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June 27, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1448-P**
PO Box 8016
Baltimore, Maryland 21244-8016

Dear Administrator Tavenner:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2014, as published as a notice of proposed rulemaking (NPRM) in the May 8, 2013 *Federal Register* (CMS-1448-P).

AHIMA is a nonprofit professional association representing more than 67,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with diagnosis and procedure classification systems, including ICD-9-CM and ICD-10-CM. 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 standards for ethical coding.

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 development of official guidance associated with the proper use of 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 comments focus on the proposed refinements to the presumptive compliance criteria methodology.

VII. Proposed Refinements to the Presumptive Compliance Criteria

Methodology (78FR26895)

VIII-B – Proposed Changes to the ICD-9-CM Codes That Meet the Presumptive Compliance Criteria (78FR26897)

The list of ICD-9-CM diagnosis codes that meet presumptive compliance criteria represents those codes that would be expected to “presumptively” meet the 60 percent rule compliance criteria. It reflects those particular diagnosis codes that, if a patient is coded using one of those codes, would more than likely be expected to meet the requirement either that the patient received intensive rehabilitative services for treatment of one or more of the specified qualifying conditions or had a comorbidity that caused significant decline in functional ability such that, even in the absence of the admitting condition, the patient would require the intensive rehabilitative treatment that is unique to inpatient rehabilitation facilities and cannot be performed in another care setting.

AHIMA disagrees with CMS’ proposed removal of a number of non-specific ICD-9-CM codes from the list of codes meeting presumptive compliance criteria. In the proposed rule, CMS states “Generally, “unspecified” codes are used when there is lack of information about location or severity of medical conditions in the medical record.” While it is true that insufficient medical record documentation to support a more specific diagnosis is one circumstance when non-specific codes are reported, there are many circumstances when non-specific codes are not only appropriate, but necessary. The medical record documentation may fully reflect the known clinical picture, but the clinical details necessary to assign a more specific code may be unknown to the medical provider. Diagnosis codes can only reflect the extent of current clinical knowledge regarding a patient’s medical condition.

The proposed rule indicates that if the inpatient rehabilitation facility (IRF) does not have enough information about the patient’s condition to assign more specific codes, CMS would expect the IRF to seek out additional information from the patient’s acute care hospital medical record to determine the appropriate, more specific code to use. IRFs must rely on the documentation provided by the referring general acute care hospital when assigning certain codes to describe the patient’s status. It is both difficult and burdensome to attempt to obtain detailed medical documentation from the transferring facility, especially when the transferring facility itself may not have the level of specificity required by the proposed changes. The difficulty is compounded when the IRF admission is further removed from the patient’s treatment in the general acute care hospital, such as when a patient is discharged from a general acute care hospital, then treated in a long-term care hospital, and then transferred to an IRF. Therefore, the ability of IRFs to obtain more specific codes from the referring hospital, instead of using non-specific codes, is often administratively unrealistic.

So, while AHIMA certainly advocates for complete, accurate medical record documentation that supports the highest level of specificity possible, there are times when access to another facility’s documentation that might support a higher level or specificity is not feasible or the necessary

clinical information is not available. For example, accessing the documentation where the duration of loss of consciousness associated with an initial traumatic brain injury might be specified could be quite administratively burdensome or even impossible. When the loss of consciousness is of short duration, the information may be typically recorded in the field, at the scene of the injury, by the emergency medical technician or the ambulance, and often is not available to the receiving IRF. Whether or not the patient lost consciousness, and for how long, may not be known by anyone, including the patient's family and initial treating provider. And it is unclear what the value of trying to track down this information is, since the medical condition requiring intensive rehabilitative services is fully identified in those ICD-9-CM codes for which the only non-specific aspect is the duration of the loss of consciousness.

Some of the "non-specific" ICD-9-CM codes proposed for deletion are not non-specific in terms of clinical information needed to demonstrate that requirements for inclusion in an IRF's 60 percent compliance threshold have been met. Traumatic brain injury codes, where the only non-specific component is the duration of loss of consciousness, have already been mentioned. Hip fracture codes 820.00, 820.10, 820.30, 820.8 and 820.9 are another example. These codes already specify the fracture as being of the "neck of femur." It is unlikely that the physician documentation would reflect anything more specific without a copy of the x-ray report, yet the x-ray may have been taken in an emergency department, at the general acute care hospital, in the nursing home, or some other location, and therefore not available as part of the IRF record. Further, the additional specificity of which portion of the neck of the femur is affected does not impact the type or intensity of rehabilitation services the patient requires.

Codes 433.91 and 434.91, which specify whether the occlusion of a cerebral infarction was of a cerebral artery or precerebral artery, are proposed to be removed from the list of codes meeting presumptive compliance criteria. The related, more specific, codes that would be required instead would identify whether the cerebral artery infarction was due to thrombosis or embolism or which precerebral artery (e.g., basilar, carotid, vertebral, or other) was affected. However, generally, thrombotic and embolic strokes are very similar with the same symptoms, causes, and treatments. Therefore, there is no basis for CMS to require IRFs to provide this additional level of specificity. Providers determine the need for acute rehabilitation services based on the degree of neurological deficits and functional impairment – not on the basis of whether the stroke was thrombotic or embolic, or which precerebral artery was involved.

The codes for tuberculous (abscess, meningitis, and encephalitis or myelitis) and tuberculoma (of the meninges, brain or spinal cord) have been proposed for removal from the list because they do not identify the type of test used to make the diagnosis. However, the entire methodology for classifying tuberculosis based on how the diagnosis was made is outdated and this structure doesn't exist in ICD-10-CM. Therefore, it would be inappropriate for CMS to require additional testing to determine how the initial tuberculosis diagnosis was made. Further, this information does not affect the patient's need for intensive rehabilitative services.

Marilyn Tavenner

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Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare IRF-PPS program for FY 2014. AHIMA is committed to working with CMS and the healthcare industry to improve the quality healthcare data for the various purposes for which it is used. 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 Sue Bowman, Senior Director of Coding Policy and Compliance at (312) 233-1115 or sue.bowman@ahima.org. In Sue's absence, please feel free to contact AHIMA's Vice President of Advocacy and Policy, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Lynne Gordon". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Lynne Thomas Gordon, MBA, RHIA
Chief Executive Officer

cc: Sue Bowman, MJ, RHIA, CCS
Dan Rode, MBA, CHPS, FHFMA