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November 19, 2019

VIA ELECTRONIC MAIL

Alec Alexander  
Deputy Administrator and Director  
Center for Program Integrity  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Deputy Administrator Alexander:

Thank you for the opportunity to provide comments on the Request for Information (RFI) on the future of program integrity.

AHIMA is the national nonprofit 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.

Although the request for information discusses several topics, we would like to offer some general comments below, followed by more specific responses to a few of the questions posed in the RFI.

### **General Comments**

#### ***Simplify payment and coverage policies and improve transparency***

Complying with Medicare and Medicaid payment, coverage, and coding rules and documentation requirements is no easy task. These rules are often complex and confusing, and differ across federal programs. Private payers have their own payment and coverage rules and documentation requirements that providers must also comply with. **Improper payments and noncompliance with payment and coverage rules could be reduced by simplifying the rules and requirements, standardizing them across federal programs, and providing greater transparency regarding payment and coverage policies, rules, and requirements.**

Differences in local coverage determinations (LCDs) also contribute to the complexity of payment and coverage policies. The Medicare Payment Advisory Commission (MedPAC), Government Accountability Office (GAO), and the Office of Inspector General of the Department of Health and Human Services (OIG) have all expressed concerns about LCDs and have either recommended steps to improve consistency across LCDs or elimination of LCDs altogether. The OIG found that LCDs sometimes defined similar clinical topics inconsistently, and they suggested that pursuing a single set of coverage policies would simplify and strengthen Medicare coverage policy while reducing the administrative burden of LCDs.<sup>1</sup> The OIG also noted that regional differences in coverage created by LCDs are contrary to the practice of evidence-based medicine that eschews local variation.<sup>2</sup> Healthcare organizations often have geographically dispersed networks of providers, further blurring regional lines.

The MedPAC recommended that Medicare eliminate local policies because they add unnecessary complexity, inconsistency, and uncertainty to the Medicare program.<sup>3</sup> Similarly, the GAO recommended that CMS replace LCDs with National Coverage Determinations (NCDs) because the broad discretion given to contractors to create LCDs resulted in inequitable variations in coverage.<sup>4</sup> Consistent with the previous recommendations of the MedPAC, the GAO, and the OIG, **AHIMA recommends that CMS continue to explore ways to improve consistency across coverage policies, and that the agency consider eliminating LCDs altogether in order to simplify Medicare coverage policies and make it easier for providers to comply with these policies.**

Private payers often have coverage policies that are similar to Medicare's, but the requirements may be slightly different, which contributes to the commission of errors. **AHIMA recommends that Medicare collaborate with private payers to standardize coding and documentation requirements for payment and coverage policies that are similar across payers.**

### *Provide proper coding education to CMS and its contractors*

It is important for both providers and payers to receive proper education to ensure the accuracy of submitted claims and the claims review process. Our members have indicated that individuals responsible for reviewing the accuracy of Medicare and Medicaid claims do not always understand coding rules/guidelines. **AHIMA recommends that personnel employed by the Medicare and Medicaid programs, state Medicaid agencies, or contractors of one of these entities (including audit contractors), and who are responsible for reviewing coding accuracy, should be educated on proper coding practice and application of official coding rules and guidelines. CMS should consider requiring that coding reviews be conducted by certified health information management professionals.**

<sup>1</sup> Office of Inspector General, Department of Health and Human Services, Local Coverage Determinations Create Inconsistency in Medicare Coverage, January 2014. <https://oig.hhs.gov/oei/reports/oei-01-11-00500.pdf>.

<sup>2</sup> Ibid.

<sup>3</sup> Medicare Payment Advisory Commission, Report to the Congress: Reducing Medicare Complexity and Regulatory Burden, December 2001. <http://www.medpac.gov/docs/default-source/contractor-reports/report-to-the-congress-reducing-medicare-complexity-and-regulatory-burden-december-2001-.pdf?sfvrsn=0>.

<sup>4</sup> Government Accountability Office, Divided Authority for Policies on Coverage of Procedures and Devices Results in Inequities, April 2003. <https://www.gao.gov/new.items/d03175.pdf>.

### ***Allow use of multiple widely accepted clinical definitions and criteria***

A single definition of a clinical condition that is uniformly used by all providers and payers does not always exist, which creates confusion and disconnects between provider policies and payer requirements. Sepsis and malnutrition are two examples of conditions for which more than one clinical definition and set of clinical criteria are in widespread use. In some instances, the same payer may use different clinical definitions for the same condition for distinct purposes. For example, the CMS sepsis quality measure (SEP-1) does not use the Sepsis-3 clinical definition, but the Recovery Audit Contractors may conduct clinical validation reviews using the Sepsis-3 clinical definition. Some private payers are relying on the Sepsis-3 definition in their audits, whereas others are not. Many providers have chosen not to adopt the Sepsis-3 definition. When payers audit based on a single clinical definition or set of clinical criteria, and providers are using a different clinical definition, confusion ensues.

**AHIMA recommends that CMS and its audit contractors allow the use of more than one clinical definition for a medical condition when more than one definition exists that is generally accepted and in widespread use across the US.**

### ***AHIMA and other health information experts should be involved in the development of requirements for a central repository of documentation for all programs and payers in electronic health records (EHRs)***

CMS indicated that it is striving toward requirements for a central repository of documentation for all programs and all payers that is easily accessible within the EHR in order to minimize improper payments and reduce provider and supplier burden. While AHIMA fully supports efforts to improve administrative efficiencies and reduce provider burdens, we believe a central repository of documentation needed by payers raises a number of questions and issues, such as who would have access to this information and how privacy and security of patient health information would be protected.

**AHIMA recommends that CMS involve AHIMA and other stakeholders with expertise in medical record documentation standards and privacy/security regulations in the development of requirements for a central repository of documentation.**

### **Provider Education**

#### ***15. What strategies, tools, or technologies exist to help CMS better connect ordering physicians, rendering providers, and suppliers with respect to their responsibility to provide proper documentation?***

Often, providers performing a diagnostic test receive little information from the ordering provider regarding the reason for the test. Technological solutions to link the ordering and rendering providers' documentation would improve this communication. Blockchain technology might be one possible approach. The revised and new certification criteria proposed as part of ONC's "21<sup>st</sup> Century Cures Act: Interoperability, Information Blocking and the ONC Health IT Certification

Program” proposed rule can also facilitate communication between providers by giving patients electronic access to health information from the ordering provider that they can share with the rendering provider.

***16. What strategies, tools, or technologies exist to help providers and suppliers become more aware of the necessary documentation requirements earlier in the claim process?***

Recovery Audit Contractors (RACs) should be required to provide sufficient details regarding their findings, which providers can use to improve their coding and billing practices and avoid the same adverse audit finding(s) in the future. Our members have told us that the information provided by the RACs is often too sketchy and ambiguous for providers to implement corrective strategies going forward.

We appreciate the opportunity to submit comments on the Request for Information on the future of program integrity. AHIMA fully supports CMS’ efforts to find new and innovative strategies and technologies to ensure program integrity that are more cost effective and less burdensome than current approaches. We hope that CMS will continue to engage extensively with stakeholders on these important issues, and we look forward to continued collaboration with the agency on new strategies and tools to improve program integrity efforts. Should you or your staff have any additional questions or comments, please contact Sue Bowman, Senior Director of Coding Policy and Compliance, at (312) 233-1115 or [sue.bowman@ahima.org](mailto:sue.bowman@ahima.org).

Sincerely,

A handwritten signature in cursive script that reads "Wylecia Wiggs Harris".

Dr. Wylecia Wiggs Harris, CAE  
Chief Executive Officer