October 10, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1506P MEDICARE Program: Hospital Outpatient Prospective Payment System and CY2007 Payment Rates, VISITS, 71 Federal Register 49506, August 23, 2006

Dear Dr. McClellan:

On behalf of the members of the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that would establish new policies and payment rates for the hospital outpatient prospective payment system (PPS) for calendar year 2007 and hospital visit coding.

In January 2003, the AHA and the AHIMA convened the Hospital Evaluation and Management Coding Panel – also known as the expert panel – whose members had coding, health information management, documentation, billing, nursing, finance, auditing and medical experience. The panel developed recommendations for CMS on the 2004 hospital outpatient PPS rulemaking process. Based on the work of this panel, the AHA and the AHIMA in June 2003 recommended a hospital evaluation and management (E/M) visit guidelines model, also known as the AHA/AHIMA hospital visit model.

The AHA and the AHIMA have reconvened this panel, and it is ready to help CMS address public comments received regarding the development of national hospital visit codes and their corresponding guidelines.

Based on collective analysis, the AHA, the AHIMA and the independent expert panel recommend the following changes for the 2007 outpatient PPS.

BACKGROUND

Since April 2000, hospitals have been using current procedural terminology (CPT) and E/M codes to report facility resources for clinic and emergency department (ED) visits. Recognizing that current E/M descriptors reflect the activities of physicians and do not adequately describe the range and mix of services provided by hospitals, CMS asked hospitals to develop internal guidelines to determine the level of clinic or ED services.

In the last several years, different national coding guideline models for reporting facility visits have been proposed and reviewed by CMS. In 2002, CMS specified that the agency would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines were developed; this was a response to individuals who were concerned about implementing code definitions without national guidelines.

We appreciate that CMS is considering the recommendations of the independent expert panel and is posting this recommendation for wider public input. **While we have eagerly awaited national guidelines for hospital visits since the implementation of outpatient PPS, we continue to support CMS' commitment to provide a minimum of six to 12 months notice to hospitals prior to implementation of national guidelines.** Sufficient time is required so providers can make necessary system changes and educate staff on new coding and documentation requirements.

In 2005, CMS contracted with the Iowa Foundation for Medical Care to retrospectively code hospital medical records using the AHA/AHIMA model. The study was an attempt to validate the modified AHA/AHIMA guidelines and examine the distribution of services resulting from their application under outpatient PPS. CMS is concerned that the study revealed the AHA/AHIMA guidelines generate a different distribution of volume by code level, compared to current hospital reporting. What these findings do reflect, however, is that there are no national coding guidelines nor a standard methodology which hospitals can use to develop their own guidelines.

As stated by CMS, many different types of models are used to assign a visit code, each using a different variable to determine the differences in hospital resource use. Some use interventions, others use time, others use clinician skill level to determine complexity. In 2003, the expert panel compared different hospitals' methodologies when developing its initial set of recommendations. This review revealed considerable variability in the levels of services, depending on which methodology was used.

PROPOSED CODES AND CODING POLICY FOR 2007

Despite previous CMS assurances that the agency would not create new codes to replace existing CPT E/M codes until national guidelines were developed, CMS proposes to establish in 2007 new Health Care Procedure Coding System (HCPCS) level II G codes to describe hospital clinic visits, ED visits and critical care services. CMS proposes five levels of clinic visit G codes, five levels of ED visit G codes for two different types of

EDs (Type A EDs, which are open 24 hours a day, seven days a week; and Type B EDs, which are not), and two critical care G codes. Until national guidelines are formally proposed and finalized, CMS said hospitals may continue to use existing internal guidelines to determine what visit would be reported using the new G codes, or adjust their guidelines to reflect the new codes and policies.

The AHA and the AHIMA continue to believe that CMS should not implement new codes for hospital clinic and ED visits unless accompanying national code definitions and national guidelines for their application are developed. Therefore, we oppose CMS' proposal to create temporary level II G codes while continuing to allow hospitals to apply their own internal guidelines to these codes. **Instead, we recommend that CMS support the continued use of the current five-level CPT codes, which would be assigned to the three existing APCs for hospital clinic and ED services until national coding definitions and guidelines are finalized.**

Creating temporary G codes without a fully developed set of national guidelines will increase confusion and add a new administrative burden requiring hospitals to manage two sets of codes – G codes for Medicare and CPT codes for non-Medicare payers – without the benefit of a standardized methodology or better claims data. Instead, our approach would provide consistent coding policy, and allow CMS and stakeholders to focus instead on developing and fine-tuning a set of national guidelines that could be applied to a future set of hospital visit codes.

