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September 26, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1715-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 2020; Proposed Rule (CMS-1715-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) 2020, as published in the August 14, 2019 *Federal Register* (CMS-1715-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 with the mission of empowering people to impact health. 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.

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

II. Provisions of the Proposed Rule for the PFS (84FR40483)

II-J – Review and Verification of Medical Record Documentation (84FR40547)

II-J-2 – Proposal (84FR40548)

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AHIMA supports the establishment of a general principle that would allow the physician, physician assistant, or advanced practice registered nurse who furnishes and bills for his professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team.

II-K –Care Management Services (84FR40548)

II-K-3 – Chronic Care Management (CCM) Services (84FR40550)

For reporting clinical staff time spent performing chronic care management activities under the direction of a physician/qualified healthcare professional, we support the adoption of two new G codes with new increments of clinical staff time to be used instead of CPT code 99490, until such time that the American Medical Association (AMA) CPT Editorial Panel revises this CPT code.

AHIMA does **not** support the proposed creation of two new G codes for complex chronic care management services that would be used under the physician fee schedule instead of CPT codes 99487 and 99489. Since the only difference between the proposed G codes and CPT codes 99487/99489 is the elimination in the G codes of the required element regarding substantial revision of a care plan, the need for new G codes is unclear. CMS stated in its rationale that they believe it isn't necessary to explicitly include substantial care plan revision, because patients requiring moderate- to high-complexity medical decision-making implicitly need and receive substantial care plan revision. CMS also noted that the service component of substantial care plan revision is a potentially duplicative service component and, therefore, it is unnecessary as a means of distinguishing eligible patients. Since CMS is not suggesting that substantial care plan revision is unlikely to occur or is unnecessary (only that it should not be explicitly included as a required element), we do not believe the creation of new G codes is justified. **We recommend that CPT codes 99487 and 99489 continue to be used for complex chronic care management services and that CMS consider proposing a revision of the code descriptors for the complex chronic care management codes to the CPT Editorial Panel.**

II-K-4 – Principal Care Management (PCM) Services (84FR40553)

We support the adoption of two new G codes for principal care management services, as these codes fill an important gap in codes for care management services. It seems reasonable to base the structure of these codes on existing CPT codes 99490 and 99491.

If the proposed new G codes for chronic care management services with new increments of clinical staff time are adopted, then AHIMA believes it would be appropriate to create an add-on code for additional time spent each month when principal care management services are furnished by clinical staff under the direction of the billing practitioner. The structure of the new G codes for principal care management services should be consistent with the codes for chronic care management services.

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The new G codes should be implemented as a temporary solution until such time as the CPT Editorial Panel can consider creating CPT codes for Principal Care Management services.

II-K-6 –Comment Solicitation on Consent for Communication Technology-Based Services
(84FR40556)

AHIMA recommends that CMS retain its current requirement that verbal consent must be documented in the medical record for each service furnished via communication technology. We are concerned that allowing a single advance beneficiary consent for a number of communication technology-based services might result in confusion on the part of both providers and beneficiaries or inappropriate utilization of these services. Since the need for communication technology-based services is often based on changes in a medical condition, new symptoms, the outcome of test results, etc., it is unclear how feasible an advance consent for multiple services really is, or how detailed such a consent would be regarding the nature of each service covered by the consent. In order for beneficiaries to consent to receipt of these services and fully understand cost-sharing obligations, they need to understand the nature of the specific service being provided and who is providing the service. We believe the best way to ensure beneficiaries are fully informed regarding the services for which they are giving their consent is to require that verbal consent be obtained for each service furnished via communication technology.

II-L – Coinsurance for Colorectal Cancer Screening Tests (84FR40556)

We believe that a verbal notification provided to the patient (with a notation in the medical record) in advance of a colorectal cancer screening would be an appropriate approach for patients to be made aware that a screening procedure could result in a diagnostic procedure if polyps are discovered and removed.

II-P –Payment for Evaluation and Management (E/M) Visits (84FR40670)

II-P-3 –Proposed Policies for CY 2021 for Office/Outpatient E/M Visits (84FR40673)

AHIMA fully supports CMS’s proposal to adopt the AMA/CPT new coding, prefatory language, and interpretive guidance framework.

We support the deletion of HCPCS code GPRO1 (extended office / outpatient E/M time), since this code would no longer be needed.

