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August 18, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1404-P**
PO Box 8013
Baltimore, Maryland 21244-1850

Re: File Code CMS-1404-P

Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2009 Payment Rates; Proposed Rule (73 *Federal Register* 41416)

Dear Mr. Weems:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Hospital Outpatient Prospective Payment System (OPPS) and calendar year 2009 Rates, as published in the July 18. 2008 *Federal Register*. Our comments focus on those areas of particular interest to our members.

AHIMA is a not-for-profit professional association representing more than 51,000 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, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most.

Consistency in medical coding and the use of medical coding standards in the US is a key issue for AHIMA. As part of this effort, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

AHIMA participates in a variety of coding usage and standardization activities in the US and internationally, including the American Medical Association's (AMA's) Current Procedural Terminology® (CPT®) Editorial Panel.

AHIMA and its members also participate in a variety of projects with other industry groups and agencies of the Health and Human Services Department related to the use of secondary data for a variety of purposes including quality monitoring, reimbursement, public health, patient safety, biosurveillance, and research.

Our detailed comments and rationale on the NPRM for OPPS are below.

VIII-B: Proposed Coding and Payment for Drug Administration Services (73FR41503)

AHIMA appreciates and supports CMS' proposal to continue the use of drug administration CPT codes for OPPS reporting in CY 2009.

IX: Proposed OPPS Payment for Hospital Outpatient Visits (73FR41505)

IX-B-1: Clinic Visits: New and Established Patient Visits (73FR41506)

We appreciate CMS' efforts to revise the definitions of "new" and "established" patient in order to make it easier for hospitals to distinguish these patient types for the purpose of correctly reporting clinic visits under the OPPS. **However, we continue to believe, consistent with the APC Panel's previous recommendation, that the distinction between new and established patients under the OPPS should be eliminated.** Any cost differences should be captured by the facility's guidelines for determining the appropriate visit code level.

IX-B-3: Visit Reporting Guidelines (73FR41510)

AHIMA continues to urge CMS to promulgate national visit guidelines for clinics and emergency department visits. It is unconscionable that CMS has failed to replace the hospital-specific coding guidelines with a set of national guidelines, when the movement throughout the healthcare industry is toward data standardization, as demonstrated by ongoing efforts to standardize quality measures, data elements, and data sets. **The use of hospital-specific internal coding guidelines is contrary to government and industry goals of data uniformity and consistency.**

Although CMS' data may indicate that hospitals are generally billing in an appropriate and consistent manner, coded visit data are not comparable across facilities because of differences among facilities' internal guidelines. Regardless of whether the national distribution of levels appears to be normal, data across hospitals are not consistent or comparable as long as visit codes are not assigned in accordance with a set of national guidelines. And reimbursement at the individual hospital level is not necessarily accurate, since there is no national standard for the facility definition of each visit code and hospitals are free to define each visit level however they wish. Also, national guidelines are needed in order to provide a standard benchmark for auditing facility visit code levels. Without a nationally-accepted standard set of guidelines, it is difficult for hospitals to know if their guidelines would be considered compliant or meet an auditor's expectations. CMS' principles for development of facility-specific

internal guidelines are not sufficient for ensuring compliance because judging compliance with these principles is subject to interpretation.

In the proposed rule, CMS encourages hospitals to contact their fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) if they have specific questions related to the creation of internal guidelines. However, we have heard anecdotally from our members that the FIs and MACs are often not able to answer these questions.

X-C-3: Proposed Partial Hospitalization Coding Update (73FR41515)

CMS is proposing to create two group therapy HCPCS level II "G" codes to replace the group therapy CPT codes currently used under the OPPS. We recommend that CMS submit a code proposal to the AMA for CPT code modifications that would include the desired time descriptors so that there is only one set of codes these services. Many private payers require the reporting of CPT codes instead of "G" codes, which results in the reporting of different codes for the same service, depending on the payer.

Use of different code sets for the same service, for different payers, is not consistent with government and industry goals data uniformity and consistency and is administratively burdensome for hospitals. The regulations for electronic transactions and code sets promulgated under the Health Insurance Portability and Accountability Act (HIPAA) indicate that maintainers of the various code set standards should work together in order to attain and maintain coding consistency and avoid duplicate codes.

