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August 26, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1414-P**
PO Box 8013
Baltimore, Maryland 21244-1850

Re: File Code CMS-1414-P

Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2010 Payment Rates; Proposed Rule (74 *Federal Register* 35232)

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 Hospital Outpatient Prospective Payment System (OPPS) and calendar year 2010 Rates, as published in the July 20. 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.

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.

II: Proposed Updates Affecting OPPS Payments (74FR35239)

II-A-2d7: Payment for Ancillary Outpatient Services When Patient Expires (-CA Modifier) (74FR35277)

AHIMA recommends that the use of the HCPCS -CA modifier be expanded to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, but the patient is stabilized medically and transferred to another acute care hospital without being admitted to the hospital where the procedure was performed. In this case, the patient did not expire, but an inpatient-only procedure was still performed on an emergent basis on an outpatient who was not subsequently admitted to that hospital.

II-A-2e1: Extended Assessment and Management Composite APCs (APCs 8002 and 8003) (74FR35279)

AHIMA appreciates CMS' decision to issue clarifying guidance regarding the correct method for reporting the starting time for observation services. We agree with the APC Panel that the current descriptions of start time for observation services located in the Medicare Claims Processing Manual has caused confusion.

IX: Proposed OPPS Payment for Hospital Outpatient Visits (74FR35349)

IX-B-1: Clinic Visits: New and Established Patient Visits (74FR35350)

For 2010, CMS proposes to retain the current definitions of "new" and "established" patients, which were refined last year to reflect whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. **We continue to believe 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. While distinctions between "new" and "established" patients are relevant for physician services, they are not relevant for facility services. Under the facility definition, an "established" patient may have been registered for any number of services, including a single diagnostic test. The mere fact that a patient has been registered before does not appreciably affect the level of facility resources utilized for the current visit.

IX-B-3: Visit Reporting Guidelines (74FR35353)

AHIMA continues to urge CMS to promulgate national visit guidelines for clinic and emergency department visits. **The use of hospital-specific internal coding guidelines is contrary to government and industry goals of data uniformity and consistency.** In an era of healthcare initiatives aimed at data standardization and interoperability, the continued lack of national facility visit guidelines is increasingly unacceptable.

Regardless of whether CMS' data shows a normal distribution of levels, 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, hospitals are at increased risk during an audit or fraud investigation. CMS' principles for development of facility-specific internal guidelines are not sufficient for ensuring compliance because judging compliance with these principles is subject to varying interpretation.

XII: OPPS Nonrecurring Technical and Policy Changes and Clarifications

(74FR35358)

XII-A-1: Kidney Disease Education Services – Background (74FR35358)

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.

XII-B-2: Proposed Payments for Services Furnished to Hospital Outpatients in a Pulmonary Rehabilitation Program (74FR35360)

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.

XII-B-3: Proposed Payments for Services Furnished to Hospital Outpatients Under a Cardiac Rehabilitation or an Intensive Cardiac Rehabilitation Program (74FR35361)

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.

XII-E: Direct Referral for Observation Services (74FR35370)

AHIMA supports CMS' proposal to modify the code descriptor for HCPCS code G0379 to remove the reference to the word "admission" and replace it with "referral." We also support CMS' plans to modify the Medicare Claims Processing Manual and the Medicare Benefit Policy Manual to remove references related to "admission" for observation services or "observation status." We agree that the term "admission" is generally used in reference to inpatient hospital care, so the use of this word in an outpatient context is confusing.

XVI: Reporting Quality Data for Annual Payment Rate Updates (74FR35394)

XVI-A: Hospital Outpatient Quality Data Reporting Under Section 109(a) of Public Law 109-432 (74FR35394)

Although CMS is considering not requiring endorsement of measures by NQF for the HOP QDRP, AHIMA encourages CMS to select and implement measures that have been endorsed by NQF. We commend CMS for using NQF endorsed measures for the CY 2009 and 2010 HOP QDRP program.

AHIMA further supports CMS' assertion that measures from the RHQDAPU should not automatically be adopted for the HOP QDRP without further analysis. If measures from the RHQDAPU apply to the HOP QDRP program we do agree in order to keep data collection and reporting burdens to a minimum, they should be selected.

XVI-B-1: Consideration in Expanding and Updating Quality Measures Under the HOP QDRP Program (74FR35396)

AHIMA commends CMS for aligning efforts to identify alternative means for hospitals such as registries and electronic health records (EHRs) to collect data once and repurpose it for multiple quality reporting initiatives.

AHIMA commends CMS for the promotion and use of registries for data collection as well as consideration for future use of data collection to reduce the burden of manual data collection. We are concerned there may be hospitals that do not currently participate in registries and may be required to participate in these proprietary registries in the future. We request clarity on what alternatives hospitals will have to provide information for future considerations should they not have the resources to participate in registry-based data collection initiatives.

Uniform data content standards are crucial in the effort to reduce burdens for hospitals. These standards will facilitate a process for automated data transmission, and EHR vendors will be more apt to integrate measurement reporting capabilities into EHR products if measure specifications are standardized across the industry. This will streamline hospital data submission procedures and enable providers to view real-time measurement results to initiate their own improvement interventions in a more timely and efficient manner.

