



October 5, 2006

Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1506-P  
PO Box 8011  
Baltimore, Maryland 21244-1850

**Re: File Code CMS-1506-P  
File Code CMS-4125-P**

**Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates; Proposed Rule (71 *Federal Register* 49506)**

Dear Dr. McClellan:

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 2007 Rates, as published in the August 23, 2006 *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 50,000 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.

### **VIII-B: Proposed CY 2007 Drug Administration Coding Changes (71FR49600)**

Currently, a combination of CPT and HCPCS level II codes are required by Medicare for facility reporting of drug administration services. Many private payers require the reporting of only CPT codes, resulting in a situation whereby hospitals are required to use different coding schemes to report drug administration services to different payers. Dual coding systems for drug administration services is administratively burdensome for hospitals and also results in data incomparability.

While we recognize that the CPT codes for drug administration services were designed for physician reporting purposes and have been somewhat confusing and difficult to apply in the facility setting, we do not believe that creation of a separate set of codes for Medicare use is a satisfactory solution, since many other payers require the use of the full set of CPT codes for drug administration services.

Consistent coding practices across payers would be less administratively burdensome and would result in improved data accuracy and comparability. We also believe that the HIPAA regulations for electronic transactions and code sets were intended to ensure that multiple code sets wouldn't be used to report the same service.

**AHIMA recommends that CMS adopt the full set of CPT drug administration codes for use under the OPPTS.** Hospitals are already using the full set of CPT codes for reporting to many non-Medicare payers. Currently, however, the CPT codes are not intuitive and easily applicable to the hospital setting. Clarification of definitions, code descriptions, and instructions is necessary in order for hospitals to be able to report these codes accurately and consistently. CMS should work with AHIMA, the American Hospital Association and the American Medical Association to provide additional guidance to hospitals on the proper use of these codes for facility reporting, including instructions for the application of the terms "initial," "subsequent," "sequential," and "concurrent." If necessary, CMS should also work with these three organizations to develop proposed CPT code modifications to address specific issues pertaining to facility reporting of drug administration services.

### **IX: Proposed Hospital Coding and Payment for Visits (71FR49604)**

We appreciate CMS' consideration of the facility visit coding guidelines developed by the American Hospital Association (AHA)/AHIMA Expert Panel and posting these guidelines for wider

public input. We also appreciate CMS' acknowledgement that the AHA/AHIMA guidelines are the most appropriate and well-developed guidelines for use in the OP-PPS. AHIMA looks forward to working with AHA and the Expert Panel to refine the guidelines to address concerns and suggestions raised by CMS and the public. We support CMS' commitment to provide a minimum of 6 to 12 months notice to hospitals prior to implementation of national guidelines. This timeframe will allow adequate education of hospital staff on the proper application of these guidelines and the documentation requirements necessary to support code levels.

We note that the AHA/AHIMA guidelines were submitted to CMS over three years ago, and some of the specific revisions CMS chose to make in their modified version, as well as other suggestions for modifications, could be a reflection of changes in clinical practice since the AHA/AHIMA guidelines were originally developed. If these guidelines had been implemented soon after their development, undoubtedly refinements would have been made since then.

**CY 2007 Proposed Coding: AHIMA opposes the creation of new G-codes to replace hospitals' reporting of the CPT emergency department and clinic evaluation and management (E/M) codes for CY 2007.** We believe that CMS should not implement new codes in the absence of accompanying national code definitions and national guidelines for their application. The CPT E/M codes should continue to be used until national guidelines are ready for implementation. Creating new codes without a set of national guidelines will increase confusion and add a new administrative burden requiring hospitals to manage two sets of codes – the proposed G-codes for Medicare and CPT E/M codes for non-Medicare payers – without the benefit of a standardized methodology or improved data.

Even when national guidelines are developed, AHIMA does not believe that temporary G-codes should be created for facility visit coding. A formal proposal should be presented to the American Medical Association's CPT Editorial Panel to create CPT codes for hospital emergency department and clinic visits. These codes could then be used by all payers. New codes and the accompanying national guidelines should not be implemented until CPT codes have been implemented.

