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June 11, 2010

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1498-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Ms. Tavenner:

The American Health Information Management Association (AHIMA) is pleased to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) and fiscal year 2011 Rates, as published as a notice of proposed rulemaking (NPRM) in the May 4, 2010 *Federal Register* (CMS-1498-P).

AHIMA is a professional association representing more than 57,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnosis and procedure classification systems that serve to create the diagnosis related groups (DRG) discussed in this proposed rule. Among AHIMA's member professionals are individuals who have engaged in ongoing in-depth education and obtained one or more certifications in the coding of health records by applying classification standards, official guidance, and AHIMA's standard for ethical coding . This response to the May 4 NPRM was done in consultation with such credentialed professionals and AHIMA staff.

As part of our effort to promote consistent coding practices, AHIMA serves as 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 ICD-9-CM, ICD-10-CM, and ICD-10-PCS code sets.

AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including value sets associated with quality measurement and in the development, planning, implementation and management of electronic health records.

Our detailed comments and rationale on the NPRM for IP-PPS are below.

## II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (75FR23861)

**We urge CMS to publish the proposed ICD-10-CM/PCS-based MS-DRGs no later than the FY 2013 IPPS proposed rule.** While we recognize that proposed MS-DRG revisions are typically published in the IPPS proposed rule for the fiscal year when they would become effective, the conversion of the MS-DRGs to ICD-10-CM/PCS is much larger and more complex than the usual annual changes to the MS-DRGs. Therefore, we believe the healthcare industry needs more lead time to review, analyze, and prepare comments on the ICD-10-CM/PCS-based MS-DRGs.

**II-D – Proposed FY 2011 MS-DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount** (75FR23865)

**AHIMA urges CMS to stop referring to their proposed payment adjustment as a "coding and documentation" adjustment and instead refer to it as a "budget neutrality" adjustment or similar term.**

AHIMA has long been an advocate of consistent coding practices and serves as one of the four Cooperating Parties responsible for development of the *ICD-9-CM Official Guidelines for Coding and Reporting* and the content of the American Hospital Association's *Coding Clinic for ICD-9-CM*. These publications provide official industry guidance on complete, accurate ICD-9-CM coding, without regard to the impact of code assignment on reimbursement.

AHIMA's Standards of Ethical Coding stipulate that "coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data." Therefore, AHIMA believes that all diagnoses and procedure should be coded and reported in accordance with the official coding rules and guidelines, which are developed under HHS authority.

As CMS has acknowledged in various regulations, including past PPS rules and the ICD-10 rule, there is a growing demand for more accurate and detailed data due to new and expanding healthcare initiatives such as value-based purchasing, present on admission (POA) reporting, quality reporting, and patient safety monitoring.

A negative payment adjustment for improved coding and documentation is at odds with industry efforts to improve the quality of healthcare data, as well as with CMS' own efforts to encourage

hospitals to improve their coding specificity. It is also inconsistent with national goals to improve quality of care.

Negative terminology used in regards to this adjustment also negatively portrays coding professionals' and clinicians' hard work and dedicated efforts toward improving the quality of documentation and coding– by directly associating these improvements with reduced payments to hospitals. AHIMA recognizes the requirement to maintain budget neutrality and the associated payment cuts that may need to occur. We also recognize that no payment cut for "coding and documentation improvements" would need to be made in the absence of a budget neutrality requirement. **Therefore, this payment adjustment should more appropriately be referred to as a "budget neutrality adjustment."** We believe this change in terminology here and in other HHS and CMS statements and documents would more accurately reflect the true basis for the payment adjustment and eliminate the current widespread misperception that this adjustment is a penalty for accurate coding and documentation improvements.

**II-F-2 – Proposed HAC Conditions for FY 2011** (75FR23882)

AHIMA supports the proposal to delete code 999.6, ABO incompatibility reaction, on the HAC list and replace it with the five new diagnosis codes for ABO incompatibility reaction, since this change reflects revisions to the ICD-9-CM code set.

**II-F-3 – RTI Program Evaluation Summary** (75FR23883)

We support CMS' efforts to encourage accurate present on admission (POA) reporting and discourage the use of the POA indicator "U" to the extent possible. Based on member feedback, we note that there is still some confusion as to the difference between the POA indicators "W" and "U," which could result in some diagnoses being reported as a "U" when "W" would be more appropriate. We have also heard from our members that that there is reluctance on the part of some physicians to report "W."

