



August 25, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 455-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology (CMS-1686-ANPRM)

Electronic submission www.regulations.gov

Dear Administrator Verma:

Thank you for the opportunity to submit comments on the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revision to Case-mix Methodology advance notice of proposed rulemaking.

AHIMA is the national non-profit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals dedicated to effective health information management, information governance, and applied informatics. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 different job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information analytics.

Although the advance notice of proposed rulemaking (ANPRM) addresses a number of potential revisions to the SNF PPS payment methodology, we offer general comments concerning the RCS-I model followed by more specific comments on the ANPRM.

General Comments:

Risk of Upcoding Under RCS-I Model

AHIMA is concerned about the risk of potential upcoding to achieve a higher case-mix classification under the RCS-I model. For example, our members are concerned that under the model, for a patient who has previously had a hip replacement in the remote past, if the condition is a part of the problem/diagnosis list from the hospital, the hip replacement could get listed as the primary diagnosis in I8000 to achieve higher reimbursement, even though the condition that the patient was most recently treated for at the hospital was pneumonia. In such an instance, the joint replacement code would place the patient in the highest case-mix classification with a case-mix index of 1.82 compared to pneumonia which would have a lower case-mix index of 1.55, all other criteria being equal. **We hope that as CMS begins its revision of the various aspects of the SNF PPS payment methodology that the agency mitigate, to the extent feasible, opportunities to upcode under the RCS-I model.**

Implementation Timeframe of the RCS-I Model

With respect to implementation of the proposed RCS-I model, AHIMA believes that implementation should be phased in over time. Specifically, we recommend, if possible, maintaining both models for calculating potential payment over a 3 - 6 month period while paying under the RUG-IV system, then transitioning to the RCS-I system at the end of the designated time period. Allowing implementation to occur over phases would enable facility management to identify how the change would affect their processes and allow them to make appropriate plans and/or interventions to manage the transition and payment under the RCS-I model.

Physical and Occupational Therapy Case-Mix Classification

Operationalizing Physical and Occupational Therapy Case-Mix Classification Using Item I8000 on the MDS 3.0

The skilled nursing community differs from the acute care community in that individuals assigning the diagnostic codes often receive little to no professional training in code assignment. Our members note that most facilities have assigned this task to the assessment coordinator who utilizes their facility's computer system code library to assign the diagnostic code. In such instances, the employee types in the diagnosis and chooses something that "looks good" from the list of offered codes. Other times, an employee may "google" the diagnosis and use a corresponding code. Often, the person tasked with assigning diagnostic codes has a minimal understanding of the coding system, including its directions, rules, guidelines, and notes that ensure the most accurate description of the diagnosis for a resident receiving care. For many SNFs, as long as the diagnosis code is accepted by the system, it is considered sufficient. Frequently, those tasked with coding responsibilities in SNFs do not look for codes

that are related nor do they utilize a second code to complete the full identification of what is going on with the patient as required by coding guidelines. For example, Alzheimer's requires two codes—many facilities will use the "G code" for Alzheimer's but the "F code" to identify dementia will be missing. Directions for additional codes are also usually not addressed as they are not part of the library referral system. This leaves open for question the accuracy and reliability of the diagnostic data gathered through the use of item I8000 on the MDS 3.0.

Our members are also concerned that the ANPRM presumes that the diagnoses and codes coming from the transferring acute care facility are in their final stage at the time of discharge from the hospital and have been communicated to the SNF. More frequently, it is the case that hospital coding staff assign the final diagnostic code(s) after a patient is discharged from the acute care facility, sometimes several days after the resident's discharge. As a result, skilled nursing facilities often receive data from the hospital at the time of discharge before the medical record is coded for reimbursement purposes and the data usually reflects the reason for admission to the hospital, not necessarily information concerning the final diagnoses. Consequently, the final diagnostic codes utilized by the hospital for the billing process and/or DRG assignment are frequently not available for SNF reference.

Our members also note that it is not always the case that the codes used at an acute care facility are the correct codes that are to be used at the SNF. For example, an acute cerebrovascular (CVA) would have a code number that starts with I63. The same condition when admitted to the SNF would be coded to a sequela of a CVA which would be coded to category I69.3. **For that reason, while it may be outside of the scope of this ANPRM, AHIMA recommends that in such instances where a trained coding professional is not employed, a certified Registered Health Information Administrator (RHIA) or Registered Health Information Technician (RHIT) professional be retained as a consultant to conduct training and/or coding audits.** This could help ensure the accuracy, reliability, and timeliness of the diagnostic data gathered through the ICD-10-CM coding system and supports a resident's ability to receive proper treatment and reimbursement.