The AHA and the AHIMA recommend that once national guidelines are developed, a formal proposal should be presented to the American Medical Association CPT Editorial Panel to create CPT codes for hospital visits. These codes could then be widely reported by hospitals to all payers. We do not believe that creating temporary G codes would be effective or efficient as an interim step, and urge CMS to wait until the implementation of new CPT codes.

PROPOSED GUIDELINES AND CMS CONCERNS

CMS reviewed more than 10 sets of guidelines submitted since 2000. We are pleased that CMS believes the AHA/AHIMA guidelines provide the best platform for refinement and adoption, and we agree that any guidelines adopted will continue to require refinement after implementation. CMS used the AHA/AHIMA model to develop a modified version of the AHA/AHIMA model and CMS is seeking comment on both versions.

CMS identified eight general areas of concern regarding the AHA/AHIMA model. We will broadly address these areas in this letter, but will continue to review the models to develop specific recommendations for CMS in the near future.

Three Levels Versus Five Levels of Codes. To determine whether three levels of visit codes or five levels are appropriate, certain issues related to standardized national

guidelines must be resolved. During the development of the visits model in 2003, the AHA/AHIMA expert panel concluded that "there was considerable difficulty in distinguishing the typical interventions performed in an ED and hospital clinic into more than three levels, once separately billable procedures were removed from the mix of interventions utilizing facility resources."

Clear guidance from CMS is required to determine what factors or interventions should or should not be included in determining the visit levels. For instance, may separately payable services be used as a proxy for intensity to drive level of service assignment? May time be taken into consideration? Having three levels versus five levels depends on the degree of specificity and discriminatory criteria associated with each level.

Lack of Clarity for Some Interventions. The AHA and the AHIMA agree that additional educational materials may be needed to provide greater clarity on interventions proposed in the model. The model submitted was an initial attempt to develop, on a very tight timeframe, a methodology around which hospital visit levels could be determined and that would address CMS' concerns with all other methodologies reviewed through 2002. The model was never intended as a stand-alone document, without explanations or supplementary educational materials.

Treatment of Separately Payable Services. While we will reconsider the inclusion of separately payable services as a proxy for patient acuity, the AHA and the AHIMA believe that this area requires further study and discussion. Coordination of services is certainly a resource-intensive activity for facility staff resources. However, not all separately payable services may reflect patient acuity; therefore, we believe the expert panel could determine which separately payable services are appropriate for inclusion.

Some Interventions Appear Overvalued. We would appreciate specific feedback from CMS regarding why the agency thought some interventions were overvalued. In determining the value for the different interventions included, the expert panel carefully evaluated the implications for facility resources for each intervention. The criteria included:

- The hospital staff time involved;
- The complexity of the intervention;
- The number of hospital staff members required to perform the intervention; and
- The skill level, qualifications or credentialing needed to perform the intervention.

Concerns of Specialty Clinics. We believe that a single set of clinic codes should be used by all types of clinics, rather than separate and distinct codes and guidelines for different types of clinics. To that end, specific facility services – not physician services – that are not currently identified in the clinic model should be identified and classified into a single clinic visit classification model. Such a classification model should appropriately recognize services for all patients, and not just the Medicare population.

Special Needs May Be in Violation of Americans with Disability Act. Unless carefully structured, proposals related to paying for patients with special needs may conflict with federal law governing discrimination. The AHA has evaluated this issue with legal counsel. The AHA/AHIMA model was intended to reflect the differences in service intensity – i.e., the type and amount of facility resources used in patient care – in order to support the appropriate assignment of a billing code for the level of services provided. It is clear that patients with special needs, such as altered mental status, language, cognitive and/or communications impairments, sometimes require increased resources in the form of additional staff time and/or specialized facility resources, and result in increased costs for the facility. While the AHA/AHIMA model was crafted so as to permit evaluation of facility resources used, it was not intended to affect the payment obligations of individual beneficiaries for items such as coinsurance. The AHA and the AHIMA would like to work further with CMS to evaluate how the Medicare program could adequately pay for its share of these increased costs without affecting individual beneficiary payment liability or otherwise raising concerns under federal law governing discrimination.

