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September 8, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1678-P**
PO Box 8013
Baltimore, Maryland 21244-1850

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Proposed Rule (CMS-1678-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 Medicare Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs for Calendar Year (CY) 2018, as published in the July 20, 2017 *Federal Register* (CMS-1678-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 dedicated to effective health information management, information governance, and applied informatics. 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. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information analytics.

Our comments and recommendations on selected sections of the OPPS proposed rule are below.

II. Proposed Updates Affecting OPPS Payments (82FR33568)

II-A-2b (3) – Brachytherapy Insertion Procedures (82FR33577)

AHIMA **does not support** the proposed creation of a code edit requiring a brachytherapy treatment code when a brachytherapy insertion code is billed. We respectfully disagree with those commenters who indicated that the insertion procedure and brachytherapy treatment delivery should appear on the same claim even when they are performed on different days. Our members have told us that when the insertion procedure and brachytherapy treatment are

performed on different days, they are reported on separate claims. Also, the device insertion and treatment delivery are not always performed in the same facility, in which case they would be on different claims.

II-A-2b (5) – Proposed Complexity Adjustment for Blue Light Cystoscopy Procedures (82FR33579)

While we agree that cystoscopy procedures involving white light only should be distinguished from those involving both white and blue light, due to differences in resource utilization, **we recommend that a proposal for an expansion of the cystoscopy CPT codes be submitted to the American Medical Association** to capture this distinction. It is preferable, and less confusing, to use the CPT code set to capture all cystoscopy procedures, rather than creating a HCPCS C-code for blue light cystoscopy that would be reported in conjunction with a CPT cystoscopy code. Outpatient cystoscopy procedures should be captured in a single, standard code set. The use of duplicative, overlapping code sets is administratively burdensome and can result in confusion, increased coding errors, and compromises in data quality.

IX. Proposed Procedures That Would Be Paid Only as Inpatient Procedures (82FR33642)

IX-B – Proposed Changes to the Inpatient Only (IPO) List (82FR33643)

We support the proposed removal of CPT codes 27447 (Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)) and 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) from the Inpatient Only List for CY 2018.

IX-C – Solicitation of Public Comments on the Possible Removal of Partial Hip Arthroplasty (PHA) and Total Hip Arthroplasty (THA) Procedures From the IPO List (82FR33644)

AHIMA is concerned about removing partial and total hip arthroplasties from the Inpatient Only (IPO) List. Feedback from our members does not support removing these procedures from the IPO list, as most of their facilities are not currently performing these procedures on an outpatient basis, and this practice would be especially risky in the Medicare population.

Additional Flexibility Needed Under Medicare & Medicaid EHR Incentive Program

AHIMA is disappointed the proposed rule does not offer additional flexibility with respect to Stage 3 Meaningful Use requirements or in the required deployment of EHRs certified to the 2015 Edition for 2018. To date, ONC has certified less than 100 EHR systems to the 2015 Edition—approximately 2 percent of all EHRs systems currently certified by ONC. Our members continue to voice concerns that they may be unable to meet the objectives and associated measures under Stage 3 Meaningful Use due to their inability to test and deploy their systems prior to the beginning of 2018. More generally, we are concerned that failure to grant additional flexibility under the Meaningful Use Stage 3 program could further bifurcate the programmatic requirements under the Medicare and Medicaid Electronic Health Record (EHR) Incentive

Program and MIPS. We encourage CMS to engage with stakeholders on this issue, and we suggest that the agency continue to identify potential opportunities to align these two programs to best serve patients.

Conclusion

AHIMA appreciates the opportunity to comment on the CY 2018 Medicare Hospital OPPS proposed rule. AHIMA is committed to working with CMS and the healthcare industry to improve the quality of healthcare data for reimbursement, quality reporting, and other applied analytics.

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,

Pamela L. Lane, MS, RHIA
Interim Chief Executive Officer

cc: Sue Bowman, MJ, RHIA, CCS, FAHIMA