XII-B: Reporting of Pathology Services for Prostate Saturation Biopsy (73FR41519)

CMS is proposing the creation of four new HCPCS level II "G" codes for pathology services for prostate saturation biopsy sampling to replace the current CPT code currently being used under the OPPS. AHIMA recommends that CMS seek corresponding CPT code modifications in order to avoid multiple ways of coding the same service. As stated above, it is administratively burdensome to have two different code sets for reporting the same services.

XVI-A-1: Reporting Hospital Outpatient Quality Data for Annual Payment Update (73FR41539)

In general where appropriate, AHIMA supports using measures from the current RHQDAPU program in the HOP QDRP where there is the same population as in the inpatient setting. This process is particularly important in establishing the continuity of care. When addressing the measures for the ED-AMI, this population is excluded in the inpatient measures setting. If a large portion of the population falls within the outpatient setting for these measures, the input measures may not be totally reflective of the care that is provided. The addition of the outpatient measures completes the picture of the overall patient population.

XVI-B: Hospital Outpatient Quality Measures for CY 2009 (73FR41540)

The four imaging measures that CMS is proposing had not received National Quality Forum (NQF) endorsement at the time the proposed rule was written. AHIMA understands CMS' appreciation and support for NQF endorsement of measures not only for inpatient measures but outpatient measures as well. We would caution CMS about finalizing the four measures prior to NQF endorsement. It is unclear if CMS expects to receive endorsement by NQF for these measures or what the process will be if these measures are not endorsed by NQF. AHIMA recommends that CMS provide further detail on the process of these measures and their expected endorsement by NQF.

XVI-C-1: Proposed Quality Measures for CY 2010 Payment Determinations (73FR41541)

AHIMA supports CMS' consideration for using data that is already being submitted for reimbursement in order to not increase the data collection and reporting burden on hospitals. However, it is important for hospitals to have a clear understanding on how the measures are derived/calculated so that they know what data is being represented for reporting purposes. Gaining access to the analytic specifications in advance will enable hospitals to review the data and replicate the data the will be reported to CMS.

AHIMA would like to ensure that the four imaging measures will follow the same guidelines as the inpatient measures for approval by a voluntary consensus building body such as the National Quality Forum (NQF) before the measure is implemented. We would like more information regarding the timing of the release of the specification for the measures in order to allow hospitals an appropriate amount of time to become familiar with and understand how these measures are to be calculated.

XVI-C-2: Proposed Process for Updating Measures (73FR41541)

AHIMA supports CMS for considering establishing a sub-regulatory process to update the technical specifications that are used to calculate measures when necessary. If a measure is no longer valid then it would be prudent to discontinue a measure that no longer brings value to the reporting process and only continues to add the burden of reporting by hospitals for no specific reason. We would like CMS to consider when changing a measure, if it relates to *how* the data is collected and reported as a result of the change, the proposed allowable timeframe of three months may not be an adequate amount of time. There also should be consideration as to how many times per year the changes will be made as this will impact a hospital's ability to continually reconfigure their data collection practices.

XVI-C-3: Possible New Quality Measures for CY 2011 and Subsequent Calendar Years (73FR41542)

CMS has identified an additional 18 measures for consideration during the CY 2011 and subsequent years. AHIMA would caution CMS on the data collection burden for the proposed measures particularly for those measures that may require manual data collection. If these proposed measures are not claims based, but based upon a combination of claims, labs, and other clinical information then there will be a significant impact on the number of records and data that must be collected in order to report on the proposed measures.

AHIMA recommends that CMS consider the need for collecting measures on the measure set for cancer. There is adequate coverage of cancer measures and enough national presence for this topic that we ask CMS to reconsider the implementation of these measures.

XVI-E-1: Requirements for HOP Quality Data Reporting for CY 2010 and Subsequent Calendar Years: Administrative Requirements (73FR41544)

AHIMA supports CMS' consideration of implementing an on-line registration submission process. This will reduce the burden of completing and submitting a paper form where there is increased chance for loss and mishandling of the form which could result in delays and rejections in participating in the program.

XVI-E-2: Requirements for HOP Quality Data Reporting for CY 2010 and Subsequent Calendar Years: Data Collection and Submission Requirements (73FR41545)

AHIMA supports the capture and integration of data in electronic health records (EHRs) is necessary to support quality measurement and reporting. As an active developer and promoter of EHR standards, we look forward to a day when all uses of data, whether produced for patient care, quality measurement, or reimbursement, accurately portray the diagnoses, severity, and services provided particularly for future automated data transmission from EHR systems to the OPPS Clinical Warehouse.