Differentiation Between New and Established Patients, and Between Standard Visits and Consultations. Differentiating hospital visit codes between new and established patients, or between standard visits and consultations, would add an unnecessary level of complexity and be difficult to implement. These distinctions should be eliminated. While current distinctions in the physician E/M codes exist, the same concepts do not apply to facility resources. From a physician's perspective, an established patient may require a shorter history and a less comprehensive physical exam. These same economies are not necessarily factors in determining facility resource codes.

For example, a person may be an established patient to a facility because of previous visits to any number of outpatient settings, including the ED, a clinic, as an inpatient, for a diagnostic exam, or for any other service. Previous services may or may not be related to the current visit, but it would be extremely burdensome for facilities to have to determine whether there was a previous encounter and whether services performed then are related to the current visit. The interventions performed during an encounter are determined by physician orders, but the actual performance of these interventions would be the same whether the patient was new or established. Every ED patient is treated using the same standard of care and the same work effort, regardless of whether the patient is new or established.

Lack of Distinction Between Type A and Type B EDs. This is not a coding issue. Hospital visit codes should be assigned on the basis of the services provided to a specific patient, and not related to a licensing issue. If there is a need to distinguish between Type A or Type B EDs, it should be done through the provider profile or some other methodology.

PROPOSED CRITICAL CARE CODING

We oppose the proposed structuring of critical care coding on the basis of time. Time is not a relevant factor to determine facility resources used and is inappropriate for hospital critical care codes for the following reasons:

- Most critical care patients are in the ED for 30 minutes or less. Typically, critical care patients are stabilized and transferred to the intensive care unit, which would then be billed as an inpatient service.

- Critical care codes in the outpatient setting most likely would apply to patients who died before they could be admitted or who were transferred to another facility.

- The goal of the ED is to stabilize the patient as quickly as possible. If a code is created that requires that a patient receive at least 30 minutes of critical care before the code can be used, then for any patient receiving less than 30 minutes of care the facility resources for these patients would not be recognized.

- Critical care patients require multiple hospital staff to be present simultaneously and may require a multidisciplinary team. It would be extremely burdensome and confusing to track time for those different individuals.

We will continue to do an in-depth review of the models and CMS' concerns. We also request CMS' assistance in a few key areas.

The AHA and the AHIMA request the opportunity to review the analysis of the AHA/AHIMA model conducted by the Iowa Foundation for Medical Care. Understanding the specific concerns and findings of this study will allow our expert panel to determine whether additional examples or education are needed and how best to modify the model. Examples of outstanding questions are whether the contractor had access and reviewed complete medical records, or only physician documentation. Typically, requests for hospital documentation by payers are answered with copies of the physician documentation and do not include nurses' notes or flow sheets. The entire medical record may provide additional information to support hospital staff interventions included in the AHA/AHIMA model that may not necessarily be part of the physician documentation.

We also would like to meet with CMS staff to understand the rationale for some of CMS' modifications of the AHA/AHIMA model. In some instances, it appeared that CMS may have considered interventions on the basis of the physician time/expertise involved, rather than the actions of hospital staff or facility resources. For example, it is unclear why patient education by hospital staff was deleted, while physician counseling of more than 60 minutes would be added. Preliminary testing of the CMS-modified model by two of the expert panel members raised concerns that the modified model did

not allow their cases to go beyond a level one code. Removing other factors such as altered mental status and scheduling/coordination of ancillary services has a significant impact on the assignment of a level of service to patients who required substantial additional hospital resources. Understanding CMS' intentions will allow us to provide a more thorough review and detailed recommendations.

We agree that additional training, education and supplemental materials (e.g. vignettes) would be helpful to aid in the application of the guidelines. We believe that these should be developed only after national guidelines are established.

The AHA and the AHIMA appreciate the opportunity to comment on hospital visit coding. We look forward to working with CMS to resolve any remaining issues and assist in the development and implementation of standardized national coding guidelines for the reporting of hospital visits. If you have questions, please feel free to contact AHA's Nelly Leon-Chisen, RHIA, director of coding and classification for, at (312) 422-3396; or AHIMA's Sue Bowman, RHIA, CCS, director of coding policy and compliance, at (312) 233-1115.

Sincerely,

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