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August 26, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1413–P
PO Box 8013
Baltimore, Maryland 21244-8013

Re: File Code CMS-1413-P

Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010 (74 *Federal Register* 33520)

Dear Ms. Frizzera:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, as published in the July 13, 2009 *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 54,000 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. 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, and biosurveillance. Our detailed comments and rationale on the NPRM for the Payment Policies under the Physician Fee Schedule are below.

II. Provisions of the Proposed Regulation

II-G-2-c Proposed 2010 Reporting Periods for Individual Eligible Professionals (74FR33560)
AHIMA supports CMS' consideration for not adding a new 6-month reporting period for claims-based reporting of individual measures. Adding a 6-month reporting period for claims-based reporting (for just one year) adds complexity and cost to an already complicated system. Also,

CMS emphasized the desire to move forward with registry-based reporting, thus making this proposal counterintuitive to the progress CMS is trying to achieve.

II-G-2-d. Proposed 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals (74FR33560)
AHIMA commends CMS for acknowledging the Health Information Technology for Economic and Clinical Health (HITECH) Act and its focus on Electronic Health Record (EHR) implementation for incentive payments, meaningful use and quality reporting. We are confident that CMS will continue to acknowledge the efforts accomplished through the HITECH initiatives and perhaps align efforts for quality reporting in order to reduce duplication and burden and improve reporting efficiencies.

An area of the proposed rule where we have concerns is the section describing the potential for retaining "claims-based reporting in years after 2010 principally for the reporting of structural measures, such as Measure #124 Health Information Technology (HIT): Adoption/Use of EHR and circumstances where claims-based reporting is the only available mechanism." It is unclear to us that HIT structural measures would be reported via claims data. If a provider had an EHR our assumption would be that this type of data may be submitted directly from the system rather than through a claim. If CMS anticipates that most quality measures will be submitted via EHRs and registries by 2010, we would naturally presume that this goal would apply to structural measures.

We are also puzzled by a statement that is presented on page 74FR33582, "(4) Proposed 2010 Individual Quality Measures Available for EHR-based Reporting indicates that this same measure (#124 Health Information Technology (HIT): Adoption/Use of EHR) is a proposed 2010 measure for EHR-based reporting". This statement appears to be in conflict with the one above regarding the use of claims data for structural measure reporting. AHIMA requests further clarification on which method CMS anticipates using for reporting purposes.

(5) Qualification Requirements for EHR Vendors and Their Products – AHIMA commends CMS for establishing standard qualifications regarding EHR-based quality reporting. The HITECH Act also requires providers who are participating in the incentive program to use certified technology as one of the requirements. We encourage CMS align initiatives with applicable provisions in HITECH regarding EHR certification requirements so that providers can follow similar qualification/certification requirements as they prepare for quality reporting for the Physician Quality Reporting Initiative (PQRI) and Meaningful Use programs. By aligning efforts this will enable providers to become familiar with requirements prior to quality reporting as outlined in the HITECH Act prior to 2011 reporting and the opportunity to gain experience with this process. Moreover, coordinating reporting standards will minimize the preparation and reporting requirements for program participants.

II-G-2-g. Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices (74FR33569)
The proposed rule describes the definition of a group practice consisting of "at least 200 or more individual eligible professionals". AHIMA is concerned that this number is unusually large and does not represent the typical size of a practice. We understand CMS is trying to be consistent with the PGP demonstration, which is based upon large group practices; however we encourage CMS to reevaluate this number and provide additional clarification. We believe reducing the number associated with this description will engage more participants in this initiative thus provide a more accurate representation.

II-G-2-h. Statutory Requirements and Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI (74FR33571)
AHIMA commends CMS for acknowledging the value and importance of requiring NQF endorsed measure for 2010 PQRI quality measures with the exception of certain circumstances as described in this section of the rule. We support this goal for using NQF endorsed measures as we believe NQF provides a rigorous and thorough standardized review framework through their Consensus Development Process (CDP) for ensuring the measures achieve consensus and endorses consensus standards. The CDP reflects a careful process designed to produce consensus from disparate groups across the healthcare industry.

II-G-2-i. Proposed 2010 PQRI Quality Measures for Individual Eligible Professionals (74FR33574)
AHIMA commends CMS for developing a table (*Table 17 Proposed 201 Measures selected from the 2009 PQRI quality measure set available for either claims-based reporting or registry-based reporting*) and a format that clearly summarizes the status of NQF endorsement, AQA adoption and the measure developer. The information presented enables the reader to quickly assess the status in a logical manner. We strongly encourage CMS to provide information, with respect to quality measures and their status, in this format in future proposed rules, final rules or any other publication where this information will be helpful.

II-G-5. Section 132: Incentives for Electronic Prescribing (E-Prescribing) – The E-Prescribing Incentive Program (74FR33593)
(4) The Reporting Numerator for the Electronic Prescribing Measure – AHIMA supports the modification to the electronic prescribing measure.

8. Section 144(a): Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services (74FR33606)
CMS is proposing to establish two new Level II HCPCS G codes to report the services of an intensive cardiac rehabilitation program. AHIMA recommends that CMS submit a CPT code proposal to the American Medical Association (AMA) for these services in order to transition the

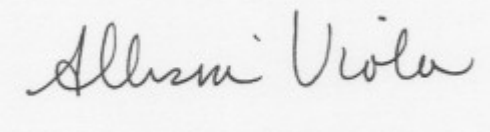
G codes to CPT codes. This would allow these services to be captured in the CPT code set and permit a standard, non-payer-specific mechanism for reporting these services.

9. Section 144(a): Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services (74FR33610)
CMS is proposing to establish one new Level II HCPCS G codes to report pulmonary rehabilitation services. AHIMA recommends that CMS submit a CPT code proposal to the American Medical Association (AMA) for these services in order to transition the G code to a CPT code. This would allow these services to be captured in the CPT code set and permit a standard, non-payer-specific mechanism for reporting these services.

10. Section 152(b): Coverage of Kidney Disease Patient Education Services (74FR33614)
CMS is proposing to establish two new Level II HCPCS G codes to describe kidney disease education (KDE) services furnished by a provider in a rural area. AHIMA recommends that the code descriptions include the phrase "furnished by a rural provider," or similar language, to make it clear that these codes are intended to identify patient encounters that meet the qualifications for coverage under the KDE benefit for the purpose of providing Medicare payment.

If AHIMA can provide any further information or if there are any questions regarding this letter and its recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or AHIMA's vice president, policy and government relations, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org. If we can be of further assistance to you in your efforts, we would welcome the opportunity to provide support.

Sincerely,



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