AHIMA supports CMS' consideration in defining data elements in a consistent manner for bother inpatient and outpatient settings. True interoperability will not occur until data definitions and codes are standardized and incorporated into technical standards. AHIMA recommends including additional text describing how common data elements will be aligned with other similar data elements in other data sets above and beyond those used in the CMS inpatient and outpatient quality measurement initiatives. This exercise will support the movement toward collecting data once so it can be repurposed multiple times for quality, population health reporting, research, and administration.

XVI-E-3: HOP QDRP Validation Requirements (73FR41546)

AHMA supports the process of random selection for data validation however we do have concerns that the pool of eligible hospitals will remain the same year over year. There may be situations where a hospital is selected time and time again for the validation process. We recommend CMS consider an alternative method for allowing a hospital to have an opportunity to sit out of the process for a minimum of one year if it has been selected.

AHIMA commends CMS for considering alternative validation processes, however we would caution CMS on changing the validation process after just one year. We recommend if CMS anticipates changing the validation process after just one year, the validation program is suspended/delayed so there can be further analysis and consideration of which method is the best approach. If CMS chooses

to implement one approach over another, then we recommend that CMS maintain the selected approach for a longer period than just one year in order to conduct trending analysis and collect data on the process so that data can be collected and appropriate changes implemented. We believe only having the program implemented for just one year would prove valuable or provide a rich source of data for analysis.

XVI-G: Proposed HOP QDRP Reconsideration and Appeals Procedures (73FR41547)

AHIMA applauds CMS for planning to use current processes as described in the proposed rule, which have been established for the IPPS and are familiar to hospitals. This is consistent with the desire by the Secretary to use standard processes and not implement new processes and procedures that are unnecessary, inefficient and wasteful. This method will also allow the hospitals to have a shorter learning curve on the methods necessary to submit measures in order to participate in the HOP QDRP program.

XVII-B: Healthcare-Associated Conditions – Broadening the Concept of the IPPS Hospital-Acquired Conditions Payment Provision to the OPPS (73FR41547)

We do not believe CMS should consider expanding the hospital-acquired condition (HAC) payment provision to other healthcare settings, including the hospital outpatient setting, at this time. The HAC payment provision under the hospital inpatient prospective payment system (IPPS) does not go into effect until October 1, 2008. Therefore, neither CMS nor hospitals have had any experience with this payment policy yet, and there has not yet been an opportunity to assess the impact and success of the HAC payment provision in the hospital inpatient setting. It is possible changes will be made in response to issues that may arise as experience is gained with this payment policy.

Also, unique factors associated with various healthcare settings, such as differences in payment system methodologies and reporting requirements, would need to be thoroughly evaluated. For example, it is not possible to identify which diagnoses reported on an outpatient claim developed during the encounter. It would not be appropriate to require present on admission (POA) indicator information to be reported on outpatient claims because the definition of the POA indicator data element for claims reporting, as established by the National Uniform Billing Committee, is limited to inpatient claims.

The administrative burden must be weighed against the perceived benefits of implementing a HAC payment provision in additional healthcare settings. It is possible that in the outpatient setting, the administrative burden of implementing a HAC payment provision (on both the CMS and provider sides) may be greater than in the hospital inpatient setting, yet the value may be less. For example, as CMS noted in the proposed rule, due to the short length of stay for outpatient encounters, much of the care of the healthcare-associated condition (and the associated costs) might often occur in another healthcare setting. However, we are concerned about the implications of CMS' suggestion that perhaps the provider that failed to prevent the occurrence of a condition in one setting should be held responsible for payment of the follow-up care in another setting. This approach would be an administrative nightmare.

Also, since a higher severity of illness does not directly affect payment under the OPPS, as it does under the IPPS, it is much more difficult to reasonably and fairly link a reduction in payment to the hospital resources expended to evaluate or treat a healthcare-associated condition. In view of the fact that OPPS payments are driven by procedures and packages of services, it is not clear to what extent OPPS providers are currently receiving additional reimbursement for the care of healthcare-associated conditions. Therefore, we believe that the burdensome process of collecting and reporting the information necessary to implement a HAC payment provision may not yield information that is all that useful.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Hospital OPPS. If AHIMA can provide any further information, or if there are any questions or concerns with regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS
Allison Viola, MBA, RHIA