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September 8, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1676-P**
PO Box 8016
Baltimore, Maryland 21244-1850

RE: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Proposed Rule (CMS-1676-P)

Dear Administrator Verma:

On behalf of the American Health Information Management Association (AHIMA), thank you for the opportunity to provide comments on the proposed changes to the Payment Policies Under the Physician Fee Schedule for Calendar Year (CY) 2018, as published in the July 21, 2017 *Federal Register* (CMS-1676-P).

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.

Our comments and recommendations on selected sections of the Physician Fee Schedule proposed rule are below.

II. Provisions of the Proposed Rule for PFS (82FR33952)

II-I – Evaluation & Management (E/M) Guidelines and Care Management Services (82FR34078)

We completely agree that the E/M documentation guidelines are outdated and that a major revision should be undertaken. Currently, E/M code levels are often driven by the volume of documentation rather than by clinical differences in patient complexity. AHIMA believes any set

of E/M documentation guidelines should accurately reflect differences in patient complexity and be readily understandable and objective. Unnecessary or clinically irrelevant documentation should not be required.

AHIMA agrees that medical decision-making is a more significant factor than history and physical exam in distinguishing differences in E/M levels and perhaps should be weighted heaviest in determining the E/M level for a patient visit. We believe the current history and exam documentation requirements are administratively burdensome, not representative of the current practice of medicine or meaningful for patient care, are ill-designed for use in an electronic documentation environment, and are vulnerable to upcoding. However, we are concerned about eliminating history and physical exam documentation requirements altogether. History and exam components that are relevant to the patient encounter provide a more complete clinical picture than medical decision-making alone and are important for quality of care. While the history and exam components are in need of substantial revision, there may be value in retaining a modified and scaled-down version of these components in the E/M documentation guidelines, especially for new patients.

We recommend that CMS work with industry stakeholders to modify the E/M documentation guidelines and pilot test the updated version in physician practices of different sizes and specialties. The goal should be to produce a relatively simple set of documentation guidelines that are easy to understand and use, distinguish meaningful differences among E/M code levels, and do not require the capture of additional documentation that is unnecessary for patient care. Comprehensive education on the updated documentation guidelines should be provided in order to facilitate their proper and consistent application.

III. Other Provisions of the Proposed Rule (82FR34080)

III-J – MACRA Patient Relationship Categories and Codes (82FR34128)

We agree with CMS that there will be a learning curve with the use of the new patient relationship HCPCS modifiers and support the proposal for voluntary reporting of these modifiers until clinicians become familiar with using them. We would be happy to work with CMS on education regarding the proper use of these modifiers. We recommend that education be targeted at both clinicians and their coding staff, since clinicians may delegate responsibility for assignment of these modifiers to staff members.

AHIMA fully supports CMS' intention to resubmit the patient relationship modifiers to the American Medical Association for future consideration for incorporation into the CPT code set.

Conclusion

AHIMA appreciates the opportunity to comment on the CY 2018 Medicare Physician Fee Schedule proposed rule. AHIMA is committed to working with CMS and the healthcare industry to improve the quality of healthcare data for reimbursement, quality reporting, and other applied analytics.

If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please contact Sue Bowman, Senior Director of Coding Policy and Compliance at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,

Pamela L. Lane, MS, RHIA
Interim Chief Executive Officer

cc: Sue Bowman, MJ, RHIA, CCS, FAHIMA