We also support the consolidation of the two add-on codes into a single add-on code and revision of the single code descriptor to better describe the work associated with visits that are part of ongoing, comprehensive primary care, and/or visits that are part of ongoing care related to a patient’s single, serious, or complex chronic condition.

We respectfully **disagree** with part of CMS’s interpretation of the revised CPT prefatory language and reporting instructions. CMS’s interpretation seems to suggest that CPT codes 99358 and 99359 (Prolonged E/M without Direct Patient Contact) could never be reported with office/outpatient E/M visit codes, even when the prolonged services occur on a different date of service. However, the introductory guidelines for new CPT code 99XXX state, “For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215), see 99358, 99359.” Therefore, we believe it would be appropriate to report CPT codes 99358 and 99359 with office/outpatient E/M visit codes when the prolonged services occur on a prior or subsequent date of service.

AHIMA recommends that CMS propose to the AMA CPT Editorial Panel that corresponding revisions be made to the E/M codes for healthcare settings other than office/outpatient so that the E/M coding structure and guidelines are consistent across all healthcare settings.

III. Other Provisions of the Proposed Regulations (84FR40680)

III-K. CY2020 Updates to the Quality Payment Program (84FR40730)

III-K-c(4) – MIPS Performance Category Measures and Activities: Promoting Interoperability Performance Category (84FR40766)

AHIMA appreciates CMS’s continued focus on prioritizing stability within the Promoting Interoperability performance category, reducing administrative burden, and improving patient access to their electronic health information, as well as further alignment with the Medicare Promoting Interoperability Program where feasible. We offer the following comments related to the proposed changes to the Promoting Interoperability performance category under MIPS.

III-K-c(4-c) – Proposed Promoting Interoperability Performance Category Performance Period (84FR40766)

AHIMA supports the minimum continuous 90-day reporting period for the 2023 MIPS payment year as proposed by CMS. We believe the shortened reporting period offers an opportunity for eligible clinicians to implement and update measures as well as allow for adjustment to other changes being proposed as part of this rule. Furthermore, we support CMS’s intent to align this reporting period with the EHR reporting period under the Medicare Promoting Interoperability Program in CY 2021.

III-K-c(4-d-i) – Proposed Changes to Measures for the Electronic Prescribing Objective (84FR40766)

AHIMA supports CMS’s proposal to make the Query of Prescription Drug Monitoring Program (PDMP) measure optional in CY 2020 for five bonus points, as well as its proposal to remove the

numerator and denominator established for the measure and instead require a “yes/no” attestation beginning in CY 2019. We continue to be concerned that existing health information technology (IT) systems are not fully integrated with PDMPs, requiring providers to log separately into PDMP databases and manually enter the data into the certified electronic health record technology (CEHRT) to document completion of the query. Our members are also concerned that separate sign-in to a non-integrated PDMP requires hand entry of demographics to search for a specific patient, which increases the probability of erroneously matching a patient to another individual’s health information, in turn raising patient safety concerns.

We are pleased that CMS recognizes these concerns and believe that such flexibility as proposed will enable early adopters of the measure to participate and potentially earn five bonus points, while providing additional time for CMS to restructure the measure in a manner that meets the needs of clinicians and other stakeholders. We also believe this will provide additional time for the Centers for Disease Control and Prevention (CDC) and the Office of the National Coordinator for Health IT (ONC) to advance and scale PDMP integration with health IT systems, including testing and refining of standards-based approaches to enable effective integration into clinical workflows as well as enhanced access and use of PDMP data.

AHIMA is also pleased that CMS proposes to remove the Verify Opioid Treatment Agreement measure from the Promoting Interoperability performance category beginning in CY 2020. In the CY 2019 Physician Fee Schedule proposed rule comment period, we expressed concern that CMS did not intend to define an opioid treatment agreement as a standardized electronic document, including data elements, content structure, or clinical purpose, for a document to be deemed a “treatment agreement” under the Verify Opioid Treatment Agreement measure. We are pleased that CMS intends to remove this measure, as we believe that the measure as originally conceived could lead to additional clinician burden and may not advance interoperability.

III-K-c(4-g) – Request for Information on Patient Matching (84FR40782)

Do stakeholders believe that CMS and ONC patient matching efforts impact burden? Please, explain.

AHIMA believes that both CMS and ONC play a critical role in helping to reduce the burden associated with patient misidentification.