**AHIMA urges CMS to collaborate with the healthcare industry, through *Coding Clinic for ICD-9-CM* and other communication mechanisms, to provide education on the use of the POA indicator "W" and to encourage the proper use of this POA indicator when clinically appropriate.**

**II-G-1a – Postsurgical Hypoinsulinemia** (75FR23898)

We concur with CMS' proposal to add diagnosis code 251.3, Postsurgical hypoinsulinemia, to the list of principal or secondary diagnosis codes assigned to MS-DRGs 008 (Simultaneous Pancreas/Kidney Transplant) and 010 (Pancreas Transplant).

**II-G-1b – Bone Marrow Transplants** (75FR23898)

We support CMS' proposal to delete MS-DRG 009 (Bone Marrow Transplant) and create two new MS-DRGs in order to differentiate allogeneic and autologous bone marrow transplants.

**II-G-2 – Administration of Tissue Plasminogen Activator (tPA) (rtPA)** (75FR23899)

With regard to CMS' analysis of claims data for diagnosis code V45.88, Status post administration of tPA in a different facility within the last 24 hours prior to admission to current facility, our members have indicated this code may be under-reported. Also note, when it is reported, it may appear in a position lower than the nine diagnoses currently processed by Medicare. So, the data analyzed by CMS may not have reflected a complete picture of cases when tPA was administered in a different facility within 24 hours prior to admission to the current facility. As facilities move to a standard electronic health record and nomenclature and exchange standard information as transfer, such as the HL7 Continuity of Care Document (CCD) standard transaction, this problem should evaporate.

**II-G-3a – New MS-DRGs for Intraoperative Fluorescence Vascular Angiography with CABG** (75FR23900)

AHIMA supports CMS' proposal not to make any MS-DRG modifications for cases reporting procedure code 88.59, Intra-operative fluorescence vascular angiography.

**II-G-3b – New MS-DRG for Intraoperative Angiography, by Any Method, with CABG** (75FR23901)

We support CMS' proposal not to create a new MS-DRG for coronary bypass with intraoperative angiography, by any method.

**II-G-3d – MS-DRG Reassignment of Intraoperative Fluorescence Vascular Angiography** (75FR23901)

We support CMS' proposal not to reassign cases with procedure code 88.59, Intra-operative fluorescence vascular angiography, to MS-DRGs 228, 229, and 230 (Other Cardiothoracic Procedures with MCC, CC, and without CC/MCC, respectively).

**II-G-4 – Gastrointestinal Stenting** (75FR23902)

We support CMS' proposal not to make any MS-DRG modifications to cases involving the use of gastrointestinal stents.

**II-G-5 – Pedicle-Based Dynamic Stabilization** (75FR23902)

AHIMA supports CMS' proposal not to reassign cases with procedure code 84.82, Insertion or replacement of pedicle-based dynamic stabilization device(s), to MS-DRG 460 (Spinal Fusion Except Cervical without MCC).

**II-G-6a – Discharges/Transfers of Neonates to a Designated Cancer Center or Children's Hospital** (75FR23903)

We commend CMS' proposal to add discharge status code 05 (Discharged/transferred to a designated cancer center or children's hospital) to the MS-DRG GROUPER logic for MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility).

**II-G-6b – Vaccinations of Newborns** (75FR23903)

We also commend the proposal to remove code V64.05, Vaccination not carried out because of caregiver refusal, from MS-DRG 794 (Neonate with Other Significant Problems) and add it to MS-DRG 795 (Normal Newborn).

**II-G-7a – Unacceptable Principal Diagnosis Edit: Addition of Code for Gastroparesis** (75FR23903)

We support CMS' proposal to add code 536.3, Gastroparesis, to the list of unacceptable principal diagnoses in the Medicare Code Editor (MCE).

**II-G-7b – Open Biopsy Check Edit** (75FR23903)

We support CMS' proposed deletion of the entire Open Biopsy Check edit from the MCE.

**II-G-7c – Noncovered Procedure Edit** (75FR23904)
We agree with the proposed addition of diagnosis code 251.3, Postsurgical hypoinsulinemia, to the list of acceptable principal or secondary diagnosis codes in the MCE that are associated with the noncovered procedure edit for procedure codes 52.80, Pancreatic transplant, not otherwise specified, and 52.82, Homotransplant of pancreas.

**II-G-9b(2) – Suggested Changes to Severity Levels for Obesity-Related and Major Osseous Defect Diagnosis Codes** (75FR23905)

We support CMS' proposal not to change the CC classification of diagnosis codes for obesity, major osseous defects, and body mass index (BMI). However, the BMI codes may be under-represented in the Medicare data because they may appear in a code position lower than the nine diagnoses currently processed by Medicare.

**II-G-9b(3) – Suggested Changes to the Severity Level for Alzheimer's Disease Diagnosis Code** (75FR23907)

We support CMS' proposal not to change the CC classification of code 331.0, Alzheimer's disease.

**II-G-9b(4) – Proposed Change to the Severity Level for Acute Renal Failure, Unspecified Diagnosis Code** (75FR23907)

We are concerned that the claims data on diagnosis code 584.9, Acute renal failure, that CMS used to support its proposal to change the severity level of this code from an MCC to a CC may be flawed due to variable terminology used by physicians and changes in the ICD-9-CM classification.

Physicians often use the terms "acute renal insufficiency" and "acute renal failure" interchangeably, resulting in some cases of acute renal insufficiency being classified as acute renal failure. Also, physicians often use the term "acute kidney injury" to mean either acute renal insufficiency or acute renal failure, but "acute kidney injury" is indexed in ICD-9-CM to code 584.9 and therefore is always classified as acute renal failure. Due to these inconsistencies, data on code 584.9 likely includes a mix of both acute renal insufficiency cases and true acute renal failure cases, resulting in dilution of the data for this code and an inaccurate reflection of the severity level for acute renal failure.

**We believe and recommend that further changes to the classification of renal conditions in ICD-9-CM are necessary, as well as physician education, are necessary to improve data on acute renal failure.**

**II-G-11b – Code Freeze** (75FR23912)

AHIMA supports the federal government's proposal to make the last regular, annual updates to both ICD-9-CM and ICD-10-CM/PCS effective on October 1, 2011, with the next regular update to ICD-10-CM/PCS scheduled for October 1, 2014. We believe this timetable balances the need to ensure ICD-9-CM and ICD-10-CM/PCS are as up-to-date as possible with the need to allow the federal government and the healthcare industry sufficient time to concentrate on ICD-10-CM/PCS transition activities.

We also support the proposal to allow limited code updates to ICD-9-CM and ICD-10-CM/PCS on October 1, 2012 in order to capture new diseases and technology. We urge CMS and the CDC to develop strict criteria that a code proposal must meet in order to qualify for the limited update during the freeze period. Application of robust standards will ensure that only code proposals that meet the intent of the limited update, and truly can't wait until the regular updates resume in

2014, are implemented during the code set freeze period. The criteria for the limited update should take into account the extent of a code proposal's impact on the code set. For example, in ICD-10-PCS, creating a new value for one of the characters or adding a root operation to a body system can potentially create many new codes.

While every effort should be made to identify and correct errors in the ICD-10-CM/PCS code sets prior to the code set freeze, errors that aren't identified until the freeze period has started should be allowed to be corrected as part of the October 1, 2012 limited update.

AHIMA **does not** support the proposal to allow a limited update to ICD-10-CM/PCS on October 1, 2013. **There should be no code set update on the ICD-10-CM/PCS "go live" date.**

We believe allowing even relatively minor code set modifications to go into effect on the ICD-10-CM/PCS implementation date would unnecessarily complicate the transition. As organizations finalize their ICD-10-CM/PCS transition activities in the months and days leading up to the compliance date, it would be problematic to introduce code changes to this process at this late stage. Code set modifications require review of systems applications, edits, policies, databases, reports, and coding products to identify the impact and make any necessary consequential changes, creating additional cost and work when organizational resources should be focused on completing final ICD-10-CM/PCS implementation activities. The source of any errors or other problems encountered after ICD-10-CM/PCS implementation could be more difficult to pinpoint if new codes create glitches in addition to any problems resulting from the complex transition to ICD-10-CM/PCS.

CMS should announce the federal government's final decision regarding a code set freeze as soon as possible, but no later than September 2010. The healthcare industry should be provided with as much advance notice as possible so ICD-10-CM/PCS planning and preparation processes and timelines can take the code set freeze into consideration. Announcing the final code set freeze decision would also alert stakeholders to the timeline for submission of code proposals that they wish to see incorporated into the code sets prior to ICD-10-CM/PCS implementation.

**II-G-11c – Processing of 25 Diagnosis Codes and 25 Procedure Codes on Hospital Inpatient Claims** (75FR23914)

AHIMA commends CMS' plans to accept and process up to 25 diagnoses and 25 procedures on hospital inpatient claims submitted on the 5010 format beginning January 1, 2011.

