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General Comment

CMS rightly seeks to differentiate providers by quality of care while minimizing burden — yet the measurement infrastructure built on top of claims data contains a structural flaw that undermines both goals simultaneously.

When two clinicians performing the identical service across any covered setting — skilled nursing, home health, inpatient rehabilitation, long-term acute care, or hospice — can legitimately arrive at different procedure codes from the same clinical encounter, cross-provider comparison becomes unreliable at its foundation. Quality signals derived from claims inherit that noise. Anomaly detection produces false positives. Peer benchmarking loses precision. Payment adjustment calculations rest on data that was never standardized at the source.

I have developed a deterministic coding system that resolves this directly. Every code is generated automatically from data elements already present on the claim. Physician input is removed from the process entirely. Same service, same documentation — same code, every provider, every setting, every time. Each segment of every generated code traces back to its source. Nothing is inferred. Nothing is ambiguous.

The result is a foundation where cross-provider quality analytics, fraud detection, and VBP performance scoring can function with a precision the current approach structurally prohibits. This directly serves the stated purpose of CMS-10945.

I welcome the opportunity to discuss further.

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