In 2015, AHIMA conducted a survey of its membership and found that of the respondents surveyed, 57 percent work to address patient duplicates regularly. Of those, 53 percent of respondents worked to address patient record duplicates on a daily basis. Challenges identified by AHIMA members in managing their Master Patient Index (MPI) or Enterprise Master Patient Index (EMPI) included but were not limited to: registration staff turnover, lack of sufficient patient search terminology and/or algorithms, as well as lack of sufficient resources to correct duplicates.

In the past six months, AHIMA resurveyed its membership to determine whether we have “moved the needle” in addressing patient misidentification as interoperability has improved. An initial review of the data indicates that HIM professionals continue to work to address patient record duplicates on a regular basis. Survey data also suggests that of the respondents surveyed, 63 percent work their patient record duplicates daily, an increase of 10 percent since 2015. Similar to the results of the earlier survey, respondents again cited registration staff turnover, lack of sufficient patient search terminology and/or algorithms, and lack of sufficient resources as unresolved challenges in patient matching.

As data exchange increases among providers and as the demand for access to quality healthcare increases, patient identification and data matching errors will become exponentially more problematic and dangerous. Accurately identifying patients and matching them to their data is essential to care coordination and a requirement for health system transformation and the continuation of our substantial progress towards nationwide interoperability, a goal of the landmark 21st Century Cures Act. Both CMS and ONC have a crucial role to play in exercising their respective programmatic authority to improve patient identification while reducing the administrative burden associated with trying to accurately match a patient to their health information.

If stakeholders believe that patient matching is leading to increased burden, what suggestions might stakeholder have to promote interoperability securely and accurately, without the requirements of a UPI, that may result in burden reduction? Please, be specific.

In the absence of a unique patient identifier, AHIMA believes there are a number of possible policy solutions that could promote interoperability while reducing administrative burden, including but not limited to:

- **Development, use, and dissemination of standardized demographic data elements:** CMS should work with ONC to require, as part of the US Core Data for Interoperability (USCDI), the use of well-tested standards for certain demographic data elements to improve patient matching rates. For example, ONC should specify the use of the US Postal Service standard for “address” under the USCDI. A recent study indicates that use of the US Postal Service standard could improve match rates by 2-3 percent.¹ We also recommend that CMS work with ONC, the industry, and experts to identify other regularly collected demographic data elements that could be incorporated into the USCDI to improve patient matching, including such elements as email address and/or mobile phone number.
- **Attestation to ONC Patient Demographic Data Quality Framework:** The use of sophisticated technologies including advanced patient matching algorithms and

¹ Grannis, Shaun J, Xu, Huiping, et al. “Evaluating the effect of data standardization and validation on patient matching accuracy.” *Journal of American Medical Informatics Association*, 2019; 5 (26): 447-456
<https://doi.org/10.1093/jamia/ocy191>

biometrics are crucial to improving patient matching. However, even the most advanced technologies cannot eliminate the risk of human error. Furthermore, there is a real cost associated with implementation and maintenance of biometric technologies. A recent 2019 survey of AHIMA members indicates that only 7 percent of respondents use biometrics during patient registration, a 3 percent increase from 2015.

For that reason, data governance and data quality improvement policies and procedures are fundamental to improving overall patient matching rates and data integrity in general. Along these lines, we recommend that CMS require eligible clinicians, eligible hospitals, and critical access hospitals (CAH) under the Promoting Interoperability Program to attest that they have evaluated their patient demographic data management practices using the ONC's Patient Demographic and Data Quality (PDDQ) Framework. Such an approach would not only ensure that appropriate processes and practices are in place to minimize patient record duplicates, thereby improving patient matching, but could also be implemented with minimal burden to program participants.

- **Development of a voluntary set of agreed-upon metrics to evaluate algorithm performance:** CMS, in coordination with ONC, should develop a set of agreed-upon metrics to evaluate algorithm performance. Such benchmarking will help shed further light on the extent of the variation in matching algorithms and offer health IT developers an opportunity to improve upon their algorithms. Such benchmarking may also help alleviate the burden and additional cost of facilities having to purchase multiple vendor systems in order to clean and maintain their MPI/EMPI. Any set of agreed-upon metrics should be developed by the industry in partnership with CMS and ONC.

Conclusion

AHIMA appreciates the opportunity to comment on the CY 2020 Medicare Physician Fee Schedule proposed rule. AHIMA is committed to working with CMS and the healthcare industry to improve the quality of health information for the provision of excellent patient care as well as the other important purposes for which this information is used.

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,



Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer