MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

May 24, 2005

Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-3122-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: File Code - CMS - 3122 - P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Secretary of Health and Human Services' proposed rule entitled *Medicare and Medicaid Programs; Hospital Conditions of Participation; Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations*, 70 Fed. Reg. 15266 (March 25, 2005). This rule addresses a critical component of the medical record: patients' medical history and physical examination. We are interested in this proposed rule because:

- two of the proposed changes to the conditions of participation could improve the quality of the history and physical, and,
- the Secretary should consider using this rule to require hospitals to identify which secondary diagnoses were present on admission on their claims forms, as we recommended in our March 2005 Report to Congress.

First, the proposed rule would allow a history and physical examination that was performed up to 30 days prior to admission to become part of the hospitals' medical record. We support this change because it may allow hospitals to use the history and physical performed by a patient's regular doctor more often than is possible under the current regulation (which currently restricts hospitals to using a prior history and physical that is seven or fewer days old at the time of the patient's admission). A patient's regular doctor may be able to incorporate knowledge of the patient's long-term health that might not be available to the intake personnel of the hospital. When patients' critical information follows them from one setting to another—from their regular doctor's office to the inpatient hospital—it can enhance the continuity and quality of patient care.

Previously, the regulations allowed hospitals up to 48 hours after admission to complete a history and physical; if a patient had a history and physical that had been taken within the

seven days prior to the admission, then no update of that information was required. The proposed rule would change the requirement so that "when a medical history and physical examination is completed within the 30 days before admission," the hospital must "ensure that an updated medical record entry documenting an examination for any changes in the patient's current condition is completed [and] documented in the patient's medical record" within 24 hours of his or her admission to the hospital. We support this change because requiring an update of a previously-conducted history and physical or conducting a new one within 24 hours helps to differentiate between conditions that developed while the patient was in the hospital from those that were present before admission.

However, the final rule needs to clarify the meaning of "documentation." The rule's reference to "documentation" could refer either to indicating only that such an examination took place *or* could refer to recording the results of the examination, e.g. the patient's new condition. The final rule should clarify that if a patient's condition has changed since the history and physical was taken—whether previous conditions have been resolved or whether new conditions have manifested—the hospital is required to document patients' current conditions in sufficient detail to represent the patient's condition upon admission.

Finally, we believe that the proposed rule is also an opportunity for the Secretary to implement a recommendation from our March 2005 Report to improve the utility of hospital claims data for measuring clinical effectiveness and patient safety. The Commission recommended that CMS should require hospitals to report information about patients' condition upon admission on the hospital claim submitted for payment. The proposed rule makes important improvements to the quality of the information regarding patients' condition on admission, but it stops short of requiring the information on the standard claim form.

Adding this information to the claim would make important data available for a far wider range of applications than simply requiring the information in patients' medical records. Reporting patients' conditions upon admission could allow CMS, hospital quality improvement personnel, researchers, and others to improve hospital quality measures. More information about patient's conditions upon admission could greatly enhance measures of patient safety and improve the risk adjustment of clinical effectiveness measures. For example, it would enable a quality measure to distinguish between a patient population that has a high rate of infections when they enter hospitals from a population that may be fairly uncomplicated but frequently acquires infections during their hospital stay.

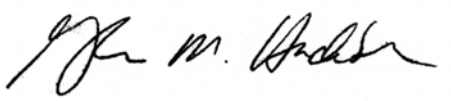
Practical models for changing the hospital claim form are available. A group of clinicians and medical coders have worked together in New York State to draw upon the years of experience in the State of California (where coding patients' condition upon admission is already required) to

develop a new template for a single, standardized instruction for coders to record this information. CMS could consider the coding guidance and claim forms from either or both of these states. Adding this information to the claim stream would require training coders and making a small adjustment to the hospital claim. However, this change is unlikely to occur if hospitals are not required to do so.

MedPAC appreciates this opportunity to comment on this proposed rule. The Commission values the willingness of CMS staff to provide relevant data and to consult with us concerning technical policy issues.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/sc/w