



August 5, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, (CMS-3295-P)

VIA ELECTRONICALLY

Dear Acting Administrator Slavitt:

Thank you for the opportunity to submit comments on the proposed rule that would update the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs.

AHIMA is the national non-profit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals dedicated to effective health information management, information governance, and applied informatics. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 different job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information analytics.

Although the proposed rule covers a number of topics, we offer specific comments related to the proposed changes to the Patient's Access to Medical Records and Medical Record Services below.

Patient's Access to Medical Records

As a member of the *GetMyHealthData* campaign, AHIMA has long advocated that consumers' access to their health information is essential to improved health and healthcare and we will continue to support efforts to clarify an individual's right to access their health information.

We appreciate that the proposed rule clarifies that "a patient has the right to access their medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or if not, in a readable hard copy form or such other form and

format as agreed to by the facility and the individual . . .” However, we are concerned that the language “within a reasonable time frame” creates ambiguity as to the period in which a hospital must provide a patient with a copy of their medical records. **We recommend that the proposed rule be revised at §482.13(d)(2) to state that a patient’s request to access their medical record must be fulfilled within the time frame set forth under HIPAA.** Such specificity would align §482.13(d)(2) with 45 CFR 164.524(b)(2), the [February 2016 OCR guidance](#) and eliminate uncertainty as to the period in which a hospital must provide patient access to their medical record under the conditions of participation (CoP).

Medical Record Services

In general, AHIMA is concerned that the rule proposes to require additional documentation related to outpatient visits to reflect all services provided to the patient. More specifically, we are concerned that the term “outpatient visit” in the proposed rule is overly broad and insufficiently defined which could lead to a tremendous documentation burden for hospitals and providers. For instance, a number of our members have noted that there is currently a distinct documentation difference between a diagnostic outpatient visit and a same-day surgery outpatient visit. It is unclear under the proposed rule whether such occurrences would both be treated as outpatient visits and therefore be required to meet the same documentation requirements. **We request that CMS clarify the definition of an “outpatient visit” in the proposed rule as to not unduly burden hospitals and providers.**

AHIMA is also concerned that §482.24(c)(4)(ii) of the proposed rule would require the documentation of “all diagnoses specific to each . . . outpatient visit.” A number of our members agree that there are diagnoses that should be documented in addition to the admitting diagnosis, particularly for elderly patients who often have complications or co-morbid conditions. However, it is often difficult for outpatient providers to document a list of diagnoses because they do not have access to all diagnoses. **We question the feasibility of documenting “all diagnoses specific to each . . . outpatient visit.” We also seek further guidance as to what CMS defines as “specific to” at §482.24(c)(4)(ii). We believe this phrase lacks sufficient specificity as to assist hospitals and providers in ensuring that the appropriate diagnoses are documented in the record and we ask CMS to provide further clarity as it relates to this language in the proposed rule.**

We agree with the documentation requirements at §482.24(c)(4)(vi) in the proposed rule. The inclusion of such documentation will help reflect the services provided to the patient. **However, to ensure that the medical record documents all pertinent information, we recommend that §482.24(c)(4)(vi) be revised to include “all diagnostic test results” rather than limited to “radiology and laboratory reports.”**

AHIMA is troubled that the proposed rule would require the documentation of “discharge and transfer summaries with outcomes of all hospitalizations, disposition of cases, and provisions for follow-up care for all . . . outpatient visits.” A number of our members have noted that currently, discharge summaries are often not required for outpatient visits and often depend on the scope of service or the length of stay.

Should documentation of discharge summaries be required for all outpatient visits as a condition of participation, we are concerned that the ability to track such information would be extremely difficult and unduly burdensome. A number of our members question how such documentation could even be monitored within their department. **Again, we ask CMS to clarify the definition of “outpatient visit” under the proposed rule. Alternatively, should discharge summaries for all outpatient visits be**

required, we recommend that the rule enumerate the content required for the discharge summaries for all outpatient visits to ensure that the appropriate information is included as part of the medical record.

Finally, AHIMA is concerned that the rule proposes to require the completion of medical records within seven days following all outpatient visits. Our members have noted that lab results often take longer than seven days to be read and integrated into the medical record, particularly if the specimen is sent to an outside entity. Furthermore, our members question whether their electronic health record (EHR) systems have the functionality to monitor these two different time periods for inpatient and outpatient visits. We understand and acknowledge the need to ensure that timely, relevant, and meaningful information is included in the medical record, particularly as the patient may be discharged home or to a post-acute care facility. **However, we recommend that there be consistency in the time frame required for completion of the medical record for all inpatient stays and outpatient visits.**

We thank you for the opportunity to submit comments on the proposed rule that would update the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. We look forward to working with CMS to ensuring the successful update and implementation of the proposed requirements for Conditions of Participation (CoP) under the Medicare and Medicaid programs. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Senior Director, Federal Relations, at lauren.riplinger@ahima.org and (202) 839-1218, or Pamela Lane, Vice President, Policy and Government Relations, at pamela.lane@ahima.org and (312) 233-1511.

Sincerely,

A handwritten signature in black ink, appearing to read "Lynne Gordon", with a stylized flourish at the end.

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