**CMS' Contracted Study to Validate AHA/AHIMA guidelines:** In response to concerns raised by CMS' contracted study of the AHA/AHIMA guidelines, we would like to point out that these guidelines were never intended to be used as a stand-alone document without additional explanation and educational materials. We expected to develop supplemental materials, in conjunction with AHA, to clarify proper application of the guidelines after they were adopted by CMS for implementation under the OP-PPS. Therefore, in the absence of this additional guidance, it is not surprising that the contractor identified elements in the guidelines that were difficult to interpret or poorly defined. Also, it is not clear, by CMS' own admission, whether the contractor had access to the complete medical records.

CMS noted that they were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of coding under the AHA/AHIMA guidelines. These findings reflect the fact that there is no set of national guidelines or a standard methodology for hospitals to develop their own guidelines. Through our participation on the AHA/AHIMA Expert Panel, we re-coded a sample of emergency department and clinic visit

records using several different hospitals' methodologies. This review revealed considerable variability in the levels of service reported, depending on which methodology was used.

Distinction Between Type A and Type B Emergency Departments: **AHIMA does not believe that the facility visit codes should distinguish between different types of emergency departments.** This is not a coding issue. The facility visit codes should be limited to describing the patient complexity and resource utilization. Other information, such as the type of emergency department where the visit occurred, should be captured through a separate methodology.

Other comments in response to CMS' concerns with the AHA/AHIMA guidelines can be found in a separate joint letter submitted by AHA and AHIMA as a result of our task force meetings.

### **XVIII-B-1-a: Proposed Revised ASC Payment System for Implementation January 1, 2008 – Proposed Definition of Surgical Procedure (71FR49636)**

AHIMA supports the expansion of the definition of surgical procedure under the Ambulatory Surgical Center (ASC) payment system to include HCPCS level II and CPT category III codes which directly crosswalk to, or are clinically similar to, procedures in the CPT category I surgical range.

### **XX: Reporting Quality Data for Improved Quality and Costs Under the OPSS (71FR49665)**

As AHIMA has noted in previous comments to CMS, we agree with the agency's desire to achieve a goal of value-based purchasing and promoting higher quality services. We acknowledge that taking the next step toward ambulatory care as offered by hospitals makes sense so long as it is recognized that eventually, sooner rather than later, any comparisons conducted on an ambulatory basis will have to cover non-hospital entities as well.

AHIMA is actively engaged in projects independently, with the Agency for Healthcare Research and Quality (AHRQ) and others to ensure that as standards for "performance data" and quality indicators are developed, implemented, and improved, the data and measures will be consistent and uniform geographically and across all sectors of the healthcare industry. We note CMS' comments on a "Hawthorne effect" coming from existing data and measure collection for hospitals. However, in the long run, it will be the ease of data collection, data uniformity, and trusted results that provide strong support for such data collection efforts. Consistency also permits those building the functional and data standards for the electronic health records to ensure appropriate secondary data is available for such purposes.

Everyone involved in the current efforts to develop an effective means for secondary data collection through paper records, the EHR, and hybrid environments, recognizes the difficulty of beginning and expanding the data collection efforts and the subsequent quality payment system that CMS and others are seeking. Until outpatient measures are developed and approved it appears acceptable in the short term to adapt the quality improvement mechanism provided by the IPPS (Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and the proposed IPPS surgical

care improvement project (SCIP) measures. We are concerned, however, that adoption of the IPPS measures might delay work necessary for outpatient measures. CMS should work with the industry and other federal agencies to develop a strategic plan for outpatient measure standards. Input to this process needs time and must occur outside of a response to this NPRM. AHIMA's HIM professionals stand ready to work with CMS, AHR, HQA, AQA, NQF and others to ensure that appropriateness and consistency are developed across the outpatient sectors of the healthcare industry. As CMS has often noted, care rendered in hospital-based ambulatory needs to be compared to the same care that can be rendered in ambulatory surgical centers, physician offices, and other sites of service.

### **XXI: Promoting Effective Use of Health Information Technology (71FR49670)**

AHIMA agrees that there is a mixed message regarding the potential of health information technology (HIT) to reduce costs. As alluded to in our comments on quality data reporting, we believe that is in the development, adoption, and implementation of standards that will lower costs and improve quality. Standards, consistency, and uniformity are necessary for software now, and as the industry moves forward in the implementation of a standard EHR and health information exchange (HIE); this includes standards for data, data definitions, terminologies, and classifications. The industry has started on the road toward President Bush's 2014 health information goal, however if we are to achieve this goal, the introduction of standards and requirements must take into account the paper to electronic transition currently under way and ensure that the development of secondary uses of data – like quality measurement – can be followed by organizations as they mature toward the EHR.