AHIMA commends and supports CMS' acknowledgement and support of the development and adoption of data content and information technology standards that will support automated data collection and reporting of clinical data from EHR systems. Recognizing the efforts conducted by CCHIT, the NHIN and HITSP is imperative to achieving meaningful use of HIT as well as the overall adoption of technology in the healthcare setting.

XVI-B-2: Retirement of HOP QDRP Quality Measures (74FR35397)

AHIMA supports efforts to discontinue data collection and reporting requirements for measures that have evidence supporting differing approaches and are no longer consistent with current clinical guidelines, especially in situations where patient safety is a concern. However we also encourage CMS to consider retiring those measures that have an increased burden where data collection and reporting outweighs the benefit of public reporting.

XVI-B-3: Proposed HOP QDRP Quality Measures for the CY 2011 Payment Determination (74FR35397)

AHIMA commends CMS for carefully assessing the data collection burden associated with chart abstraction and thus retaining the existing 11 HOP QDRP measures without the addition of new

measures for CY 2011. However, given the recent developments with the Office of the National Coordinator's (ONC) efforts to identify and recommend measures to be used for achieving "meaningful use" we are unclear on the relationship and consideration for aligning efforts between the OPPS CY 2011 and the 2011 measures identified within the meaningful use matrix. To minimize data collection and reporting burdens, we strongly encourage CMS to consider aligning the HOP QDRP with the measures for meaningful use and provide clarity on those measures that appear to be similar such as the OPPS CY2011 "OP-4: Aspirin at Arrival" and the meaningful use matrix measure for 2011, "Improve quality, safety, efficiency, and reduce health disparities: % patients at high-risk for cardiac events on aspirin prophylaxis [OP]".

XVI-C: Possible Quality Measures Under Consideration for CY 2012 and Subsequent Years (74FR35397)

As described in the previous section, AHIMA strongly encourages CMS to align efforts with those conducted through ONC in identifying and selecting measures for reporting in the outpatient environment.

XVI-E-2a: Proposed Requirements for HOPD Quality Data Reporting for CY 2011 and Subsequent Years – General Data Collection and Submission Requirements (74FR35401)

AHIMA supports CMS' consideration in defining data elements in a consistent manner for both 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-3a: HOP QDRP Validation Requirements – Proposed Data Validation Requirements for CY 2011 (74FR35402)

The description of the HOP QDRP validation program highlights efforts to limit burden on hospitals as well as an opportunity to gain experience with the medical documentation requests and validation process before results are used in a payment determination.

After careful review of the proposed program we are uncertain about its goals. In one statement CMS declares "the results of the validation will not affect a hospital's CY 2011 annual payment update because we want to give hospitals time to gain experience with the medical documentation requests and the validation process… In another statement CMS indicates, "However, failure to provide this documentation may result in a 2.0 percentage point reduction

in the hospital's CY 2011 payment update." These statements appear to conflict with one another and AHIMA requests further clarification on the proposed validation program.

XVI-E-3b: HOP QDRP Validation Requirements – Proposed Data Validation Approach for CY 2012 and Subsequent Years (74FR35403)

AHIMA commends CMS for using a measure level match for the HOP QDRP program rather than a data element match as used within the RHQDAPU program. This approach will remove focus from data element disparities and more toward the measures and their results.

Regarding the accuracy rate of a 90 percent reliability score and CMS' belief "…that hospitals will be able to attain higher accuracy rates based on the proposed measure level match approach versus a data element level approach." We recommend CMS provide some data to support this belief and recommendation so that individuals reporting on the measures can fully understand the change in the program's expectations.

XVI-H: Reporting of ASC Quality Data (74FR35404)

AHIMA commends CMS for choosing to defer quality data reporting for ASCs. As the healthcare industry continues to move toward increased utilization of electronic health records in order to meet the requirements outlined in the American Recovery and Reinvestment Act (ARRA) for incentive payments, we encourage CMS to focus on electronic submission of data for quality reporting once it has been determined to move forward with the ASC quality data program.

XVI-I: Electronic Health Records (74FR35405)

AHIMA commends and supports CMS' acknowledgement and support of the development and adoption of data content and information technology standards that will support automated data collection and reporting of clinical data from EHR systems. Recognizing the efforts conducted by CCHIT, the NHIN and HITSP is imperative to achieving meaningful use of HIT as well as the overall adoption of technology in the healthcare setting.

XVII: Healthcare-Associated Conditions (74FR35405)

XVII-C: CY 2010 Approach to Healthcare-Associated Conditions Under the OPPS (74FR35407)

AHIMA commends CMS for deferring the expansion of the IPPS HAC program to an OPPS HOP-HAC program for reasons outlined and discussed in Subsection B of the OPPS proposed

rule ("Public Comments and Recommendations on Issues regarding Healthcare-Associated Conditions from the Joint IPPS/OPPS Listening Session").

We appreciate CMS' recognition that there are many operational challenges to such an expansion that will require further consideration and infrastructure development and that the current IPPS HAC program should be evaluated prior to its expansion to other settings.

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 me at (312) 233-1115 or sue.bowman@ahima.org or in my absence contact Dan Rode AHIMA's (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Sue Bowman, RHIA, CCS
Director, Coding Policy and Compliance

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President Policy and Government Relations
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