This is a change AHIMA has long advocated , and we appreciate CMS' recognition that a complete picture of patients' clinical conditions and procedures is necessary in order to accurately measure quality, analyze outcomes, assess severity of illness, and determine reimbursement. We hope that other payers, including Medicaid, will follow Medicare's lead as

they prepare for implementation of the 5010 versioning. We urge CMS to make providers aware of this change so that claims systems do not necessarily limit the codes submitted.

## IV. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs (75FR23956)

Because the transition to ICD-10-CM/PCS is rapidly approaching and will impact the quality measurement reporting program, we strongly encourage CMS to provide an overview of the plans for transitioning the measures to reflect the code changes. We understand the NPRM discusses measure submission requirements up to December 31, 2012 discharges, we do believe providing the industry with additional information will assist with transition planning and preparation.

**IV-A-2 – Retirement of RHQDAPU Program Measures** (75FR23960)

For additional considerations regarding the criteria for retiring of measures, AHIMA recommends that CMS evaluate the burden of collection and reporting the data against the value received from reporting the measures.

AHIMA supports CMS' reasoning for retiring the AHRQ Mortality for Selected Surgical Procedures (composite) measure and we commend CMS for discontinuing the use of this measure based on the National Quality Forum (NQF) panel's guidance.

**IV-A-3a – Proposed Expansion Plan for Quality Measures for the FY 2012, FY 2013, and FY 2014 Payment Determinations: Consideration in Expanding and Updating Quality Measures Under the RHQDAPU Program** (75FR23964)

AHIMA commends CMS for giving careful consideration of the issues and goals for future expansion of the RHQDAPU program as outlined in the section, "a. Considerations in Expanding and Updating Quality Measures Under the RHQDAPU Program." (75FR23964)

We also commend CMS' intentions for exploring mechanisms of data submission through the use of EHRs. We support CMS for taking steps to align data collection requirements with other measurement initiatives to reduce data collection burden for hospitals. This supports AHIMA's "collect once, repurpose many times" stance of leveraging data that has been collected once and repurposed for other uses. This helps to reduce the data collection burden and data integrity issues.

**IV-A-3b(1) – Proposed Retention of 45 Existing RHQDAPU Program Quality Measures for the FY 2012 Payment Determination** (75FR23965)

AHIMA supports CMS' intention to retire narrowly specified measures as it places additional burden for data collection and reporting.

AHIMA commends CMS for listening to the stakeholder community regarding the recommendation to retire those measures determined to demonstrate high performance nationwide. We believe this displays an effort to continue working with the community to align and prioritize nationwide healthcare quality priorities and goals.

Conversely, we are concerned about those measures that are identified for retirement in FY 2012 but proposed for use in the "*Electronic Health Record Incentive Program (Meaningful Use)*" NPRM (75FR1844) (i.e., AMI-3, AMI-5, PN-3b, and SCIP-Infection-2). We understand that the Meaningful Use Program is initially voluntary; however we do believe this activity diverges away from CMS' desire to harmonize and align initiatives for the improvement of quality. **AHIMA urges CMS to review these and future measures in comparison with meaningful use requirements for a coordinated approach toward aligning national priorities for quality measurement and improvement.**

We do support CMS' goal of retiring project specific measures (e.g., smoking cessation) and adoption of more broadly specified measures (e.g., global immunization).

**IV-A-3b(2) – Proposed New Claims-Based Measures** (75FR23965)

Chart B on page 23884 indicates a small frequency for Air Embolism and Blood Incompatibility. **We recommend that CMS does not adopt these two measures due to the small frequency and opportunity for comparability.**

**IV-A-3c(1) – Proposed Retention of FY 2012 Payment Determination Measures for the FY 2013 Payment Determination** (75FR23970)

We generally support CMS' proposal to retain the measures from one year to the next for continuity, but **we encourage CMS to regularly review measures to assess the need for retirement (e.g., high performance nationwide, scientifically valid, etc.).**

**IV-A-3c(2) – Proposed New Chart-Abstracted Measure for the FY 2013 Payment Determination** (75FR23965)

We commend CMS for requesting NQF to review and potentially broaden the current endorsed measure specification to include the AMI population.

**IV-A-3c(4) – Proposed New Registry-Based Measures** (75FR23971)

AHIMA commends CMS for leveraging alternative data sources, such as registries, to avoid additional data collection burden for hospitals participating in the RHQDAPU program.