It is also important to note that with standards, quality measurement reporting or any secondary data reporting effort will be much easier, more accurate and much less costly once standard EHRs are in place. Before full use of EHRs is achieved collection of information in a paper or hybrid system remains a high consumer of human resources. The higher volume of outpatients as opposed to inpatients will also significantly inflate the costs and burdens of facilities, in as much as the same burden is often experienced with much lower reimbursement per encounter.

Development of a standard EHR and HIEs will not provide the full answer. Beyond the standardization of quality measures, for instance, CMS must take aggressive steps to ensure terminologies and classification standards are in place so that the quality or performance measurements can be evaluated with the condition of the patient. AHIMA urges the Health and Human Services Department (HHS) and the American Health Information Community (the Community), which include CMS, to adopt and provide for the implementation of modern terminologies such as those identified in the Consolidated Health Informatics (CHI), and especially the SNOMED-CT® adopted by CHI and approved by the National Committee on Vital and Health Statistics.

A standard EHR, with a SNOMED-CT terminology and functional standards and architecture designed to provide adequate and appropriate secondary data, will allow for achieving the goal of lowering costs and improving quality, but more is needed. The US must upgrade its primary

diagnoses classification system ICD-9-CM (volumes 1 and 2) to a 21<sup>st</sup> century standard ICD-10-CM.

The need for this change has been known for 13 years and the potential to resolve this need has been available since the turn of the century. But now, six years later, we have not moved to make the changes. Without the use of the ICD-10-CM classification, providers, health plans, QIOs, and others will continue to either rely on incomplete data coming from the claim, or demand additional data from providers – which translates into an inefficient use of resources and increased administrative costs for all.

It has been suggested that CMS finalize a rule for HIPAA attachments. AHIMA suggests instead that steps be taken to improve the initial data provided on the claims: the diagnosis and procedure codes. In addition, now that the industry has achieved electronic claims processing, AHIMA joins others and recommends that CMS and other payers accept and promote the transmission of all diagnostic and procedure codes associated with an encounter or stay, and not to limit this data (codes) to standards developed for paper claims in the 1980s (nine diagnoses on the UB-92).

## **XXII: Health Care Information Transparency Initiative (71FR49671)**

While AHIMA supports the goal of transparency and the ability of healthcare consumers to have data on which to make choices, we must note that only through receiving and reviewing quality (appropriate, clear, consistent) information can a consumer make decisions to purchase quality healthcare. If data standards are not updated to reflect the contents of 21<sup>st</sup> century health records, and provide for consistent evaluation, the data provided to individuals is suspect. Much of the data used currently in quality measurement and payment comes from the claim. Yet the claim data is currently not capable of providing the detail necessary to accurately determine the diagnoses and procedures related to the patient's care. If transparency is the goal we must improve the data, not just the mechanisms to provide data.

## **XXIII: Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for the FY 2008 IPPS Annual Payment Update (71FR49672)**

### **Re: File Code CMS-4125-P**

Most of AHIMA's comments on quality, above, also apply to this section. While we applaud CMS' further development of quality measures, we suggest they all be done in concert with the current AQA-HQA effort, and the recent recommendations of the Secretary for uniform measures across the industry. AHIMA is actively engaged in the goal of evaluating measures and highlighting gaps as well as working to ensure an appropriate standard EHR capable of producing secondary data that can support the uniform efforts and data collection mention here and above.

Since item 4 [71FR49674] relates to mortality, AHIMA must note that at some point CMS should consider the comparison of US mortality and morbidity data in its quest for quality measurement. Until ICD-10-CM and ICD-10-PCS are in use, such a comparison could be approached with a crosswalk between ICD-9-CM morbidity data, and ICD-10 mortality data. The additional

information contained in the US mortality database at the National Center for Health Statistics may prove most useful for full outcome information.

## **Conclusion**

We appreciate 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](mailto:sue.bowman@ahima.org), or myself at (202) 659-9440 or [dan.rode@ahima.org](mailto:dan.rode@ahima.org).

Sincerely,



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cc. Sue Bowman, RHIA, CCS