM/PCS to be a substantive change that should follow current proposed rulemaking processes. We respectfully request clarification regarding the publication, preview, and comment period for ICD-9-CM to ICD-10-CM/PCS mappings for all value sets for diagnoses and procedures used by measures specified in this rule.

XIII-C-Removal or Suspension of Quality Measures from the Hospital OQR Program Measure Set (78FR43645)

AHIMA commends the efforts of CMS to continually review measures to ensure conformance to criteria of the program. AHIMA supports the removal of measures as proposed, under this section.

XIII-E-Possible Quality Measures for the CY 2016 Payment Determination and Subsequent Years (78FR43647)

AHIMA supports the use of measures that have been *fully endorsed at the specified delivery level/setting* by the National Quality Forum (NQF) and reviewed and recommended for implementation in federal programs by the Measure Application Partnership (MAP). The NQF endorsement procedure ensures the critical review of the science of a measure and its development through a multi-stakeholder, transparent, consensus process. The MAP pre-rulemaking procedure ensures the critical review for appropriateness of use in federal programs through a multi-stakeholder, transparent consensus process. We encourage the use of this tiered review process for selection of measures in federal programs.

XIII-E-2-Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedure (NOF#0564) (78FR43649)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XIII-E-3-Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (NOF #0658) (78FR43649)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XIII-E-4-Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use (NOF #0659) (78FR43649)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XIII-E-5-Cataracts—Improvement in Patient’s Visual Function Within 90 Days Following Cataract Surgery (NOF # 1536) (78FR43650)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XIII-F-Possible Hospital OQR Program Measure Topics for Future Consideration (78FR43651)

AHIMA urges a paced approach to the adoption of additional quality measures and respectfully requests concomitant alignment with Meaningful Use, the development of standards, an interoperability framework, and health information exchange networks to support quality measurement, which requires exchange of data across the continuum of care. AHIMA urges careful consideration of confidentiality, privacy, and security regulations, including the patchwork of state regulations that will have to be addressed for successful implementation of measures for use by Partial Hospitalization Programs (PHPs) in Hospital Outpatient Departments (HOPDs) which require exchange of data across the continuum of care.

XIII-H-2-f- Proposed Data Submission Requirements for Measure Data Submitted via Web-Based Tool for the CY 2016 Payment Determination and Subsequent Years (78FR43655)

AHIMA urges the development and implementation of a comprehensive results validation/verification program that covers chart-abstracted measures, aggregate-level web-based measures, and claims-based measures. We urge CMS and ONC to align efforts to verify data through demonstration or other projects that review the comparability of results of manually abstracted measures with electronically specified/EHR extracted measures. AHIMA would be happy to work with CMS and other stakeholders on such demonstration or evaluation projects.

AHIMA believes that adherence to established health information principles and standards is essential for achieving healthcare data integrity. AHIMA has an extensive program and process for certification and credentialing of clinical documentation improvement and clinical data analytics professionals and would be pleased to provide detailed information on the programs. AHIMA and its members focus considerable attention on the importance of clinical data collection, accuracy, and integrity, and we urge CMS to consider such factors in data submission and reporting requirements.

XIII-H-3-Hospital OQR Program Validation Requirements for Chart-Abstracted Measure Data Submitted Directly to CMS for the CY 2015 Payment Determination and Subsequent Years (78FR43656)

As noted above, AHIMA urges the development of a comprehensive results validation/verification program that covers chart-abstracted measures, aggregate-level web-based measures, and claims-based measures. We further urge CMS and ONC to align efforts to verify through demonstration or other projects the comparability of results of manually abstracted measures with electronically specified/EHR extracted measures.

XV-Proposed Requirements for the Ambulatory Surgical Centers Quality Reporting (ASCQR) Program (78FR43660)

XV-B-ASCQR Program Quality Measures (78FR43660)

AHIMA supports and commends CMS' efforts to move toward greater alignment and harmonization across the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs.

XV-B-3-Proposed Additional ASCQR Program Quality Measures for the CY 2016 Payment Determination and Subsequent Years (78FR43661)

AHIMA supports the use of measures which have been *fully endorsed at the specified delivery level/setting* by the National Quality Forum (NQF) and reviewed and recommended for implementation in federal programs by the Measure Application Partnership (MAP.) The NQF endorsement procedure ensures the critical review of the science of a measure and its development through a multi-stakeholder, transparent, consensus process. The MAP pre-rulemaking procedure ensures the critical review for appropriateness of use in federal programs through a multi-stakeholder, transparent consensus process. We encourage the use of this tiered review process for selection of measures in federal programs.

XV-B-3-a-Complications within 30 Days Following Cataract Surgery Requiring Additional surgical Procedures (NQF #) (78FR43661)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XV-B-3-b-Endoscopy/Polyp Surveillance: Appropriate Follow-Up for Normal Colonoscopy in Average Risk Patients (NQF #0658) (78FR43662)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XV-B-3-c-Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use (NQF #0659) (78FR43662)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XV-B-3-d-Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (NQF #1536) (78FR43663)

AHIMA supports the MAP recommendation that implementation of the measure be contingent upon full endorsement of the measure for the facility level based upon testing for the facility level of analysis.

XV-B-5-Technical Specification Updates and Data Publication (78FR43664)

AHIMA considers conversion of a measure to use ICD-10-CM/PCS to be a substantive change which should follow current proposed rulemaking processes. We respectfully request clarification regarding the publication, preview, and comment period for ICD-9-CM to ICD-10-CM/PCS mappings for all value sets for diagnoses and procedures used by measures specified in this rule.

XV-D-7-ASCQR Program Validation of Claims-Based and CMS Web-Based Measures (78FR43670)

As noted above, AHIMA urges the development of a comprehensive results validation/verification program that covers chart-abstracted measures, aggregate-level web-based measures, and claims-based measures. We again urge CMS and ONC to align efforts to verify through demonstration projects the comparability of results of manually abstracted measures with electronically specified/EHR extracted measures.

Department of Health and Human Services
AHIMA Comments on CY 2014 OPSS Proposed Rule
Page 7

AHIMA thanks you for the opportunity to provide comments and if we can provide any further information, or if there are any questions regarding our feedback, please feel free to contact me or contact Meryl Bloomrosen, Vice President, Thought Leadership, Practice Excellence, and Public Policy at Meryl.bloomrosen@ahima.org. Please let us know if we can be of further assistance to you in your efforts.

Sincerely,

A handwritten signature in black ink, appearing to read "Lynne Gordon". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Lynne Thomas Gordon, MBA, RHIA, FACHE, CAE
CEO, AHIMA