



**American Hospital  
Association**

September 24, 2012

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The Honorable Kathleen Sebelius  
Secretary  
Department of Health and Human Services  
200 Independence Ave., S.W.  
Room 445-G  
Washington, DC 20201

The Honorable Eric H. Holder, Jr.  
Attorney General  
U.S. Department of Justice  
950 Pennsylvania Ave., N.W.  
Washington, DC 20530

Dear Secretary Sebelius and Attorney General Holder:

America's hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries. Hospitals have a longstanding commitment to compliance, establishing programs and committing resources to ensure that they receive only the payment to which they are entitled. We agree that the alleged practices described in your letter, such as the so-called "cloning" of medical records and "upcoding" of the intensity of care, should not be tolerated.

Electronic health records hold great promise for improving the efficiency and effectiveness of care. Hospitals have made great strides to comply with the Administration's regulations for implementing this technology, which also enhances their ability to correctly document and code the care a patient has received.

It's critically important to recognize that more accurate documentation and coding does not necessarily equate with fraud. Medicare and Medicaid payment rules are highly complex and the complexity is increasing. We have made numerous requests to the Centers for Medicare & Medicaid Services (CMS) to develop national guidelines for the reporting of hospital emergency department (ED) and clinic visits. This is a request that the AHA has made to CMS 11 times (starting in 2001) since the outpatient prospective payment system (OPPS) was first implemented.

Since April 2000, hospitals have been using the American Medical Association's (AMA) Current Procedural Terminology (CPT<sup>®</sup>) evaluation and management (E/M) codes to report facility resources for clinic and ED visits. Recognizing that the E/M descriptors, which were designed to reflect the activities of physicians, did not adequately describe the range and mix of services provided in hospitals, CMS instructed hospitals to develop internal hospital guidelines to determine the level of clinic or ED services provided. In 2003, the AHA and the American Health Information Management Association (AHIMA) recommended that CMS implement national hospital E/M visit guidelines based on the work of an independent expert panel comprised of representatives with coding, health information management, documentation, billing, nursing, finance, auditing and medical experience.



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In the 2004 and 2005 OPPS rules, CMS stated it would consider national coding guidelines recommended by the panel. **However, to date, CMS has not established national hospital E/M guidelines.**

For calendar year (CY) 2013, as it has for every year since implementing OPPS, CMS proposes that, until national guidelines are established, hospitals should continue to report visits according to their own internal hospital guidelines to determine the different levels of clinic and ED visits. In the proposed rule, CMS notes its continued expectation that hospitals' internal guidelines should comport with the principles listed in the 2008 OPPS final rule. Hospitals with more specific questions related to the creation of internal guidelines are directed to contact their local fiscal intermediaries or Medicare Administrative Contractors (MACs).

**The AHA has long called for national guidelines for hospital ED and clinic visits, and we stand ready to work with CMS in the development and vetting of such guidelines. Once national guidelines are developed, we recommend that a formal proposal be presented to the AMA's CPT<sup>®</sup> Editorial Panel to create unique CPT<sup>®</sup> codes for hospital reporting of ED and clinic visits based on the national guidelines.** These codes then could be widely reported by hospitals to all payers.

Hospitals share the Administration's goal of a health system that offers high-quality, affordable care and work hard to ensure billing is correct the first time. What's needed is clearer guidance from CMS, not duplicative audits that divert much needed resources from patient care. In recent years, CMS has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. No one questions the need for auditors to identify billing mistakes; but the flood of new auditing programs, such as Recovery Audit Contractors, MACs and others, is drowning hospitals with a deluge of redundant audits, unmanageable medical record requests and inappropriate payment denials. For example, respondents to AHA's latest RACTrac survey are appealing more than 40 percent of denials with a success rate of 75 percent. While the payment accuracy programs may be well intentioned, they need to be streamlined with duplicative audits eliminated and inappropriate denials halted. Furthermore, investments should be made in provider education and payment system fixes to prevent payment mistakes before they occur.

Thank you for your attention to this issue. On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, we look forward to working with you and other stakeholders as we continue to improve health care for patients.

Sincerely,

Rich Umbdenstock  
President and CEO