Use of First Line in Item I8000 to Report the ICD-10-CM Code

Many conditions treated in SNF facilities use "aftercare codes." **For that reason, our members recommend that the RCS-I model allow two diagnoses slots to be recognized for use as the primary diagnosis at I8000 on the MDS.** Should a second code be unnecessary to explain the condition for which the patient is admitted to the SNF, the instructions could direct SNFs to not use the second line. For example, a post-operative right total hip replacement requires two codes to accurately code this condition:

Z47.1 Aftercare following joint replacement, and
Z96.641 to identify the right hip

Other conditions such as a stroke sequela may also have multiple late effects of sequela that meet the criteria of the primary diagnosis, such as hemiparesis, dysphagia, aphasia. These three conditions could meet the criteria of the primary diagnosis, but under a scenario where the RCS-I model allows two diagnoses slots, an assessment coordinator could select the two that might reflect the need for different therapy disciplines that might become involved with treatment (which identifies the acuity of the patient). Instructions could be added to the RAI Users Manual to use two lines, if necessary, to fully describe the primary diagnosis, or if two conditions would equally meet the definition of the primary diagnosis. If one line is needed to describe the primary diagnosis such as N30.9 for a UTI, instructions could state “leave the second line blank.”

Conditions and Extensive Services to be Used for Non-Therapy Ancillary (NTA) Classification

AHIMA seeks clarification on the following conditions and extensive services as there could be some confusion in how these conditions and services are defined. Additionally, it is important to note, there is a difference, from a coding standpoint, between a "status" diagnosis and an "aftercare" diagnosis.

For example, Z94.0: Kidney Transplant Status is defined as an individual who has had a kidney transplant in the remote past for which no particular attention or treatment is being given or required. In contrast, Z48.22: Aftercare following kidney transplant indicates that the individual just had (or recently received) a kidney transplant at the hospital and there is a need for “aftercare” or treatment or attention to this patient due to the recent kidney transplant. Our members suggest that the term “kidney transplant status” be changed to “aftercare following kidney transplant.”

Our members also suggest that “Major Organ Transplant Status” be changed to “Aftercare following a Major Organ Transplant” to cover all major organ transplant aftercare, including the kidney, heart, liver, lung, bone marrow, heart and lung, and multiple organ transplants. Each of these has a specific code number in the Z48.2 category.

Our members also recommend that the specific organ transplant not be listed. Rather, the condition “Transplant” should be changed to “Encounter for Aftercare” which would include kidney transplant coded to category Z48.2 and also include heart, liver, lung, bone marrow, heart and lung, multiple organ transplant, or other organ transplant.

AHIMA members also suggest “Major Organ Transplant Status” be changed to “Major Organ Transplant Aftercare” and should include all post-operative major organ transplants, including kidney transplants. “Transplant” should also be changed to “Organ Transplant Status.”

5 Day SNF PPS Scheduled Assessment to Classify a Resident under the RCS-I Model

AHIMA supports CMS' proposal to decrease the number of assessments that must be completed during a given resident's stay in a SNF under the RCS-I model. Under the current SNF PPS system, the time and effort required to continuously track the number of days for a specific assessment and the RUG category for therapy is increasingly administratively burdensome and as a result, does not focus on quality of service or the increasing or decreasing assessment and treatment needs of the resident. By decreasing the number of assessments required to be completed during the benefit period as well the elimination of the need to track the days and minutes of therapy, the assessment coordinator will be able to focus on the accuracy of the information and clinical support needs rather than the completion of a required number of assessments.

Potential Impact of Implementing RCS-I on Medicaid Criteria

As you know, many states have converted to the RUG-IV model for calculating their payments for Medicaid services. Although there may be a concern regarding a negative impact on the Medicaid beneficiaries, our members' experiences in this field suggest that states utilize a different method for calculating the payment even though they use the RUG classification system to categorize the residents' levels of need and/or care. In addition, as CMS notes in the ANPRM, the RCS-I model would help eliminate therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS. Our members also find that few residents in SNF facilities are receiving therapy services under the Medicaid program in the first place. Additionally, many state Medicaid programs are converting to a managed care model which may or may not utilize a case mix classification system for payment calculations. Instead, many of the managed care programs use capitation payment arrangements for Medicaid calculations. Consequently, our members foresee limited impact on the provision of Medicaid services with a transition to the RCS-I model.

We thank you for the opportunity to submit comments on the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology ANPRM. We hope that CMS will continue to engage extensively with stakeholders on the ANPRM and we look forward to working with CMS to ensuring successful revision of certain aspects of the SNF PPS. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Senior Director, Federal Relations, at lauren.riplinger@ahima.org or at (202) 839-1218.

Sincerely,



Pamela L. Lane, MS, RHIA
Interim Chief Executive Officer