As outlined within the NPRM, CMS describes the activities that will support the new registry-based reporting efforts. It is our understanding from reading the rule that the following will occur:
1. The four proposed registry-based measures must be issued through a CMS qualified registry. (23997)
2. December 31, 2010 – At the latest, the list of qualified registries will be posted. (23997)
3. January 1, 2011 – The registry-based measures are based upon discharges beginning with this date for FY 2013 quality measurement reporting. (23972)

AHIMA believes allowing one day between the postings of qualified registries and required discharges for reporting is alarming! We are concerned that participating hospitals may contract with a registry only to find out their registry is not on the CMS approved list. This late notice may prevent hospitals from collecting registry-based measurements or cause hardship or added expense.

**AHIMA strongly recommends that CMS post the list of qualified registries earlier than the proposed December 31, 2010 timeframe**.

**IV-A-5a(2) – Synchronization of RHQDAPU Program Data Submission and Validation Quarters With Quarters Used To Make Payment Determinations** (75FR23985)

AHIMA supports CMS' efforts to synchronize time frames for submission and validation of data to calendar quarters (which is consistent with the January 1 effective dates of the measures). Historically, it has been a challenge to align measures and determine what fiscal year a measure was adopted and what period of time was being used for payment validation.

In order to support the industry's requirements for data submission we believe it would be beneficial for CMS to provide a table in the final rule containing the submission requirements for all the different types of data/measures or add the submission requirements to each of the measure listing tables for each FY Payment Determination.

**IV-A-5a(4) – Synchronization of RHQDAPU Program Data Submission and Validation Quarters With Quarters Used To Make Payment Determinations** (75FR23990)

CMS provides the structural measure submission requirements for FY 2012 payment determination but does not provide this information for FY 2013 or FY 2014. **We request further clarification regarding whether hospitals will be required to submit the registry**

**participation information for FY 2013 and beyond or if CMS will assume this is the case based on the submission of registry-based measurement data.**

**IV-A-7b – Proposed Supplements to the Chart Validation Process for the FY 2013 Payment Determinations and Subsequent Years** (75FR23993)

AHIMA supports CMS' proposal to include hospitals that failed validation in one year to be included in the following year of pooled hospitals as a method to verify that a hospital has in fact corrected their data collection process. Additionally, we support CMS' proposal to change the selection process to include hospitals with less than the 100 case minimum. This will allow an opportunity for all hospitals to be included in the pool for validation, increasing the overall quality and reliability of the RHQDAPU program data set.

**IV-A-12c – Electronic Health Records (EHRs): HITECH Act EHR Provisions** (75FR23996)

Per the Meaningful Use proposed rule, "*II. Provisions of the Proposed Regulations A. Definitions Across the Medicare FFS, Medicare Advantage, and Medicaid Programs 3. Sections 4101(a) and4102(a)(1) of HITECH Act: Reporting on Clinical Quality Measures Using EHR by EPs and All Eligible Hospitals"* (75FR1870), CMS indicated hospitals would not be required to conduct duplicate quality reporting for different programs, particularly with the RHQDAPU program. After an analysis of the IPPS NPRM we do not find any information regarding alignment of initiatives and coordination with the Meaningful Use Program. **We request CMS to provide acknowledgement and further information concerning the association of the two programs and coordination of reporting requirements.**

**IV-A-13 – Qualifications of Registries for RHQDAPU Data Submission** (75FR23997)

CMS discusses adding validation samples for the NHSN measures, however we do not see reference to the validation of registry based measure data in this section. Registry-based measures are also Chart Abstracted measures; we believe there should be some discussion of how CMS plans to validate this data also. As part of qualifying a registry, CMS outlines the requirements that they are able to perform data quality validation checks and must submit an 'acceptable data validation strategy' to CMS by December 2011 but we believe any chart abstracted measure data should have a standardized method of insuring the accuracy of the data regardless of the source and this should be more explicit in the CMS rules.

## Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for FY 2011. AHIMA is committed to working with CMS and the healthcare industry to improve the quality healthcare data for reimbursement, quality

reporting, and other purposes. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact me at (312) 233-1115 or sue.bowman@ahima.org. In my absence, please feel free to contact AHIMA's vice president for policy and government relations, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org, or AHIMA's director for federal affairs, Allison Viola, at (202) 659-9440 or allison.viola@ahima.org.

Sincerely,

Sue Bowman, RHIA, CCS
Director, Coding Policy and Compliance

cc: Dan Rode, MBA, CHPS, FHFMA
Allison Viola, MBA, RHIA